Hospital: Medicare Provider Number: Reporting Period To: UCCR Version: Contact Information Contact Preson for this report: Contact Title: Contact Email: Contact Phone Number: Filling Date:

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

Health Safety Net Assessment

	SCHEDULE A: MASSHEALTH FEE-FOR	-SERVICE (F	FS) COSTS						FILING DATE:	1/0/00	
	SCHEDGEE AL PIASSHEALITH LE L'OI	C SERVICE (I	10) 00010					IICCR Vers	sion (Interim/Final):		0
	COMPUTATION OF MASSHEALTH FEE-FOR-SE	DVICE COSTS						OCCK VEIS	non (Internity) mary.		<u> </u>
	COMPUTATION OF MASSHEALTH FEE-FOR-SE	KVICE COSIS					0				
						PROVIDER NUMBER:	0		REPORTING PERIOD:	FROM:	1/0/00
										то:	1/0/00
	COST CENTER DESCRIPTION	(FROM 2552 WKSHT B PART I COL 24)	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)
Ln No.		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
	INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults and Pediatrics (General Routine Care)			0		0.000		0		0	0
	Intensive Care Unit			0		0.000		0		0	0
	Coronary Care Unit			0		0.000		0		0	0
	Burn Intensive Care Unit			0		0.000		0		0	0
	Surgical Intensive Care Unit			0		0.000		0		0	0
	Other Special Care (specify)			0		0.000		0		0	0
	Subprovider IPF			0		0.000		0		0	0
	Subprovider IRF			0		0.000		0		0	0
	Subprovider (specify)			0		0.000		0		0	0
	Nursery			0		0.000		0		0	0
44	Skilled Nursing Facility			0		0.000		0		0	0
	Nursing Facility			0		0.000		0		0	0
46	Other Long Term Care			0		0.000		0		0	0
	ANCILLARY SERVICE COST CENTERS										
50	Operating Room			0		0.000		0		0	0
	Recovery Room			0		0.000		0		0	0
52	Labor Room and Delivery Room			0		0.000		0		0	0
	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
	Radioisotope			0		0.000		0		0	0
	Computed Tomography (CT) Scan			0		0.000		0		0	0
	Magnetic Resonance Imaging (MRI)			0		0.000		0		0	0
	Cardiac Catheterization			0		0.000		0		0	0
	Laboratory			0		0.000		0		0	0
	PBP Clinical Laboratory Services-Program Only			0		0.000		0		0	0
	Whole Blood & Packed Red Blood Cells			0		0.000		0		0	0
	Blood Storing, Processing, & Trans.			0		0.000		0		0	0
	Intravenous Therapy			0		0.000		0		0	0
	Respiratory Therapy			0		0.000		0		0	0
	Physical Therapy			0		0.000		0		0	0
	Occupational Therapy			0		0.000		0		0	0
	Speech Pathology			0		0.000		0		0	0
	Electrocardiology			0		0.000		0		0	0
	Electroencephalography			0		0.000		0		0	0
71	Medical Supplies Charged to Patients			0		0.000		0		0	0
	Implantable Devices Charged to Patients			0		0.000		0		0	
	Drugs Charged to Patients			0		0.000		0		0	0
	Renal Dialysis			0		0.000		0		0	0
	ASC (Non-Distinct Part)			0		0.000		0		0	0
76	Other Ancillary (specify)			0		0.000		0		0	0
	OUTPATIENT SERVICE COST CENTERS				1	1	1	1	1		
	Rural Health Clinic			0		0.000		0		0	0
	Federally Qualified Health Center			0		0.000		0		0	0
	Clinic			0		0.000		0		0	0
	Emergency			0		0.000		0		0	0
92	Observation Beds (see instructions)			0		0.000		0		0	0

	COUEDINE A MACCHEAUTH FEE FOR	CEDVICE (EC) COCTO								
	SCHEDULE A: MASSHEALTH FEE-FOR	K-SEKVICE (I	-FS) COSTS						FILING DATE:	1/0/00	
								UCCR Vers	sion (Interim/Final):		0
	COMPUTATION OF MASSHEALTH FEE-FOR-SE	RVICE COSTS				PROVIDER NAME:	0				
						PROVIDER NUMBER:	0		REPORTING PERIOD:	FROM:	1/0/00
										то:	1/0/00
1 No.	COST CENTER DESCRIPTION	COSTS INCLUDING INTERNS & RESIDENTS (FROM 2552 WKSHT B PART I COL 24)	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 (6)	MASSHEALTH FFS I/P COSTS (COL 5 x COL 6 except lines 30-46) (7)	MASSHEALTH FFS OUTPATIENT CHARGES (8)	MASSHEALTH FFS O/P COSTS (COL 5 x COL 8)	TOTAL MASSHEALTH. I/P AND O/P COST: (COL 7 + COL 9)
	INPATIENT ROUTINE SERVICE COST CENTERS										
93	Other Outpatient Service (specify)			0		0.000		0		0	
	OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis			0		0.000		0		0	
	Ambulance Services			0		0.000		0		0	
96	Durable Medical Equipment-Rented			0		0.000		0		0	
97	Durable Medical Equipment-Sold			0		0.000		0		0	
98	Other Reimbursable (specify)			0		0.000		0		0	
99	Outpatient Rehabilitation Provider (specify)			0		0.000		0		0	
100	Intern-Resident Service (not appvd. tchng. prgm.)			0		0.000		0		0	
101	Home Health Agency			0		0.000		0		0	
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition			0		0.000		0		0	
106	Heart Acquisition			0		0.000		0		0	
107	Liver Acquisition			0		0.000		0		0	
	Lung Acquisition			0		0.000		0		0	
	Pancreas Acquisition			0		0.000		0		0	
	Intestinal Acquisition			0		0.000		0		0	
	Islet Acquisition			0		0.000		0		0	
	Other Organ Acquisition (specify)			0		0.000		0		0	
	Ambulatory Surgical Center (Distinct Part)			0		0.000		0		0	
	Hospice			0		0.000		0		0	
117	Other Special Purpose (specify)			0		0.000		0		0	
118	SUBTOTAL (sum of lines 30-117)	0	0	0	0		0	0	0	0	
	NONREIMBURSABLE COST CENTERS										
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										
											<i>*</i>

	SCHEDULE B: ROUTINE COST CENTER	R PER DIEMS	•							FILING DATE:	1/0/00	
									UCCR Ve	rsion (Interim/Final):	0	
	COMPUTATION OF ROUTINE COST CENTER P	ER DIEMS						PROVIDER NAME:	0			
								PROVIDER NUMBER:	0		FROM:	1/0/00
									ı		то:	1/0/00
	COST CENTER DESCRIPTION	TOTAL COSTS (COL 3 OF SCHEDULE A)	TOTAL PATIENT DAYS (WS S -3 PART I 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-FLIGIBLE INPATIENT COSTS (COL 3 x COL 10)
Ln No.		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
	INPATIENT ROUTINE SERVICE COST CENTERS											
1	Adults and Pediatrics (General Routine Care)	0		0.00		0		0		0		
8	Intensive Care Unit	0		0.00		0		0		0		
9	Coronary Care Unit	0		0.00		0		0		0		
10	Burn Intensive Care Unit	0		0.00		0		0		0		
11	Surgical Intensive Care Unit	0		0.00		0		0		0		
12	Other Special Care (specify)	0		0.00		0		0		0		
13	Nursery	0		0.00		0		0		0		
16	Subprovider IPF	0		0.00		0		0		0		
17	Subprovider IRF	0		0.00		0		0		0		
18	Subprovider (specify)	0		0.00		0		0		0		
19	Skilled Nursing Facility	0		0.00		0		0		0		
20	Nursing Facility	0		0.00		0		0		0		
21	Other Long Term Care	0		0.00		0		0		0		
	TOTAL PATIENT DAYS		0		0		0		0		0	

		1					1	1		T	
	SCHEDULE C: MEDICAID MCO (MMCO), H	CN C LINITAL	CIIDED & DII	N -ELTCIPLE CO	NCTC						
	SCHEDULE C. MEDICAID MCO (MMCO), H.	I W DIATIA	SUKED & DUF	AL-ELIGIBLE CO	1313						
	COMPUTATION OF MASSACHUSETTS MEDICAID MC	O AND LOW I	NCOME LINCOM	DENCATED CARE	COSTS						
	COMPUTATION OF MASSACHUSETTS MEDICALD MC	J AND LOW I	NCOME UNCOM	PENSATED CARE	1						
		1		1							
									HSN & UNINSURED		
				MASS. MMCO INPATIENT COSTS			TOTAL MASS. MMCO I/P AND	HSN & UNINSURED CARE	INPATIENT COSTS (COL 1 x COL 7 except lines 30 -	HSN & UNINSURED CARE	HSN & UNINSURED CARE OUTPATIENT COSTS (COL
		HOSPITAL COST TO	MASS.	(COL 1 x COL 2	MASS. MMCO OUTPATIENT	MASS. MMCO OUTPATIENT	O/P COSTS	INPATIENT CHARGES	46)	OUTPATIENT CHARGES	1 x COL 9)
	COST CENTER DESCRIPTION	CHARGE RATIOS (SCH A COL 5)	MMCO INPATIENT CHARGES	except lines 30 - 46)	CHARGES	COSTS (COL 1 x COL 4)	(COL 3 + COL 5)				
		(SCH A COL 3)									
Ln No.		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
	Adults and Pediatrics (General Routine Care)	0.000		0		0	0		0		0
31	Intensive Care Unit	0.000		0		0	0		0		0
32	Coronary Care Unit	0.000		0		0	0		0		0
33	Burn Intensive Care Unit	0.000		0		0	0		0		0
34	Surgical Intensive Care Unit	0.000		0		0	0		0	-	0
35 40	Other Special Care (specify) Subprovider IPF	0.000		0	1	0	0		0		0
40	Subprovider IPF Subprovider IRF	0.000		0	1	0	0		0		0
41	Subprovider (specify)	0.000		0	<u> </u>	0	0		0		0
43	Nursery	0.000		0		0	0		0		0
44	Skilled Nursing Facility	0.000		0		0	0		0		0
45	Nursing Facility	0.000		0		0	0		0		0
46	Other Long Term Care	0.000		0		0			0		0
	ANCILLARY SERVICE COST CENTERS										
50	Operating Room	0.000		0		0	0		0		0
51	Recovery Room	0.000		0		0	0		0		0
52	Labor Room and Delivery Room	0.000		0		0			0		0
53	Anesthesiology	0.000		0		0	0		0		0
54	Radiology-Diagnostic	0.000		0		0	0		0		0
55	Radiology-Therapeutic	0.000		0		0	0		0		0
56	Radioisotope	0.000		0		0	0		0		0
57	Computed Tomography (CT) Scan	0.000		0		0	0		0	-	0
58 59	Magnetic Resonance Imaging (MRI) Cardiac Catheterization	0.000		0		0	0		0		0
60	Laboratory	0.000		0		0	0		0		0
61	PBP Clinical Laboratory Services-Program Only	0.000		0		0	0		0		0
62	Whole Blood & Packed Red Blood Cells	0.000		0		0	0		0		0
63	Blood Storing, Processing, & Trans.	0.000		0		0	0		0		0
64	Intravenous Therapy	0.000		0		0	0		0		0
65	Respiratory Therapy	0.000		0		0	0		0		0
66	Physical Therapy	0.000		0		0	0		0		0
67	Occupational Therapy	0.000		0	ļ	0	0		0		0
68	Speech Pathology	0.000		0		0	0		0		0
69	Electrocardiology	0.000		0		0	0		0		0
70	Electroencephalography	0.000		0	1	0	0	-	0	1	0
71	Medical Supplies Charged to Patients	0.000		0	-	0	0		0	 	0
72	Implantable Devices Charged to Patients	0.000		0	-	0	0		0	1	0
73 74	Drugs Charged to Patients Renal Dialysis	0.000		0	1	0	0		0		0
75	ASC (Non-Distinct Part)	0.000		0		0	0		0		0
76	Other Ancillary (specify)	0.000		0	1	0			0		0
	OUTPATIENT SERVICE COST CENTERS										
88	Rural Health Clinic	0.000		0		0	0		0		0
89	Federally Qualified Health Center	0.000		0		0	0		0		0
90	Clinic	0.000		0		0	0		0		0
91	Emergency	0.000		0		0	0		0		0
92	Observation Beds	0.000		0		0	0		0		0
93	Other Outpatient Service (specify)	0.000		0		0	0		0		0
	OTHER REIMBURSABLE COST CENTERS										

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-	SCHEDULE C: MEDICAID MCO (MMCO), HS	N & HNTN	SIIDED & DIIA	I -FI TGTRI F CO	OCTC						1
-	SCHEDULE C. MEDICALD MCO (MMCO), III	JIV & OIVIIV	JORED & DOF	IL-LLIGIBLE CO	7515						
	COMPUTATION OF MASSACHUSETTS MEDICAID MCC	ANDIOWI	NCOME LINCOM	DENCATED CARE	COCTC						
-	COMPUTATION OF MASSACHUSETTS MEDICALD MCC	AND LOW I	NCOME UNCOM	PENSATED CARE	10515						+
-											
									HSN & UNINSTRHO		
Ln No.	COST CENTER DESCRIPTION	HOSPITAL COST TO CHARGE RATIOS (SCH A COL 5)	MASS. MMCO INPATIENT CHARGES (2)	MASS. MMCO INPATIENT COSTS (COL 1 x COL 2 except lines 30 - 46)	MASS. MMCO OUTPATIENT CHARGES (4)	MASS. MMCO OUTPATIENT COSTS (COL 1 x COL 4)	TOTAL MASS. MMCO I/P AND O/P COSTS (COL 3 + COL 5)	HSN & UNINSURED CARE INPATIENT CHARGES	INPATIENT COSTS (COL 1 x COL 7 except lines 30 - 46)	HSN & UNINSURED CARE OUT PATIENT CHARGES	HSN & UNINSURED CARE OUTPATIENT COSTS (COL 1 x COL 9)
94	Home Program Dialysis	0.000	``	0		0	0	` ` `	0		0
95	Ambulance Services	0.000		0		0	0		0		0
	Durable Medical Equipment-Rented	0.000		0		0	0		0		0
97	Durable Medical Equipment-Sold	0.000		0		0	0		0		0
98	Other Reimbursable (specify)	0.000		0		0	0		0		0
	Outpatient Rehabilitation Provider (specify)	0.000		0		0	0		0		0
100	Intern-Resident Service (not appvd. tchng. prgm.)	0.000		0		0	0		0		0
	Home Health Agency	0.000		0		0	0		0		0
	SPECIAL PURPOSE COST CENTERS	-		-		-			-		-
105	Kidney Acquisition	0.000		0		0	0		0		0
106	Heart Acquisition	0.000		0		0	0		0		0
107	Liver Acquisition	0.000		0		0	0		0		0
108	Lung Acquisition	0.000		0		0	0		0		0
109	Pancreas Acquisition	0.000		0		0	0		0		0
110	Intestinal Acquisition	0.000		0		0	0		0		0
111	Islet Acquisition	0.000		0		0	0		0		0
112	Other Organ Acquisition (specify)	0.000		0		0	0		0		0
115	Ambulatory Surgical Center (Distinct Part)	0.000		0		0	0		0		0
116	Hospice	0.000		0		0	0		0		0
117	Other Special Purpose (specify)	0.000		0		0	0		0		0
118	SUBTOTAL (sum of lines 30-117)		0	0	0	0	0	0	0	0	0
	NONREIMBURSABLE COST CENTERS										
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										

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	SCHEDULE C: MEDICAID MCO (MMCO), HS					FILING DATE:	1/0/00
	(UCCR	Version (Interim/Final):		0	
	COMPUTATION OF MASSACHUSETTS MEDICAID MCC		PROVIDER NAME:		C)	
			PROVIDER NUMBER:	0		FROM:	1/0/00
						то:	1/0/00
		TOTAL HSN & UNINSURED CARE		DUAL ELIGIBLE INPATIENT COSTS		DUAL ELIGIBLE	TOTAL DUAL ELIGIBLE
		COSTS	DUAL ELIGIBLE	(COL 1 x COL 12 except lines 30 -	DUAL ELIGIBLE	OUTPATIENT COSTS (COL	COSTS
	COST CENTER DESCRIPTION	(COL 8 + COL 10)	INPATIENT CHARGES	46)	OUTPATIENT CHARGES	1 x COL 14)	(COL 13 + COL 15)
Ln No.	ALII. 18 F. (C. 18 II. C.)	(11)	(12)	(13)	(14)	(15)	(16)
30 31	Adults and Pediatrics (General Routine Care) Intensive Care Unit	0		0		0	0
32	Coronary Care Unit	0		0		0	0
33	Burn Intensive Care Unit	0		0		0	0
34	Surgical Intensive Care Unit	0		0		0	0
35	Other Special Care (specify)	0		0		0	0
40	Subprovider IPF	0		0		0	0
41	Subprovider IRF	0		0		0	0
42	Subprovider (specify)	0		0		0	0
43	Nursery	0		0		0	0
44	Skilled Nursing Facility	0		0		0	0
45	Nursing Facility	0		0		0	0
46	Other Long Term Care	0		0		0	0
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	0		0		0	0
51	Recovery Room	0		0		0	0
52	Labor Room and Delivery Room	0		0		0	0
53	Anesthesiology	0		0		0	0
54	Radiology-Diagnostic	0		0		0	0
55	Radiology-Therapeutic	0		0		0	0
56	Radioisotope	0		0		0	0
57	Computed Tomography (CT) Scan	0		0		0	0
58	Magnetic Resonance Imaging (MRI)	0		0		0	0
59	Cardiac Catheterization	0		0		0	0
60	Laboratory	0		0		0	0
61	PBP Clinical Laboratory Services-Program Only	0		0		0	0
62	Whole Blood & Packed Red Blood Cells	0		0		0	0
64	Blood Storing, Processing, & Trans. Intravenous Therapy	0		0		0	0
65	Respiratory Therapy	0		0		0	0
66	Physical Therapy	0		0		0	0
67	Occupational Therapy	0		0		0	0
68	Speech Pathology	0		0		0	0
69	Electrocardiology	0		0		0	0
70	Electroencephalography	0		0		0	0
71	Medical Supplies Charged to Patients	0		0		0	0
72	Implantable Devices Charged to Patients	0		0		0	0
73	Drugs Charged to Patients	0	-	0		0	0
74	Renal Dialysis	0		0		0	0
75	ASC (Non-Distinct Part)	0		0		0	0
76	Other Ancillary (specify)	0		0		0	0
	OUTPATIENT SERVICE COST CENTERS			1	1	1	
88	Rural Health Clinic	0		0		0	0
89	Federally Qualified Health Center	0		0		0	0
90	Clinic	0		0		0	0
91	Emergency	0		0		0	0
92	Observation Beds	0		0		0	0
93	Other Outpatient Service (specify)	0		0		0	0
	OTHER REIMBURSABLE COST CENTERS						

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							<u> </u>
	SCHEDULE C: MEDICAID MCO (MMCO), HS					FILING DATE:	1/0/00
				Version (Interim/Final):		0	
	COMPUTATION OF MASSACHUSETTS MEDICAID MCC		PROVIDER NAME:				
			PROVIDER NUMBER:	0		FROM:	1/0/00
						TO:	1/0/00
	COST CENTER DESCRIPTION	CARE COSTS (COL 8 + COL 10)	DUAL ELIGIBLE INPATIENT CHARGES	INPAT LELGIBLE INPAT LENT COSTS (COL 1 x COL 12 except lines 30 - 46)	DUAL ELIGIBLE OUTPATIENT CHARGES	DUAL ELIGIBLE OUTPATIENT COSTS (COL 1 x COL 14)	TOTAL DUAL ELIGIBLE COSTS (COL 13 + COL 15)
Ln No.		(11)	(12)	(13)	(14)	(15)	(16)
94	Home Program Dialysis	0		0		0	0
95	Ambulance Services	0		0	_	0	0
96	Durable Medical Equipment-Rented	0		0		0	0
97	Durable Medical Equipment-Sold	0		0		0	0
98	Other Reimbursable (specify)	0		0		0	0
99	Outpatient Rehabilitation Provider (specify)	0		0		0	0
100	Intern-Resident Service (not appvd. tchng. prgm.)	0		0		0	0
101	Home Health Agency	0		0		0	0
	SPECIAL PURPOSE COST CENTERS						
105	Kidney Acquisition	0		0		0	0
106	Heart Acquisition	0		0		0	0
107	Liver Acquisition	0		0		0	0
108	Lung Acquisition	0		0		0	0
109	Pancreas Acquisition	0		0		0	0
110	Intestinal Acquisition	0		0		0	0
111	Islet Acquisition	0		0		0	0
112	Other Organ Acquisition (specify)	0		0		0	0
115	Ambulatory Surgical Center (Distinct Part)	0		0		0	0
116	Hospice	0		0		0	0
117	Other Special Purpose (specify)	0		0		0	0
118	SUBTOTAL (sum of lines 30-117)	0	0	0	0	0	0
	NONREIMBURSABLE COST CENTERS						
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						

Company Comp	- 1		I	1		I	I	I	I	1	1	1	
COMPUTATION OF UNCOMPRISED PRYSTEIN COSTS		SCHEDULE D: LINCOMPENSATED PHYSICIA	AN COSTS										
Control Cont		SCHEDULE D. UNCOMPENSATED FITTSTEEL	11 00313										UCCR V
Control Cont		COMPUTATION OF UNCOMPENSATED PHYSICIAN C	OSTS	l								PROVIDER NAME:	
Secretary Case Control Secretary Case Co		COM CIATOR OF CHOOM ENDATED I HISTORIA	1									PROVIDER NUMBER:	
Secretary Case Control Secretary Case Co													
		COST CENTER DESCRIPTION	COMPONENT OF PHYSICIAN COSTS (FROM 2552 WKSHT A-8 2 COL 4)	RELATED TO PHYSICIAN SERVICES IF NOT INCLUDED IN COL 1 (FROM 2552 WKSHT A- 8)	COSTS (COL 1 + COL 2)	AND O/P CHARGES	CHARGE RATIO (COL 3 / COL 4)	AND O/P PHYSICIAN CHARGES	AND O/P PHYSICIAN COSTS (COL 5 x COL 6)	PHYSICIAN CHARGES	PHYSICIAN COSTS (COL 5 x COL 8)	AND O/P PHYSICIAN CHARGES	(COL 5 x COL 10)
Second Care Use	Ln No.		(1)	(2)		(4)		(6)		(8)		(10)	
Scientific Cost 181													0
Description of the Control 0 0.000 0 0 0 0 0 0													
Source S													0
Store (special (see (special))												1	0
Selegorate IF													0
Section Sect	40	Subprovider IPF			0				0		0		0
Secret (Color)					0								0
Section Sect	42	Subprovider (specify)								ļ		ļ	0
A													0
April 12 April 12 April 13 April 14 April 15 April 15										 		 	0
NOLLAW STANCE COST CAPTERS										 		 	0
Description	70				0	l	0.000	l		1			
Solution Solution	50				0		0.000		0	1	0	1	0
Scale None and Delivery Room 0 0.000 0 0 0 0 0 0													0
Selectory Chargostic 0 0.000 0 0 0 0 0 0													0
Selectory The specific Selectory S					0		0.000		0				0
Separate Researce Imaging (PT) Scin Separate Researce Imaging (PT)													0
Strong test Testing (NR)													0
Selbagatic Resource Imaging (REI) 0 0.000 0 0 0 0 0 0 0													0
SO CARDA CATHERITIZED SO SO SO SO SO SO SO S													
Solutions													
Sept Chiral Laboratory Services Program Only 0 0 0 0 0 0 0 0 0													0
Comparison Com													0
6 0 0 0 0 0 0 0 0													0
65 Reprietory Threapy	63	Blood Storing, Processing, & Trans.			0		0.000		0		0		0
66 Physical Therapy													0
C Cocquetoral Therapy													0
Sel Speck Pathology													0
68 Bertroardology										 		-	0
70 Bectroenceptalography										 		 	0
71 Medical Supplies Charged to Patients													0
T2 Implantable Devices Charged to Patients													0
74 Renal Dialysis							0.000		0		0		0
75 ASC (Non-District Part)			_		0		0.000						0
To Other Ancillary (specify)										ļ		ļ	0
OUTPATIENT SERVICE COST CENTERS													0
See Rural Health Clinic					0	L	0.000	L	0	<u> </u>	0	<u> </u>	0
Sep Federally Qualified Health Center	_									1	1		
90 Clinic 0 0 0.000 0 0 0 0 0 0 0 0 0 0 0 0 0 0												-	0
91 Emergency 0 0 0.000 0 0.000 0 0 0 0 0 0 0 0 0 0										<u> </u>		 	0
92 Observation Beds 0 0 0.000 0 0 0 0 0 0 0 0 0 0 0 0 0 0										1			0
93 Other Outpatient Service (specify) 0 0 0.000 0 0 0 0 0 0 0 0 0 0 0 0 0 0										1		1	0
94 Home Program Dialysis 0 0.000 0 0 0 0 95 Ambulance Services 0 0.000 0 0 0 0 96 Durable Medical Equipment-Rented 0 0.000 0 0 0 0 97 Durable Medical Equipment-Sold 0 0.000 0 0 0 0 0 98 Other Reimbursable (specify) 0 0.000 0 0 0 0 0 99 Outpatient Rehabilitation Provider (specify) 0 0.000 0 0 0 0 0 0	93	Other Outpatient Service (specify)											0
95 Ambulance Services 0 0 0.000 0 0 0 0 0 0 0 0 0 0 0 0 0 0													
96 Durable Medical Equipment-Rented 0 0 0.000 0 0 0 0 0 0 0 0 97 Durable Medical Equipment-Sold 0 0.000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0										ļ		ļ	0
97 Durable Medical Equipment-Sold 0 0.000 0 0 0 98 Other Reimbursable (specify) 0 0.000 0 0 0 0 99 Outpatient Rehabilitation Provider (specify) 0 0.000 0 0 0 0													0
98 Other Reimbursable (specify) 0 0.000 0 0 0 0 99 Outpatient Rehabilitation Provider (specify) 0 0.000 0 0 0 0 0										ļ		 	0
99 Outpatiert Rehabilitation Provider (specify) 0 0.000 0 0 0										 		-	0
										 		 	0
					0		0.000		0	 	0		0

1					1	1	1					
	SCHEDULE D: UNCOMPENSATED PHYSICIA	AN COSTS										
												UCCR Ve
	COMPUTATION OF UNCOMPENSATED PHYSICIAN C	OSTS									PROVIDER NAME	
											PROVIDER NUMBER	
	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)
Ln No.		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
101	Home Health Agency			0		0.000		0		0		0
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition			0		0.000		0		0		0
106	Heart Acquisition			0		0.000		0		0		0
107	Liver Acquisition			0		0.000		0		0		0
108	Lung Acquisition			0		0.000		0		0		0
109	Pancreas Acquisition			0		0.000		0		0		0
110	Intestinal Acquisition			0		0.000		0		0		0
111	Islet Acquisition			0		0.000		0		0		0
112	Other Organ Acquisition (specify)			0		0.000		0		0		0
115	Ambulatory Surgical Center (Distinct Part)			0		0.000		0		0		0
	Hospice			0		0.000		0		0		0
117	Other Special Purpose (specify)			0		0.000		0		0		0
	SUBTOTAL (sum of lines 30-117)	0	0	0	0		0	0	0	0	0	0
	NONREIMBURSABLE COST CENTERS											
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	· · · · · · · · · · · · · · · · · · ·	<u> </u>		<u></u>	**************************************	<u></u>	<u> </u>				
				<u> </u>	<u> </u>					<u> </u>	<u> </u>	<u> </u>

	SCHEDULE D: UNCOMPENSATED PHYSICIA	4	FILING DATE:	1/0/00
		rsion (Interim/Final):		0
	COMPUTATION OF UNCOMPENSATED PHYSICIAN O		0	
)	FROM:	1/0/00
			TO:	1/0/00
	COST CENTER DESCRIPTION	DUAL ELIGIBLE I/P AND O/P PHYSICIAN CHARGES	DUAL ELIGIBLE I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 12)	TOTAL UCCR PHYSICIA COSTS (COL 7 + COL 9 + COL 11 + COL 13)
No.		(12)	(13)	(14)
30	Adults and Pediatrics (General Routine Care)		0	
	Intensive Care Unit		0	
	Coronary Care Unit	-	0	
	Burn Intensive Care Unit Surgical Intensive Care Unit		0	
	Other Special Care (specify)		0	
	Subprovider IPF		0	
	Subprovider IRF		0	
	Subprovider (specify)		0	-
43	Nursery		0	
	Skilled Nursing Facility		0	
	Nursing Facility		0	
46	Other Long Term Care ANCILLARY SERVICE COST CENTERS		0	
50	Operating Room		0	
	Recovery Room		0	
	Labor Room and Delivery Room		0	
	Anesthesiology		0	
	Radiology-Diagnostic		0	
	Radiology-Therapeutic		0	
	Radioisotope		0	
	Computed Tomography (CT) Scan		0	
	Magnetic Resonance Imaging (MRI) Cardiac Catheterization		0	
	Laboratory		0	
	PBP Clinical Laboratory Services-Program Only		0	
	Whole Blood & Packed Red Blood Cells		0	
63	Blood Storing, Processing, & Trans.		0	
	Intravenous Therapy		0	
	Respiratory Therapy	-	0	
	Physical Therapy Occupational Therapy		0	
	Speech Pathology		0	
	Bectrocardiology		0	
	Electroencephalography	<u> </u>	0	
71	Medical Supplies Charged to Patients		0	-
	Implantable Devices Charged to Patients		0	
	Drugs Charged to Patients	 	0	
	Renal Dialysis	-	0	
	ASC (Non-Distinct Part) Other Ancillary (specify)	 	0	
/0	OUTPATIENT SERVICE COST CENTERS			
88	Rural Health Clinic		0	
	Federally Qualified Health Center		0	
	Clinic		0	
91	Emergency		0	-
	Observation Beds	ļ	0	
93	Other Outpatient Service (specify)		0	
04	OTHER REIMBURSABLE COST CENTERS		0	
	Home Program Dialysis Ambulance Services	 	0	
	Durable Medical Equipment-Rented	1	0	
	Durable Medical Equipment-Sold	İ	0	
	Other Reimbursable (specify)		0	
	Outpatient Rehabilitation Provider (specify)	1	0	

	SCHEDULE D: UNCOMPENSATED PHYSICIA		FILING DATE:	1/0/00
		rsion (Interim/Final):		0
				U
	COMPUTATION OF UNCOMPENSATED PHYSICIAN C		0	
)	FROM:	1/0/00
			TO:	1/0/00
				TOTAL UCCR PHYSICIAN
			DUAL ELIGIBLE I/P AND	COSTS
	COST CENTER DESCRIPTION	DUAL ELIGIBLE I/P AND	O/P PHYSICIAN COSTS	(COL7 + COL9
		O/P PHYSICIAN CHARGES	(COL 5 x COL 12)	+ COL 11 + COL 13)
Ln No.		(12)	(13)	(14)
101	Home Health Agency		0	0
	SPECIAL PURPOSE COST CENTERS			
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
	Other Special Purpose (specify)		0	0
118	SUBTOTAL (sum of lines 30-117)	0	0	0
	NONREIMBURSABLE COST CENTERS			
190	Gift, Flower, Coffee Shop, & Canteen			
191	Research			
192	Physicians' Private Offices			
193	Nonpaid Workers			
194	Other Nonreimbursable (specify)			
	Cross Foot Adjustments			
201	Negative Cost Centers			

SCHEDULE E: SAFETY NET HEALTH CARE SYSTEM (SNHCS)

SUMMARY OF SNHCS EXPENDITURES

Ln No.	Hospital Description (1)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

13	
14	
15	
16	TOTAL

Safety Net Care Cost Ratio

Ln. No.	SYSTEM FINANCIAL REQUIREMENTS, ADDITIONAL NARRATIVE DES
Ln. No.	SISIEM FINANCIAL REQUIREMENTS, ADDITIONAL NARRATIVE DES
1	
2	
_	
3	
4	
5	
6	
7	
-	
8	
9	
4.0	
10	
11	
12	
13	
14	
15	
10	

PW = agency initials

EXPENDITURES

	FV 700 0 475
	FILING DATE:
UCCR VERSION (INTERIM/FINAL)	0
PROVIDER NAME:	0
PROVIDER NUMBER:	0
REPORTING PERIOD:	FROM:
	то:
Total System Expense (2)	Schedule E Allowable Category (Select Category) (3)

\$0	
#PTV/01	1
#DIV/0!	
CRIPTION:	

1/0/00
1/0/00
1/0/00

1/0/00		
1/0/00		
Is this expense included on the hospital's CMS-2552 Worksheet A, column 7 (4)	Proportion of Expense Allocable to Medicaid-Eligible, HSN & Uninsured Patients (5)	Schedule E Allocation Ratio (Automatically Calculated) (6)
		0%
		0%
		0%
		0%
		0%
		0%
		0%
		0%
		0%
		0%
		0%
		0%

	0%
	0%
	0%
0	

Allowable Schedule E Expense (7)		
\$0		
\$0		
\$0		
\$0		
\$0		
\$0		
\$0		
\$0		
\$0		
\$0		
\$0		
\$0		

\$0
\$0
\$0

	SCHEDULE F: MEDICAID AND UNINSURED R	EVENUE						
					Filing Date:	1/0/00		
				UCCR V	ersion (Interim/Final):	0		
				PROVIDER NAME:)	
				PROVIDER NUMBER:)	
						REPORTING PERIOD:	FROM:	1/0/00
							то:	1/0/00
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
Ln No.	REVENUE DESCRIPTION	MEDICAID FFS INPATIENT	MEDICAID FFS OUTPATIENT	MMCO INPATIENT	MMCO OUTPATIENT	HSN & UNINSURED (Inpatient & Outpatient)	DUAL ELIGIBLE (Inpatient & Outpatient)	TOTAL REVENUE (SUM of COL 1 through 6)
LITTO.	HOSPITAL AND CLINIC REVENUE							
1	Payer Medical Claims Revenue (For column 6, report Medicaid payments)							0
2	Payer Performance or Incentive Payments							0
3	Supplemental Payment (specify)							0
4	Supplemental Payment (specify)							0
5	Supplemental Payment (specify)							0
6	Medicare Revenue							0
7	Third Party and Self Pay Revenue							0
8	Other Revenue (specify)							0
9	SUBTOTAL: HOSPITAL AND CLINIC (Sum Line 1-8)	0	0	0	0	0	0	0
	PHYSICIAN REVENUE							
10	Payer Medical Claims Revenue (For column 6, report Medicaid payments)							0
11	Payer Performance Payment Revenue							0
12	Supplemental Payment (specify)							0
13	Medicare Revenue							0
14	Third Party and Self Pay Revenue							0
15	Other Revenue (specify)							0
16	SUBTOTAL: PHYSICIAN (Sum Line 10-15)	0	0	0	0	0	0	0
17	TOTAL REVENUE (Line 9 + Line 16)	0	0	0	0	0	0	0
18	TOTAL COST LIMIT PROTOCOL REVENUE Line 17 - Line 11 - Line 2)	0	0	0	0	0	0	0

Filing Date:	1/0/00			
UCCR Version		0		
PROVIDER NAME:	0			
PROVIDER NUMBER(S):		0		
REPORTING PERIOD:	FROM:	1/0/00		
	TO:	1/0/00		

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

_			

SCHEDULE G-2: STATUS OF PRIOR YEAR FILINGS

Hospitals are required to submit final UCCR based on an audited and settled Fiscal Year CMS-2552 reports, with

Fiscal year	Hospital Fiscal Year End Date	CMS-2552 Status	Interim UCCR Submitted?	Final UCCR Submitted?
2015				
2016				
2017				
2018				
2019				

nin five months of receipt of the audited report. Please indicate the status of the hospital's 2552 and UCCR filings.

Note

Massachusetts Uncompensated Care Cost Limit Calculation

Medicare Provider Number:

Hospital:

FYE Report Basis:

A. TOTAL COSTS

- 1 MassHealth FFS hospital costs
- 2 Medicaid Managed Care hospital costs
- 3 HSN & Uninsured hospital costs
- 4 Dual-Eligible hospital costs
- 5 Subtotal: Medicaid and Uninsured Hospital Costs
- 6 MassHealth FFS physician costs
- 7 Medicaid Managed Care physician costs
- 8 HSN & Uninsured physician costs
- 9 Dual-Eligible physician costs
- 10 Subtotal: Medicaid and Uninsured Physician Costs
- 11 Schedule E: Safety Net System Expenses
- 12 HSN Adjustment (if assessment not on 2552)
- 13 TOTAL COSTS

B. TOTAL REVENUE

- 1 MassHealth FFS Inpatient Revenue
- 2 MassHealth FFS Outpatient Revenue
- 3 Subtotal: MassHealth FFS Revenue
- 4 Medicaid MCO Inpatient Revenue
- 5 Medicaid MCO Outpatient Revenue
- 6 Subtotal: Medicaid MCO Revenue
- 7 HSN & Uninsured Inpatient/Outpatient Revenue
- 8 Dual-Eligible Inpatient/Outpatient Revenue
- 9 TOTAL COST LIMIT REVENUE

C. TOTAL UNCOMPENSATED CARE COST LIMIT CALCULATION

- 1 Total Costs
- 2 Total Revenue

3 Available Room Under Cost Limit

D. EXPLANATION OF EOHHS ADJUSTMENTS

0
0
1/0/00

<u>Source</u>	<u>Claimed Amount</u>	EOHHS Adjustments
Schedule A, line 118, column 10	\$0	\$0
Schedule C, line 118, column 6	\$0	\$0
Schedule C, line 118, column 11	\$0	\$0
Schedule C, line 118, column 16	\$0	\$0
Sum lines A.1 to A.4	\$0	\$0
Schedule D, line 118, column 7	\$0	\$0
Schedule D, line 118, column 9	\$0	\$0
Schedule D, line 118, column 11	\$0	\$0
Schedule D, line 118, column 13	\$0	\$0
Sum lines A.6 to A.9	\$0	\$0
Schedule E, Total	\$0	\$0
HSN Assessment * public payer mix	\$0	\$0
Lines A.5 + A.10 + A.11 + A.12	\$0	\$0

<u>Source</u>	<u>Claimed Amount</u>	EOHHS Adjustments
Schedule F, line 18, col 1	\$0	\$0
Schedule F, line 18, col 2	\$0	\$0
Line B.1 + B.2	\$0	\$0
Schedule F, line 18, col 3	\$0	\$0
Schedule F, line 18, col 4	\$0	\$0
Line B.4 + B.5	\$0	\$0
Schedule F, line 18, col 5	\$0	\$0
Schedule F, line 18, col 6	\$0	\$0
Line B.3 + B.6 + B.7 + B.8	\$0	\$0

	<u>Claimed Amount</u>	EOHHS Adjustments
Line A. 13	\$0	\$0
Line B. 9	\$0	\$0

Line C.1 - C.2	\$0	\$0

#N/A

Allowed Amoun	<u>t</u>
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0

<u> Allowed Amount</u>	
	\$0
	\$0