

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period January 1, 2009 to December 31, 2009

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
1	Totals From OMH-1			
Payors:				
2	Medicaid			
3	Medicaid Managed Care			
4	Child and Family Health Plus			
5	Medicare			
6	Other Private Insurance			
7	Participant Fees- Copays and Deductibles			
Uncompensated Care:				
8	Participant Fees- Not Including Copays			
9	Third Party - Non-Covered Services			
10	Third Party - Non-Eligible Licensed Staff			
11	Third Party- Non-Eligible Out of Network			
12	Total Visits (Sum of Lines 2-11)*			
13	Visits Eligible for Uncompensated Care Reimbursement (Sum Lines 8-11)			
14	Uncompensated Care Visits (Line 13) as Percent of Total Visits (Line 12)			

* Line 12 Visits should equal Line 1 Visits.

OMH-4
 Rev. October 2009