KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Bob Wilson Memorial Hospital

Kansas Medicaid Provider Number(s): 100099420A

Medicare Provider Number: 170110

Cost Report Fiscal Year: From: 1 1 2015 To: 12 31 2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$1,712,198.19
Plus HCAIP Payments	$149,127.00
Less DSH Payment	($657,815.66)
Total UC for Pool Calculation:	$1,203,509.52

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

1-3-18

Date

Amanda Vaughan

Name (Print or type)

1-3-18

Date

Sharisbauge@centura.org

Email address

620 272-2552

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Children's Mercy South

Kansas Medicaid Provider Number(s): 100080290B

Medicare Provider Number: 173300

Cost Report Fiscal Year: From: 7/1/2015 To: 6/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$9,713,161.85
Plus HCAIP Payments	$846,576.99
Less DSH Payment	($2,585,028.69)
Total UC for Pool Calculation:	$7,974,710.15

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

1-2-2018

Date

David Cauble

Name (Print or type)

1-2-2018

Date

~~david~~ dacauble@cmh.edu

Email address

816-302-0279

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Coffeyville Regional Medical Center

Kansas Medicaid Provider Number(s): 100107200A

Medicare Provider Number: 170145

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $3,043,016.80

Plus HCAIP Payments $218,876.00

Less DSH Payment ($705,335.76)

Total UC for Pool Calculation: $2,556,557.05

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12/27/17

Date

Lori Rexwinkle

Name (Print or type)

12/27/17

Date

lrexwinkle@crmcinc.org

Email address

620-252-1147

Contact Phone Number

cc: marileem@crmcinc.org

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Cushing Memorial Hospital

Kansas Medicaid Provider Number(s): 100088000A

Medicare Provider Number: 170133

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$2,580,442.91
Plus HCAIP Payments	$503,180.00
Less DSH Payment	($662,457.92)
Total UC for Pool Calculation:	$2,421,164.99

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 1/2/18

Signature / Date

Jackie Martin 1/2/18

Name (Print or type) / Date

jwmartin@saint-lukes.org 913-684-1305

Email address / Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Geary Community Hospital

Kansas Medicaid Provider Number(s): 100089280A

Medicare Provider Number: 170074

Cost Report Fiscal Year: From: 5/1/2015 To: 4/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$2,952,934.16
Plus HCAIP Payments	$415,949.64
Less DSH Payment	($714,508.55)
Total UC for Pool Calculation:	$2,654,375.25

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 12-29-17

Signature Date

Stephen J. Doherty

Name (Print or type) Date

sjdoherty@gchks.org 785-210-3302

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Great Bend Regional Hospital, LLC

Kansas Medicaid Provider Number(s): 100396140A

Medicare Provider Number: 170191

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$2,037,785.62
Plus HCAIP Payments	$703,652.00
Less DSH Payment	($336,492.83)
Total UC for Pool Calculation:	$2,404,944.79

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	(Yes)	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature — Date: 12/22/2017

Tim Lehman

Name (Print or type) — Date: 12/22/2017

tlehman@gbregional.com

Email address — Contact Phone Number: (620) 791-6815

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Hays Medical Center

Kansas Medicaid Provider Number(s): 100098970A

Medicare Provider Number: 170013

Cost Report Fiscal Year: From: 7/1/2015 To: 6/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $3,257,847.40

Plus HCAIP Payments $1,095,737.72

Less DSH Payment ($0.00)

Total UC for Pool Calculation: $4,353,585.12

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	(Yes)	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

1-3-18

Date

George Harms, CFO

Name (Print or type)

1-3-18

Date

george.harms@haysmed.com

Email address

785-623-6510

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Kansas Heart Hospital

Kansas Medicaid Provider Number(s): 100340110A

Medicare Provider Number: 170186

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$96,067.07
Plus HCAIP Payments	$73,463.00
Less DSH Payment	($0.00)
Total UC for Pool Calculation:	$169,530.07

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]
Signature

3/14/18
Date

Steve Smith
Name (Print or type)

3/14/18
Date

SSmith@kansasheart.com
Email address

316 630-5000
Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Kansas Medical Center

Kansas Medicaid Provider Number(s): 200408390C

Medicare Provider Number: 170197

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$455,544.44
Plus HCAIP Payments	$39,916.00
Less DSH Payment	($0.00)
Total UC for Pool Calculation:	$495,460.44

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	No
Inpatient psychiatric service distinct part unit (beds)	Yes	No
Level I or Level II trauma services	Yes	No
Did the hospital system provide Level I, II and III NICU services?	Yes	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	Yes	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12-27-2017

Date

STEVEN N. HADLEY

Name (Print or type)

Date

Steven.hadley@ksmedcenter.com

Email address

316-201-6559

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Labette County Medical Center

Kansas Medicaid Provider Number(s): 100088190A

Medicare Provider Number: 170120

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$1,594,513.69
Plus HCAIP Payments	$271,757.00
Less DSH Payment	($144,022.50)
Total UC for Pool Calculation:	$1,722,248.19

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature — Date: 12-29-2017

THOMAS L MACKEOWN — Name (Print or type) — Date: 12:29:2017

tmac@labettehealth.com — Email address — Contact Phone Number: 620 820 5251

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Lawrence Memorial Hospital

Kansas Medicaid Provider Number(s): 100099120A

Medicare Provider Number: 170137

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$5,973,040.67
Plus HCAIP Payments	$1,044,785.00
Less DSH Payment	($638,289.41)
Total UC for Pool Calculation:	$6,379,536.26

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] — Signature

12/26/2017 — Date

Joseph D. Pedley — Name (Print or type)

12/26/2017 — Date

joseph.pedley@lmh.org — Email address

785-505-6133 — Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: McPherson Memorial Hospital

Kansas Medicaid Provider Number(s): 100002710A

Medicare Provider Number: 170105

Cost Report Fiscal Year: From: 7/1/2015 To: 6/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $1,962,974.98

Plus HCAIP Payments $130,562.93

Less DSH Payment ($505,438.18)

Total UC for Pool Calculation: $1,588,099.74

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	No
Inpatient psychiatric service distinct part unit (beds)	Yes	No
Level I or Level II trauma services	Yes	No
Did the hospital system provide Level I, II and III NICU services?	Yes	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	Yes	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 1-3-18

Signature Date

Terri Gehring 1-3-18

Name (Print or type) Date

terrig@mcphersonhospital.org 620-241-2250

Email address Contact Phone Number

Revised

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

***Please Note:** Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Menorah Medical Center

Kansas Medicaid Provider Number(s): 100642360A

Medicare Provider Number: 170182

Cost Report Fiscal Year: From: 6/1/2015 To: 5/31/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$1,712,484.32
Plus HCAIP Payments	$735,618.05
Less DSH Payment	($0.00)
Total UC for Pool Calculation:	$2,448,102.36

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	No
Inpatient psychiatric service distinct part unit (beds)	Yes	No
Level I or Level II trauma services	Yes	No
Did the hospital system provide Level I, II and III NICU services?	Yes	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	Yes	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12/28/17

Date

Charles E. Laird

Name (Print or type)

12/28/17

Date

Charles.laird@hcahealthcare.com

Email address

913-498-7177

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Mercy Health Center - Fort Scott

Kansas Medicaid Provider Number(s): 100089300B

Medicare Provider Number: 170058

Cost Report Fiscal Year: From: 7/1/2015 To: 6/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$1,691,572.15
Plus HCAIP Payments	$323,032.62
Less DSH Payment	($321,071.68)
Total UC for Pool Calculation:	$1,693,533.09

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	(Yes)	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]
Signature

12/28/2017
Date

Reta Baker
Name (Print or type)

12/28/2017
Date

reta.baker@mercy.net
Email address

620-223-7057
Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Mercy Hospital - Moundridge

Kansas Medicaid Provider Number(s): 100099200A

Medicare Provider Number: 170075

Cost Report Fiscal Year: From: 10/1/2015 To: 9/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$190,217.16
Plus HCAIP Payments	$25,151.85
Less DSH Payment	($27,634.55)
Total UC for Pool Calculation:	$187,734.46

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 12-27-17

Signature Date

Royce Holderman 12-27-17

Name (Print or type) Date

rh@mercyh.org 620-345-6391

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Mercy Regional Health Center - Manhattan

Kansas Medicaid Provider Number(s): 100265560A

Medicare Provider Number: 170142

Cost Report Fiscal Year: From: 4/1/2015 To: 3/31/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $6,046,846.52

Plus HCAIP Payments $711,485.79

Less DSH Payment ($0.00)

Total UC for Pool Calculation: $6,758,332.31

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes (circled)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	No (circled)
Level I or Level II trauma services	Yes	No (circled)
Did the hospital system provide Level I, II and III NICU services?	Yes	No (circled)
Did the hospital have less than $300 million in Net Inpatient Revenue?	Yes (circled)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature 1/3/19 Date

James Fraser

Name (Print or type) 1/3/19 Date

Jim.Fraser@Ascension.org.

Email address 785-776-2810 Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Miami County Medical Center

Kansas Medicaid Provider Number(s): 100099280A

Medicare Provider Number: 170109

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$1,425,431.04
Plus HCAIP Payments	$207,771.00
Less DSH Payment	($0.00)
Total UC for Pool Calculation:	$1,633,202.04

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12/27/17

Date

Tierney L. Grasser

Name (Print or type)

Date

tierney.grasser@olathehealth.org

Email address

913.791.4461

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Morton County Health System

Kansas Medicaid Provider Number(s): 100087540A

Medicare Provider Number: 170166

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$568,104.65
Plus HCAIP Payments	$84,191.00
Less DSH Payment	($0.00)
Total UC for Pool Calculation:	$652,295.65

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 12/27/17

Signature Date

RICHARD BERGLING 12/27/17

Name (Print or type) Date

rbergling@mchswecare.com 620-697-5200

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Newton Medical Center

Kansas Medicaid Provider Number(s): 100102820A

Medicare Provider Number: 170103

Cost Report Fiscal Year: From: 7/1/2015 To: 6/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $3,355,425.31

Plus HCAIP Payments $431,545.99

Less DSH Payment ($0.00)

Total UC for Pool Calculation: $3,786,971.30

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12-27-17

Date

Todd P. Kasitz

Name (Print or type)

12-27-17

Date

todd.kasitz@newtonmed.com

Email address

316-804-6096

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Olathe Medical Center

Kansas Medicaid Provider Number(s): 100099250A

Medicare Provider Number: 170049

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$7,553,017.21
Plus HCAIP Payments	$845,734.00
Less DSH Payment	($0.00)
Total UC for Pool Calculation:	$8,398,751.21

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12/27/17

Date

Tierney L. Grasser

Name (Print or type)

Date

tierney.grasser@olathehealth.org

Email address

913.791.4461

Contact Phone Number

Revised

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Overland Park Regional Medical Center

Kansas Medicaid Provider Number(s): 100453760A

Medicare Provider Number: 170176

Cost Report Fiscal Year: From: 6/1/2015 To: 5/31/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $10,241,731.52

Plus HCAIP Payments $2,454,071.10

Less DSH Payment ($0.00)

Total UC for Pool Calculation: $12,695,802.62

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	No
Inpatient psychiatric service distinct part unit (beds)	Yes	No
Level I or Level II trauma services	Yes	No
Did the hospital system provide Level I, II and III NICU services?	Yes	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	Yes	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12/28/17

Date

Kevin J. Hicks

Name (Print or type)

12/28/17

Date

Kevin.hicks6@hcahealthcare.com

Email address

913-541-5301

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Prairie Ridge

Kansas Medicaid Provider Number(s): 200641910E

Medicare Provider Number: 0

Cost Report Fiscal Year: From: 7/1/2015 To: 6/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $204,881.76

Plus HCAIP Payments $0.00

Less DSH Payment ($190,344.00)

Total UC for Pool Calculation: $14,537.76

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

3/15/2018

Date

Jon Corbin

Name (Print or type)

3/15/2018

Date

JCorbin@kuc.org

Email address

913-890-7413

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Prairie View Hospital

Kansas Medicaid Provider Number(s): 100005670A

Medicare Provider Number: 174016

Cost Report Fiscal Year: From: 7/1/2015 To: 6/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$405,670.46
Plus HCAIP Payments	$0.00
Less DSH Payment	($376,885.00)
Total UC for Pool Calculation:	$28,785.46

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 1/2/18

Signature Date

Lisa Ramsey 1/2/18

Name (Print or type) Date

ramseylrc@pvi.org 316-284-6351

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Pratt Regional Medical Center

Kansas Medicaid Provider Number(s): 100099320A

Medicare Provider Number: 170027

Cost Report Fiscal Year: From: 10/1/2015 To: 9/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $1,083,661.22

Plus HCAIP Payments $136,804.61

Less DSH Payment ($0.00)

Total UC for Pool Calculation: $1,220,465.83

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

1-4-18

Date

Susan Page

Name (Print or type)

Date

SPage@pmc.org

Email address

620 450-1436

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Promise Regional Medical Center

Kansas Medicaid Provider Number(s): 100088340A

Medicare Provider Number: 170020

Cost Report Fiscal Year: From: 7 1 2015 To: 6 30 2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$3,973,509.18
Plus HCAIP Payments	$501,836.95
Less DSH Payment	($0.00)
Total UC for Pool Calculation:	$4,475,346.12

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]
Signature

1/2/18
Date

Cassandra J. Dolen
Name (Print or type)

Date

dolenc@hutchregional.com
Email address

620-513-4556
Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Providence Medical Center

Kansas Medicaid Provider Number(s): 201074830A

Medicare Provider Number: 170146

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$7,798,830.05
Plus HCAIP Payments	$2,082,585.00
Less DSH Payment	($1,164,771.47)
Total UC for Pool Calculation:	$8,716,643.59

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 1-4-18

Signature Date

Dave Dulny 1/4/18

Name (Print or type) Date

DDulny@primehealthcare.com 913-596-4846

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Ransom Memorial Hospital

Kansas Medicaid Provider Number(s): 100099270A

Medicare Provider Number: 170014

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $2,288,565.25

Plus HCAIP Payments $279,914.00

Less DSH Payment ($448,360.08)

Total UC for Pool Calculation: $2,120,119.17

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

3/14/18

Date

Matt Heyn

Name (Print or type)

3/14/18

Date

heyn@ransom.org

Email address

785-229-8309

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC DSH Survey. Data from the Survey populates this application

General Information

Hospital Name: Saint Catherine Hospital

Kansas Medicaid Provider Number(s): 100088310A

Medicare Provider Number: 170023

Cost Report Fiscal Year: From: 7 1 2015 To: 6 30 2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$5,682,333.51
Plus HCAIP Payments	$803,215.57
Less DSH Payment	($1,046,738.98)
Total UC for Pool Calculation:	$5,438,810.10

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

Date 1-3-18

Amanda Vaughan

Name (Print or type)

Date 1-3-18

Sharisbarge@ascension.org

Email address

620 272-2552

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Saint Francis Health Center

Kansas Medicaid Provider Number(s): 100080610A

Medicare Provider Number: 170016

Cost Report Fiscal Year: From: 7/1/2015 To: 6/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$12,816,236.37
Plus HCAIP Payments	$1,488,233.91
Less DSH Payment	($2,161,957.01)
Total UC for Pool Calculation:	$12,142,513.27

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	(Yes)	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12/22/17

Date

JAMES W. ADAMS III

Name (Print or type)

Date

JIM.ADAMS@ardenthealth.com

Email address

615-296-3339

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Saint John Hospital

Kansas Medicaid Provider Number(s): 201074770A

Medicare Provider Number: 170009

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $2,050,446.44

Plus HCAIP Payments $396,673.00

Less DSH Payment ($406,926.57)

Total UC for Pool Calculation: $2,040,192.87

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

1-4-18

Date

Dave Dulny

Name (Print or type)

1-4-18

Date

DDulny@primehealthcare.com

Email address

913-596-4846

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Saint Luke's South Hospital

Kansas Medicaid Provider Number(s): 100332210A

Medicare Provider Number: 170185

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $1,116,077.18

Plus HCAIP Payments $387,551.00

Less DSH Payment ($0.00)

Total UC for Pool Calculation: $1,503,628.18

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12/27/17

Date

ROBERT OLM-SHIPMAN

Name (Print or type)

12/27/17

Date

ROLMSHIPMAN@SAINT-LUKES.ORG

Email address

913-317-7903

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Salina Regional Health Center

Kansas Medicaid Provider Number(s): 100105940A

Medicare Provider Number: 170012

Cost Report Fiscal Year: From: 10/1/2015 To: 9/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $5,003,800.35

Plus HCAIP Payments $897,922.36

Less DSH Payment ($0.00)

Total UC for Pool Calculation: $5,901,722.70

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	(Yes)	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12-27-17

Date

Joe Talon

Name (Print or type)

Date

mtaskine@srhc.com

Email address

785-452-7004

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Salina Surgical Hospital

Kansas Medicaid Provider Number(s): 100358410A

Medicare Provider Number: 170187

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $82,518.12

Plus HCAIP Payments $12,215.00

Less DSH Payment ($0.00)

Total UC for Pool Calculation: $94,733.12

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

12/26/2017

Date

LuAnn Puvogel

Name (Print or type)

12/26/2017

Date

luann.puvogel@salinasurgical.com

Email address

785-493-0685

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Shawnee Mission Medical Center

Kansas Medicaid Provider Number(s): 100093850A

Medicare Provider Number: 170104

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$14,362,582.28
Plus HCAIP Payments	$2,581,559.00
Less DSH Payment	($0.00)
Total UC for Pool Calculation:	$16,944,141.28

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 1-3-2018

Signature Date

Karsten Randolph 1-3-2018

Name (Print or type) Date

Karsten.Randolph@AHSS.org 913.676-2152

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: South Central Kansas RMC

Kansas Medicaid Provider Number(s): **100080590A**

Medicare Provider Number: 170150

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $ 1,455,557.13

Plus HCAIP Payments $ 218,828.00

Less DSH Payment $ (616,186.42)

Total UC for Pool Calculation: $ 1,058,198.70

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	(Yes)	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]
Signature

12/15/17
Date

Virgil Watson
Name (Print or type)

12/15/17
Date

virgilw@sckrmc.org
Email address

620-441-5900
Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Southwest Medical Center

Kansas Medicaid Provider Number(s): **100099490A**

Medicare Provider Number: 170068

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $ ~~1,367,566.66~~ **2,195,081**

Plus HCAIP Payments $ 485,290.00

Less DSH Payment $ (292,095.58)

Total UC for Pool Calculation: $ ~~1,760,761.08~~ **2,388,275**

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature — Date: 1/10/2018

Amber Williams

Name (Print or type) — Date: 1/10/2018

awilliams@swmedcenter.com — (620) 629-6680

Email address — Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Stormont-Vail Regional Health Center

Kansas Medicaid Provider Number(s): 100099400A

Medicare Provider Number: 170086

Cost Report Fiscal Year: From: 10/1/2015 To: 9/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $14,177,832.14

Plus HCAIP Payments $4,129,336.65

Less DSH Payment ($1,258,949.17)

Total UC for Pool Calculation: $17,048,219.62

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	(Yes)	No
Did the hospital system provide Level I, II and III NICU services?	(Yes)	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 1.5.18

Signature Date

Robert Langland 1.5.18

Name (Print or type) Date

rlanglan@stormontvail.org 785-354-6148

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Sumner Regional Medical Center

Kansas Medicaid Provider Number(s): 100088990A

Medicare Provider Number: 170039

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $515,043.20

Plus HCAIP Payments $146,161.00

Less DSH Payment ($56,480.17)

Total UC for Pool Calculation: $604,724.04

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	(Yes)	No
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

1/4/2017

Date

ERIC CHRISTENSEN

Name (Print or type)

1/4/2017

Date

ERICC@SRMCKS.ORG

Email address

620-399-1294

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name: Susan B. Allen Memorial Hospital

Kansas Medicaid Provider Number(s): 100088620A

Medicare Provider Number: 170017

Cost Report Fiscal Year: From: 1/1/2015 To: 12/31/2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$4,464,118.66
Plus HCAIP Payments	$403,163.00
Less DSH Payment	($1,127,867.60)
Total UC for Pool Calculation:	$3,739,414.07

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	Yes	(No)

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 12/29/17

Signature Date

Jennifer Gerken 12/29/17

Name (Print or type) Date

jgerken@sbamh.org 316.322.4544

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: VIA CHRISTI HOSPITAL - PITTSBURG

Kansas Medicaid Provider Number(s): 100099300A

Medicare Provider Number: 170006

Cost Report Fiscal Year: From: 4/1/2015 To: 3/31/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $5,372,240.71

Plus HCAIP Payments $904,133.85

Less DSH Payment ($1,000,551.50)

Total UC for Pool Calculation: $5,275,823.07

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes (circled)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	No (circled)
Level I or Level II trauma services	Yes	No (circled)
Did the hospital system provide Level I, II and III NICU services?	Yes	No (circled)
Did the hospital have less than $300 million in Net Inpatient Revenue?	Yes (circled)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 1/3/18

Signature Date

Mike Joy 1/3/18

Name (Print or type) Date

Mike.Joy@viachristi.org 316-858-4932

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Via Christi Hospital - Saint Teresa

Kansas Medicaid Provider Number(s): 200677860A

Medicare Provider Number: 170200

Cost Report Fiscal Year: From: 8/1/2015 To: 7/31/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$2,664,841.39
Plus HCAIP Payments	$312,129.64
Less DSH Payment	($0.00)
Total UC for Pool Calculation:	$2,976,971.03

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

1/4/18

Date

Claudio J. Ferraro

Name (Print or type)

1/4/18

Date

claudio.Ferraro@ascension.org

Email address

(316) 796-7802

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Via Christi Regional Medical Center

Kansas Medicaid Provider Number(s): 100080640B

Medicare Provider Number: 170122

Cost Report Fiscal Year: From: 10/1/2015 To: 9/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$53,376,113.41
Plus HCAIP Payments	$5,945,409.30
Less DSH Payment	($13,376,922.22)
Total UC for Pool Calculation:	$45,944,600.49

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	No
Inpatient psychiatric service distinct part unit (beds)	Yes	No
Level I or Level II trauma services	Yes	No
Did the hospital system provide Level I, II and III NICU services?	Yes	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	Yes	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

1-3-18

Date

Michael McCullough

Name (Print or type)

Date

Michael.mccullough@ascension.org

Email address

316-715-3223

Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Via Christi Rehabilitation Center

Kansas Medicaid Provider Number(s): 100105420A

Medicare Provider Number: 173028

Cost Report Fiscal Year: From: 10/1/2015 To: 9/30/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$622,752.23
Plus HCAIP Payments	$125,336.72
Less DSH Payment	($0.00)
Total UC for Pool Calculation:	$748,088.95

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	Yes	(No)
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 1-4-18

Signature Date

Michael McCullough

Name (Print or type) Date

michael-mccullough@ascension.org

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Wesley Medical Center

Kansas Medicaid Provider Number(s): 100327110A

Medicare Provider Number: 170123

Cost Report Fiscal Year: From: 1 1 2015 To: 12 31 2015

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC): $12,129,916.57

Plus HCAIP Payments $5,879,029.00

Less DSH Payment ($740,699.65)

Total UC for Pool Calculation: $17,268,245.92

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	(Yes)	No
Did the hospital system provide Level I, II and III NICU services?	(Yes)	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	Yes	(No)

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted] 1/4/18

Signature Date

Patrick Whitmore

Name (Print or type) Date

Patrick.Whitmore@hcahealthcare.com 316-962-2055

Email address Contact Phone Number

KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.

General Information

Hospital Name: Western Plains Medical Complex

Kansas Medicaid Provider Number(s): 100098790A

Medicare Provider Number: 170175

Cost Report Fiscal Year: From: 3/1/2015 To: 2/29/2016

UC Demonstration Year: **2018 - DY 6**

Amount of Uncompensated Care (UC):	$4,021,627.39
Plus HCAIP Payments	$468,281.88
Less DSH Payment	($1,134,766.63)
Total UC for Pool Calculation:	$3,355,142.63

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the cost report year?

Level II or Level III NICU services	(Yes)	No
Inpatient psychiatric service distinct part unit (beds)	Yes	(No)
Level I or Level II trauma services	Yes	(No)
Did the hospital system provide Level I, II and III NICU services?	Yes	(No)
Did the hospital have less than $300 million in Net Inpatient Revenue?	(Yes)	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

[redacted]

Signature

1-4-18

Date

RYAN PUGH

Name (Print or type)

1-4-18

Date

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Contact Phone Number