# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: July 1, 2014 to June 30, 2015*

**SCHEDULE OMH-1**
**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. # | | | | | | | | | | | | | | | | |
| | 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) | | | | | | | | | | | | | | | | |
| | On Site Rehabilitation (0320) | | | | | | | | | | | | | | | | |
| 10 | Brief Day | 0.33 | | | | | | | | | | | | | | | |
| 11 | Half Day & Pre-Admission Half Day Visits | 0.50 | | | | | | | | | | | | | | | |
| 12 | Full Day & Pre-Admission Full Day Visits | 1.00 | | | | | | | | | | | | | | | |
| 13 | Collateral, Home & Crisis Visits | 0.33 | | | | | | | | | | | | | | | |
| | Other/Residential/Total | | | | | | | | | | | | | | | | |
| 14 | All Other | 1.00 | | | | | | | | | | | | | | | |
| 15 | Residential (Patient Days) | 1.00 | | | | | | | | | | | | | | | |
| 16 | Total | | | | | | | | | | | | | | | | |

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: July 1, 2014 to June 30, 2015*

**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 |
| | 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 & Pre-Admission Half Day Visits | 0.50 | | | | | | | | | | | | | | | |
| 12 | Full Day & Pre-Admission Full Day Visits | 1.00 | | | | | | | | | | | | | | | |
| 13 | Collateral, Home Visit & Crisis Visits | 0.33 | | | | | | | | | | | | | | | |
| | Other/Residential/Total | | | | | | | | | | | | | | | | |
| 14 | All Other | 1.00 | | | | | | | | | | | | | | | |
| 15 | Residential (Patient Days) | 1.00 | | | | | | | | | | | | | | | |
| 16 | Total | | | | | | | | | | | | | | | | |

# NEW YORK STATE
CONSOLIDATED FISCAL REPORT
*For the Period: July 1, 2014 to June 30, 2015*

**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
*For the Period: July 1, 2014 to June 30, 2015*

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

Page _____

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) | | |