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 Medicald Provider Nun	nber(s): 100099420A	
Medicare Provider Number:	170110	
Cost Report Fiscal Year:	From: 1 2015 To: 12 31 20	015
UC Demonstration Year:	2018 - DY 6	
Amount of Uncompensated Car	e (UC): \$1,712,198.19	
Plus HCAIP Payments	\$149,127.00	
Less DSH Payment	(\$657,815.6	<u>66</u>)
Total UC for Pool Calculation:	\$1,203,509.52	
Criteria for Additional Unifor Did the hospital provide the following the control of the control	m Percentage owing during the cost report year?	
Level II or Level III NIC	CU services	Yes
Inpatient psychiatric ser	vice distinct part unit (beds)	Yes No
Level I or Level II traun	na services	Yes
Did the hospital system provide	Level I, II and III NICU services?	Yes
Did the hospital have less than \$	300 million in Net Inpatient Revenue?	Yes No
Signer must be an individual legal Owner, a General Partner, a special Signature A Marcha (Print or type)	ally responsible for the conduct of the difficulty authorized Corporation Officer	contracted hospital such as the r or a Hospital Administrator.
Email address	centura, org	620 272-2552 Contact Phone Number

General Information Hospital Name: Children's Mercy	South				
Kansas Medicaid Provider Number	(s): 100080290B				
Medicare Provider Number: 17	3300				
Cost Report Fiscal Year: From	om: 7/1/2015 To: 6/30/2016				
UC Demonstration Year: 20	18 - DY 6				
Amount of Uncompensated Care (1	JC): \$9,713,161.85				
Plus HCAIP Payments	\$846,576.99				
Less DSH Payment	(\$2,585,028.69	<u></u>			
Total UC for Pool Calculation:	\$7,974,710.15				
Criteria for Additional Uniform Did the hospital provide the follow			_		
Level II or Level III NICU	services	Yes	(N_0)		
Inpatient psychiatric servic	ent psychiatric service distinct part unit (beds)				
Level I or Level II trauma	ervices	Yes	No		
Did the hospital system provide Le	vel I, II and III NICU services?	Yes	(No)		
Did the hospital have less than \$30) 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. 1 - 2 - 2018 Signature Date					
David Caub Name (Print or type)	e	/- Z - 70 Date	018		
Email address	ole @ cmh. edu	810-302 Contact Phone Nu			

General Information Hospital Name: Coffeyville R	egional l	Medical (Center			
Kansas Medicaid Provider Num	ber(s):	1001072	200A			
Medicare Provider Number:	170145					
Cost Report Fiscal Year:	From:	1/1/2015	5	To: 12/31/201	5	
UC Demonstration Year:	2018 - 1	DY 6				
Amount of Uncompensated Car	e (UC):	-	\$3,	,043,016.80		
Plus HCAIP Payments		-	\$218,8	876.00		
Less DSH Payment				(\$705,335.76	<u> </u>	
Total UC for Pool Calculation:			\$2,556,	557.05		_
Criteria for Additional Unifor Did the hospital provide the foll		_	cost rep	oort year?		
Level II or Level III NI	CU servi	ces			Yes	No
Inpatient psychiatric service distinct part unit (beds)					Yes	Na
Level I or Level II traur	na servic	es			Yes	(No)
Did the hospital system provide	Level I,	II and III	NICU	services?	Yes	No
Did the hospital have less than \$	5300 mil	lion in Ne	et Inpati	ient Revenue?	Yes) No
Signer must be an individual leg Owner, a General Partner, a spe	· · ·				-	
					12/27/	17
Signature					Date	<u> </u>
Name (Print or type)	n Kle	·			12 27 1 Date	7
Irexwinkle con Email address Cc'. Marilee			<u> </u>	<u> </u>	Contact Phone	52-1147 Number

General Information Hospital Name: Cushing Me	morial Hospital			
Kansas Medicaid Provider Nu	mber(s): 10008	88000A		
Medicare Provider Number:	170133			
Cost Report Fiscal Year:	From: 1/1/20	To: 12/31/2015		
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Ca	are (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 Uniformation Did the hospital provide the fo	-			
Level II or Level III N	ICU services		Yes	No
Inpatient psychiatric s	Yes	No		
Level I or Level II tra	Yes	No		
Did the hospital system provide	de Level I, II and	I III NICU services?	Yes	No
Did the hospital have less than	n \$300 million in	Net Inpatient Revenue?	Yes	No
Signer must be an individual l Owner, a General Partner, a s			•	
Signature /			1/2/18 Date	
Jackie Mar	tin		1/2/18	
Name (Print or type)			Date	
	tin@saint	lukes.org	913-68	<u>'</u>
Email address			Contact Phone N	lumber

General Information Hospital Name: Geary Comm	nunity Hospital			
Kansas Medicaid Provider Nun	nber(s): 10008	39280A		
Medicare Provider Number:	170074			
Cost Report Fiscal Year:	From: 5/1/20	To: 4/30/2016		
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Ca	re (UC):	\$2,952,934.16		
Plus HCAIP Payments		\$415,949.64		
Less DSH Payment		(\$714,508.55	1	
Total UC for Pool Calculation:		\$2,654,375.25		
Criteria for Additional Unifo Did the hospital provide the fol	-	he cost report year?		
Level II or Level III N	ICU services		Yes	No
Inpatient psychiatric se	ervice distinct pa	art unit (beds)	Yes	Mo
Level I or Level II trau	ma services		Yes	No
Did the hospital system provide	e 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 le Owner, a General Partner, a sp			•	
A-1			12.29.17	<u></u>
Signature			Date	
Stephen J. Dol	nerty			
Name (Print or type)	-		Date	
5 doherty @ 9	chks.org		785-2	10-3302
Email address		 	Contact Phone N	lumber

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 Num	nber(s):	10039	5140A				
Medicare Provider Number:	170191						
Cost Report Fiscal Year:	From:	1/1/201	5	To: 12/31/20	15		
UC Demonstration Year:	2018 -	DY 6					
Amount of Uncompensated Car	e (UC):		\$:	2,037,785.62			
Plus HCAIP Payments			\$703	,652.00			
Less DSH Payment				(\$336,492.8	3_)		
Total UC for Pool Calculation:			\$2,404	1,944.79			
Criteria for Additional Unifor Did the hospital provide the foll			e cost re	eport year?			
Level II or Level III NI	CU servi	ces				Yes	No
Inpatient psychiatric ser	vice dist	inct part	t unit (b	eds)		Yes	(No)
Level I or Level II traun	na servio	es				Yes	No
Did the hospital system provide Level I, II and III NICU services?						Yes	No
Did the hospital have less than \$	300 mil	lion in N	let Inpa	tient Revenue?		Yes	No
Signer must be an individual leg Owner, a General Partner, a spec						ospital Admi	nistrator.
Signature		***************************************		the state of the s	Date	17/22/20	Fe colores
Tim letour						12/12/20	11
Name (Print or type)					Date		
Hatimeco phimic	nel 1	Der-			10	20) 791-	6815
Email address					Conta	ict Phone Nu	mber

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 Num	ber(s):	1000989	970A		
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 Car	e (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 Unifor Did the hospital provide the following		~	cost report year?	_	
Level II or Level III NI	CU serv	ices		Yes	No
Inpatient psychiatric ser	rvice dis	tinct part	unit (beds)	Yes	No
Level I or Level II traur	na servi	ces		Yes	No
Did the hospital system provide	Level I	, II and II	I NICU services?	Yes	No
Did the hospital have less than S	\$300 mi	llion in N	et 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.					

General Information Hospital Name: Kansas Hear	t Hospital					
Kansas Medicaid Provider Nun	nber(s): 10034	0110A				
Medicare Provider Number:	170186					
Cost Report Fiscal Year:	From: 1/1/201	15	To: 12/31/2015	,		
UC Demonstration Year:	2018 - DY 6					
Amount of Uncompensated Car	re (UC):	\$9	5,067.07			
Plus HCAIP Payments		\$73,4	53.00_			
Less DSH Payment			(\$0.00)			
Total UC for Pool Calculation:		\$169,5	30.07			
Criteria for Additional Unifor Did the hospital provide the fol		e cost rep	oort year?			
Level II or Level III NI	CU services			7	Yes	Ra
Inpatient psychiatric se	rvice distinct par	t unit (be	ds)	•	Yes	No
Level I or Level II traus	ma services			7	Yes	(13)
Did the hospital system provide	Level I, II and I	III NICU	services?	· •	Yes	(Ng
Did the hospital have less than	\$300 million in ?	Net Inpati	ent Revenue?	7	?es	Ño
Signer must be an individual le Owner, a General Partner, a spe Signature	gally responsible cifically authoriz	for the c	onduct of the co	or a Hospid	ospital such tal Administr	as the ator.
Sheve Smth				3/1	14/18	
Name (Print or type)				Date		
SSM. The Kainsashear	t.com			316	630-500	<u> </u>
Email address				Contact P	hone Numbe	r

General Information Hospital Name: Kansas Medi	cal Center			
Kansas Medicaid Provider Nun	nber(s): 20040	8390C		
Medicare Provider Number:	170197			
Cost Report Fiscal Year:	From: 1/1/201	To: 12/31/201	5	
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Ca	re (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 Unifo Did the hospital provide the fol	9	ne cost report year?		
Level II or Level III N	ICU services		Yes	No,
Inpatient psychiatric se	rvice distinct par	rt unit (beds)	Yes	No
Level I or Level II trau	ma services		Yes	No
Did the hospital system provide	e 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 le Owner, a General Partner, a sp			r or a Hospital A	Administrator.
Signature	7		/2 - 2 Date	7.7017
STEVENIN. HARLAY				
Name (Print or type)			Date	
Steven. healtey & Ks	in edcenter	· cen	316-20	01-6559
Email address			Contact Phon	e Number

General Information Hospital Name: Labette Coun	nty Medical Center	
Kansas Medicaid Provider Nun	nber(s): 100088190A	
Medicare Provider Number:	170120	
Cost Report Fiscal Year:	From: 1/1/2015 To: 12/31/2	015
UC Demonstration Year:	2018 - DY 6	¥.
Amount of Uncompensated Car	re (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 Unifo Did the hospital provide the fol	rm Percentage llowing during the cost report year?	
Level II or Level III N	ICU services	Yes (No)
Inpatient psychiatric se	ervice distinct part unit (beds)	Yes No
Level I or Level II trau	ıma services	Yes No
Did the hospital system provide	e Level I, II and III NICU services?	Yes
Did the hospital have less than	\$300 million in Net Inpatient Revenu	e? (Yes) No
Owner, a General Partner, a sp	egally responsible for the conduct of the ecifically authorized Corporation Offi	
Signature		Date
I HOMAS L MARAR Name (Print or type)	OND	12:29:2017 Date
Email address	tehealth.com	620 820 5251 Contact Phone Number

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

nospital Name: Lawrence Me	moriai Hospitai			
Kansas Medicaid Provider Num	ber(s): 100099120A	L		
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 Car	e (UC):	\$5,973,040.67		
Plus HCAIP Payments	\$1	,044,785.00		
Less DSH Payment		(\$638,289.41	7	
Total UC for Pool Calculation:	\$6,3	79,536.26		
Criteria for Additional Unifor Did the hospital provide the follo	-	report year?		
Level II or Level III NI	CU services		Yes	No
Inpatient psychiatric se	rvice distinct part unit	(beds)	Yes	No
Level I or Level II traus	na services		Yes	No
Did the hospital system provide	Level I, II and III NI	CU services?	Yes	No
Did the hospital have less than	300 million in Net In	patient Revenue?	Yes	No
Signer must be an individual lead Owner, a General Partner, a spe		orporation Officer	•	nistrator.
Signature	0			
Name (Print or type)	dlex		12/26/20 Date	17
Email address	dley almhoo	g	785-505 Contact Phone No	

Hospital Name: McPherson M	emorial Hospital	i			
Kansas Medicaid Provider Num	ber(s): 100002	710A			14
Medicare Provider Number:	170105				
Cost Report Fiscal Year:	From: 7/1/201	5	To: 6/30/2016		
UC Demonstration Year:	2018 - DY 6				
Amount of Uncompensated Car	e (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 Unifor Did the hospital provide the foll		e cost rep	oort year?		
Level II or Level III NI	CU services			Yes	No
Inpatient psychiatric ser	rvice distinct part	t unit (be	eds)	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 S	§300 million in N	Net Inpat	ient Revenue?	Yes	No
Signer must be an individual legowner, a General Partner, a special Signature					
Terri Gehring Name (Print or type)				/-3-/8 Date	
terrig@ mepherson. Email address	hospital.on	9		Contact Phone	

General Information Hospital Name: Menorah Me	edical Center					
Kansas Medicaid Provider Nu	mber(s): 10	0642360	\ .			
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 Ca	ire (UC):		\$1,712,484.32			
Plus HCAIP Payments		\$7	35,618.05			
Less DSH Payment			(\$0.00)			
Total UC for Pool Calculation	:	\$2,4	148,102.36	.		
Criteria for Additional Uniformal Did the hospital provide the fo		_	report year?			
Level II or Level III NICU services Yes						o
Inpatient psychiatric service distinct part unit (beds)					es N	0
Level I or Level II trauma services					es N	0
Did the hospital system provid	le Level I, II :	and III NI	CU services?	Y	es N	0
Did the hospital have less than \$300 million in Net Inpatient Revenue?					es N	0
Signer must be an individual le Owner, a General Partner, a sp						
Signature	/ /			Date	/*/	_
Charles E. Laird				12/28/1	7	
Name (Print or type)				Date		_
Charles.laird@hcahealthcar	e.com			913-498-	7177	
Email address				Contact Ph	none Number	

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		8					
Cost Report Fiscal Year:	From: 7/1	/2015	To: 6/30/2016					
UC Demonstration Year:	2018 - DY	6						
Amount of Uncompensated Car	e (UC):	<u></u>	\$1,691,572.15					
Plus HCAIP Payments		\$32	23,032.62					
Less DSH Payment			(\$321,071.68	1				
Total UC for Pool Calculation:		\$1,6	93,533.09					
Criteria for Additional Unifor Did the hospital provide the fol			report year?					
Level II or Level III NI	CU services	•		Yes	No			
Inpatient psychiatric se	rvice distinc	t part unit	(beds)	Yes	No			
Level I or Level II trau	ma services			Yes	Ng			
Did the hospital system provide	Level I, II	and III NIC	U services?	Yes	No			
Did the hospital have less than	\$300 millior	ı in Net Inp	patient 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.								
				1212812	710			
Signature				Date				
Reta B Name (Print or type)	aker	~		12(2K)	2017.			
reta.baken	o mer	cy.n	et	Contact Phone Nu	3-705 mber			

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 Car	e (UC):		\$190,217.16		
Plus HCAIP Payments		\$2	5,151.85		
Less DSH Payment			(\$27,634.55)		
Total UC for Pool Calculation:		\$187	7,734.46		
Criteria for Additional Unifor Did the hospital provide the fol		_	report year?		
Level II or Level III NI	CU services			Yes	No
Inpatient psychiatric se	rvice distinc	t part unit	(beds)	Yes	(No)
Level I or Level II traus	Yes	No)			
Did the hospital system provide	e Level I, II a	and III NIC	CU services?	Yes	(No)
Did the hospital have less than	\$300 million	n in Net In	patient Revenue?	Yes	No
Signer must be an individual le Owner, a General Partner, a spe				-	
Signature			· · · · · · · · · · · · · · · · · · ·	Date	
Royce Holden Name (Print or type)	un	•		12-27-1 Date	7
Email address	ng			(626-3 45- Contact Phone Nur	(63 9) nber

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

To: 3/31/2016

General Information

Medicare Provider Number:
Cost Report Fiscal Year:

Hospital Name: Mercy Regional Health Center - Manhattan

From: 4/1/2015

Kansas Medicaid Provider Number(s): 100265560A

UC Demonstration Year:	2018 - DY 6				
Amount of Uncompensated Ca	re (UC):	\$6,046,846.52			
Plus HCAIP Payments		\$711,485.79		107	
Less DSH Payment		(\$0.00)			·
Total UC for Pool Calculation:		\$6,758,332,31			
Criteria for Additional Unifor Did the hospital provide the fol		cost report year?			
Level II or Level III NI	CU services		(Yes	No
Inpatient psychiatric se	rvice distinct part	unit (beds)		Yes	No
Level I or Level II traus	ma services			Yes	No
Did the hospital system provide	Level I, II and II	I NICU services?		Yes	No
Did the hospital have less than	\$300 million in N	et Inpatient Revenue?	<	Yes	No
Signer must be an individual leg Owner, a General Partner, a spe Signature James FR 186	cifically authoriz				
Name (Print or type)			Date	11	·
JIM. FRASER (Email address	ASCHNSIO	N.ORG.	78 Contac	5 - 77 6 - et Phone Nur	2810 nber

General Information Hospital Name: Miami Cour	nty Medical Ce	nter			
Kansas Medicaid Provider Nu	mber(s): 100	099280 <i>A</i>	A		
Medicare Provider Number:	170109				
Cost Report Fiscal Year:	From: 1/1/2	2015	To: 12/31/2015		
UC Demonstration Year:	2018 - DY 6	;			
Amount of Uncompensated C	are (UC):		\$1,425,431.04		
Plus HCAIP Payments		\$2	07,771.00		
Less DSH Payment			(\$0.00)		
Total UC for Pool Calculation	1:	\$1,	533,202.04		
Criteria for Additional Unif Did the hospital provide the fo	-	-	t 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 provi	Yes	No			
Did the hospital have less that	n \$300 million	in Net Ir	npatient Revenue?	Yes	No
Signer must be an individual Owner, a General Partner, a s				•	nistrator.
Tierney L. Grasser			-		
Name (Print or type)				Date	
tierney.grasser@olathehe	alth.org			913.791.4461	
Email address				Contact Phone Nu	mber

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 Coun	ty Health S	System					
Kansas Medicaid Provider Num	ber(s): 1	000875	40A				
Medicare Provider Number:	170166						
Cost Report Fiscal Year:	From: 1/	/1/2015		To: 12	/31/2015		
UC Demonstration Year:	2018 - DY	Y 6					
Amount of Uncompensated Car	e (UC):	_	\$56	8,104.6	<u>55</u>		
Plus HCAIP Payments		_	\$84,19	1.00			
Less DSH Payment				(\$0.0	00_)		
Total UC for Pool Calculation:			\$652,29	5.65			
Criteria for Additional Unifor Did the hospital provide the foll		-	cost rep	ort yea	ar?		
Level II or Level III NI	CU service	es				Yes	No
Inpatient psychiatric service distinct part unit (beds)						Yes	No
Level I or Level II traus	na services	S				Yes	No
Did the hospital system provide	Level I, II	and III	NICU	service	es?	Yes	No
Did the hospital have less than S	\$300 millio	on in Ne	et Inpat	ient Re	venue?	Yes	No
Signer must be an individual leg Owner, a General Partner, a spe							
						12/22	112
Signature	1)				$\frac{12/27}{\text{Date}}$	///
RICHARD BERE Name (Print or type)	LING				-	$\frac{12/27}{\text{Date}}$	17
rbergling(a) mc Email address	hs wec	410.	l Om		_	620-697 Contact Phone N	

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: 6/30/20	016
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 Revenu	rie? (Yes) No
Signer must be an individual legally responsible for the conduct of to Owner, a General Partner, a specifically authorized Corporation Off	
	12 - 27 - 17
Signature	Date
Name (Print or type)	17-27-17 Date
toold. Kasitz @ newtonned.com Email address	316-301(-6076 Contact Phone Number

General Information Hospital Name: Olathe Medic	al Cente	r			
Kansas Medicaid Provider Num	ber(s):	1000992	50A		
Medicare Provider Number:	170049				
Cost Report Fiscal Year:	From:	1/1/2015	To: 12/31/2015		
UC Demonstration Year:	2018 - 1	DY 6			
Amount of Uncompensated Car	e (UC):	-	\$7,553,017.21		
Plus HCAIP Payments		_	\$845,734.00		
Less DSH Payment			(\$0.00)		
Total UC for Pool Calculation:		4	\$8,398,751.21		
Criteria for Additional Unifor Did the hospital provide the following		•	cost report year?		
Level II or Level III NI	Yes	No			
Inpatient psychiatric se	Yes	No			
Level I or Level II traus	Yes	No			
Did the hospital system provide	Level I,	II and III	NICU services?	Yes	No
Did the hospital have less than	\$300 mil	lion in Ne	t Inpatient Revenue?	Yes	No
Signer must be an individual le Owner, a General Partner, a spe		-		or a Hospital Adminis	trator.
Signature			a de la companya de	$\frac{1 / 2 / 2 / 1}{Date}$	
Tierney L. Grasser					1
Name (Print or type)				Date	
tierney.grasser@olatheheal	th.org			913.791.4461	
Email address				Contact Phone Numi	ner .

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 Num	ber(s):	1004537	760A					
Medicare Provider Number:	170176	i						
Cost Report Fiscal Year:	From:	6/1/2015	i	To: 5/31/2016				
UC Demonstration Year:	2018 -	DY 6						
Amount of Uncompensated Car	e (UC):		\$1	0,241,731.52				
Plus HCAIP Payments		-	\$2,45	4,071.10				
Less DSH Payment				(\$0.00)				
Total UC for Pool Calculation:			\$12,69	5,802.62				
Criteria for Additional Unifor Did the hospital provide the following			cost re	port year?				
Level II or Level III NI	CU serv	ices			Yes	No		
Inpatient psychiatric service distinct part unit (beds) Yes						No		
Level I or Level II traur	na servi	ces			Yes	No		
Did the hospital system provide Level I, II and III NICU services? Yes						No		
Did the hospital have less than \$	300 mi	llion in Ne	et Inpat	ient 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.								
Name (Print or type)	ルレ	(J. b	hil	<u>.</u>	Date 28/1 Date	2		
Keyi'n. h. eks 6 e he Email address	ahea	ith car	<u>c.lo</u>	<u> </u>	9/3 -54/ Contact Phone N	<u>-5301</u> umber		

General Information Hospital Name: Prairie Ridge	2				
Kansas Medicaid Provider Nur		200641910	E		
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 Ca	re (UC):		\$204,881.76		
Plus HCAIP Payments			0.00		
Less DSH Payment			(\$190,344.00)		
Total UC for Pool Calculation:		\$14	4,537.76		
Criteria for Additional Uniform Did the hospital provide the fo	llowing	during the cos	st report year?		
Level II or Level III N	ICU ser	vices		Yes	No
Inpatient psychiatric se	t (beds)	Yes	No		
Level I or Level II trai	ıma serv	ices		Yes	No
Did the hospital system provid	e Level	I, II and III N	ICU services?	Yes	No
Did the hospital have less than	\$300 m	illion in Net L	npatient Revenue?	Yes	No
Signer must be an individual le Owner, a General Partner, a sp	egally re	sponsible for the specific spe	the conduct of the co Corporation Officer o	intracted hospital so a Hospital Admi $3/15/28/8$	uch as the nistrator.
Signature				Date	
JanCorbin				3/15/2018	
Name (Print or type)			•	Date	
Jeorbin @ kuc.org				913-890-	1413
Email address				Contact Phone Nu	ımber

General Information Hospital Name: Prairie View	Hospital			
Kansas Medicaid Provider Num	nber(s): 100005	670A		
Medicare Provider Number:	174016			
Cost Report Fiscal Year:	From: 7/1/201	5 To: 6/30/2016		
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Car	e (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 Unifor Did the hospital provide the following	_	cost report year?		
Level II or Level III NI	CU services		Yes	No
Inpatient psychiatric se	rvice distinct part	unit (beds)	Yes	No
Level I or Level II traus	ma services		Yes	No
Did the hospital system provide	Level I, II and II	I NICU services?	Yes	No
Did the hospital have less than S	\$300 million in N	et Inpatient Revenue?	Yes	No
Signer must be an individual leg Owner, a General Partner, a spe			-	
		¥	1/2/18	
Signature			Date	
Name (Print or type)	u		//2//8 Date	
ramsey rapy Email address	i-org		3/10-284-10 Contact Phone Num	

General Information Hospital Name: Pratt Regions	al Medical Center			
Kansas Medicaid Provider Nun	nber(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 Ca	re (UC):	\$1,083,661.22		
Plus HCAIP Payments	\$1:	36,804.61		
Less DSH Payment		(\$0.00)		
Total UC for Pool Calculation:	\$1,2	20,465.83		
Criteria for Additional Unifo Did the hospital provide the fol	**	report year?		
Level II or Level III N	ICU services		Yes	No
Inpatient psychiatric se	ervice distinct part unit	(beds)	Yes	No
Level I or Level II trau	ma services		Yes	No
Did the hospital system provide	e Level I, II and III NIC	CU services?	Yes	No
Did the hospital have less than	\$300 million in Net In	patient Revenue?	Yes	No
Signer must be an individual le Owner, a General Partner, a sp Signature			•	
Name (Print or type)	lage		Date	eroductude residentiale quantification
rame (Finit of type)			Date	
Email address	m (05)		Contact Phone Num	50-1436

General Information Hospital Name: Promise Regi	onal Medical (Center			
Kansas Medicaid Provider Num	ber(s): 1000	88340A			
Medicare Provider Number:	170020				
Cost Report Fiscal Year:	From: 712	015 To:	6 30 2016		
UC Demonstration Year	$2018 - D\bar{Y}/6$				
Amount of Uncompensated Car	e (UC):	\$3,973,	509.18		
Plus HCAIP Payments		\$501,836.9	95		
Less DSH Payment		15	(00.00		
Total UC for Pool Calculation:		\$4,475,346.	12		
Criteria for Additional Unifor Did the hospital provide the fol	-		year?		
Level II or Level III NI				Yes	(No)
Inpatient psychiatric se	rvice distinct p	part unit (beds)		Yes	No
Level I or Level II traus				Yes	No
Did the hospital system provide	Level I, II an	d III NICU serv	vices?	Yes	No
Did the hospital have less than	\$300 million i	n Net Inpatient	Revenue?	Yes	No
Signer must be an individual le Owner, a General Partner, a spe				r a Hospital Admi	
Signature				1/2/18 Date	
Cassandra J. Name (Print or type)	Dolen			Date	
dolenc@hutc Email address	hregio	nal.com		Contact Phone N	-4556 .imber

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 M	fedical Center			
Kansas Medicaid Provider Num	ber(s): 2010	74830A		
Medicare Provider Number:	170146			
Cost Report Fiscal Year:	From: 1/1/20	To: 12/31/201	5	
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Car	e (UC):	\$7,798,830.05		
Plus HCAIP Payments		\$2,082,585.00		
Less DSH Payment		(\$1,164,771.4	47)	
Total UC for Pool Calculation:		\$8,716,643.59		
Criteria for Additional Unifor Did the hospital provide the foll	_			
Level II or Level III NIC	CU services		Yes	No
Inpatient psychiatric ser	Yes	No		
Level I or Level II traun	Yes	No		
Did the hospital system provide	Level I, II and	III NICU services?	Yes	No
Did the hospital have less than \$	Yes	No		
Signer must be an individual leg Owner, a General Partner, a spec			•	
Signature			Date	
Name (Print or type)			1/4/18 Date	
Doulny @ primetreal Email address	Hhcare.c	em	913 - 596 - Contact Phone Nu	

General Information Hospital Name: Ransom Me	morial Hospital	1		
Kansas Medicaid Provider Nu	mber(s): 1000	099270A	25	
Medicare Provider Number:	170014			
Cost Report Fiscal Year:	From: 1/1/2	2015 To: 12/31/2015	5	
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Ca	are (UC):	\$2,288,565.25		
Plus HCAIP Payments		\$279,914.00		
Less DSH Payment		(\$448,360.08	ī	
Total UC for Pool Calculation	:	\$2,120,119.17		
Criteria for Additional Unifo Did the hospital provide the fo	_			
Level II or Level III N	IICU services		Ves	No
Inpatient psychiatric s	ervice distinct p	part unit (beds)	Yes	(10)
Level I or Level II tra	uma services		Yes	NO
Did the hospital system provid	le Level I, II an	d III NICU services?	Yes	10
Did the hospital have less than	\$300 million is	n Net Inpatient Revenue?		No
Signer must be an individual l Owner, a General Partner, a sp			or a Hospital Admin	istrator.
Signature /)/14/18 Date	
Name (Print or type)			3/14/18 Date	
heyn @ cansom. oco			785-224	-83 oq
Email address			Contact Phone Nun	nber

General Information Hospital Name: Saint Cather	ine Hospital			
Kansas Medicaid Provider Nur	mber(s): 100088	310A		
Medicare Provider Number:	170023			
Cost Report Fiscal Year:	From: 7 1 2015	To: 6 30 201	16	
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Car	re (UC):	\$5,682,333.51		
Plus HCAIP Payments	-	\$803,215.57		
Less DSH Payment		(\$1,046,738	3.98)	
Total UC for Pool Calculation:		\$5,438,810.10		
Criteria for Additional Unifor Did the hospital provide the foll	m Percentage owing during the	cost report year?		
Level II or Level III NI	CU services		Yes	No
Inpatient psychiatric ser	vice distinct part t	unit (beds)	Yes	No
Level I or Level II traun			Yes	(No)
Did the hospital system provide	Level I, II and III	NICU services?	Yes	No
Did the hospital have less than \$				No
Signer must be an individual legion owner, a General Partner, a special partner, a special partner of the second o	ufically authorized	Corneration Office	contracted hospital such r or a Hospital Adminis ———————————————————————————————————	trator.
Name (Print or type)	ughar		Date 1	- 18
Email address (e penti	110.019	Contact Phone Number	<u>25</u> 52 er

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

Medicare Provider Number:

Hospital Name: Saint Francis Health Center

Kansas Medicaid Provider Number(s): 100080610A

170016

Cost Report Fiscal Year:	From: 7/1/20	To: 6/30/2016		
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Ca	re (UC):	\$12,816,236.37		
Plus HCAIP Payments		\$1,488,233.91		
Less DSH Payment		(\$2,161,957.0	1)	
Total UC for Pool Calculation:		\$12,142,513.27	<u> </u>	
Criteria for Additional Unifo	•	ne cost report year?		
Level II or Level III N	ICU services		Yes	No
Inpatient psychiatric se	ervice distinct pa	rt unit (beds)	Yes	No
Level I or Level II trau	Yes	No		
Did the hospital system provid	e 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 le Owner, a General Partner, a sp			or a Hospital Admini	strator.
			$\frac{12/22}{Date}$	17
Signature	*		Date	
JAMES W. AI	JAMS	Π		
Name (Print or type)			Date	
Jim. A DAMS @	ardent	health.con	615-291	J- 3330
Email address			Contact Phone Num	ber

General Information Hospital Name: Saint John H	ospital				
Kansas Medicaid Provider Nun	nber(s):	201074770.	A		
Medicare Provider Number:	17000	9			
Cost Report Fiscal Year:	From:	1/1/2015	To: 12/31/2015	5	
UC Demonstration Year:	2018 -	DY 6			
Amount of Uncompensated Car	e (UC):		\$2,050,446.44		
Plus HCAIP Payments		\$3	396,673.00	<u></u>	
Less DSH Payment			(\$406,926.57	_	
Total UC for Pool Calculation:		<u>\$2,</u>	040,192.87		
Criteria for Additional Unifor Did the hospital provide the fol		_	t report year?		
Level II or Level III NI	Yes	No			
Inpatient psychiatric se	rvice dis	stinct part unit	(beds)	Yes	No
Level I or Level II traus	na servi	ces		Yes	No
Did the hospital system provide	Level I	, II and III NI	CU services?	Yes	No
Did the hospital have less than	\$300 mi	llion in Net In	patient Revenue?	Yes	No
Signer must be an individual le Owner, a General Partner, a spe					inistrator.
Signature				Date	
Dave Dulay				1-4-18	,
Name (Print or type)				Date	-
DDulny Oprimehea	thea	re .com		913-596	
Email address				Contact Phone Nu	ımber

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

To: 12/31/2015

General Information

Medicare Provider Number:

Cost Report Fiscal Year:

Hospital Name: Saint Luke's South Hospital

Kansas Medicaid Provider Number(s): 100332210A

170185

From: 1/1/2015

UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Ca	ге (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 Unifo	_			
Did the hospital provide the fol	llowing during the	e cost report year?		
Level II or Level III N	ICU services		Yes	No
Inpatient psychiatric se	ervice distinct part	unit (beds)	Yes	No
Level I or Level II trau		Yes	(NO)	
Did the hospital system provide	II NICU services?	Yes	No	
Did the hospital have less than	let Inpatient Revenue?	Yes	No	
Signer must be an individual le Owner, a General Partner, a sp			•	
Signature	2		12/27/ Date 12/27/	17
Name (Print or type)	HIPMAN		12/27/1	7
Email address	SAINT- CC	kss.02G	9/3-3/7 - Contact Phone Nu	7903 mber

General Information Hospital Name: Salina Regio	nal Health Cente	r		
Kansas Mcdicaid Provider Nun	nber(s): 10010	5940A		
Medicare Provider Number:	170012			
Cost Report Fiscal Year:	From: 10/1/20	To: 9/30/2016	i	
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Car	re (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 Unifor Did the hospital provide the follo	_	e cost report year?		
Level II or Level III NI	CU services		Yes	No
Inpatient psychiatric se	rvice distinct par	t unit (beds)	Yes	No
Level I or Level II traur	na services		Yes	(No)
Did the hospital system provide	Level I, II and I	II NICU services?	Yes	No
Did the hospital have less than \$	300 million in N	let Inpatient Revenue?	Yes	No
Signer must be an individual leg Owner, a General Partner, a spe Signature				
Name (Print or type)	*		Date	
mtaskine@ Sr	he.com		785-452- Contact Phone Numb	7004 er

General Information Hospital Name: Salina Surgica	al Hospita	al					
Kansas Medicaid Provider Num	ber(s):	1003584	10A				
Medicare Provider Number:	170187						
Cost Report Fiscal Year:	From:	1/1/2015		To: 12/31/	2015		
UC Demonstration Year:	2018 - D	OY 6					
Amount of Uncompensated Car	e (UC):	_	\$8	2,518.12			
Plus HCAIP Payments		_	\$12,2	15.00			
Less DSH Payment				(\$0.00)			
Total UC for Pool Calculation:		7	\$94,73	3.12			
Criteria for Additional Uniformal Did the hospital provide the following			cost re	port year?			
Level II or Level III NI	CU servi	ces				Yes	No
Inpatient psychiatric se	rvice dist	inct part i	unit (be	eds)		Yes	No
Level I or Level II traus	na servic	es				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?					ue?	Yes	No
Signer must be an individual le Owner, a General Partner, a spe	gally respecifically	oonsible f authorize	or the o	conduct of oration Of	the co	ontracted hospital or a Hospital Adm	ninistrator.
Signature						Date	
Name (Print or type)						12/21/2017 Date	7
Luann Duvogel O Salin Email address	a surg	ical . Co	0m			785-55- Contact Phone N	O685 Number

General Information Hospital Name: Shawnee Mis	sion Medical Cer	nter		
Kansas Medicaid Provider Num	ber(s): 100093	850A		
Medicare Provider Number:	170104			
Cost Report Fiscal Year:	From: 1/1/201	5 To: 12/31/2015		
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Car	e (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 Unifor Did the hospital provide the following	_	e cost report year?		
Level II or Level III NI	CU services		Yes	No
Inpatient psychiatric se	rvice distinct part	t unit (beds)	Yes	No
Level I or Level II traus	ma services		Yes	No
Did the hospital system provide	Level I, II and I	II NICU services?	Yes	No
Did the hospital have less than	\$300 million in N	Net Inpatient Revenue?	Yes	No
Signer must be an individual le Owner, a General Partner, a spe	- · •		-	nistrator.
Karsten Ra Name (Print or type)	ndolph		<u>/- こ - 2 ט </u> Date	8
Karsten, Randolf Email address	oh@ AHSS	· or g	913 · 676 Contact Phone Nu	

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 Nur	nber(s):	10008	30590A					
Medicare Provider Number:	170150)						
Cost Report Fiscal Year:	From:	1/1/20	15	To:	12/31/20	15		
UC Demonstration Year:	2018 -	DY 6						
Amount of Uncompensated Ca	re (UC):		\$	1,4	<u> 155,557.1.</u>	3	-	
Plus HCAIP Payments			\$	218,	<u>828.00</u>			
Less DSH Payment				\$_(_	616,18	6.42		
Total UC for Pool Calculation:			\$ <u>1.0</u>	<u> 58,198</u>	8.70			
Criteria for Additional Unifo Did the hospital provide the fo			ne cost re	eport y	еаг?			
Level II or Level III N	ICU serv	rices					Yes	No
Inpatient psychiatric se	ervice dis	stinct pa	rt unit (b	eds)			Yes	No
Level I or Level II trau	ıma servi	ces					Yes	No
Did the hospital system provid	e Level I	, II and	III NICU	J servi	ces?		Yes	No
Did the hospital have less than	\$300 mi	llion in l	Net Inpa	tient R	Revenue?		Yes	No
Signer must be an individual le Owner, a General Partner, a sp	egally res	ponsible authori	e for the zed Cor	condu poratio	ct of the c on Officer	ontract or a H	ed hospital su ospital Admir	ich as the
						12	2/15/1-	7
Signature						Date		
Name (Print or type)	<u>n</u>	<u>-</u>				Date	415/17	
Wilmock	YM(. NY	7 1			1025	UIII-GE	うつひ
Email address	1 1 16	- 01)			Cont	act Phone Nu	mber

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

Medicare Provider Number:

Hospital Name: Southwest Medical Center

Kansas Medicaid Provider Number(s): 100099490A

170068

Cost Report Fiscal Year:	From: 1/1/201	5	To: 12/31/20	115	
UC Demonstration Year:	2018 - DY 6				
Amount of Uncompensated Ca	re (UC):	\$	1,367,566,6	2,195,081	
Plus HCAIP Payments		\$	485,290.00		
Less DSH Payment			\$ (292,09	P5. 58	1
Total UC for Pool Calculation:		\$ _/	<u>60.761.08</u> 2,3 1	88,275	
Criteria for Additional Unifo Did the hospital provide the fol	517	e cost re	eport year?		
Level II or Level III N	ICU services			Yes	No
Inpatient psychiatric se	rvice distinct par	t unit (b	eds)	Yes	No
Level I or Level II trau	ma services			Yes	No
Did the hospital system provide	e Level I. II and I	II NICU	services?	Yes	No
Did the hospital have less than	\$300 million in N	Net Inpa	tient Revenue?	Yes) No
Signer must be an individual le Owner, a General Partner, a sp Signature					
o ignature ○				Date	
Amber Wi	lliams			1/10/	2018
Name (Print or type)				Date	
<u>GWILLAMS Q</u> . Email address	Swmede	cen	ter.com	(l _o 20) l _o 2 Contact Phone	9 - 6680 Number

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

Medicare Provider Number:

Hospital Name: Stormont-Vail Regional Health Center Kansas Medicaid Provider Number(s): 100099400A

170086

Cost Report Fiscal Year:	From:	10/1/2015	To: 9/30/2016		
UC Demonstration Year:	2018 -	DY 6			
Amount of Uncompensated Car	e (UC):		\$14,177,832.14		
Plus HCAIP Payments		\$4	,129,336.65		
Less DSH Payment			(\$1,258,949.1	<u>7_)</u>	
Total UC for Pool Calculation:		<u>\$17</u>	,048,219.62		
Criteria for Additional Unifor Did the hospital provide the foll		0	t report year?		
Level II or Level III NI	CU serv	rices		Yes	No
Inpatient psychiatric se	rvice di	stinct part unit	(beds)	Yes	No
Level I or Level II traus	ma serv	ices		Yes	No
Did the hospital system provide	Level 1	, II and III NI	CU services?	(es)	No
Did the hospital have less than	\$300 mi	llion in Net It	npatient Revenue?	Yes	No
Name (Print or type)	ecificall	v authorized (Corporation Officer	or a Hospital Adm	
Email address	<u> </u>	<u> </u>	, or g	Contact Phone N	Y Ø190 Number

Hospital Name: Sumner Region	onal Medical Center			
Kansas Medicaid Provider Num	ber(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 Car	re (UC):	\$515,043.20		
Plus HCAIP Payments	\$1	46,161.00		
Less DSH Payment		(\$56,480.17)		
Total UC for Pool Calculation:	\$60	4,724.04		
Criteria for Additional Unifo Did the hospital provide the fol Level II or Level III Ni Inpatient psychiatric se Level I or Level II trau Did the hospital system provid Did the hospital have less than	lowing during the cost ICU services ervice distinct part unit ima services e Level I, II and III NI	(beds) CU services?	Yes Yes Yes Yes	No No No No
Signer must be an individual le Owner, a General Partner, a/sp Signature ERIC CHK Name (Print or type)	egally responsible for the ecifically authorized (the conduct of the co	or a Hospital Admin	ch as the istrator.
ERICC C SE	CMEKS. OF	<u>e 6</u>	Contact Phone Num	99-1294 mber

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 Nu	mber(s): 1000	88620A				
Medicare Provider Number:	170017					
Cost Report Fiscal Year:	From: 1/1/20	015	To: 12/31/2015	5		
UC Demonstration Year:	2018 - DY 6					
Amount of Uncompensated C	are (UC):	\$4	1,464,118.66			
Plus HCAIP Payments		\$403	,163.00	<u> </u>		
Less DSH Payment			_(\$1,127,867.6	0_)		
Total UC for Pool Calculation	1:	\$3,739	9,414.07			
Criteria for Additional Unif Did the hospital provide the fo	_		eport year?			
Level II or Level III N	NICU services			Yes		(No)
Inpatient psychiatric s	service distinct p	art unit (b	eds)	Yes		No
Level I or Level II tra	uma services			Yes	ati	(No)
Did the hospital system provide	de Level I, II and	I III NICU	J services?	Yes		(No
Did the hospital have less than	n \$300 million in	Net Inpa	tient Revenue?	Yes		No
Signer must be an individual lowner, a General Partner, a se	legally responsib	le for the	conduct of the c poration Officer	ontracted hosp or a Hospital A	ital such a Administra	is the
Signature				12 29 Date	+	
Name (Print or type)	erken		<u> </u>	12 24 Date	A	
Gerten W Sho Estail address	inh.og			310, 3.	99. 45 ne Number	

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 Num	ber(s):	100099	300A		
Medicare Provider Number:	170006	5			
Cost Report Fiscal Year:	From:	4/1/2015	To: 3/31/2016		
UC Demonstration Year:	2018 -	DY 6			
Amount of Uncompensated Car	e (UC):		\$5,372,240.71		
Plus HCAIP Payments		,	\$904,133.85		
Less DSH Payment			(\$1,000,551.5	<u>0)</u>	
Total UC for Pool Calculation:			\$5,275,823.07		
Criteria for Additional Unifor Did the hospital provide the foll		_	cost report year?		
Level II or Level III NI	CU serv	rices		Yes	No
Inpatient psychiatric ser	Yes	No			
Level I or Level II traur	na servi	ces		Yes	ONO.
Did the hospital system provide	Level I	, II and II	I NICU services?	Yes	No
Did the hospital have less than S	300 mi	llion in N	et Inpatient Revenue?	Yes	No
Signer must be an individual leg Owner, a General Partner, a spe					
MIKE TOG Name (Print or type)				1/3/18 Date	
Mike. Joy @ Vi Email address	acha	isti.or	<u> </u>	316 - 858 - 4 Contact Phone N	

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

Medicare Provider Number:

Hospital Name: Via Christi Hospital - Saint Teresa Kansas Medicaid Provider Number(s): 200677860A

170200

Cost Report Fiscal Year:	From:	8/1/201	5 To: 7/31/2016		
UC Demonstration Year:	2018 -	DY 6			
Amount of Uncompensated Car	e (UC):		\$2,664,841.39		
Plus HCAIP Payments			\$312,129.64		
Less DSH Payment			(\$0.00)	9-	
Total UC for Pool Calculation:			\$2,976,971.03		
Criteria for Additional Unifor Did the hospital provide the follow		_	e cost report year?		
Level II or Level III NI	CU serv	ices		Yes	N
Inpatient psychiatric se	rvice dis	tinct par	t unit (beds)	Yes	No
Level I or Level II traus	na servi	ces		Yes	No
Did the hospital system provide	Level I	II and I	II NICU services?	Yes	No
Did the hospital have less than S	\$300 mi	llion in N	Net Inpatient Revenue?	Yes	No
Signer must be an individual leg Owner, a General Partner, a spe					
Signature	(Date /	
Claudis T	r- f	-470	ano	1/4/18 Date	<u> </u>
claudio. Ferra Email address	∕o a	<u>) asc</u>	ension.org	(316) 796 Contact Phone Nu	-7802 mber

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:	17012	2				
Cost Report Fiscal Year:	From:	10/1/201	5 To:	9/30/2016		
UC Demonstration Year:	2018 -	DY 6				
Amount of Uncompensated Care	e (UC):		\$53,376	,113.41		
Plus HCAIP Payments		-	\$5,945,409	.30		
Less DSH Payment			_(_\$	13,376,922.2	2_)	
Total UC for Pool Calculation:			\$45,944,600	.49		_
Criteria for Additional Unifor Did the hospital provide the follo		_	cost report	year?		
Level II or Level III NIC	CU serv	vices			Yes	No
Inpatient psychiatric ser	vice di	stinct part	unit (beds)		A ES)	No
Level I or Level II traun	na serv	ices			Yes	No
Did the hospital system provide	Level 1	I, II and II	I NICU serv	rices?	Yes	No
Did the hospital have less than \$	300 m	illion in N	et Inpatient	Revenue?	Yes	No
Signer must be an individual leg Owner, a General Partner, a special Signature Michael MC W Name (Print or type) Michael McWlovske Email address) o je	y authorize	ed Corporat	ion Officer o	Ta Hospital Additional	4ministrator. 2 ダー32 <u>レ</u> ろ

General Information Hospital Name: Via Christi Re	ehabilitation Cen	ter			
Kansas Medicaid Provider Num	ber(s): 100105	420A			
Medicare Provider Number:	173028				
Cost Report Fiscal Year:	From: 10/1/20	15 T	o: 9/30/2016		
UC Demonstration Year:	2018 - DY 6				
Amount of Uncompensated Car	e (UC):	\$622	2,752.23		
Plus HCAIP Payments		\$125,33	6.72		
Less DSH Payment		_	(_\$0.00_)		
Total UC for Pool Calculation:		\$748,088	.95		
Criteria for Additional Unifor Did the hospital provide the foll	_	e cost repo	ort year?		
Level II or Level III NI	CU services			Yes	No
Inpatient psychiatric ser	vice distinct part	t unit (bed	s)	Yes	No
Level I or Level II traur	na services			Yes	No
Did the hospital system provide	Level I, II and I	II NICU s	ervices?	Yes	No
Did the hospital have less than S	\$300 million in N	Vet Inpatie	nt Revenue?	Yes	No
Signer must be an individual leg Owner, a General Partner, a spe				•	
				1-4-18	
Signature				Date	
Michael McCollan	55				
Name (Print or type)				Date	
Michael-Mcalloyl	<u>@ascessia</u>	<u>، ، ٥٨</u>	-	Contact Phone No	ımber

General Information Hospital Name: Wesley Medi	cal Center	
Kansas Medicaid Provider Nun	nber(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 Ca	re (UC): \$12,129,916.57	
Plus HCAIP Payments	\$5,879,029.00	
Less DSH Payment	(\$740,699.65	1 :-
Total UC for Pool Calculation:	\$17,268,245.92	
Criteria for Additional Unifo Did the hospital provide the fol	rm Percentage lowing during the cost report year?	
Level II or Level III N	ICU services	Yes No
Inpatient psychiatric so	rvice distinct part unit (beds)	Yes (No)
Level I or Level II trau	ma services	Yes No
Did the hospital system provide	e Level I, II and III NICU services?	Yes No
Did the hospital have less than	\$300 million in Net Inpatient Revenue?	Yes (No)
_	gally responsible for the conduct of the coecifically authorized Corporation Officer	-
Patrick Whitm	ore.	
Name (Print or type)		Date
Patrick. Whitmo	re@hcahealthcare.com	314-942-2055 Contact Phone Number

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 Plair	ıs Medical Com	plex		
Kansas Medicaid Provider Num	ber(s): 10009	8790A		
Medicare Provider Number:	170175			
Cost Report Fiscal Year:	From: 3/1/201	To: 2/29/2016		
UC Demonstration Year:	2018 - DY 6			
Amount of Uncompensated Care	e (UC):	\$4,021,627.39		
Plus HCATP Payments		\$468,281.88		
Less DSH Payment		(\$1,134,766.6	53_)	
Total UC for Pool Calculation:		\$3,355,142.63	· · · · · · · · · · · · · · · · · · ·	
Criteria for Additional Unifor Did the hospital provide the follo	-	e cost report year?		
Level II or Level III NIC	CU services		Yes	No
Inpatient psychiatric ser	vice distinct par	t unit (beds)	Yes	No
Level I or Level II traun	na services		Yes	No
Did the hospital system provide	Level I, II and I	II NICU services?	Yes	No
Did the hospital have less than \$	300 million in N	Net Inpatient Revenue?	Yes	No
Signer must be an individual leg Owner, a General Partner, a spec	ally responsible ifically authoriz	for the conduct of the code Corporation Officer	ontracted hospital suc or a Hospital Admini	h as the strator.
Signature		and the state of t	Date	
RYAJ PUGI	4		1-4-18	
Name (Print or type)			Date	
Tyan. Pugh @ 19 Email address	int. net		620-225-8 Contact Phone Num	2 406 ber