Schedule of Uncompensated Care Cost (per CMS Audit Rule) for Small Rural Hospitals SFY 2017, *rev. 8/2/16*

Yellow Highlighted Areas Are Input

Hospital Name	Hospital Name
Medicaid #	7 digit Medicaid #
FYE	0/00/0000

Input

CMS Audit Rule --Medicaid Summary Sheet	Inpatient	Inpatient Psych/Magellan/ Magellan SMO	Outpatient	Rural Health Clinic (Licensed as Hospital Services)	Hospital Based Ambulance	Totals
PLEASE DO NOT OVERRIDE FORMULAS (NOTE: UNINSURED PATIENT DATA REQUIRES DIRECT INPUT ON SUMMARY)						
Cost:						
Medicaid Inpatient Costs	$ -	$ -				$ -
Medicaid Outpatient/RHC Costs			$ -	$ -		$ -
Fee Schedule Costs, Lab			$ -			$ -
Crossover Costs - *All Plans*		$ -	$ -	$ -		$ -
Ambulance Costs (see calculation) - All Plans					$ -	$ -
Total Costs (1)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	$ -
Payments:						
Medicaid Inpatient Payments	$ -	$ -				$ -
Cost Report Outpatient/RHC Settlement			$ -	$ -		$ -
Primary Payers - OP/RHC (Per EIDR)	$ -	$ -	$ -	$ -		$ -
Crossover Payments (see calculation--see (G) on templets) - *All Plans*		$ -	$ -	$ -		$ -
Fee Schedule Payments --Lab			$ -			$ -
Ambulance Payments (see calculation) - All Plans					$ -	$ -
Total Payments (2)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Medicaid Shortfall/(Long fall) (1) - (2)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
(Hospital Internal Records)						
Costs of Treating Uninsured Patients *(Per Provider's Records)*	$ -	$ -	$ -	$ -	$ -	$ -
Less : Payments from Patients	$ -	$ -	$ -	$ -	$ -	$ -
Net Uninsured Costs (3)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Total Uncompensated Care Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
(Medicaid Shortfall(Long fall) + Net Uninsured Costs)						

** Filed cost report #'s as submitted to Medicaid Intermediary to be used & updated using more recent EIDR or Provider's logs on attached worksheets. Please submit copies of applicable CR pages, Fee Sch w/PS&R cost calculation and uninsured log summary of charges, days & payments.

Prepared By	Telephone #	E-mail address

The following certification is to be completed by the hospital's CEO or CFO

Based on the above cited source reporting fiscal year end cost report, I certify that the hospital has incurred those uncompensated costs. I certify that from a review of currently available information and to the best of my knowledge from such review, that the hospital will incur similar uncompensated care costs constituting public expenditures during state fiscal year 2017. Since these uncompensated care costs are public expenditures, they are eligible for Medicaid disproportionate share payments in state fiscal year 2017. I agree to maintain all documentation to support the above calculation. I understand that this information will be audited in accordance with CMS DSH audit & reporting rule to ensure accuracy and compliance with state and federal regulations. I understand that in accordance with federal law and the approved state plan, the limit for State Fiscal Year 2017 disproportionate share payments will be determined based on actual hospital uncompensated costs for dates of service from July 1, 2016 through June 30, 2017.

Signature	Title	Date

E-Mail Address

Schedule of Uncompensated Care Cost (per CMS Audit Rule) for Public Hospitals SFY 2016

Yellow Highlighted Areas Are Input

Hospital Name	Hospital Name
Medicaid #	7 digit Medicaid #
FYE	0/00/0000

CMS Audit Rule --Medicaid Summary Sheet	Inpatient	Inpatient Psych/Magellan/ Magellan SMO	Outpatient	Hospital Based Ambulance	Totals
PLEASE DO NOT OVERRIDE FORMULAS					
Cost:					
Medicaid Inpatient Costs	$ -	$ -			$ -
Medicaid Outpatient Cost			$ -		$ -
OP Fee Schedule Costs, Lab,Rehab,ASC, Clinic			$ -		$ -
Crossover Costs - *All Plans*		$ -	$ -		$ -
Ambulance Costs (see calculation) - All Plans				$ -	$ -
Total Costs (1)	**$ -**	**$ -**	**$ -**	**$ -**	$ -
Payments:					
Medicaid Inpatient Payments	$ -	$ -			$ -
Cost Report Outpatient Settlement			$ -		$ -
Primary Payers - OP (Per EIDR)	$ -	$ -	$ -		$ -
Crossover Payments (see calculation--see (G) on templets) -*All Plans*		$ -	$ -		$ -
Fee Schedule Payments --Lab, Rehab, ASC, Clinic			$ -		$ -
Ambulance Payments (see calculation) - All Plans				$ -	$ -
Total Payments (2)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Medicaid Shortfall/(Long fall) (1) - (2)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
(Hospital Internal Records)					
Costs of Treating Uninsured Patients *(Per Provider's Records)*	$ -	$ -	$ -	$ -	$ -
Less : Payments from Patients	$ -	$ -	$ -	$ -	$ -
Net Uninsured Costs (3)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Total Uncompensated Care Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
(Medicaid Shortfall(Long fall) + Net Uninsured Costs)					

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Prepared By | Telephone # | E-mail address

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Signature | Title | Date

E-Mail Address