

SCHEDULE OF UNCOMPENSATED CARE COST (PRIVATE HOSPITAL)

Hospital Name: _____

Provider Number - Acute: _____ Psych: _____

Source cost reporting fiscal year end: _____

	Source	Amounts excl. RHC & Hospital Based Ambulance	Rural Health Clinics		Hosp. Based Ambulance Amounts	Amounts incl. RHC & Hosp. Based Ambulance
			Licensed as Hospital Service	Not licensed as Hospital Service		
I. Total Cost						
Less:						
Medicaid Net Revenues(Excl. DSH Payments):						
Inpatient Acute (Incl. NICU/PICU)						
Inpatient Psychiatric						
Inpatient Rehab.						
Outlier Payments						
Outpatient Cost Based						
Outpatient Fee Schedule						
II. Total Medicaid Net Revenues						
Medicare Costs:						
Inpatient Acute						
Inpatient Psychiatric						
Inpatient Rehab.						
Outpatient Cost Based						
Outpatient Fee Schedule						
III. Total Medicare Costs						
IV. Private Insurance Costs						
V. Self Pay Net Revenue						
VI. All Other Hospital Patient Care Net Revenue or Cost Not Included in Above-listed Revenues & Costs (Please Itemize):						
VII. Total - Uncompensated Care Cost						

Prepared By: _____ Telephone #: _____

I agree to maintain all documentation to support the above calculation. I understand that this information will be audited by the Medicaid audit intermediary as part of the regular cost report audit process 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 2006 disproportionate share payments will be determined based on actual hospital uncompensated costs for dates of service from July 1, 2005 through June 30, 2006.

Signature

Title

Date