

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: January 1, 2020 to December 31, 2020*

**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. #	( )	
		<b>TOTAL VISITS</b>	<b>REVENUE EARNED BY PAYOR</b>
	<b>Payors:</b>		
1	Medicare Only		
2	Medicaid Fee-for-Service Only		
3	Medicaid Managed Care		
4	Medicaid Fee-for-Service and Medicare		
5	Medicaid Managed Care and Medicare		
6	Medicaid Fee-for-Service 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		
	<b>Safety Net:</b>		
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 1-9, 11, 12, 13 and 14)		
16	Visits Eligible for Safety Net Reimbursement (Sum Lines 11-14)		
17	Safety Net Visits (Line 16) as Percent of Total Visits (Line 15)		