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:	

Health Safety Net Assessment

SCHEDULE A: MASSHEALTH FEE-FOR-SERVICE (FFS) COSTS

FILING DATE: 1/0/00

UCCR Version (Interim/Final): 0

COMPUTATION OF MASSHEALTH FEE-FOR-SERVICE COSTS

PROVIDER NAME: 0

PROVIDER NUMBER: 0

REPORTING PERIOD: FROM: 1/0/00 TO: 1/0/00

Ln No.	COST CENTER DESCRIPTION	COSTS INCLUDING INTERNS & RESIDENTS (FROM 2552 WKSHT B PART I COL 24) (1)	RECLASS (LINE 30 TO LINE 92) AND POST STEPDOWN COSTS (FROM WKSHT B -2 COL 4 LINES 54, 60, 89 & 90) (2)	TOTAL COSTS (COL 1 + COL 2) (3)	CHARGES (FROM 2552 WKSHT C PART I COL 8) (4)	HOSPITAL COST TO CHARGE RATIOS (COL 3 / COL 4) (5)	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) (9)	TOTAL MASSHEALTH. FFS I/P AND O/P COSTS (COL 7 + COL 9) (10)
	INPATIENT ROUTINE SERVICE COST CENTERS										
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
	ANCILLARY SERVICE COST CENTERS										
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
	OUTPATIENT SERVICE COST CENTERS										
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 (see instructions)			0		0.000		0		0	0

SCHEDULE A: MASSHEALTH FEE-FOR-SERVICE (FFS) COSTS

FILING DATE: 1/0/00

UCCR Version (Interim/Final): 0

COMPUTATION OF MASSHEALTH FEE-FOR-SERVICE COSTS

PROVIDER NAME: 0

PROVIDER NUMBER: 0 | **REPORTING PERIOD:** FROM: 1/0/00 TO: 1/0/00

Ln No.	COST CENTER DESCRIPTION	COSTS INCLUDING INTERNS & RESIDENTS (FROM 2552 WKSHT B PART I COL 24) (1)	RECLASS (LINE 30 TO LINE 92) AND POST STEPDOWN COSTS (FROM WKSHT B -2 COL 4 LINES 54, 60, 89 & 90) (2)	TOTAL COSTS (COL 1 + COL 2) (3)	CHARGES (FROM 2552 WKSHT C PART I COL 8) (4)	HOSPITAL COST TO CHARGE RATIOS (COL 3 / COL 4) (5)	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) (9)	TOTAL MASSHEALTH. FFS I/P AND O/P COSTS (COL 7 + COL 9) (10)
	INPATIENT ROUTINE SERVICE COST CENTERS										
93	Other Outpatient Service (specify)			0		0.000		0		0	0
	OTHER REIMBURSABLE COST CENTERS										
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
97	Durable Medical Equipment-Sold			0		0.000		0		0	0
98	Other Reimbursable (specify)			0		0.000		0		0	0
99	Outpatient Rehabilitation Provider (specify)			0		0.000		0		0	0
100	Intern-Resident Service (not appvd. tchng. prgm.)			0		0.000		0		0	0
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
116	Hospice			0		0.000		0		0	0
117	Other Special Purpose (specify)			0		0.000		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										

SCHEDULE B: ROUTINE COST CENTER PER DIEMS

FILING DATE: 1/0/00

UCCR Version (Interim/Final): 0

COMPUTATION OF ROUTINE COST CENTER PER DIEMS

PROVIDER NAME: 0

PROVIDER NUMBER: 0 FROM: 1/0/00

TO: 1/0/00

Ln No.	COST CENTER DESCRIPTION	TOTAL COSTS (COL 3 OF SCHEDULE A) (1)	TOTAL PATIENT DAYS (WS S -3 PART I COL 8) (2)	PER DIEM (COL 1 / COL 2) (3)	FFS PATIENT DAYS (4)	FFS INPATIENT COSTS (COL 3 x COL 4) (5)	MMCO PATIENT DAYS (6)	MMCO INPATIENT COSTS (COL 3 x COL 6) (7)	HSN & UNINSURED CARE PATIENT DAYS (8)	HSN & UNINSURED CARE INPATIENT COSTS (COL 3 x COL 8) (9)	DUAL-ELIGIBLE PATIENT DAYS (10)	DUAL-ELIGIBLE INPATIENT COSTS (COL 3 x COL 10) (11)
	INPATIENT ROUTINE SERVICE COST CENTERS											
1	Adults and Pediatrics (General Routine Care)	0		0.00		0		0		0		0
8	Intensive Care Unit	0		0.00		0		0		0		0
9	Coronary Care Unit	0		0.00		0		0		0		0
10	Burn Intensive Care Unit	0		0.00		0		0		0		0
11	Surgical Intensive Care Unit	0		0.00		0		0		0		0
12	Other Special Care (specify)	0		0.00		0		0		0		0
13	Nursery	0		0.00		0		0		0		0
16	Subprovider IPF	0		0.00		0		0		0		0
17	Subprovider IRF	0		0.00		0		0		0		0
18	Subprovider (specify)	0		0.00		0		0		0		0
19	Skilled Nursing Facility	0		0.00		0		0		0		0
20	Nursing Facility	0		0.00		0		0		0		0
21	Other Long Term Care	0		0.00		0		0		0		0
	TOTAL PATIENT DAYS		0		0		0		0		0	

SCHEDULE C: MEDICAID MCO (MMCO), HSN & UNINSURED & DUAL-ELIGIBLE COSTS

COMPUTATION OF MASSACHUSETTS MEDICAID MCO AND LOW INCOME UNCOMPENSATED CARE COSTS

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)
30	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	Other Special Care (specify)	0.000		0		0	0		0		0
40	Subprovider IPF	0.000		0		0	0		0		0
41	Subprovider IRF	0.000		0		0	0		0		0
42	Subprovider (specify)	0.000		0		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		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		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	Magnetic Resonance Imaging (MRI)	0.000		0		0	0		0		0
59	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		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		0	0		0		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		0
73	Drugs Charged to Patients	0.000		0		0	0		0		0
74	Renal Dialysis	0.000		0		0	0		0		0
75	ASC (Non-Distinct Part)	0.000		0		0	0		0		0
76	Other Ancillary (specify)	0.000		0		0	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										

SCHEDULE C: MEDICAID MCO (MMCO), HSN & UNINSURED & DUAL-ELIGIBLE COSTS

COMPUTATION OF MASSACHUSETTS MEDICAID MCO AND LOW INCOME UNCOMPENSATED CARE COSTS

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)
94	Home Program Dialysis	0.000		0		0	0		0		0
95	Ambulance Services	0.000		0		0	0		0		0
96	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
99	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
101	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										

SCHEDULE C: MEDICAID MCO (MMCO), HS

FILING DATE: 1/0/00

UCCR Version (Interim/Final): 0

COMPUTATION OF MASSACHUSETTS MEDICAID MC

PROVIDER NAME: 0

PROVIDER NUMBER: 0 | FROM: 1/0/00

TO: 1/0/00

Ln No.	COST CENTER DESCRIPTION	TOTAL HSN & UNINSURED CARE COSTS (COL 8 + COL 10) (11)	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	0
31	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
63	Blood Storing, Processing, & Trans.	0		0		0	0
64	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						
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						

SCHEDULE C: MEDICAID MCO (MMCO), HS

COMPUTATION OF MASSACHUSETTS MEDICAID MC

		FILING DATE:	1/0/00
UCCR Version (Interim/Final):	0		
PROVIDER NAME:	0		
PROVIDER NUMBER:	0	FROM:	1/0/00
		TO:	1/0/00

Ln No.	COST CENTER DESCRIPTION	TOTAL HSN & UNINSURED CARE COSTS (COL 8 + COL 10) (11)	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)
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						

SCHEDULE D: UNCOMPENSATED PHYSICIAN COSTS

UCCR Ve

PROVIDER NAME:

PROVIDER NUMBER: 0

COMPUTATION OF UNCOMPENSATED PHYSICIAN COSTS

Ln No.	COST CENTER DESCRIPTION	PROFESSIONAL COMPONENT OF PHYSICIAN COSTS (FROM 2552 WKSHT A-8-2 COL 4) (1)	OVERHEAD COSTS RELATED TO PHYSICIAN SERVICES IF NOT INCLUDED IN COL 1 (FROM 2552 WKSHT A-8) (2)	TOTAL PHYSICIAN COSTS (COL 1 + COL 2) (3)	TOTAL PHYSICIAN I/P AND O/P CHARGES (4)	PHYSICIAN COST-TO-CHARGE RATIO (COL 3 / COL 4) (5)	MASSHEALTH FFS I/P AND O/P PHYSICIAN CHARGES (6)	MASSHEALTH FFS I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 6) (7)	MASS. MMCO I/P AND O/P PHYSICIAN CHARGES (8)	MASS. MMCO I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 8) (9)	HSN & UNINSURED I/P AND O/P PHYSICIAN CHARGES (10)	HSN & UNINSURED I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 10) (11)
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
	ANCILLARY SERVICE COST CENTERS											
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
	OUTPATIENT SERVICE COST CENTERS											
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
	OTHER REIMBURSABLE COST CENTERS											
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
97	Durable Medical Equipment-Sold			0		0.000		0		0		0
98	Other Reimbursable (specify)			0		0.000		0		0		0
99	Outpatient Rehabilitation Provider (specify)			0		0.000		0		0		0
100	Intern-Resident Service (not appvd. tchng. prgm.)			0		0.000		0		0		0

SCHEDULE D: UNCOMPENSATED PHYSICIAN COSTS

UCCR Ve

PROVIDER NAME:

PROVIDER NUMBER:

COMPUTATION OF UNCOMPENSATED PHYSICIAN COSTS

Ln No.	COST CENTER DESCRIPTION	PROFESSIONAL COMPONENT OF PHYSICIAN COSTS (FROM 2552 WKSHT A-8-2 COL 4) (1)	OVERHEAD COSTS RELATED TO PHYSICIAN SERVICES IF NOT INCLUDED IN COL 1 (FROM 2552 WKSHT A-8) (2)	TOTAL PHYSICIAN COSTS (COL 1 + COL 2) (3)	TOTAL PHYSICIAN I/P AND O/P CHARGES (4)	PHYSICIAN COST-TO-CHARGE RATIO (COL 3 / COL 4) (5)	MASSHEALTH FFS I/P AND O/P PHYSICIAN CHARGES (6)	MASSHEALTH FFS I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 6) (7)	MASS. MMCO I/P AND O/P PHYSICIAN CHARGES (8)	MASS. MMCO I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 8) (9)	HSN & UNINSURED I/P AND O/P PHYSICIAN CHARGES (10)	HSN & UNINSURED I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 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
116	Hospice			0		0.000		0		0		0
117	Other Special Purpose (specify)			0		0.000		0		0		0
118	**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											

	SCHEDULE D: UNCOMPENSATED PHYSICIA		**FILING DATE:**	**1/0/00**
		rsion (Interim/Final):	**0**	
	COMPUTATION OF UNCOMPENSATED PHYSICIAN C	**0**		
		)	**FROM:**	**1/0/00**
			TO:	**1/0/00**
Ln No.	**COST CENTER DESCRIPTION**	DUAL ELIGIBLE I/P AND O/P PHYSICIAN CHARGES (12)	DUAL ELIGIBLE I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 12) (13)	TOTAL UCCR PHYSICIAN COSTS (COL 7 + COL 9 + COL 11 + COL 13) (14)
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
	ANCILLARY SERVICE COST CENTERS			
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
	OUTPATIENT SERVICE COST CENTERS			
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
	OTHER REIMBURSABLE COST CENTERS			
94	Home Program Dialysis		0	0
95	Ambulance Services		0	0
96	Durable Medical Equipment-Rented		0	0
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

	SCHEDULE D: UNCOMPENSATED PHYSICIA		FILING DATE:	1/0/00
		rsion (Interim/Final):	0	
	COMPUTATION OF UNCOMPENSATED PHYSICIAN C	0		
		)	FROM:	1/0/00
			TO:	1/0/00
Ln No.	COST CENTER DESCRIPTION	DUAL ELIGIBLE I/P AND O/P PHYSICIAN CHARGES (12)	DUAL ELIGIBLE I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 12) (13)	TOTAL UCCR PHYSICIAN COSTS (COL 7 + COL 9 + COL 11 + COL 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
117	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)			
200	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
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

PW = agency initials

EXPENDITURES

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

$0	

#DIV/0!

SCRIPTION:

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
$0

SCHEDULE F: MEDICAID AND UNINSURED REVENUE

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

Ln No.	REVENUE DESCRIPTION	(1) MEDICAID FFS INPATIENT	(2) MEDICAID FFS OUTPATIENT	(3) MMCO INPATIENT	(4) MMCO OUTPATIENT	(5) HSN & UNINSURED (Inpatient & Outpatient)	(6) DUAL ELIGIBLE (Inpatient & Outpatient)	(7) TOTAL REVENUE (SUM of COL 1 through 6)
	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**

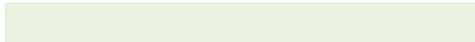
Filing Date:	1/0/00		
UCCR Version		0	
PROVIDER NAME:	0		
PROVIDER NUMBER(S):	0		
REPORTING PERIOD:	FROM:	1/0/00	
	TO:	1/0/00	

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				



ıin 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

Source	Claimed Amount	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**

Source	Claimed Amount	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**

	Claimed Amount	EOHHS Adjustments
Line A. 13	$0	$0
Line B. 9	$0	$0

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

#N/A

Allowed Amount
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0

Allowed Amount
$0
$0
$0
$0
$0
$0
$0
$0
$0

Allowed Amount
$0
$0