NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2012 to December 31, 2012

SCHEDULE OMH-1
UNITS OF SERVICE
BY PROGRAM/SITE

AGENCY NAME:_____

AGENCY CODE:_____

Line No.	COLUMN NUMBER																	
	PROGRAM CODE (PROGRAM CODE INDEX)		( )			( )			( )			( )			( )		
	PROGRAM TYPE																	
	PROG/SITE ID. #																	
	TYPE OF SERVICE (PROGRAM CODE)	WEIGHT FACTOR	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS
	Partial Hospitalization (2200)																
1	Regular	N/A															
2	Collateral	N/A															
3	Group Collateral	N/A															
4	Crisis	N/A															
	Intensive Psychiatric Rehab. (2320)																
5	Regular	N/A															
	Clinic Treatment (2100)																
6	Service Days	1.00															
	Continuing Day Treatment (1310)																
7	Half Day	0.50															
8	Full Day	1.00															
	PROS (6340) (7340) (8340)																
9	PROS Units	1.00															
	Day Treatment (0200)																
	Sheltered Workshop (0340)																
	On Site Rehabilitation (0320)																
10	Brief Day	0.33															
11	Half Day	0.50															
12	Full Day	1.00															
13	Collateral	0.33															
14	All Other	1.00															
15	Residential (Patient Days)	1.00															
16	Total																

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2012 to December 31, 2012

SCHEDULE OMH-2

MEDICAID
UNITS OF SERVICE
BY PROGRAM/SITE

AGENCY NAME:_____
AGENCY CODE:_____

Line No.	COLUMN NUMBER																	
	PROGRAM CODE (PROGRAM CODE INDEX)		( )			( )			( )			( )			( )		
	PROGRAM TYPE																	
	PROG/SITE ID. #																	
			MEDICAID			MEDICAID			MEDICAID			MEDICAID			MEDICAID		
	TYPE OF SERVICE (PROGRAM CODE)	WEIGHT FACTOR	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS
	Partial Hospitalization (2200)																
1	Regular	N/A															
2	Collateral	N/A															
3	Group Collateral	N/A															
4	Crisis	N/A															
	Intensive Psychiatric Rehab. (2320)																
5	Regular	N/A															
	Clinic Treatment (2100)																
6	Service Days	1.00															
	Continuing Day Treatment (1310)																
7	Half Day	0.50															
8	Full Day	1.00															
	PROS (6340) (7340) (8340)																
9	PROS Units	1.00															
	Day Treatment (0200)																
10	Brief Day	0.33															
11	Half Day	0.50															
12	Full Day	1.00															
13	Collateral	0.33															
14	All Other	1.00															
15	Residential (Patient Days)	1.00															
16	Total																

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2012 to December 31, 2012

SCHEDULE OMH-3
CLIENT
INFORMATION

AGENCY NAME:_____
AGENCY CODE:_____

Line No.						
	COLUMN NUMBER					
	PROGRAM CODE (PROGRAM CODE INDEX)	( )	( )	( )	( )	( )
	PROGRAM TYPE					
	PROG/SITE ID. #					
	PERSONS SERVED DURING THE YEAR					
1	Persons on Rolls, Beginning of Year					
2	New Persons added to Rolls					
3	Persons Removed from Rolls					
4	Persons on Rolls, End of Year					

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2012 to December 31, 2012

SCHEDULE OMH-4
UNITS OF SERVICE
BY PAYOR
BY PROGRAM/SITE

AGENCY NAME:_____
AGENCY CODE:_____

Line No.			
	PROGRAM CODE (PROGRAM CODE INDEX)	( )	
	PROGRAM TYPE		
	PROG/SITE ID. #		
		TOTAL VISITS	REVENUE EARNED BY PAYOR
	Payors:		
1	Medicare Only		
2	Medicaid Fee-for-Service Only		
3	Medicaid Managed Care		
4	Medicaid and Medicare		
5	Medicaid Managed Care and Medicare		
6	Medicaid and Other Private Insurance		
7	Medicaid Managed Care and Other Private Insurance		
8	Child Health Plus or Family Health Plus		
9	Other Private Insurance		
10	Participant Fees- Co-pays and Deductibles		
	Uncompensated Care:		
11	Participant Fees- Not Including Co-pays		
12	Third Party - Not Paid - Non-Covered Services		
13	Third Party - Not Paid - Non-Eligible Licensed Staff		
14	Third Party - Not Paid - Non-Eligible Out of Network		
15	Total Visits (Sum of Lines 1-14)		
16	Visits Eligible for Uncompensated Care Reimbursement (Sum Lines 11-14)		
17	Uncompensated Care Visits (Line 16) as Percent of Total Visits (Line 15)		