

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2010 to June 30, 2011*

**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 |     |
|          | <b>Partial Hospitalization (2200)</b>      |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
| 1        | Regular                                    | N/A           |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
| 2        | Collateral                                 | N/A           |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
| 3        | Group Collateral                           | N/A           |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
| 4        | Crisis                                     | N/A           |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
|          | <b>Intensive Psychiatric Rehab. (2320)</b> |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
| 5        | Regular                                    | N/A           |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
|          | <b>Clinic Treatment (2100)</b>             |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
| 6        | Service Days                               | 1.00          |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
|          | <b>Continuing Day Treatment (1310)</b>     |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
| 7        | Half Day                                   | 0.50          |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
| 8        | Full Day                                   | 1.00          |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
|          | <b>PROS (6340) (7340) (8340)</b>           |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
| 9        | PROS Units                                 | 1.00          |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
|          | <b>Day Treatment (0200)</b>                |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
|          | <b>Sheltered Workshop (0340)</b>           |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
|          | <b>On Site Rehabilitation (0320)</b>       |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |     |
| 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: July 1, 2010 to June 30, 2011*

SCHEDULE OMH-2

MEDICAID  
UNITS OF SERVICE  
BY PROGRAM/SITE

Page \_\_\_\_\_

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 |
|          | <b>Partial Hospitalization (2200)</b>      |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
| 1        | Regular                                    | N/A           |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
| 2        | Collateral                                 | N/A           |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
| 3        | Group Collateral                           | N/A           |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
| 4        | Crisis                                     | N/A           |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
|          | <b>Intensive Psychiatric Rehab. (2320)</b> |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
| 5        | Regular                                    | N/A           |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
|          | <b>Clinic Treatment (2100)</b>             |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
| 6        | Service Days                               | 1.00          |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
|          | <b>Continuing Day Treatment (1310)</b>     |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
| 7        | Half Day                                   | 0.50          |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
| 8        | Full Day                                   | 1.00          |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
|          | <b>PROS (6340) (7340) (8340)</b>           |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
| 9        | PROS Units                                 | 1.00          |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
|          | <b>Day Treatment (0200)</b>                |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |              |                 |               |
| 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**  
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**SCHEDULE OMH-3**  
**CLIENT**  
**INFORMATION**

Page \_\_\_\_\_

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

Page \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_  
 AGENCY CODE: \_\_\_\_\_

| Line No. | PROGRAM CODE (PROGRAM CODE INDEX)<br>PROGRAM TYPE<br>PROG/SITE ID. #     | ( ) | TOTAL VISITS | REVENUE EARNED BY PAYOR |
|----------|--|-----|--------------|-------------------------|
|          | <b>Payors:</b>   |     |              |                         |
| 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                                |     |              |                         |
|          | <b>Uncompensated Care:</b>   |     |              |                         |
| 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) |     |              |                         |