

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: January 1, 2015 to December 31, 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																