NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2014 to December 31, 2014

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

Page _____

AGENCY NAME:____

AGENCY CODE:____

Line No.		
Line	PROGRAM CODE (PROGRAM CODE INDEX)	( )
No.	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)		