

**Uniform Medicaid and Uninsured Uncompensated Care Cost and Charge Report (UCCR)**

Hospital:	
Medicare Provider Number:	
Reporting Period From:	
Reporting Period To:	
UCCR Version:	

Contact Information

Contact Person for this report:	
Contact Title:	
Contact Email:	
Contact Phone Number:	

Filing Date:	
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Is the amount of the HSN assessment included as a cost in the CMS-2552 used to complete this report?


If yes, please report the amount here:

<b>SCHEDULE A: MASSHEALTH FEE-FOR-SERVICE (FFS) COSTS</b>											
										FILING DATE: 1/0/1900	
										UCCR Version (Interim/Final): 0	
<b>COMPUTATION OF MASSHEALTH FEE-FOR-SERVICE COSTS</b>											
										PROVIDER NAME: 0	
										PROVIDER NUMBER: 0	
										REPORTING PERIOD: FROM: 1/0/1900	
										TO: 1/0/1900	
Ln No.	COST CENTER DESCRIPTION	COSTS INCLUDING INTERNS & RESIDENTS (FROM 2552 WKSHT B PART I COL 24)	OBSERVATION COST RECLASS (LINE 30 TO LINE 92) AND POST STEPDOWN COSTS (FROM WKSHT B-2 COL 4 LINES 54, 60, 89 & 90)	TOTAL COSTS (COL 1 + COL 2)	CHARGES (FROM 2552 WKSHT C PART I COL 8)	HOSPITAL COST TO CHARGE RATIOS (COL 3 / COL 4)	MASSHEALTH FFS INPATIENT CHARGES	MASSHEALTH FFS I/P COSTS (COL 5 x COL 6 except lines 30-46)	MASSHEALTH FFS OUTPATIENT CHARGES	MASSHEALTH FFS O/P COSTS (COL 5 x COL 8)	TOTAL MASSHEALTH FFS I/P AND O/P COSTS (COL 7 + COL 9)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>											
30	Adults and Pediatrics (General Routine Care)			0		0.000		0		0	0
31	Intensive Care Unit			0		0.000		0		0	0
32	Coronary Care Unit			0		0.000		0		0	0
33	Burn Intensive Care Unit			0		0.000		0		0	0
34	Surgical Intensive Care Unit			0		0.000		0		0	0
35	Other Special Care (specify)			0		0.000		0		0	0
40	Subprovider IPF			0		0.000		0		0	0
41	Subprovider IRF			0		0.000		0		0	0
42	Subprovider (specify)			0		0.000		0		0	0
43	Nursery			0		0.000		0		0	0
44	Skilled Nursing Facility			0		0.000		0		0	0
45	Nursing Facility			0		0.000		0		0	0
46	Other Long Term Care			0		0.000		0		0	0
<b>ANCILLARY SERVICE COST CENTERS</b>											
50	Operating Room			0		0.000		0		0	0
51	Recovery Room			0		0.000		0		0	0
52	Labor Room and Delivery Room			0		0.000		0		0	0
53	Anesthesiology			0		0.000		0		0	0
54	Radiology-Diagnostic			0		0.000		0		0	0
55	Radiology-Therapeutic			0		0.000		0		0	0
56	Radioisotope			0		0.000		0		0	0
57	Computed Tomography (CT) Scan			0		0.000		0		0	0
58	Magnetic Resonance Imaging (MRI)			0		0.000		0		0	0
59	Cardiac Catheterization			0		0.000		0		0	0
60	Laboratory			0		0.000		0		0	0
61	PBP Clinical Laboratory Services-Program Only			0		0.000		0		0	0
62	Whole Blood & Packed Red Blood Cells			0		0.000		0		0	0
63	Blood Storing, Processing, & Trans.			0		0.000		0		0	0
64	Intravenous Therapy			0		0.000		0		0	0
65	Respiratory Therapy			0		0.000		0		0	0
66	Physical Therapy			0		0.000		0		0	0
67	Occupational Therapy			0		0.000		0		0	0
68	Speech Pathology			0		0.000		0		0	0
69	Electrocardiology			0		0.000		0		0	0
70	Electroencephalography			0		0.000		0		0	0
71	Medical Supplies Charged to Patients			0		0.000		0		0	0
72	Implantable Devices Charged to Patients			0		0.000		0		0	0
73	Drugs Charged to Patients			0		0.000		0		0	0
74	Renal Dialysis			0		0.000		0		0	0
75	ASC (Non-Distinct Part)			0		0.000		0		0	0
76	Other Ancillary (specify)			0		0.000		0		0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>											
88	Rural Health Clinic			0		0.000		0		0	0



SCHEDULE B: ROUTINE COST CENTER PER DIEMS											FILING DATE:	1/0/1900		
COMPUTATION OF ROUTINE COST CENTER PER DIEMS											UCCR Version (Interim/Final):		0	
											PROVIDER NAME:	0		
											PROVIDER NUMBER:	0	FROM:	1/0/1900
													TO:	1/0/1900
Ln No.	COST CENTER DESCRIPTION	TOTAL COSTS (COL 3 OF SCHEDULE A)	TOTAL PATIENT DAYS (WS 5 -3 PART 1 COL 8)	PER DIEM (COL 1 / COL 2)	FFS PATIENT DAYS	FFS INPATIENT COSTS (COL 3 x COL 4)	MMCO PATIENT DAYS	MMCO INPATIENT COSTS (COL 3 x COL 6)	HSN & UNINSURED CARE PATIENT DAYS	HSN & UNINSURED CARE INPATIENT COSTS (COL 3 x COL 8)	DUAL-ELIGIBLE PATIENT DAYS	DUAL-ELIGIBLE INPATIENT COSTS (COL 3 x COL 10)		
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>														
30	Adults and Pediatrics (General Routine Care)	0		0.00		0		0		0		0		
31	Intensive Care Unit	0		0.00		0		0		0		0		
32	Coronary Care Unit	0		0.00		0		0		0		0		
33	Burn Intensive Care Unit	0		0.00		0		0		0		0		
34	Surgical Intensive Care Unit	0		0.00		0		0		0		0		
35	Other Special Care (specify)	0		0.00		0		0		0		0		
40	Subprovider IPF	0		0.00		0		0		0		0		
41	Subprovider IRF	0		0.00		0		0		0		0		
42	Subprovider (specify)	0		0.00		0		0		0		0		
43	Nursery	0		0.00		0		0		0		0		
44	Skilled Nursing Facility	0		0.00		0		0		0		0		
45	Nursing Facility	0		0.00		0		0		0		0		
46	Other Long Term Care	0		0.00		0		0		0		0		
<b>TOTAL PATIENT DAYS</b>			0		0		0		0		0			

<b>SCHEDULE C: MEDICAID MCO (MMCO), HSN &amp; UNINSURED &amp; DUAL-ELIGIBLE COSTS</b>												
<b>COMPUTATION OF MASSACHUSETTS MEDICAID MCO AND LOW INCOME UNCOMPENSATED CARE COSTS</b>												
Ln No.	COST CENTER DESCRIPTION	HOSPITAL COST TO CHARGE RATIOS (SCH A COL 5) (1)	MASS. MMCO INPATIENT CHARGES (2)	MASS. MMCO INPATIENT COSTS (COL 1 x COL 2 except lines 30 - 46) (3)	MASS. MMCO OUTPATIENT CHARGES (4)	MASS. MMCO OUTPATIENT COSTS (COL 1 x COL 4) (5)	TOTAL MASS. MMCO I/P AND O/P COSTS (COL 3 + COL 5) (6)	HSN & UNINSURED CARE INPATIENT CHARGES (7)	HSN & UNINSURED INPATIENT COSTS (COL 1 x COL 7 except lines 30 - 46) (8)	HSN & UNINSURED CARE OUTPATIENT CHARGES (9)	HSN & UNINSURED CARE OUTPATIENT COSTS (COL 1 x COL 9) (10)	TOTAL HSN & UNINSURED CARE COSTS (COL 8 + COL 10) (11)
30	Adults and Pediatrics (General Routine Care)	0.000		0		0	0		0		0	0
31	Intensive Care Unit	0.000		0		0	0		0		0	0
32	Coronary Care Unit	0.000		0		0	0		0		0	0
33	Burn Intensive Care Unit	0.000		0		0	0		0		0	0
34	Surgical Intensive Care Unit	0.000		0		0	0		0		0	0
35	Other Special Care (specify)	0.000		0		0	0		0		0	0
40	Subprovider IPF	0.000		0		0	0		0		0	0
41	Subprovider IRF	0.000		0		0	0		0		0	0
42	Subprovider (specify)	0.000		0		0	0		0		0	0
43	Nursery	0.000		0		0	0		0		0	0
44	Skilled Nursing Facility	0.000		0		0	0		0		0	0
45	Nursing Facility	0.000		0		0	0		0		0	0
46	Other Long Term Care	0.000		0		0	0		0		0	0
<b>ANCILLARY SERVICE COST CENTERS</b>												
50	Operating Room	0.000		0		0	0		0		0	0
51	Recovery Room	0.000		0		0	0		0		0	0
52	Labor Room and Delivery Room	0.000		0		0	0		0		0	0
53	Anesthesiology	0.000		0		0	0		0		0	0
54	Radiology-Diagnostic	0.000		0		0	0		0		0	0
55	Radiology-Therapeutic	0.000		0		0	0		0		0	0
56	Radioisotope	0.000		0		0	0		0		0	0
57	Computed Tomography (CT) Scan	0.000		0		0	0		0		0	0
58	Magnetic Resonance Imaging (MRI)	0.000		0		0	0		0		0	0
59	Cardiac Catheterization	0.000		0		0	0		0		0	0
60	Laboratory	0.000		0		0	0		0		0	0
61	PBP Clinical Laboratory Services-Program Only	0.000		0		0	0		0		0	0
62	Whole Blood & Packed Red Blood Cells	0.000		0		0	0		0		0	0
63	Blood Storing, Processing, & Trans.	0.000		0		0	0		0		0	0
64	Intravenous Therapy	0.000		0		0	0		0		0	0
65	Respiratory Therapy	0.000		0		0	0		0		0	0
66	Physical Therapy	0.000		0		0	0		0		0	0
67	Occupational Therapy	0.000		0		0	0		0		0	0
68	Speech Pathology	0.000		0		0	0		0		0	0
69	Electrocardiology	0.000		0		0	0		0		0	0
70	Electroencephalography	0.000		0		0	0		0		0	0
71	Medical Supplies Charged to Patients	0.000		0		0	0		0		0	0
72	Implantable Devices Charged to Patients	0.000		0		0	0		0		0	0
73	Drugs Charged to Patients	0.000		0		0	0		0		0	0
74	Renal Dialysis	0.000		0		0	0		0		0	0
75	ASC (Non-Distinct Part)	0.000		0		0	0		0		0	0
76	Other Ancillary (specify)	0.000		0		0	0		0		0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>												
88	Rural Health Clinic	0.000		0		0	0		0		0	0
89	Federally Qualified Health Center	0.000		0		0	0		0		0	0
90	Clinic	0.000		0		0	0		0		0	0
91	Emergency	0.000		0		0	0		0		0	0
92	Observation Beds	0.000		0		0	0		0		0	0



<b>SCHEDULE C: MEDICAID MCO (MMCO),</b>				<b>FILING DATE: 1/0/1900</b>		
		<b>UCCR Version (Interim/Final):</b>		<b>0</b>		
<b>COMPUTATION OF MASSACHUSETTS MEDICAID M</b>		<b>PROVIDER NAME:</b>		<b>0</b>		
		<b>PROVIDER NUMBER:</b>		<b>FROM: 1/0/1900</b>		
				<b>TO: 1/0/1900</b>		
Ln No.	<b>COST CENTER DESCRIPTION</b>	DUAL ELIGIBLE INPATIENT CHARGES  (12)	DUAL ELIGIBLE INPATIENT COSTS (COL 1 x COL 12 except lines 30 - 46)  (13)	DUAL ELIGIBLE OUTPATIENT CHARGES  (14)	DUAL ELIGIBLE OUTPATIENT COSTS (COL 1 x COL 14)  (15)	TOTAL DUAL ELIGIBLE COSTS (COL 13 + COL 15)  (16)
30	Adults and Pediatrics (General Routine Care)		0		0	0
31	Intensive Care Unit		0		0	0
32	Coronary Care Unit		0		0	0
33	Burn Intensive Care Unit		0		0	0
34	Surgical Intensive Care Unit		0		0	0
35	Other Special Care (specify)		0		0	0
40	Subprovider IPF		0		0	0
41	Subprovider IRF		0		0	0
42	Subprovider (specify)		0		0	0
43	Nursery		0		0	0
44	Skilled Nursing Facility		0		0	0
45	Nursing Facility		0		0	0
46	Other Long Term Care		0		0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room		0		0	0
51	Recovery Room		0		0	0
52	Labor Room and Delivery Room		0		0	0
53	Anesthesiology		0		0	0
54	Radiology-Diagnostic		0		0	0
55	Radiology-Therapeutic		0		0	0
56	Radioisotope		0		0	0
57	Computed Tomography (CT) Scan		0		0	0
58	Magnetic Resonance Imaging (MRI)		0		0	0
59	Cardiac Catheterization		0		0	0
60	Laboratory		0		0	0
61	PBP Clinical Laboratory Services-Program Only		0		0	0
62	Whole Blood & Packed Red Blood Cells		0		0	0
63	Blood Storing, Processing, & Trans.		0		0	0
64	Intravenous Therapy		0		0	0
65	Respiratory Therapy		0		0	0
66	Physical Therapy		0		0	0
67	Occupational Therapy		0		0	0
68	Speech Pathology		0		0	0
69	Electrocardiology		0		0	0
70	Electroencephalography		0		0	0
71	Medical Supplies Charged to Patients		0		0	0
72	Implantable Devices Charged to Patients		0		0	0
73	Drugs Charged to Patients		0		0	0
74	Renal Dialysis		0		0	0
75	ASC (Non-Distinct Part)		0		0	0
76	Other Ancillary (specify)		0		0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	Rural Health Clinic		0		0	0
89	Federally Qualified Health Center		0		0	0
90	Clinic		0		0	0
91	Emergency		0		0	0
92	Observation Beds		0		0	0

<b>SCHEDULE C: MEDICAID MCO (MMCO),</b>		<b>FILING DATE: 1/0/1900</b>				
		<b>UCCR Version (Interim/Final):</b>		<b>0</b>		
<b>COMPUTATION OF MASSACHUSETTS MEDICAID M</b>		<b>PROVIDER NAME:</b>		<b>0</b>		
		<b>PROVIDER NUMBER:</b>		<b>FROM: 1/0/1900</b>		
				<b>TO: 1/0/1900</b>		
Ln No.	<b>COST CENTER DESCRIPTION</b>	DUAL ELIGIBLE INPATIENT CHARGES  (12)	DUAL ELIGIBLE INPATIENT COSTS (COL 1 x COL 12 except lines 30 - 46)  (13)	DUAL ELIGIBLE OUTPATIENT CHARGES  (14)	DUAL ELIGIBLE OUTPATIENT COSTS (COL 1 x COL 14)  (15)	TOTAL DUAL ELIGIBLE COSTS (COL 13 + COL 15)  (16)
93	Other Outpatient Service (specify)		0		0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94	Home Program Dialysis		0		0	0
95	Ambulance Services		0		0	0
96	Durable Medical Equipment-Rented		0		0	0
97	Durable Medical Equipment-Sold		0		0	0
98	Other Reimbursable (specify)		0		0	0
99	Outpatient Rehabilitation Provider (specify)		0		0	0
100	Intern-Resident Service (not appvd. tchnq. prgm.)		0		0	0
101	Home Health Agency		0		0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
105	Kidney Acquisition		0		0	0
106	Heart Acquisition		0		0	0
107	Liver Acquisition		0		0	0
108	Lung Acquisition		0		0	0
109	Pancreas Acquisition		0		0	0
110	Intestinal Acquisition		0		0	0
111	Islet Acquisition		0		0	0
112	Other Organ Acquisition (specify)		0		0	0
115	Ambulatory Surgical Center (Distinct Part)		0		0	0
116	Hospice		0		0	0
117	Other Special Purpose (specify)		0		0	0
118	<b>SUBTOTAL (sum of lines 30-117)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop, & Canteen					
191	Research					
192	Physicians' Private Offices					
193	Nonpaid Workers					
194	Other Nonreimbursable (specify)					
200	Cross Foot Adjustments					
201	Negative Cost Centers					

<b>SCHEDULE D: UNCOMPENSATED PHYSICIAN COSTS</b>													
<b>COMPUTATION OF UNCOMPENSATED PHYSICIAN COSTS</b>											<b>UCCR Version (Interim/Final):</b>		
											<b>PROVIDER NAME:</b>		
											<b>PROVIDER NUMBER:</b>	<b>0</b>	
Ln No.	COST CENTER DESCRIPTION	PROFESSIONAL COMPONENT OF PHYSICIAN COSTS (FROM 2552 WKSHT A-8-2 COL 4)	OVERHEAD COSTS RELATED TO PHYSICIAN SERVICES IF NOT INCLUDED IN COL 1 (FROM 2552 WKSHT A-8)	TOTAL PHYSICIAN COSTS (COL 1 + COL 2)	TOTAL PHYSICIAN I/P AND O/P CHARGES	PHYSICIAN COST-TO-CHARGE RATIO (COL 3 / COL 4)	MASSHEALTH FFS I/P AND O/P PHYSICIAN CHARGES	MASSHEALTH FFS I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 6)	MASS. MMCO I/P AND O/P PHYSICIAN CHARGES	MASS. MMCO I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 8)	HSN & UNINSURED I/P AND O/P PHYSICIAN CHARGES	HSN & UNINSURED I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 10)	DUAL ELIGIBLE I/P AND O/P PHYSICIAN CHARGES
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
30	Adults and Pediatrics (General Routine Care)			0		0.000		0		0		0	
31	Intensive Care Unit			0		0.000		0		0		0	
32	Coronary Care Unit			0		0.000		0		0		0	
33	Burn Intensive Care Unit			0		0.000		0		0		0	
34	Surgical Intensive Care Unit			0		0.000		0		0		0	
35	Other Special Care (specify)			0		0.000		0		0		0	
40	Subprovider IPF			0		0.000		0		0		0	
41	Subprovider IRF			0		0.000		0		0		0	
42	Subprovider (specify)			0		0.000		0		0		0	
43	Nursery			0		0.000		0		0		0	
44	Skilled Nursing Facility			0		0.000		0		0		0	
45	Nursing Facility			0		0.000		0		0		0	
46	Other Long Term Care			0		0.000		0		0		0	
<b>ANCILLARY SERVICE COST CENTERS</b>													
50	Operating Room			0		0.000		0		0		0	
51	Recovery Room			0		0.000		0		0		0	
52	Labor Room and Delivery Room			0		0.000		0		0		0	
53	Anesthesiology			0		0.000		0		0		0	
54	Radiology-Diagnostic			0		0.000		0		0		0	
55	Radiology-Therapeutic			0		0.000		0		0		0	
56	Radioisotope			0		0.000		0		0		0	
57	Computed Tomography (CT) Scan			0		0.000		0		0		0	
58	Magnetic Resonance Imaging (MRI)			0		0.000		0		0		0	
59	Cardiac Catheterization			0		0.000		0		0		0	
60	Laboratory			0		0.000		0		0		0	
61	PBP Clinical Laboratory Services-Program Only			0		0.000		0		0		0	
62	Whole Blood & Packed Red Blood Cells			0		0.000		0		0		0	
63	Blood Storing, Processing, & Trans.			0		0.000		0		0		0	
64	Intravenous Therapy			0		0.000		0		0		0	
65	Respiratory Therapy			0		0.000		0		0		0	
66	Physical Therapy			0		0.000		0		0		0	
67	Occupational Therapy			0		0.000		0		0		0	
68	Speech Pathology			0		0.000		0		0		0	
69	Electrocardiology			0		0.000		0		0		0	
70	Electroencephalography			0		0.000		0		0		0	
71	Medical Supplies Charged to Patients			0		0.000		0		0		0	
72	Implantable Devices Charged to Patients			0		0.000		0		0		0	
73	Drugs Charged to Patients			0		0.000		0		0		0	
74	Renal Dialysis			0		0.000		0		0		0	
75	ASC (Non-Distinct Part)			0		0.000		0		0		0	
76	Other Ancillary (specify)			0		0.000		0		0		0	
<b>OUTPATIENT SERVICE COST CENTERS</b>													
88	Rural Health Clinic			0		0.000		0		0		0	
89	Federally Qualified Health Center			0		0.000		0		0		0	
90	Clinic			0		0.000		0		0		0	
91	Emergency			0		0.000		0		0		0	
92	Observation Beds			0		0.000		0		0		0	
93	Other Outpatient Service (specify)			0		0.000		0		0		0	
<b>OTHER REIMBURSABLE COST CENTERS</b>													
94	Home Program Dialysis			0		0.000		0		0		0	
95	Ambulance Services			0		0.000		0		0		0	
96	Durable Medical Equipment-Rented			0		0.000		0		0		0	



<b>SCHEDULE D: UNCOMPENSATED PHYSICIAN</b>		<b>FILING DATE:</b>	<b>1/0/1900</b>
		<b>0</b>	
<b>COMPUTATION OF UNCOMPENSATED PHYSICIAN<sup>0</sup></b>			
		<b>FROM:</b>	<b>1/0/1900</b>
		<b>TO:</b>	<b>1/0/1900</b>
<b>Ln No.</b>	<b>COST CENTER DESCRIPTION</b>	<b>DUAL ELIGIBLE I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 12) (13)</b>	<b>TOTAL UCCR PHYSICIAN COSTS (COL 7 + COL 9 + COL 11 + COL 13) (14)</b>
30	Adults and Pediatrics (General Routine Care)	0	0
31	Intensive Care Unit	0	0
32	Coronary Care Unit	0	0
33	Burn Intensive Care Unit	0	0
34	Surgical Intensive Care Unit	0	0
35	Other Special Care (specify)	0	0
40	Subprovider IPF	0	0
41	Subprovider IRF	0	0
42	Subprovider (specify)	0	0
43	Nursery	0	0
44	Skilled Nursing Facility	0	0
45	Nursing Facility	0	0
46	Other Long Term Care	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>			
50	Operating Room	0	0
51	Recovery Room	0	0
52	Labor Room and Delivery Room	0	0
53	Anesthesiology	0	0
54	Radiology-Diagnostic	0	0
55	Radiology-Therapeutic	0	0
56	Radioisotope	0	0
57	Computed Tomography (CT) Scan	0	0
58	Magnetic Resonance Imaging (MRI)	0	0
59	Cardiac Catheterization	0	0
60	Laboratory	0	0
61	PBP Clinical Laboratory Services-Program Only	0	0
62	Whole Blood & Packed Red Blood Cells	0	0
63	Blood Storing, Processing, & Trans.	0	0
64	Intravenous Therapy	0	0
65	Respiratory Therapy	0	0
66	Physical Therapy	0	0
67	Occupational Therapy	0	0
68	Speech Pathology	0	0
69	Electrocardiology	0	0
70	Electroencephalography	0	0
71	Medical Supplies Charged to Patients	0	0
72	Implantable Devices Charged to Patients	0	0
73	Drugs Charged to Patients	0	0
74	Renal Dialysis	0	0
75	ASC (Non-Distinct Part)	0	0
76	Other Ancillary (specify)	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88	Rural Health Clinic	0	0
89	Federally Qualified Health Center	0	0
90	Clinic	0	0
91	Emergency	0	0
92	Observation Beds	0	0
93	Other Outpatient Service (specify)	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>			
94	Home Program Dialysis	0	0
95	Ambulance Services	0	0
96	Durable Medical Equipment-Rented	0	0

<b>SCHEDULE D: UNCOMPENSATED PHYSICIAN</b>		<b>FILING DATE:</b>	<b>1/0/1900</b>
		<b>0</b>	
<b>COMPUTATION OF UNCOMPENSATED PHYSICIAN<sup>0</sup></b>			
		<b>FROM:</b>	<b>1/0/1900</b>
		<b>TO:</b>	<b>1/0/1900</b>
<b>Ln No.</b>	<b>COST CENTER DESCRIPTION</b>	<b>DUAL ELIGIBLE I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 12) (13)</b>	<b>TOTAL UCCR PHYSICIAN COSTS (COL 7 + COL 9 + COL 11 + COL 13) (14)</b>
97	Durable Medical Equipment-Sold	0	0
98	Other Reimbursable (specify)	0	0
99	Outpatient Rehabilitation Provider (specify)	0	0
100	Intern-Resident Service (not appvd. tchng. prgm.)	0	0
101	Home Health Agency	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>			
105	Kidney Acquisition	0	0
106	Heart Acquisition	0	0
107	Liver Acquisition	0	0
108	Lung Acquisition	0	0
109	Pancreas Acquisition	0	0
110	Intestinal Acquisition	0	0
111	Islet Acquisition	0	0
112	Other Organ Acquisition (specify)	0	0
115	Ambulatory Surgical Center (Distinct Part)	0	0
116	Hospice	0	0
117	Other Special Purpose (specify)	0	0
118	<b>SUBTOTAL (sum of lines 30-117)</b>	<b>0</b>	<b>0</b>
<b>NONREIMBURSABLE COST CENTERS</b>			
190	Gift, Flower, Coffee Shop, & Canteen		
191	Research		
192	Physicians' Private Offices		
193	Nonpaid Workers		
194	Other Nonreimbursable (specify)		
200	Cross Foot Adjustments		
201	Negative Cost Centers		

**SCHEDULE E: SAFETY NET HEALTH CARE SYSTEM (SNHCS) EXPENDITURES**

**SUMMARY OF SNHCS EXPENDITURES**

UCCR VERSION (INTERIM/FINAL)	FILING DATE:	1/0/1900
PROVIDER NAME:		0
PROVIDER NUMBER:		0
REPORTING PERIOD:	FROM:	1/0/1900
	TO:	1/0/1900

Ln. No.	SYSTEM FINANCIAL REQUIREMENTS DESCRIPTION	TOTAL SYSTEM EXPENDITURE (1)	MEDICAID-ELIGIBLE / HSN & UNINSURED PAYER MIX PROPORTION (2)	MEDICAID / HSN & UNINSURED SHARE OF SYSTEM EXPENDITURE (COL. 1 x COL. 2) (3)
1				0
2				0
3				0
4				0
5				0
6				0
7				0
8				0
9				0
10				0
11				0
12				0
13				0
14				0
15				0
<b>TOTAL</b>		<b>0</b>		<b>0</b>

Safety Net Care Cost Ratio

#DIV/0!

Ln. No.	SYSTEM FINANCIAL REQUIREMENTS, ADDITIONAL NARRATIVE DESCRIPTION:
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	



<b>Filing Date:</b>	<b>1/0/1900</b>		
<b>UCCR Version</b>	<b>0</b>		
<b>PROVIDER NAME:</b>	<b>0</b>		
<b>PROVIDER NUMBER(S):</b>	<b>0</b>		
<b>REPORTING PERIOD:</b>	<b>FROM:</b>	1/0/1900	
	<b>TO:</b>	1/0/1900	

**Use this space to provide any additional information relevant to this filing:**