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

<table>
<thead>
<tr>
<th>Amount of Uncompensated Care (UC):</th>
<th>$1,712,198.19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plus HCAIP Payments</td>
<td>$149,127.00</td>
</tr>
<tr>
<td>Less DSII Payment</td>
<td>($657,815.66)</td>
</tr>
<tr>
<td>Total UC for Pool Calculation:</td>
<td>$1,203,509.52</td>
</tr>
</tbody>
</table>

**Criteria for Additional Uniform Percentage**
Did the hospital provide the following during the cost report year?

- Level II or Level III NICU services
  - Yes
- Inpatient psychiatric service distinct part unit (beds)
  - Yes
- Level I or Level II trauma 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

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.

**Signature**

**Amanda Vaughan**

**Name (Print or type)**

**Email address**

<table>
<thead>
<tr>
<th>Contact Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>620-272-7537</td>
</tr>
</tbody>
</table>
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
UC Demonstration Year: 2018 - DY 6
Amount of Uncompensated Care (UC): $9,713,161.85
Plus HCAIP Payments: $846,575.89
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
- Inpatient psychiatric service distinct part unit (beds): Yes
- Level I or Level II trauma 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

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.

Signature ____________________________  1-2-2018  

Date

David Cauble
Name (Print or type)  1-2-2018

Phone: 816-302-0179  

Email address: david dcauble @ cmh.edu  

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
- Inpatient psychiatric service distinct part unit (beds): No
- Level I or Level II trauma services: No

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

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.

[Signature] 12/27/17
Date

[Lori Remsinkle] 12/27/17
Name (Print or type)

[remsinkle@crmcinc.org] 12/20-252-1147
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: 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

- Inpatient psychiatric service distinct part unit (beds)
  - Yes

- Level I or Level II trauma 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

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.

Signature / [Redacted] /

Name (Print or type) Jackie Martin

Email address jwmartin@saint-lukes.org

Date 1/2/18

Contact Phone Number 913-684-1305
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
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
- Inpatient psychiatric service distinct part unit (beds)
- Level I or Level II trauma services

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.

Signature
Date 18:39:17

Name (Print or type)
Stephen J. Doherty
Date

Email address sdoherty@gchks.org
Contact Phone Number 785-210-9902
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 $733,652.00
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
- Inpatient psychiatric service distinct part unit (beds)
- Level I or Level II trauma services

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.

Signature

Date 11/22/2017

Name (Print or type)

Date 12/22/2017

Email address

Contact Phone Number (620) 794-6815
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
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.

Signature

Date

Name (Print or type)

Date

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: 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: $73,453.00
Less DSH Payment: (50.00)
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
- Inpatient psychiatric service distinct part unit (beds): Yes
- Level I or Level II trauma 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

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.

[Signature]
Date: 3/4/18

Name (Print or type):
Steve Smith
Date: 3/4/18

Email address:
SteveSmith@KansasHeart.com
Contact Phone Number: 316 630-5460
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.

[Signature]

[Date] 12-27-2017

[Name] STEVEN N. HARLEY

[Email address] Steven.harley@ksmedcenter.com

[Date] 316-201-6505

[Contact Phone Number]
KauCare 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  
12/29/2017  
Date

Thomas L. Moore
Name (Print or type)  
12/29/2017  
Date

Lmac@labettehealth.com  
Email address  
820 820 5251  
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: 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
- Inpatient psychiatric service distinct part unit (beds): No
- Level I or Level II trauma services: No

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

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.

Signature: ____________________________
Date: 12/26/2017

Name (Print or type): Joseph D. Priddy
Date: 12/26/2017

Email address: joseph_priddy@lmh.org
Contact Phone Number: 785-505-6135
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
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.

[Signature]
Signature

[Date]
Date

Terri Gehring
Name (Print or type)

[t@mephersonhospital.org]
Email address

[Contact Phone Number]

[Date]
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
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.

Signature ____________________________ Date 12/28/17

Charles E. Laird
Name (Print or type)

Charles.laird@hcahealthcare.com
Email address

12/28/17
Date

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
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.

Signature

Reta Baker
Name (Print or type)

reta.baker@mercy.net Email address

12/28/2017 Date

12/28/2017 Date

620-223-7657 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
- Inpatient psychiatric service distinct part unit (beds) Yes
- Level I or Level II trauma 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

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.

Signature

Date 12-27-17

Name (Print or type)

Date 12-27-17

Email address

Contact Phone Number 620-345-6391
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
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] [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.

Signature ____________________________ Date 1/3/17

Name (Print or type) JAMES FRASER [JIM.FRASER@ASCENSION.ORG] Date 1/8/19

Email address
Contact Phone Number 785-776-2810
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
Inpatient psychiatric service distinct part unit (beds)
Level I or Level II trauma services
Did the hospital system provide Level I, II and III NICU services?
Did the hospital have less than $300 million in Net Inpatient Revenue?

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.

Signature

Date

Tierney L. Grasser
Name (Print or type)

 tierney.grasser@olathehealth.org
Email address

Date

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
- Inpatient psychiatric service distinct part unit (beds)
  - Yes
- Level I or Level II trauma 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

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.

Signature,

Date

Name (Print or type)

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
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
Inpatient psychiatric service distinct part unit (beds)
Level I or Level II trauma services

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.

Signature

12-27-17
Date

Todd P. Kae tz
Name (Print or type)

12-27-17
Date

todd. kae tz @ newtonmed.com
Email address

316-301-6096
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.

Signature

Date 10/27/17

Tierney L. Grasser
Name (Print or type)

tierney.grasser@olathehealth.org
Email address

Date 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: Overland Park Regional Medical Center
Kansas Medicaid Provider Number(s): 100453760A
Medicare Provider Number: 170176
UC Demonstration Year: 2018 - DY 6
Amount of Uncompensated Care (UC): $10,241,731.52
Plus HCAIP Payments $2,454,074.10
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.

Signature
Date 12/28/17

Name (Print or type) Kevin J. Hicks
Date 12/28/17

Email address Kevin.hicks6@hghhealthcare.com Contact Phone Number 913-541-5301
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
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 [ X ]
  Inpatient psychiatric service distinct part unit (beds)
    Yes [ X ] No [ ]
  Level I or Level II trauma services
    Yes [ X ] No [ ]

Did the hospital system provide Level I, II and III NICU services? Yes [ X ] No [ ]
Did the hospital have less than $300 million in Net Inpatient Revenue? Yes [ X ] 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.

[Blacked out]

Signature

Jocorbin [Redacted] 3/15/2018
Name (Print or type)

Email address

Jcorbin & kuc.org 9/13-890-7413
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


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
- 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.

Signature [Redacted] 1/2/18 Date 1/2/18

Lisa Ramsey Name (Print or type) Date

ramseyjr@pvu.org Email address 3/16/284-1035 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 (50.00)
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.

Signature ____________________________  Date 1-4-18

Name (Print or type) Susan Page

Email address Susan_PAGE@prattmed.org

Contact Phone Number 620-450-1436
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
UC Demonstration Year: 2018 - DY 6

Amount of Uncompensated Care (UC): $3,973,509.18
Plus HCAIP Payments $501,836.95
Less DSH Payment $ (50.00)
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.

Signature

Date 1/2/18

Cassandra J. Dolan

Name (Print or type)

Email address dolenc@hutchregional.com

Contact Phone Number 620-513-4556
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.

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: 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.

______________________________
Signature

3/14/18
Date

Matt Hey
Name (Print or type)

Hey@casem.org
Email address

785-224-8309
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
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.

Signature

Amanda Vaughan
Name (Print or type)

Email address

Date 1-3-18

Date 1-3-18

Contact Phone Number 620-272-2587
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
UC Demonstration Year:  2018 - DY 6
Amount of Uncompensated Care (UC):  $12,816,236.37
Plus HCAIP Payments  $1,488,733.91
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.

Signature

James W. Adams III
Name (Print or type)

Email address

Jim.Adams@ArdentHealth.com  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.

Signature

Dave Dulny
Name (Print or type)

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.

Signature ___________________________ Date 12/27/17

Name (Print or type) ROBERT OLMSHIEMAN  Date 12/27/17

Email address ROBERT.OLMSHIEMAN@SAINT-LUKES.ORG Contact Phone Number 913.317.7903
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: $5,801,722.70

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.

[Signature]

Name (Print or type) [Name]

Email address [Email]

Contact Phone Number [Phone]
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
- Inpatient psychiatric service distinct part unit (beds): Yes
- Level I or Level II trauma 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

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.

Signature

Name (Print or type)

Email address

Date

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.

Signature

Date  1-3-2018

Name (Print or type)  Karsten Randolph
Date  1-3-2018

Email address  Karsten.Randolph@AHSS.org
Contact Phone Number  913.676.2152
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 $(1,616,186.42)

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.

[Signature]

Date: 12/15/17

Name (Print or type): Virgail Watson

Date: 12/15/17

Email address: virgail.watson@krmc.org

Contact Phone Number: 785-627-5900
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): 106099490A
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): $1,092,095.00 2,195,081
Plus HCAIP Payments $483,790.00
Less DSH Payment $(92,095.58)
Total UC for Pool Calculation: $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.

Signature

Amber Williams
Name (Print or type)

Email address

1/10/2018 Date

williams@swmedcenter.com (620) 629-6680
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.

Signature

Date 1.5.18

Name (Print or type) Robert Langland

Date 1.5.18

Email address rlangland@stormontvail.org

Contact Phone Number 785-334-6148
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.

Signature

Date 1/4/2017

Name (Print or type) ERIC CHRISTENSEN

Date 1/4/2017

Email address ERIC.C.SRMCKS.ORG

Contact Phone Number 620-399-1294
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
- Inpatient psychiatric service distinct part unit (beds)
- Level I or Level II trauma services

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

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.

Signature

Name (Print or type)

Email address

Date 12/29/17

Date 12/29/17

Contact Phone Number 316.322.4544
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
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 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.

_________________________ 1/3/18
Signature

_________________________ 1/3/18
Name (Print or type)

_________________________ 316-847-4932
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
Inpatient psychiatric service distinct part unit (beds)
Level I or Level II trauma services

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

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.

Signature
Claudio J. Ferraro
Name (Print or type)
Email address claudio.ferraro@ascension.org
Date 1/4/18
Contact Phone Number (316) 796-7802
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): 10080640B
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 55,945,409.30
Less DSH Payment (513,376,927.22)
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.

Signature

Michael, MCAH

Name (Print or type)

Email address michael.mcavoy@kansas.gov

Date 1-3-18

Contact Phone Number 316-715-3223
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 $125,335.72
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.

______________________________  1-4-18
Signature

______________________________
Name (Print or type)

______________________________
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.

Signature

Patrick Whitmore
Name (Print or type)

Patrick.Whitmore@heahealthcare.com 316-942-2055
Email address

Date
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
UC Demonstration Year: 2018 - DY 6
Amount of Uncompensated Care (UC): $4,021,627.39
Plus HCAIP Payments
Less DSH Payment ($1,334,766.63 )
Total UC for Pool Calculation: $3,355,162.63

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
Did the hospital have less than $300 million in Net Inpatient Revenue? Yes

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.

Signature

RYAD PUGH
Name (Print or type)

Email address
ryan.pugh@ipmt.net

Date 1-4-18

Contact Phone Number 620-225-8906