

Ohio Department of Medicaid
HOSPITAL COST REPORT
STATE FISCAL YEAR 2011
 CERTIFICATION BY OFFICER OF HOSPITAL

In accordance with current Medicaid regulations (42CFR, 455.18, 455.19), all cost reports must contain the following:

This is to certify that the foregoing information is true, accurate, and complete.
 I understand that payment of this Medicaid claim will be from Federal and State funds,
 and that any falsification, or concealment of a material fact, may be prosecuted under
 Federal and State laws.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report supporting schedules prepared for:

Provider Name	Medicaid Number	National Provider Identifier
Street Address	Federal ID Number	
City, State and Zip Code	Medicare Provider Number(s)	

for the cost reporting period beginning _____ and ending _____, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions and regulations including independent certification of Schedule F, and the accuracy of the OBRA Survey, except as noted.

Signature of Officer or Administrator of Provider(s)	Date of Signature
Print or Type Name	Title

Name of Individual Report Was Prepared By	Title
---	-------

Name of Person to Contact Regarding Report	Title
Telephone Number (Include Area Code & Extension (if applicable))	

OBRA SURVEY

Medicaid programs must, on an annual basis, determine whether hospitals which receive disproportionate share payments under Medicaid meet certain federally-mandated requirements. For instance, urban non-children's hospitals which receive disproportionate share payments and which offer non-emergency obstetrical services must have at least two obstetricians on staff who have agreed to service Medicaid patients. Rural hospitals which offer non-emergency obstetrical services must have at least two physicians (not necessarily obstetricians) who have agreed to provide obstetrical services to Medicaid recipients in order to receive Medicaid disproportionate share payments. A related requirement is that states must provide disproportionate share payments to hospitals with a low-income utilization rate that exceeds 25 percent.

Complete Section A and Section B for your facility for this cost reporting period.

Section A

1 Does your hospital predominantly serve patients less than 18 years of age? (If answer to this question is Yes, please proceed to Section B.)

Answer:		
YES	NO	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2 As of December 22, 1987, did your hospital offer non-emergency obstetric services to the general population? (If answer to this question is No, please proceed to Section B, if Yes answer question 3.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

3 Does your hospital currently offer non-emergency obstetric services to the general population? (If answer to this question is Yes, please proceed to Section B.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

4 Answer the one question below appropriate to your hospital. If your hospital is deemed a rural hospital for purposes of Medicare reimbursement, answer question (a). If your hospital is an urban hospital for purposes of Medicare reimbursement, answer question (b).

a Rural: Does your hospital have at least two physicians (may or may not be obstetricians) with staff privileges who have agreed to provide non-emergency obstetric services to Medicaid recipients? **If you responded No, please explain below.**

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

b Urban: Does your hospital have at least two obstetricians with staff privileges who have agreed to provide non-emergency obstetric services to Medicaid recipients? **If you responded No, please explain below.**

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

Section B

The following section should be completed by hospitals to determine if a low-income utilization rate (as described below) which exceeds 25% exists.

"Low-income utilization rate" means, according to federal law, the sum of (1) and (2) below:

(1) the fraction, expressed as a percentage:

(a) the numerator of which is the sum for a period of Medicaid (Ohio only) revenues (payments including HMO payments for patient services plus the amount of cash subsidies (including HCAP and UPL payments) for patient services received directly from state and local governments.

(b) the denominator of which is the total patient services revenue -- including such cash subsidies -- for the period.

(2) the fraction, expressed as a percentage:

(a) the numerator of which is the total (gross) hospital inpatient charges in a period attributable to charity care (not including contractual allowances and discounts and bad debts) less the portion of any subsidies received in the period from state and local governments reasonably attributed to inpatient hospital services.

(b) the denominator of which is total (gross) hospital inpatient charges in the period.

Provide the following information from your financial records:

Fraction 1	Medicaid Revenues:		
	Plus: Government Cash Subsidies:		
	Total patient revenues including cash subsidies:		Fraction (1)

Fraction 2	Total hospital inpatient charges for charity care (not including allowances, discounts and bad debts):		
	Less: Government cash subsidies:		
	Total inpatient charges:		Fraction (2)

Sum of Fraction (1) and (2) expressed as a percent:

**SFY 2011 INPATIENT
BILLING CODE ALLOCATION**

New Line No.	Old Line No.	Cost Center Description	UB-92 Revenue Center Codes
			001, 100, 110-113, 116, 117, 119-123, 126, 127, 129-133, 136, 137, 139, 150-153, 156, 157, 159, 160, 164, 169, 206, 214, 230, 232, 239, 240-243, 249
30	25	Adults and Pediatrics	
31	26	Intensive Care Unit	200, 201-204, 208, 209, 233
32	27	Coronary Care Unit	210-213, 219, 234
33	28	Burn Intensive Care Unit	207
34	29	Surgical Intensive Care Unit	204
36	30	Other Special Care (specify)	*
40	25a	Subprovider - Distinct Psych Unit	114, 124, 134, 154
41	25b	Subprovider - Distinct Phys Rehab	118, 128, 138, 158
42	31	Nursery Intensive Care	174
43	33	Nursery	170-173, 179, 231
44	34	SNF NF ICF OLTC	*
45		Other Routine (specify)	*
46		Other Routine (specify)	*
49	35	Sub-Total (Lines 30 - 48)	*
50	37	Operating Room	360-362, 367, 369
51	38	Recovery Room	710, 719
52	39	Labor Room and Delivery Room	720-724, 729
53	40	Anesthesiology	370-372, 379
54	41	Radiology-Diagnostic	320-324, 329, 400, 401, 403, 409, 790, 799, 920
55	42	Radiology-Therapeutic	330-333, 335, 339
56	43	Radioisotope	340-342, 349
57	41a	Computed Tomography (CT) Scan	350-352, 359
58	41d	Magnetic Resonance Imaging (MRI)	610-612, 614-616, 618, 619
59	53a	Cardiac Catheterization	481
60	44	Laboratory	300-302, 304-307, 309-312, 314, 319, 921, 923-925, 929
61	44A	Oncology	280, 289
62	46	Whole Blood & Packed Red Blood Cells	380-387, 389
63	47	Blood Storing, Processing, & Trans.	390, 391, 399
64	48	Intravenous Therapy	260-264, 269
65	49	Respiratory Therapy	410, 412, 413, 419
66	50	Physical Therapy	420-424, 429, 530, 531, 539, 922, 940, 942, 949, 952
67	51	Occupational Therapy	430-434, 439
68	52	Speech Pathology / Audiology	440-444, 449, 470-472, 479
69	53	Electrocardiology	480, 482, 483, 489, 730-732, 739
70	54	Electroencephalography	740, 749
71	55	Medical Supplies Charged to Patients	270-272, 274-276, 278, 279, 291, 621-623
72		Implantable Devices Charged to Patients	*
73	56	Drugs Charged to Patients	250-252, 254, 255, 257-259, 634, 637
74	57	Renal Dialysis	800-804, 809, 880-881, 889
75	37a	ASC (Non-Distinct Part)	490, 499
76	59	Psychiatric / Psychologic	900, 909, 910, 914-916, 918-919
77	69	Gastrointestinal Svcs	750, 759
78	41b	Ultrasound	402
79	41c	PET Scan	404
80	49a	Pulmonary Function	460, 469
81	50a	Cardiac Rehabilitation	943
82	37c	Treatment / Observ Room / Cast Room	700, 709, 760-762, 769
88		Rural Health Clinic (RHC)	*
89		Federally Qualified Health Center (FQHC)	*
90	60	Clinic	510-517, 519, 770, 771, 779
91	61	Emergency	450-452, 456, 459
92	62	Observation Beds (see instructions)	*
93		Other Outpatient Service (specify)	*
100		Other Reimbursable (specify)	*
101		Outpatient Rehabilitation Provider (specify)	*
103		Ambulatory Surgical Center (Distinct Part)	*
105	58	Organ Acquisition	810-812, 819
106		Lines 106 - 132 Open for Provider Use	*

Please refer to OAC 5101:3-2-02 for a list of inpatient and outpatient covered services.

*Billing codes should be allocated into revenue centers as indicated above. Any deviation from the above must be designated above to indicate where the billing codes were allocated, and why they were allocated differently than requested.

*Do not include observation bed costs and charges reported on line 62 of the JFS 2930 and HCFA 2552-96 in revenue center 82.

*If one revenue center code is applicable to more than one revenue center, please show which revenue centers it was allocated to on the following page

* Please list the revenue center codes allocated to these revenue centers.

**SFY 2011 INPATIENT
BILLING CODE ALLOCATION**

Line	Line	Cost Center Description	UB-92 Revenue Center Codes
			001, 100, 110-113, 116, 117, 119-123, 126, 127, 129-133, 136, 137, 139, 150-153, 156, 157, 159, 160, 164, 169, 206, 214, 230, 232, 239, 240-243, 249
30	25	Adults and Pediatrics	
31	26	Intensive Care Unit	200, 201-204, 208, 209, 233
32	27	Coronary Care Unit	210-213, 219, 234
33	28	Burn Intensive Care Unit	207
34	29	Surgical Intensive Care Unit	204
36	30	Other Special Care (specify)	*
40	25a	Subprovider - Distinct Psych Unit	114, 124, 134, 154
41	25b	Subprovider - Distinct Phys Rehab	118, 128, 138, 158
42	31	Nursery Intensive Care	174
43	33	Nursery	170-173, 179, 231
44	34	SNF NF ICF OLTC	*
45		Other Routine (specify)	*
46		Other Routine (specify)	*
49	35	Sub-Total (Lines 30 - 48)	*
50	37	Operating Room	360-362, 367, 369
51	38	Recovery Room	710, 719
52	39	Labor Room and Delivery Room	720-724, 729
53	40	Anesthesiology	370-372, 379
54	41	Radiology-Diagnostic	320-324, 329, 400, 401, 403, 409, 790, 799, 920
55	42	Radiology-Therapeutic	330-333, 335, 339
56	43	Radioisotope	340-342, 349
57	41a	Computed Tomography (CT) Scan	350-352, 359
58	41d	Magnetic Resonance Imaging (MRI)	610-612, 614-616, 618, 619
59	53a	Cardiac Catheterization	481
60	44	Laboratory	300-302, 304-307, 309-312, 314, 319, 921, 923-925, 929
61	44A	Oncology	280, 289
62	46	Whole Blood & Packed Red Blood Cells	380-387, 389
63	47	Blood Storing, Processing, & Trans.	390, 391, 399
64	48	Intravenous Therapy	260-264, 269
65	49	Respiratory Therapy	410, 412, 413, 419
66	50	Physical Therapy	420-424, 429, 530, 531, 539, 922, 940, 942, 949, 952
67	51	Occupational Therapy	430-434, 439
68	52	Speech Pathology / Audiology	440-444, 449, 470-472, 479
69	53	Electrocardiology	480, 482, 483, 489, 730-732, 739
70	54	Electroencephalography	740, 749
71	55	Medical Supplies Charged to Patients	270-272, 274-276, 278, 279, 291, 621-623
72		Implantable Devices Charged to Patients	*
73	56	Drugs Charged to Patients	250-252, 254, 255, 257-259, 634, 637
74	57	Renal Dialysis	800-804, 809, 880-881, 889
75	37a	ASC (Non-Distinct Part)	490, 499
76	59	Psychiatric / Psychologic	900, 909, 910, 914-916, 918-919
77	69	Gastrointestinal Svcs	750, 759
78	41b	Ultrasound	402
79	41c	PET Scan	404
80	49a	Pulmonary Function	460, 469
81	50a	Cardiac Rehabilitation	943
82	37c	Treatment / Observ Room / Cast Room	700, 709, 760-762, 769
88		Rural Health Clinic (RHC)	*
89		Federally Qualified Health Center (FQHC)	*
90	60	Clinic	510-517, 519, 770, 771, 779
91	61	Emergency	450-452, 456, 459
92	62	Observation Beds (see instructions)	*
93		Other Outpatient Service (specify)	*
94	63	Home Program Dialysis	*
95	64	Ambulance Services	*
96	65	Durable Medical Equipment-Rented	*
97	66	Durable Medical Equipment-Sold	*
98	67	Home Health Agency	*
99	68	Hospice	*
100		Other Reimbursable (specify)	*
101		Outpatient Rehabilitation Provider (specify)	*
102		Intern-Resident (not appvd. tchnlg. prgm.)	*
103		Ambulatory Surgical Center (Distinct Part)	*
105	58	Organ Acquisition	810-812, 819
106		Lines 106 - 132 Open for Provider Use	*

Please refer to OAC 5101:3-2-02 for a list of inpatient and outpatient covered services.

Follow the same procedures as outlined on the Inpatient Billing Code Allocation Sheet

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

SETTLEMENT SUMMARY

SFY 2011 Settlement Summary

ODM 02930 Settlement Summary

Title XIX Title V Title XIX
Transplant Total

1. AMT DUE ODJFS/(PROV)(2930-H)
2. AMT RECD WITH INT FILING
3. INTERIM SETTLEMENT AMOUNT
4. AMENDED INTERIM
5. AMENDED FINAL
6. NET AMT PD (SUM 2 THROUGH 5)
7. ADJUSTMENTS
8. TOTAL DUE ODFJS/(PROV)
lines 1 - 6 +7

(\$)=Monies owed/paid to hospitals by ODJFS
\$ = Monies owed/paid to ODJFS by hospitals

****N O T I C E **** THE ATTACHED WORKSHEETS MAY REFLECT MINOR DIFFERENCES CAUSED BY ROUNDING WHICH WILL NOT AFFECT THE SETTLEMENT RESULTS

Settlement Approved By

Auditor In Charge
Cost Reporting Unit

Date

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

JODM 02930 Schedule A

1	2	3
INPATIENT	OUTPATIENT	TOTAL

- 1. Skilled Nursing Facility
- 2. Observation Beds
- 3. Home Health Agency
- 4. Home Dialysis
- 5. Meals on Wheels
- 6. Hospice
- 7. Professional Fees (SEE NOTE)
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.
- 16.
- 17.
- 18.
- 19.
- 20.
- 21.
- 22.
- 23.
- 24.

NOTE: Please list professional fees by specific cost center.

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

COST DISTRIBUTION

ODM 02930 Schedule B

	1	2	3	4	5	6	7	8	9	10	11
	Facility Costs	Interns & Residents Costs	Total Facility Costs	Total Facility Charges	Ratio (3/4)	Total I/P Charges	Total I/P Costs	Total O/P Charges	Total O/P Costs	Total O/P Non-Reim Charges	Total O/P Non-Reim Costs
30. Adults and Pediatrics											
31. Intensive Care Unit											
32. Coronary Care Unit											
33. Burn Intensive Care Unit											
34. Surgical Intensive Care Unit											
36. Other Special Care (specify)											
40. Subprovider - Distinct Psych Unit											
41. Subprovider - Distinct Phys Rehab											
42. Nursery Intensive Care											
43. Nursery											
44. SNF NF ICF OLTC											
45. Other Routine (specify)											
46. Other Routine (specify)											
49. Sub-Total (Lines 30 - 48)											
50. Operating Room											
51. Recovery Room											
52. Labor Room and Delivery Room											
53. Anesthesiology											
54. Radiology-Diagnostic											
55. Radiology-Therapeutic											
56. Radioisotope											
57. Computed Tomography (CT) Scan											
58. Magnetic Resonance Imaging (MRI)											
59. Cardiac Catheterization											
60. Laboratory											
61. Oncology											
62. Whole Blood & Packed Red Blood Cells											
63. Blood Storing, Processing, & Trans.											
64. Intravenous Therapy											
65. Respiratory Therapy											
66. Physical Therapy											
67. Occupational Therapy											
68. Speech Pathology / Audiology											
69. Electrocardiology											
70. Electroencephalography											
71. Medical Supplies Charged to Patients											
72. Implantable Devices Charged to Patients											
73. Drugs Charged to Patients											
74. Renal Dialysis											
75. ASC (Non-Distinct Part)											
76. Psychiatric / Psychologic											
77. Gastrointestinal Svcs											
78. Ultrasound											
79. PET Scan											
80. Pulmonary Function											
81. Cardiac Rehabilitation											
82. Treatment / Observ Room / Cast Room											
88. Rural Health Clinic (RHC)											
89. Federally Qualified Health Center (FQHC)											
90. Clinic											

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

COST DISTRIBUTION

ODM 02930 Schedule B

	1	2	3	4	5	6	7	8	9	10	11
	Facility Costs	Interns & Residents Costs	Total Facility Costs	Total Facility Charges	Ratio (3/4)	Total I/P Charges	Total I/P Costs	Total O/P Charges	Total O/P Costs	Total O/P Non-Reim Charges	Total O/P Non-Reim Costs
91. Emergency											
92. Observation Beds (see instructions)											
93. Other Outpatient Service (specify)											
94. Home Program Dialysis											
95. Ambulance Services											
96. Durable Medical Equipment-Rented											
97. Durable Medical Equipment-Sold											
98. Home Health Agency											
99. Hospice											
100. Other Reimbursable (specify)											
101. Outpatient Rehabilitation Provider (specif											
102. Intern-Resident (not appvd. tchnng. prgm											
103. Ambulatory Surgical Center (Distinct Part											
105. Organ Acquisition											
106.											
107.											
108.											
109.											
110.											
111.											
112.											
113.											
114.											
115.											
116.											
117.											
118.											
119.											
120.											
121.											
122.											
123.											
124.											
125.											
126.											
127.											
128.											
129.											
130.											
131.											
132.											
199. Subtotal (sum of lines 50 to 198)											
200. Subtotal (sum of lines 49 + 199)											
201. Less Observation Beds											
202. Total (line 200 minus line 201)											

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

TITLE XIX ROOM COST COMPUTATION

ODM 02930 Schedule C

SECTION I	1 Total Costs All Patients	2 Swing Bed Costs	3 Adj Total Costs Col 1 + 2	4 Total Facility Days	5 Per Diem Col 3 / 4	6 Title XIX Days	7 Title XIX Costs Col 5 * 6	8 Title V Days	9 Title V Costs Col 5 * 8	10 Title XIX Trans Days	11 Title XIX Trans Costs Col 5 * 10
30. Adults and Pediatrics											
31. Intensive Care Unit											
32. Coronary Care Unit											
33. Burn Intensive Care Unit											
34. Surgical Intensive Care Unit											
36. Other Special Care (specify)											
40. Subprovider - Distinct Psych Unit											
41. Subprovider - Distinct Phys Rehab											
42. Nursery Intensive Care											
43. Nursery											
45. Other Routine (specify)											
46. Other Routine (specify)											
49. Sub-Total (Lines 30 - 48)											

DISCHARGE STATISTICS

ODM 02930 Schedule C-1

SECTION I - INPATIENT DATA	Total Facility	Title XIX On or Before 12/31/10	Title XIX On or After 01/01/11	Title V	Title XIX Transplant	Medicaid HMO On or Before 12/31/10	Medicaid HMO On or After 01/01/11
50. Adult & Ped							
51. Distinct Part Psych							
52. Distinct Part Rehab							
53. Nursery							
54. Total							
55. Capital Add-On Rate							
SECTION II - OUTPATIENT DATA							
56. Outpatient Visits							
SECTION III - MISC. DATA							
57. Total Hospital Beds							
58. Net Number of Interns & Residents							

MEDICAID HMO INPATIENT DAYS

ODM 02930 Schedule C-2

SECTION I	Per Diem (Sec. I, Col 5)	Medicaid HMO Days	Medicaid HMO Costs
30. Adults and Pediatrics			
31. Intensive Care Unit			
32. Coronary Care Unit			
33. Burn Intensive Care Unit			
34. Surgical Intensive Care Unit			
36. Other Special Care (specify)			
40. Subprovider - Distinct Psych Unit			
41. Subprovider - Distinct Phys Rehab			
42. Nursery Intensive Care			
43. Nursery			
45. Other Routine (specify)			
46. Other Routine (specify)			
49. Sub-Total (Lines 30 - 48)			

Provider Name

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

TITLE XIX COST COMPUTATION

ODM 02930 Schedule D

	1	2	3	4	5	6	7	8	9
	Ratio	Title XIX I/P Charges	Title XIX I/P Costs	Title XIX O/P Charges	Title XIX O/P Costs	Title XIX O/P Lab Charges	Title XIX O/P Lab Costs	Title XIX Transplant Charges	Title XIX Transplant Costs
30. Adults and Pediatrics									
31. Intensive Care Unit									
32. Coronary Care Unit									
33. Burn Intensive Care Unit									
34. Surgical Intensive Care Unit									
36. Other Special Care (specify)									
40. Subprovider - Distinct Psych Unit									
41. Subprovider - Distinct Phys Rehab									
42. Nursery Intensive Care									
43. Nursery									
45. Other Routine (specify)									
46. Other Routine (specify)									
49. Sub-Total (Lines 30 - 48)									
50. Operating Room									
51. Recovery Room									
52. Labor Room and Delivery Room									
53. Anesthesiology									
54. Radiology-Diagnostic									
55. Radiology-Therapeutic									
56. Radioisotope									
57. Computed Tomography (CT) Scan									
58. Magnetic Resonance Imaging (MRI)									
59. Cardiac Catheterization									
60. Laboratory									
61. Oncology									
62. Whole Blood & Packed Red Blood Cells									
63. Blood Storing, Processing, & Trans.									
64. Intravenous Therapy									
65. Respiratory Therapy									
66. Physical Therapy									
67. Occupational Therapy									
68. Speech Pathology / Audiology									
69. Electrocardiology									
70. Electroencephalography									
71. Medical Supplies Charged to Patients									
72. Implantable Devices Charged to Patients									
73. Drugs Charged to Patients									
74. Renal Dialysis									
75. ASC (Non-Distinct Part)									
76. Psychiatric / Psychologic									
77. Gastrointestinal Svcs									
78. Ultrasound									
79. PET Scan									
80. Pulmonary Function									
81. Cardiac Rehabilitation									
82. Treatment / Observ Room / Cast Room									
88. Rural Health Clinic (RHC)									
89. Federally Qualified Health Center (FQHC)									

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

TITLE XIX COST COMPUTATION

ODM 02930 Schedule D

	1	2	3	4	5	6	7	8	9
	Ratio	Title XIX I/P Charges	Title XIX I/P Costs	Title XIX O/P Charges	Title XIX O/P Costs	Title XIX O/P Lab Charges	Title XIX O/P Lab Costs	Title XIX Transplant Charges	Title XIX Transplant Costs
90. Clinic									
91. Emergency									
92. Observation Beds (see instructions)									
93. Other Outpatient Service (specify)									
100. Other Reimbursable (specify)									
101. Outpatient Rehabilitation Provider (specify)									
102. Intern-Resident (not appvd. tchnng. prgm.)									
103. Ambulatory Surgical Center (Distinct Part)									
105. Organ Acquisition									
106.									
107.									
108.									
109.									
110.									
111.									
112.									
113.									
114.									
115.									
116.									
117.									
118.									
119.									
120.									
121.									
122.									
123.									
124.									
125.									
126.									
127.									
128.									
129.									
130.									
131.									
132.									
199. Subtotal (sum of lines 50 to 198)									
202. Total (sum of lines 49 + 199)									

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

TITLE V COST COMPUTATION

ODM 02930 Schedule D1

	1	2	3	4	5	6	7	8	9	10	11
	Total Costs	Prof. Component	Adjusted Costs	Total Charges	Prof. Component	Adjusted Charges	Ratio	Title V I/P Charges	Title V I/P Costs	Title V op Charges	Title V O/P Costs
30. Adults and Pediatrics											
31. Intensive Care Unit											
32. Coronary Care Unit											
33. Burn Intensive Care Unit											
34. Surgical Intensive Care Unit											
36. Other Special Care (specify)											
40. Subprovider - Distinct Psych Unit											
41. Subprovider - Distinct Phys Rehab											
42. Nursery Intensive Care											
43. Nursery											
45. Other Routine (specify)											
46. Other Routine (specify)											
49. Sub-Total (Lines 30 - 48)											
50. Operating Room											
51. Recovery Room											
52. Labor Room and Delivery Room											
53. Anesthesiology											
54. Radiology-Diagnostic											
55. Radiology-Therapeutic											
56. Radioisotope											
57. Computed Tomography (CT) Scan											
58. Magnetic Resonance Imaging (MRI)											
59. Cardiac Catheterization											
60. Laboratory											
61. Oncology											
62. Whole Blood & Packed Red Blood Cells											
63. Blood Storing, Processing, & Trans.											
64. Intravenous Therapy											
65. Respiratory Therapy											
66. Physical Therapy											
67. Occupational Therapy											
68. Speech Pathology / Audiology											
69. Electrocardiology											
70. Electroencephalography											
71. Medical Supplies Charged to Patients											
72. Implantable Devices Charged to Patients											
73. Drugs Charged to Patients											
74. Renal Dialysis											
75. ASC (Non-Distinct Part)											
76. Psychiatric / Psychologic											
77. Gastrointestinal Svcs											
78. Ultrasound											
79. PET Scan											
80. Pulmonary Function											
81. Cardiac Rehabilitation											
82. Treatment / Observ Room / Cast Room											
88. Rural Health Clinic (RHC)											
89. Federally Qualified Health Center (FQHC)											
90. Clinic											
91. Emergency											

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

TITLE V COST COMPUTATION

ODM 02930 Schedule D1

	1	2	3	4	5	6	7	8	9	10	11
	Total Costs	Prof. Component	Adjusted Costs	Total Charges	Prof. Component	Adjusted Charges	Ratio	Title V I/P Charges	Title V I/P Costs	Title V op Charges	Title V O/P Costs
92. Observation Beds (see instructions)											
93. Other Outpatient Service (specify)											
100. Other Reimbursable (specify)											
101. Outpatient Rehabilitation Provider (specify)											
102. Intern-Resident (not appvd. tchnng. prgm.)											
103. Ambulatory Surgical Center (Distinct Part)											
105. Organ Acquisition											
106.											
107.											
108.											
109.											
110.											
111.											
112.											
113.											
114.											
115.											
116.											
117.											
118.											
119.											
120.											
121.											
122.											
123.											
124.											
125.											
126.											
127.											
128.											
129.											
130.											
131.											
132.											
199. Subtotal (sum of lines 50 to 198)											
202. Total (sum of lines 49 + 199)											

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

Miscellaneous Cost & Payment Information

ODM 02930 Schedule E/F

- Medical Education Costs
- 1. Non-Physician Anesthetists
- 2. Nursing School Costs
- 3. Interns & Residents Costs
- 4. Paramedic Education Costs
- 5. Total Med Ed Costs

Medical Education Add-on Verification

Direct:
 Indirect:
 (1 = Yes, 0 = No)

- Title XIX Lab Payments
- 6. Title XIX O/P Lab Payments

Net Patient Revenue | Section 1011 Payments

7a. Net Patient Revenue

7b. Section 1011 Payments

UNCOMPENSATED CARE DATA

	1	2	3	4	5	6	7
Section I	Gross Charges Patients w/ Insurance	Gross Charges Patients w/ No Insurance	Title XIX I/P & O/P Cost/Chg Ratio	Costs for Patients w/ Insurance	Costs for Patients w/ No Insurance	Receipts Patients w/ Insurance	Receipts Patients w/ No Insurance

Inpatient Charges

- 8. Disability Assistance
- 9. Uncompensated Care < 100%
- 10. Uncompensated Care > 100%
- 11. Total Inpatient

Outpatient Charges

- 12. Disability Assistance
- 13. Uncompensated Care < 100%
- 14. Uncompensated Care > 100%
- 15. Total Outpatient

Inpatient Discharges	Total Discharges / Visits Patients		Unduplicated Discharges / Visits Patients	
	w/ Insurance	w/ No Insurance	w/ Insurance	w/ No Insurance

- 16. Disability Assistance
- 17. Uncompensated Care < 100%
- 18. Uncompensated Care > 100%
- 19. Total Inpatient

Outpatient Visits

- 20. Disability Assistance
- 21. Uncompensated Care < 100%
- 22. Uncompensated Care > 100%
- 23. Total Outpatient

Section II

Free Standing Psych Hospitals

	Payments From Insurance	Payments From Self-Pay	Charges From Charity Care	Gov't Cash Subsidies Rec.	Uncomp Costs Patients With Insurance	Medicaid Days Age 21 and Under	Medicaid Days Age 22 to 64	Medicaid Days Age 65 and Over
--	-------------------------	------------------------	---------------------------	---------------------------	--------------------------------------	--------------------------------	----------------------------	-------------------------------

24. Required Data

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

Disability Assistance (DA) - Detail

ODM 02930 Schedule F1

	1 Ratio	2 I/P Charges DA w/ Ins.	3 I/P Costs DA w/ Ins.	4 O/P Charges DA w/ Ins.	5 O/P Costs DA w/ Ins.	6 I/P Charges DA w/o Ins.	7 I/P Costs DA w/o Ins.	8 O/P Charges DA w/o Ins.	9 O/P Costs DA w/o Ins.
30. Adults and Pediatrics									
31. Intensive Care Unit									
32. Coronary Care Unit									
33. Burn Intensive Care Unit									
34. Surgical Intensive Care Unit									
36. Other Special Care (specify)									
40. Subprovider - Distinct Psych Unit									
41. Subprovider - Distinct Phys Rehab									
42. Nursery Intensive Care									
43. Nursery									
45. Other Routine (specify)									
46. Other Routine (specify)									
49. Sub-Total (Lines 30 - 48)									
50. Operating Room									
51. Recovery Room									
52. Labor Room and Delivery Room									
53. Anesthesiology									
54. Radiology-Diagnostic									
55. Radiology-Therapeutic									
56. Radioisotope									
57. Computed Tomography (CT) Scan									
58. Magnetic Resonance Imaging (MRI)									
59. Cardiac Catheterization									
60. Laboratory									
61. Oncology									
62. Whole Blood & Packed Red Blood Cells									
63. Blood Storing, Processing, & Trans.									
64. Intravenous Therapy									
65. Respiratory Therapy									
66. Physical Therapy									
67. Occupational Therapy									
68. Speech Pathology / Audiology									
69. Electrocardiology									
70. Electroencephalography									
71. Medical Supplies Charged to Patients									
72. Implantable Devices Charged to Patients									
73. Drugs Charged to Patients									
74. Renal Dialysis									
75. ASC (Non-Distinct Part)									
76. Psychiatric / Psychologic									
77. Gastrointestinal Svcs									
78. Ultrasound									
79. PET Scan									
80. Pulmonary Function									
81. Cardiac Rehabilitation									
82. Treatment / Observ Room / Cast Room									
88. Rural Health Clinic (RHC)									

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

Disability Assistance (DA) - Detail

ODM 02930 Schedule F1

	1 Ratio	2 I/P Charges DA w/ Ins.	3 I/P Costs DA w/ Ins.	4 O/P Charges DA w/ Ins.	5 O/P Costs DA w/ Ins.	6 I/P Charges DA w/o Ins.	7 I/P Costs DA w/o Ins.	8 O/P Charges DA w/o Ins.	9 O/P Costs DA w/o Ins.
89. Federally Qualified Health Center (FQHC)									
90. Clinic									
91. Emergency									
92. Observation Beds (see instructions)									
93. Other Outpatient Service (specify)									
100. Other Reimbursable (specify)									
101. Outpatient Rehabilitation Provider (specify)									
102. Intern-Resident (not appvd. tchnng. prgm.)									
103. Ambulatory Surgical Center (Distinct Part)									
105. Organ Acquisition									
106.									
107.									
108.									
109.									
110.									
111.									
112.									
113.									
114.									
115.									
116.									
117.									
118.									
119.									
120.									
121.									
122.									
123.									
124.									
125.									
126.									
127.									
128.									
129.									
130.									
131.									
132.									
199. Subtotal (sum of lines 50 to 198)									
202. Total (sum of lines 49 + 199)									
204. Receipts Net Costs									
205. Total Discharges Visits									
206. Unduplicated Discharges Visits									

Provider Name

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

Uncompensated Care (UC) < 100% - Detail

ODM 02930 Schedule F2

	1 Ratio	2 I/P Charges UC w/ Ins.	3 I/P Costs UC w/ Ins.	4 O/P Charges UC w/ Ins.	5 O/P Costs UC w/ Ins.	6 I/P Charges UC w/o Ins.	7 I/P Costs UC w/o Ins.	8 O/P Charges UC w/o Ins.	9 O/P Costs UC w/o Ins.
30. Adults and Pediatrics									
31. Intensive Care Unit									
32. Coronary Care Unit									
33. Burn Intensive Care Unit									
34. Surgical Intensive Care Unit									
36. Other Special Care (specify)									
40. Subprovider - Distinct Psych Unit									
41. Subprovider - Distinct Phys Rehab									
42. Nursery Intensive Care									
43. Nursery									
45. Other Routine (specify)									
46. Other Routine (specify)									
49. Sub-Total (Lines 30 - 48)									
50. Operating Room									
51. Recovery Room									
52. Labor Room and Delivery Room									
53. Anesthesiology									
54. Radiology-Diagnostic									
55. Radiology-Therapeutic									
56. Radioisotope									
57. Computed Tomography (CT) Scan									
58. Magnetic Resonance Imaging (MRI)									
59. Cardiac Catheterization									
60. Laboratory									
61. Oncology									
62. Whole Blood & Packed Red Blood Cells									
63. Blood Storing, Processing, & Trans.									
64. Intravenous Therapy									
65. Respiratory Therapy									
66. Physical Therapy									
67. Occupational Therapy									
68. Speech Pathology / Audiology									
69. Electrocardiology									
70. Electroencephalography									
71. Medical Supplies Charged to Patients									
72. Implantable Devices Charged to Patients									
73. Drugs Charged to Patients									
74. Renal Dialysis									
75. ASC (Non-Distinct Part)									
76. Psychiatric / Psychologic									
77. Gastrointestinal Svcs									
78. Ultrasound									
79. PET Scan									
80. Pulmonary Function									
81. Cardiac Rehabilitation									
82. Treatment / Observ Room / Cast Room									
88. Rural Health Clinic (RHC)									

Provider Name

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

Uncompensated Care (UC) < 100% - Detail

ODM 02930 Schedule F2

	1 Ratio	2 I/P Charges UC w/ Ins.	3 I/P Costs UC w/ Ins.	4 O/P Charges UC w/ Ins.	5 O/P Costs UC w/ Ins.	6 I/P Charges UC w/o Ins.	7 I/P Costs UC w/o Ins.	8 O/P Charges UC w/o Ins.	9 O/P Costs UC w/o Ins.
89. Federally Qualified Health Center (FQHC)									
90. Clinic									
91. Emergency									
92. Observation Beds (see instructions)									
93. Other Outpatient Service (specify)									
100. Other Reimbursable (specify)									
101. Outpatient Rehabilitation Provider (specify)									
102. Intern-Resident (not appvd. tchnng. prgm.)									
103. Ambulatory Surgical Center (Distinct Part)									
105. Organ Acquisition									
106.									
107.									
108.									
109.									
110.									
111.									
112.									
113.									
114.									
115.									
116.									
117.									
118.									
119.									
120.									
121.									
122.									
123.									
124.									
125.									
126.									
127.									
128.									
129.									
130.									
131.									
132.									
199. Subtotal (sum of lines 50 to 198)									
202. Total (sum of lines 49 + 199)									
204. Receipts Net Costs									
205. Total Discharges Visits									
206. Unduplicated Discharges Visits									

Provider Name

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

Uncompensated Care (UC) > 100% - Detail

ODM 02930 Schedule F3

	1 Ratio	2 I/P Charges UC w/ Ins.	3 I/P Costs UC w/ Ins.	4 O/P Charges UC w/ Ins.	5 O/P Costs UC w/ Ins.	6 I/P Charges UC w/o Ins.	7 I/P Costs UC w/o Ins.	8 O/P Charges UC w/o Ins.	9 O/P Costs UC w/o Ins.
30. Adults and Pediatrics									
31. Intensive Care Unit									
32. Coronary Care Unit									
33. Burn Intensive Care Unit									
34. Surgical Intensive Care Unit									
36. Other Special Care (specify)									
40. Subprovider - Distinct Psych Unit									
41. Subprovider - Distinct Phys Rehab									
42. Nursery Intensive Care									
43. Nursery									
45. Other Routine (specify)									
46. Other Routine (specify)									
49. Sub-Total (Lines 30 - 48)									
50. Operating Room									
51. Recovery Room									
52. Labor Room and Delivery Room									
53. Anesthesiology									
54. Radiology-Diagnostic									
55. Radiology-Therapeutic									
56. Radioisotope									
57. Computed Tomography (CT) Scan									
58. Magnetic Resonance Imaging (MRI)									
59. Cardiac Catheterization									
60. Laboratory									
61. Oncology									
62. Whole Blood & Packed Red Blood Cells									
63. Blood Storing, Processing, & Trans.									
64. Intravenous Therapy									
65. Respiratory Therapy									
66. Physical Therapy									
67. Occupational Therapy									
68. Speech Pathology / Audiology									
69. Electrocardiology									
70. Electroencephalography									
71. Medical Supplies Charged to Patients									
72. Implantable Devices Charged to Patients									
73. Drugs Charged to Patients									
74. Renal Dialysis									
75. ASC (Non-Distinct Part)									
76. Psychiatric / Psychologic									
77. Gastrointestinal Svcs									
78. Ultrasound									
79. PET Scan									
80. Pulmonary Function									
81. Cardiac Rehabilitation									
82. Treatment / Observ Room / Cast Room									
88. Rural Health Clinic (RHC)									

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

Uncompensated Care (UC) > 100% - Detail

ODM 02930 Schedule F3

	1 Ratio	2 I/P Charges UC w/ Ins.	3 I/P Costs UC w/ Ins.	4 O/P Charges UC w/ Ins.	5 O/P Costs UC w/ Ins.	6 I/P Charges UC w/o Ins.	7 I/P Costs UC w/o Ins.	8 O/P Charges UC w/o Ins.	9 O/P Costs UC w/o Ins.
89. Federally Qualified Health Center (FQHC)									
90. Clinic									
91. Emergency									
92. Observation Beds (see instructions)									
93. Other Outpatient Service (specify)									
100. Other Reimbursable (specify)									
101. Outpatient Rehabilitation Provider (specify)									
102. Intern-Resident (not appvd. tchnng. prgm.)									
103. Ambulatory Surgical Center (Distinct Part)									
105. Organ Acquisition									
106.									
107.									
108.									
109.									
110.									
111.									
112.									
113.									
114.									
115.									
116.									
117.									
118.									
119.									
120.									
121.									
122.									
123.									
124.									
125.									
126.									
127.									
128.									
129.									
130.									
131.									
132.									
199. Subtotal (sum of lines 50 to 198)									
202. Total (sum of lines 49 + 199)									
204. Receipts Net Costs									
205. Total Discharges Visits									
206. Unduplicated Discharges Visits									

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

CAPITAL RELATED COST REIMBURSEMENT

ODM 02930 Schedule G

	1	2	3	4	5	6	7
	Total Charges All Patients	Capital Cost	Reserved	Total Capital Cost	Ratio	Title XIX I/P Charges	Title XIX Capital Cost
30. Adults and Pediatrics							
31. Intensive Care Unit							
32. Coronary Care Unit							
33. Burn Intensive Care Unit							
34. Surgical Intensive Care Unit							
36. Other Special Care (specify)							
40. Subprovider - Distinct Psych Unit							
41. Subprovider - Distinct Phys Rehab							
42. Nursery Intensive Care							
43. Nursery							
44. SNF NF ICF OLTC							
45. Other Routine (specify)							
46. Other Routine (specify)							
49. Sub-Total (Lines 30 - 48)							
50. Operating Room							
51. Recovery Room							
52. Labor Room and Delivery Room							
53. Anesthesiology							
54. Radiology-Diagnostic							
55. Radiology-Therapeutic							
56. Radioisotope							
57. Computed Tomography (CT) Scan							
58. Magnetic Resonance Imaging (MRI)							
59. Cardiac Catheterization							
60. Laboratory							
61. Oncology							
62. Whole Blood & Packed Red Blood Cells							
63. Blood Storing, Processing, & Trans.							
64. Intravenous Therapy							
65. Respiratory Therapy							
66. Physical Therapy							
67. Occupational Therapy							
68. Speech Pathology / Audiology							
69. Electrocardiology							
70. Electroencephalography							
71. Medical Supplies Charged to Patients							
72. Implantable Devices Charged to Patients							
73. Drugs Charged to Patients							
74. Renal Dialysis							
75. ASC (Non-Distinct Part)							
76. Psychiatric / Psychologic							
77. Gastrointestinal Svcs							
78. Ultrasound							
79. PET Scan							
80. Pulmonary Function							
81. Cardiac Rehabilitation							
82. Treatment / Observ Room / Cast Room							
88. Rural Health Clinic (RHC)							
89. Federally Qualified Health Center (FQHC)							
90. Clinic							

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

CAPITAL RELATED COST REIMBURSEMENT

ODM 02930 Schedule G

	1	2	3	4	5	6	7
	Total Charges All Patients	Capital Cost	Reserved	Total Capital Cost	Ratio	Title XIX I/P Charges	Title XIX Capital Cost
91. Emergency							
92. Observation Beds (see instructions)							
93. Other Outpatient Service (specify)							
94. Home Program Dialysis							
95. Ambulance Services							
96. Durable Medical Equipment-Rented							
97. Durable Medical Equipment-Sold							
98. Home Health Agency							
99. Hospice							
100. Other Reimbursable (specify)							
101. Outpatient Rehabilitation Provider (specify)							
102. Intern-Resident (not appvd. tchnng. prgm.)							
103. Ambulatory Surgical Center (Distinct Part)							
105. Organ Acquisition							
106.							
107.							
108.							
109.							
110.							
111.							
112.							
113.							
114.							
115.							
116.							
117.							
118.							
119.							
120.							
121.							
122.							
123.							
124.							
125.							
126.							
127.							
128.							
129.							
130.							
131.							
132.							
199. Subtotal (sum of lines 50 to 198)							
200. Total							
201. Capital Payments For Period							
202. Amount Due Program/(Provider)							

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

SETTLEMENT CALCULATION

ODM 02930 Schedule H

	1	2	3	4
	Title XIX	Title V	Title XIX Transplant	Title XIX Misc. Adjustments
Section I I/P Services				
1. Inpatient Program Cost				
2. Amount Received From Program				
3. Amount Receivable From Program				
4. Amount Recv'd/Due 3rd Party Payors				
5. Upper Limit Payments Misc Adjustments				
6. Capital Pymts (2930-G)				
7. Total I/P Payments				
8. Total Program Charges				
9. Out Of State Pymnt Over Chgs/Cost				
Section II O/P Services				
10. Outpatient Program Cost				
11. Amount Received From Program				
12. Amount Receivable From Program				
13. Amount Recv'd/Due 3rd Party Payors				
14. Upper Limit Payments Misc. Adjustments				
15. Total O/P Payments				
16. Total Program Charges				
17. Costs Over Payments				
18. Costs Over Charges				
19. Out Of State Pymnt Over Chgs/Cost				
Section III Upper Payments Test				
20. I/P & O/P Program Costs				
21. I/P & O/P Program Payments				
22. I/P & O/P Program Charges				
23. Payments Over Costs				
24. Charges Over Costs	FALSE			
25. Payments Over Costs/Charges	FALSE			
Section IV Program Summary				
26. Settlement (Section III, Line 27)				
27. Cap Cost Due Program/(Provider)				
28. Total Amount Due Program/(Provider)				

Provider Name _____

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

Title XIX HMO Cost Computation

ODM 02930 Schedule I

	1	2	3	4	5	6	7	8
	Ratio	Title XIX HMO I/P Charges	Title XIX HMO I/P Costs	Title XIX HMO O/P Charges	Title XIX HMO O/P Costs		Capital Ratio	Title XIX HMO Capital Costs
30. Adults and Pediatrics								
31. Intensive Care Unit								
32. Coronary Care Unit								
33. Burn Intensive Care Unit								
34. Surgical Intensive Care Unit								
36. Other Special Care (specify)								
40. Subprovider - Distinct Psych Unit								
41. Subprovider - Distinct Phys Rehab								
42. Nursery Intensive Care								
43. Nursery								
45. Other Routine (specify)								
46. Other Routine (specify)								
49. Sub-Total (Lines 30 - 48)								
50. Operating Room								
51. Recovery Room								
52. Labor Room and Delivery Room								
53. Anesthesiology								
54. Radiology-Diagnostic								
55. Radiology-Therapeutic								
56. Radioisotope								
57. Computed Tomography (CT) Scan								
58. Magnetic Resonance Imaging (MRI)								
59. Cardiac Catheterization								
60. Laboratory								
61. Oncology								
62. Whole Blood & Packed Red Blood Cells								
63. Blood Storing, Processing, & Trans.								
64. Intravenous Therapy								
65. Respiratory Therapy								
66. Physical Therapy								
67. Occupational Therapy								
68. Speech Pathology / Audiology								
69. Electrocardiology								
70. Electroencephalography								
71. Medical Supplies Charged to Patients								
72. Implantable Devices Charged to Patients								
73. Drugs Charged to Patients								
74. Renal Dialysis								
75. ASC (Non-Distinct Part)								
76. Psychiatric / Psychologic								
77. Gastrointestinal Svcs								
78. Ultrasound								
79. PET Scan								
80. Pulmonary Function								
81. Cardiac Rehabilitation								
82. Treatment / Observ Room / Cast Room								

Provider Name

Service Period	NPI #	Provider #	Fed. ID.	Provider Type	Stage
----------------	-------	------------	----------	---------------	-------

Title XIX HMO Cost Computation

ODM 02930 Schedule I

	1	2	3	4	5	6	7	8
	Ratio	Title XIX HMO I/P Charges	Title XIX HMO I/P Costs	Title XIX HMO O/P Charges	Title XIX HMO O/P Costs		Capital Ratio	Title XIX HMO Capital Costs
88. Rural Health Clinic (RHC)								
89. Federally Qualified Health Center (FQHC)								
90. Clinic								
91. Emergency								
92. Observation Beds (see instructions)								
93. Other Outpatient Service (specify)								
100. Other Reimbursable (specify)								
101. Outpatient Rehabilitation Provider (specify)								
102. Intern-Resident (not appvd. tchnng. prgm.)								
103. Ambulatory Surgical Center (Distinct Part)								
105. Organ Acquisition								
106.								
107.								
108.								
109.								
110.								
111.								
112.								
113.								
114.								
115.								
116.								
117.								
118.								
119.								