

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2016 to December 31, 2016

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) | | | |

