NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2016 to June 30, 2017

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

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)**		