DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

Stephanie Muth
State Medicaid Director
Texas Health and Human Services Commission
4900 Lamar Boulevard
MC: H100
P.O. Box 13247
Austin, Texas 78751

JUN 13 2019

Dear Ms. Muth:

The Centers for Medicare & Medicaid Services (CMS) is approving Uncompensated Care (UC) application tools for Texas' section 1115(a) demonstration (11-W-00278/6), entitled "Texas Healthcare Transformation and Quality Improvement Program." The UC applications collect cost and payment data for services reimbursable under the UC pool, and are submitted by providers to the state annually. The tools conform the manner by which Texas compensates providers for Uncompensated Care Costs to CMS' Uncompensated Care policy, as laid out in the demonstration's Special Term and Condition (STC) 33.

Your project officer for this demonstration is Mr. Eli Greenfield. He is available to answer any questions concerning your section 1115 demonstration. Mr. Greenfield's contact information is:

Center for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-26-12
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-6157
Facsimile: (410) 786-5882
E-mail: Eli.Greenfield@cms.hhs.gov

Sincerely,

[redacted]

Angela D. Garner
Director, Division of System Reform Demonstrations

cc: Bill Brooks, Director, Division of Medicaid Field Operations South

Please complete all green highlighted cells

PROVIDER NAME:

PROVIDER TEXAS PROVIDER IDENTIFIER(TPI).:

REPORT PERIOD FROM:
TO:

CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS APPLICATION MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER STATE LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS APPLICATION WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE INFORMATI0N CONTAINED IN THIS APPLICATION PREPARED BY THE ABOVE NAMED PROVIDER FOR THE PERIOD AS STATED ABOVE AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS OF THE STATE OF TEXAS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS APPLICATION WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS.

OFFICER OR ADMINISTRATOR OF PROVIDER

TITLE

EMAIL

STREET 1
STREET 2
CITY
STATE
ZIP
MAILING ADDRESS

PHONE NUMBER

DATE

UC TOOL PROVIDER CONTACT

TITLE

EMAIL

STREET 1
STREET 2
CITY, STATE, ZIP
STATE
ZIP
MAILING ADDRESS

PHONE NUMBER

DATE

PROVIDER NAME:	0	PROVIDER NO:	0
		Cost Periods:	1
UC COST SUMMARY		PERIOD FROM:	**1/0/1900**
		TO:	**1/0/1900**

COSTS FROM WORKSHEET D	Worksheet D Column #	Worksheet D Line 82 1	Adjustments to Reflect Demonstration Year Costs 2	Adjusted UC Costs 3
Uninsured Charity Costs Inpatient	**4**	0		0
Uninsured Charity Costs Outpatient	**5**	0		0
TOTAL UC Costs		0	0	0

PROVIDER NAME: 0					PROVIDER NO.: 0					WORKSHEET A	
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES							FROM: 1/0/1900				
Please complete all green highlighted cells					INDIRECT RATE: **0.0%**		TO: **1/0/1900**				
		COST CENTER DESCRIPTIONS (omit cents)	(From WS A-1) PHYSICIAN CLINICAL SVCS	From WS A-2 NON-PHYS SALARIES	OTHER (Non- Capital Eqpt, Supplies)	TOTAL (col. 1 + 2 + 3)	(From WS A-6) RECLASSIFI-CATIONS	RECLASSIFIED DIR COSTS (col. 4 ± col. 5)	(From WS A-8) ADJUSTMENTS	INDIRECT COSTS (at rate above)	NET EXPENSES FOR ALLOCATION (col. 6 ± col. 7 + col. 8)	Cost Report
			1	2	3	4	5	6	7	8	9	
		GENERAL SERVICE COST CENTERS										
		HOSPITAL BASED SITES										
1	0500	Anesthesia	0			0		0		0	0	
2	0600	Dermatology	0			0		0		0	0	
3	0700	Emergency Medicine	0			0		0		0	0	
4	0800	Family and Community Medicine	0			0		0		0	0	
5	0900	Internal Medicine	0			0		0		0	0	
6	600	Neurology	0			0		0		0	0	
7	700	Neurosurgery	0			0		0		0	0	
8	800	Obstetrics and Gynecology	0			0		0		0	0	
9	900	Ophthalmology	0			0		0		0	0	
10	1000	Orthopedic Surgery	0			0		0		0	0	
11	1100	Otolaryngology	0			0		0		0	0	
12	1200	Pathology	0			0		0		0	0	
13	1300	Pediatrics	0			0		0		0	0	
14	1400	Physical Medicine and Rehabilitation	0			0		0		0	0	
15	1500	Psychiatry	0			0		0		0	0	
16	1600	Radiation Oncology	0			0		0		0	0	
17	1700	Radiology	0			0		0		0	0	
18	1800	Surgery	0			0		0		0	0	
23	2300	Urology	0			0		0		0	0	
24	2400	Anesthesiology Pain	0			0		0		0	0	
25	2500	Other	0			0		0		0	0	
26	2600	Other	0			0		0		0	0	
27	2700	Other	0			0		0		0	0	
28	2800	Other	0			0		0		0	0	
29	2900	Other	0			0		0		0	0	
		NON-HOSPITAL BASED SITES										
31	3100	Anesthesia	0			0		0		0	0	
32	3200	Dermatology	0			0		0		0	0	
33	3300	Emergency Medicine	0			0		0		0	0	
34	3400	Family and Community Medicine	0			0		0		0	0	
35	3500	Internal Medicine	0			0		0		0	0	
36	3600	Neurology	0			0		0		0	0	
37	3700	Neurosurgery	0			0		0		0	0	
38	3800	Obstetrics and Gynecology	0			0		0		0	0	
39	3900	Ophthalmology	0			0		0		0	0	
40	4000	Orthopedic Surgery	0			0		0		0	0	
41	4100	Otolaryngology	0			0		0		0	0	
42	4200	Pathology	0			0		0		0	0	
43	4300	Pediatrics	0			0		0		0	0	
44	4400	Physical Medicine and Rehabilitation	0			0		0		0	0	
45	4500	Psychiatry	0			0		0		0	0	
46	4600	Radiation Oncology	0			0		0		0	0	
47	4700	Radiology	0			0		0		0	0	
48	4800	Surgery	0			0		0		0	0	
49	4900	Urology	0			0		0		0	0	
50	5000	Anesthesiology Pain	0			0		0		0	0	
51	5100	Other	0			0		0		0	0	
52	5200	Other	0			0		0		0	0	
53	5300	Other	0			0		0		0	0	
54	5400	Other	0			0		0		0	0	

PROVIDER NAME: 0						PROVIDER NO.: 0				WORKSHEET A	
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES							FROM: 1/0/1900				
Please complete all green highlighted cells						INDIRECT RATE: **0.0%**	TO: 1/0/1900				
		COST CENTER DESCRIPTIONS (omit cents)	(From WS A-1) PHYSICIAN CLINICAL SVCS	From WS A-2 NON-PHYS SALARIES	OTHER (Non- Capital Eqpt, Supplies)	TOTAL (col. 1 + 2 + 3)	(From WS A-6) RECLASSIFI-CATIONS	RECLASSIFIED DIR COSTS (col. 4 ± col. 5)	(From WS A-8) ADJUSTMENTS	INDIRECT COSTS (at rate above)	NET EXPENSES FOR ALLOCATION (col. 6 ± col. 7 + col. 8)	Cost Report
			1	2	3	4	5	6	7	8	9	
55	5500	Other	0			0		0		0	0	
		OTHER										
56	5600	Other	0			0		0		0	0	
57	5700	Other	0			0		0		0	0	
58	5800	Other	0			0		0		0	0	
59	5900	Other	0			0		0		0	0	
60	6000	Other	0			0		0		0	0	
61	6100	Other	0			0		0		0	0	
62	6200	Other	0			0		0		0	0	
63	6300	Other	0			0		0		0	0	
64	6400	Other	0			0		0		0	0	
65	6500	Other	0			0		0		0	0	
66	6600	Other	0			0		0		0	0	
67	6700	Other	0			0		0		0	0	
68	6800	Other	0			0		0		0	0	
69	6900	Other	0			0		0		0	0	
70	7000	Other	0			0		0		0	0	
71	7100	Other	0			0		0		0	0	
72	7200	Other	0			0		0		0	0	
73	7300	Other	0			0		0		0	0	
74	7400	Other	0			0		0		0	0	
75	7500	Other	0			0		0		0	0	
76	7600	Other	0			0		0		0	0	
77	7700	Other	0			0		0		0	0	
78	7800	Other	0			0		0		0	0	
79	7900	Other	0			0		0		0	0	
80		SUBTOTALS (sum of lines 1-79)	0	0	0	0	0	0	0	0	0	
		NONREIMBURSABLE COST CENTERS										
81	8100	Basic Science Departments				0	0	0			0	
82	8200	Academic				0	0	0			0	
83	8300	Research Centers				0	0	0			0	
84	8400	Office of Curricular Support/Medical Education				0		0			0	
85	8500	Hospital Administration				0	0	0			0	
86	8600	Non Reimbursable				0		0			0	
90		TOTAL (sum of lines 80-86)	0	0	0	0	0	0	0	0	0	

WORKSHEET A-1

PROVIDER NAME: 0 PROVIDER NO.: 0

CLINICAL PHYSICIAN SALARY & BENEFITS COSTS

FROM: **1/0/1900**

Please complete all green highlighted cells

TO: **1/0/1900**

		COST CENTER DESCRIPTIONS (omit cents)	WORK	BENCHMARK WORK	% OF BENCHMARK (col. 1 / 2)	TOTAL PHYSICIAN SALARY/BENEFIT	TOTAL (col. 3 X 4)
			1	2	3	4	5
		HOSPITAL BASED SITES					
1	0500	Anesthesia			-		-
2	0600	Dermatology			-		-
3	0700	Emergency Medicine			-		-
4	800	Family and Community Medicine			-		-
5	0900	Internal Medicine			-		-
6	600	Neurology			-		-
7	700	Neurosurgery			-		-
8	800	Obstetrics and Gynecology			-		-
9	900	Ophthalmology			-		-
10	1000	Orthopedic Surgery			-		-
11	1100	Otolaryngology			-		-
12	1200	Pathology			-		-
13	1300	Pediatrics			-		-
14	1400	Physical Medicine and Rehabilitation			-		-
15	1500	Psychiatry			-		-
16	1600	Radiation Oncology			-		-
17	1700	Radiology			-		-
18	1800	Surgery			-		-
23	2300	Urology			-		-
24	2400	Anesthesiology Pain			-		-
25	2500	Neonatology			-		-
26	2600	Endocrinology			-		-
27	Therapy	Therapy			-		-
28	2800	Other			-		-
29	2900	Other			-		-
		NON-HOSPITAL BASED SITES					
31	3100	Anesthesia			-		-
32	3200	Dermatology			-		-
33	3300	Emergency Medicine			-		-
34	3400	Family and Community Medicine			-		-
35	3500	Internal Medicine			-		-
36	3600	Neurology			-		-
37	3700	Neurosurgery			-		-
38	3800	Obstetrics and Gynecology			-		-
39	3900	Ophthalmology			-		-
40	4000	Orthopedic Surgery			-		-
41	4100	Otolaryngology			-		-
42	4200	Pathology			-		-
43	4300	Pediatrics			-		-
44	4400	Physical Medicine and Rehabilitation			-		-
45	4500	Psychiatry			-		-
46	4600	Radiation Oncology			-		-
47	4700	Radiology			-		-
48	4800	Surgery			-		-

WORKSHEET A-1

PROVIDER NAME: 0 PROVIDER NO.: 0

CLINICAL PHYSICIAN SALARY & BENEFITS COSTS

FROM: **1/0/1900**

TO: **1/0/1900**

Please complete all green highlighted cells

		COST CENTER DESCRIPTIONS (omit cents)	WORK	BENCHMARK WORK	% OF BENCHMARK (col. 1 / 2)	TOTAL PHYSICIAN SALARY/BENEFIT	TOTAL (col. 3 X 4)
			1	2	3	4	5
49	4900	Urology			-		-
50	5000	Anesthesiology Pain			-		-
51	5100	Other			-		-
52	5200	Other			-		-
53	5300	Other			-		-
54	5400	Other			-		-
55	5500	Other			-		-
		OTHER					
56	5600	Other			-		-
57	5700	Other			-		-
58	5800	Other			-		-
59	5900	Other			-		-
60	6000	Other			-		-
61	6100	Other			-		-
62	6200	Other			-		-
63	6300	Other			-		-
64	6400	Other			-		-
65	6500	Other			-		-
66	6600	Other			-		-
67	6700	Other			-		-
68	6800	Other			-		-
69	6900	Other			-		-
70	7000	Other			-		-
71	7100	Other			-		-
72	7200	Other			-		-
73	7300	Other			-		-
74	7400	Other			-		-
75	7500	Other			-		-
76	7600	Other			-		-
77	7700	Other			-		-
78	7800	Other			-		-
79	7900	Other			-		-
80		SUBTOTALS (sum of lines 5-79)					0

(i) A Physicians individual Work RVU/ASA are limited to the standard benchmark RVU/ASA per FTE

WORKSHEET A-2

PROVIDER NAME: 0	PROVIDER NO.: 0	FROM:	**1/0/1900**
CLINICAL MID LEVEL PROFESSIONAL SALARY & BENEFITS COSTS		TO:	**1/0/1900**
COST CENTER - WORKSHEET A			

Please complete all green highlighted cells

										To WS A Column 2	To WS A Column 2	
	1	2	3	4	5	6	7	8	9	10	11	12
Practitioner Type	Name	EID	Total Comp	Adjustment/ (Offsets)	Comp to be Allocated (col 3+4)	% Hosp-Based	% Non Hospital-Based	Other	% Non-Billable	Hospital-Based Comp (Col 5 x 6)	Non Hospital-Based Comp (Col 5 x 7)	Non-Billable Comp (Col 5 x 9)
CERTIFIED REGISTERED NURSE ANESTHETISTS												
CRNA #1					$0					$0	$0	$0
CRNA #2					$0					$0	$0	$0
CRNA #3					$0					$0	$0	$0
NURSE PRACTITIONERS					$0							
					$0					$0	$0	$0
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DENTISTS												
DENTIST #1					$0					$0	$0	$0
DENTIST #2					$0					$0	$0	$0
DENTIST #3					$0					$0	$0	$0
CERTIFIED NURSE MIDWIVES					$0							
CNMW #1					$0					$0	$0	$0
CNMW #2					$0					$0	$0	$0
CNMW #3					$0					$0	$0	$0
CLINICAL SOCIAL WORKERS												
					$0					$0	$0	$0
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Therapists												
Therapy					$0					$0	$0	$0
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Therapy					$0					$0	$0	$0
Therapy					$0					$0	$0	$0
CLINICAL PSYCHOLOGISTS												
CLIN PSYCH #1					$0					$0	$0	$0
CLIN PSYCH #2					$0					$0	$0	$0
CLIN PSYCH #3					$0					$0	$0	$0
OPTOMETRISTS												
OD #1					$0					$0	$0	$0
OD #2					$0					$0	$0	$0
OD #3					$0					$0	$0	$0
TOTAL COSTS										$0	$0	$0

PROVIDER NAME: 0		PROVIDER NO.: 0		WORKSHEET A-6
RECLASSIFICATIONS			FROM: 1/0/1900	
Please complete all green highlighted cells			TO: 1/0/1900	

			INCREASES				DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER	Cost Report	
		1	2	3	4	5	6	7	8	9	10	
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
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22												
23												
24												
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31												
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33												
34												
35												
36												
37												
38												
39												
40												
41												
42												
43												
44												
45												
46												

PROVIDER NAME: 0		PROVIDER NO.: 0								WORKSHEET A-6	
RECLASSIFICATIONS						FROM: 1/0/1900					
Please complete all green highlighted cells						TO: 1/0/1900					
		INCREASES				DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER	Cost Report
		1	2	3	4	5	6	7	8	9	10
47											
48											
49											
50											
51											
52											
53											
54											
55											
56											
57											
58											
59											
60											
61											
62											
63											
64											
65											
66											
67											
68											
69											
70											
71											
72											
73	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)										

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 5, lines as appropriate.

WORKSHEET A-8

PROVIDER NAME:	0	PROVIDER NO.:	0
ADJUSTMENTS		FROM:	**1/0/1900**
Please complete all green highlighted cells		TO:	**1/0/1900**

	EXPLANATION OF ADJUSTMENT(S)	CODE (1)	ADJUSTMENT AMOUNT				Cost Report
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
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27							
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40							
41							
42							

DY 4 Texas Physician Uncompensated Care Application

WORKSHEET A-8

PROVIDER NAME: 0 PROVIDER NO.: 0

ADJUSTMENTS FROM: **1/0/1900**

Please complete all green highlighted cells TO: **1/0/1900**

	EXPLANATION OF ADJUSTMENT(S)	CODE (1)	ADJUSTMENT AMOUNT				Cost Report
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70							
71							
72							
73							

(1) A letter (A, B, etc.) must be entered on each line to identify each adjustment.

Transfer the amounts in columns 4 and 5 to Worksheet A, column 7, lines as appropriate.

WORKSHEET B

PROVIDER NAME:	0	PROVIDER NO:	0
COST ALLOCATION - GENERAL SERVICE COSTS **Please complete all green highlighted cells**		FROM: TO:	**1/0/1900** **1/0/1900**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOC (from Wkst. A, col. 9)	TOTAL BILLED CHARGES	COST/CHARGE RATIO	Cost Report
		1	2	3	
	GENERAL SERVICE COST CENTERS				
	PHYSICIAN COSTS (HOSPITAL BASED SVCS)				
1	Anesthesia	0		0.00%	
2	Dermatology	0		0.00%	
3	Emergency Medicine	0		0.00%	
4	Family and Community Medicine	0		0.00%	
5	Internal Medicine	0		0.00%	
6	Neurology	0		0.00%	
7	Neurosurgery	0		0.00%	
8	Obstetrics and Gynecology	0		0.00%	
9	Ophthalmology	0		0.00%	
10	Orthopedic Surgery	0		0.00%	
11	Otolaryngology	0		0.00%	
12	Pathology	0		0.00%	
13	Pediatrics	0		0.00%	
14	Physical Medicine and Rehabilitation	0		0.00%	
15	Psychiatry	0		0.00%	
16	Radiation Oncology	0		0.00%	
17	Radiology	0		0.00%	
18	Surgery	0		0.00%	
23	Urology	0		0.00%	
24	Anesthesiology Pain	0		0.00%	
25	Other	0		0.00%	
26	Other	0		0.00%	
27	Other	0		0.00%	
28	Other	0		0.00%	
29	Other	0		0.00%	
	PHYSICIAN COSTS (NON-HOSPITAL BASED CLINICS)				
31	Anesthesia	0		0.00%	
32	Dermatology	0		0.00%	
33	Emergency Medicine	0		0.00%	
34	Family and Community Medicine	0		0.00%	
35	Internal Medicine	0		0.00%	
36	Neurology	0		0.00%	
37	Neurosurgery	0		0.00%	
38	Obstetrics and Gynecology	0		0.00%	
39	Ophthalmology	0		0.00%	
40	Orthopedic Surgery	0		0.00%	
41	Otolaryngology	0		0.00%	
42	Pathology	0		0.00%	
43	Pediatrics	0		0.00%	
44	Physical Medicine and Rehabilitation	0		0.00%	
45	Psychiatry	0		0.00%	
46	Radiation Oncology	0		0.00%	
47	Radiology	0		0.00%	
48	Surgery	0		0.00%	
49	Urology	0		0.00%	
50	Anesthesiology Pain	0		0.00%	
51	Other	0		0.00%	
52	Other	0		0.00%	

PROVIDER NAME:	0		PROVIDER NO:	0	
COST ALLOCATION - GENERAL SERVICE COSTS **Please complete all green highlighted cells**			FROM: TO:	**1/0/1900** **1/0/1900**	
	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOC (from Wkst. A, col. 9)	TOTAL BILLED CHARGES	COST/CHARGE RATIO	Cost Report
		1	2	3	
53	Other	0		0.00%	
54	Other	0		0.00%	
55	Other	0		0.00%	
	OTHER				
56	Other	0		0.00%	
57	Other	0		0.00%	
58	Other	0		0.00%	
59	Other	0		0.00%	
60	Other	0		0.00%	
61	Other	0		0.00%	
62	Other	0		0.00%	
63	Other	0		0.00%	
64	Other	0		0.00%	
65	Other	0		0.00%	
66	Other	0		0.00%	
67	Other	0		0.00%	
68	Other	0		0.00%	
69	Other	0		0.00%	
70	Other	0		0.00%	
71	Other	0		0.00%	
72	Other	0		0.00%	
73	Other	0		0.00%	
74	Other	0		0.00%	
75	Other	0		0.00%	
76	Other	0		0.00%	
77	Other	0		0.00%	
78	Other	0		0.00%	
79	Other	0		0.00%	
				0.00%	
80	SUBTOTALS (sum of lines 1-79)	0	0	0	
	NONREIMBURSABLE COST CENTERS				
81	Basic Science Departments	0			
82	Academic	0			
83	Research Centers	0			
84	Office of Curricular Support/Medical Education	0			
85	Hospital Administration	0			
86	Non Reimbursable	0			
	Unreconciled Rounding				
87	Cross Foot Adjustments				
88	Negative Cost Centers				
90	TOTAL	0	0		

PROVIDER NAME:	0	PROVIDER NO.:	0			**WORKSHEET D**
APPORTIONMENT OF CLINICAL PHYSICIAN COSTS				FROM:	**1/0/1900**	
Please complete all green highlighted cells				TO:	**1/0/1900**	

				PROGRAM CHARGES		PROGRAM COSTS	
		COST CENTER DESCRIPTIONS (omit cents)	(From WS B) COST/CHARGE RATIO	Uninsured Charity Inpatient Billed Charges	Uninsured Charity Outpatient Billed Charges	Uninsured Charity Inpatient	Uninsured Charity Outpatient
			1	2	3	4	5
		HOSPITAL BASED SITES					
1	0500	Anesthesia	0.00%			0	0
2	0600	Dermatology	0.00%			0	0
3	0700	Emergency Medicine	0.00%			0	0
4	0800	Family and Community Medicine	0.00%			0	0
5	0900	Internal Medicine	0.00%			0	0
6	600	Neurology	0.00%			0	0
7	700	Neurosurgery	0.00%			0	0
8	800	Obstetrics and Gynecology	0.00%			0	0
9	900	Ophthalmology	0.00%			0	0
10	1000	Orthopedic Surgery	0.00%			0	0
11	1100	Otolaryngology	0.00%			0	0
12	1200	Pathology	0.00%			0	0
13	1300	Pediatrics	0.00%			0	0
14	1400	Physical Medicine and Rehabilitation	0.00%			0	0
15	1500	Psychiatry	0.00%			0	0
16	1600	Radiation Oncology	0.00%			0	0
17	1700	Radiology	0.00%			0	0
18	1800	Surgery	0.00%			0	0
23	2300	Urology	0.00%			0	0
24	2400	Anesthesiology Pain	0.00%			0	0
25	2500	Other	0.00%			0	0
26	2600	Other	0.00%			0	0
27	2700	Other	0.00%			0	0
28	2800	Other	0.00%			0	0
29	2900	Other	0.00%			0	0
		NON-HOSPITAL BASED SITES					
31	3100	Anesthesia	0.00%			0	0
32	3200	Dermatology	0.00%			0	0
33	3300	Emergency Medicine	0.00%			0	0
34	3400	Family and Community Medicine	0.00%			0	0
35	3500	Internal Medicine	0.00%			0	0
36	3600	Neurology	0.00%			0	0
37	3700	Neurosurgery	0.00%			0	0
38	3800	Obstetrics and Gynecology	0.00%			0	0
39	3900	Ophthalmology	0.00%			0	0
40	4000	Orthopedic Surgery	0.00%			0	0
41	4100	Otolaryngology	0.00%			0	0
42	4200	Pathology	0.00%			0	0
43	4300	Pediatrics	0.00%			0	0
44	4400	Physical Medicine and Rehabilitation	0.00%			0	0
45	4500	Psychiatry	0.00%			0	0
46	4600	Radiation Oncology	0.00%			0	0
47	4700	Radiology	0.00%			0	0
48	4800	Surgery	0.00%			0	0
49	4900	Urology	0.00%			0	0
50	5000	Anesthesiology Pain	0.00%			0	0
51	5100	Other	0.00%			0	0
52	5200	Other	0.00%			0	0

PROVIDER NAME: 0	PROVIDER NO.:	0			**WORKSHEET D**
APPORTIONMENT OF CLINICAL PHYSICIAN COSTS			FROM:	**1/0/1900**	
Please complete all green highlighted cells			TO:	**1/0/1900**	

				PROGRAM CHARGES		PROGRAM COSTS	
		COST CENTER DESCRIPTIONS (omit cents)	(From WS B) COST/CHARGE RATIO	Uninsured Charity Inpatient Billed Charges	Uninsured Charity Outpatient Billed Charges	Uninsured Charity Inpatient	Uninsured Charity Outpatient
			1	2	3	4	5
53	5300	Other	0.00%			0	0
54	5400	Other	0.00%			0	0
55	5500	Other	0.00%			0	0
		OTHER					
56	5600	Other	0.00%			0	0
57	5700	Other	0.00%			0	0
58	5800	Other	0.00%			0	0
59	5900	Other	0.00%			0	0
60	6000	Other	0.00%			0	0
61	6100	Other	0.00%			0	0
62	6200	Other	0.00%			0	0
63	6300	Other	0.00%			0	0
64	6400	Other	0.00%			0	0
65	6500	Other	0.00%			0	0
66	6600	Other	0.00%			0	0
67	6700	Other	0.00%			0	0
68	6800	Other	0.00%			0	0
69	6900	Other	0.00%			0	0
70	7000	Other	0.00%			0	0
71	7100	Other	0.00%			0	0
72	7200	Other	0.00%			0	0
73	7300	Other	0.00%			0	0
74	7400	Other	0.00%			0	0
75	7500	Other	0.00%			0	0
76	7600	Other	0.00%			0	0
77	7700	Other	0.00%			0	0
78	7800	Other	0.00%			0	0
79	7900	Other	0.00%			0	0
						0	0
80		SUBTOTALS (sum of lines 5-79)		0	0	0	0
81		LESS: PAYMENTS					
82		NET UNREIMBURSED COST				0	0

TEXAS HOSPITAL DISPROPORTIONATE SHARE AND UNCOMPENSATED CARE APPLICATION

SUMMARY SCHEDULE

PROVIDER NAME: 0
MEDICARE PROVIDER NO.: 0
TPI: 0

FROM: 1/0/1900
TO: 1/0/1900

	Source	1 Amount	2 Adjustments to Reflect Demonstration Year Costs	3 Adjusted UC Costs (Column 1 + 2)
UC Uninsured Charity Inpatient Physician & Mid-Level Professional Costs	Schedule 1, Column 2c	-	-	-
UC Uninsured Charity Outpatient Physician & Mid-Level Professional Costs	Schedule 1, Column 2d	-	-	-
UC Pharmacy Uninsured Charity Costs	Schedule 2, Column 3d	-	-	-
UC Uncompensated Uninsured Charity Costs	Sched 3-HSL(Uninsured Charity)	-	-	-
TOTAL	UC Total	-	-	-
DSH Hospital Unreimbursed Costs	DSH HSL	-	[redacted]	-
Non-Covered Services	Non-Covered Services	0		-
Total Uncompensated Care Costs (UCC)	Total UCC	-		-

TEXAS HOSPITAL DISPROPORTIONATE SHARE AND UNCOMPENSATED CARE APPLICATION

PROVIDER NAME:

DBA (Doing Business As):

MEDICARE PROVIDER NO.:

TEXAS PROVIDER IDENTIFIER (TPI):

NATIONAL PROVIDER IDENTIFIER (NPI):

MONTH OF HOSPITAL'S FISCAL YEAR-END:

COST REPORT PERIOD
FROM:
TO:

STATUS:

HOSPITAL PHYSICAL ADDRESS:

Street 1:
Street 2:
City:
State:
Zip Code:
County:

CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS APPLICATION MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER STATE LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS APPLICATION WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE INFORMATI0N CONTAINED IN THIS APPLICATION PREPARED BY THE ABOVE NAMED PROVIDER FOR THE PERIOD AS STATED ABOVE AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS OF THE STATE OF TEXAS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS APPLICATION WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS.

IF PARTICIPATING IN THE DISPROPORTIONATE SHARE (DSH) HOSPITAL PROGRAM, BY SIGNING THIS CERTIFICATION I ALSO CERTIFY:

I have examined the Disproportionate Share Application data and the information contained herein is true and correct with the conditions of participation and will remain in effect throughout DSH Program Year 2020 (October 1, 2019 through September 30, 2020). I hereby certify that the contact and identification section, the two physician certification section, the trauma certification section, out of state data, inpatient days, tax appropriation, payments received from governmental sources and charity charges, hospital cost report section, and the uninsured charges and payments section are accurate and true. I agree to retain DSH records for the next five years, to provide access and/or submit the records when requested for the Federal DSH audit which will occur approximately three years from the 2020 DSH program year (October 1, 2019-September 30, 2020).

Request to Participate:
2020 Disproportionate Share (DSH):
DY 9 Uncompensated Care (UC):

Ownership Type

Rural hospital--A hospital located in a county with 60,000 or fewer persons according to the most recent United States Census; or a Medicare-designated Sole Community Hospital,or a Critical Access Hospital; or a Medicare-designated Rural Referral Center that is either not located in a Metropolitan Statistical Area (MSA) or is located in an MSA but has 100 or fewer beds.

Is the hospital a Rural Hospital?

Has the hospital had a change in ownership or operation since 10/1/2018?

If yes, have you notified HHSC Rate Analysis of this change?

Is the hospital in the process of or has the hospital filed for bankruptcy?

To your knowledge will the hospital be closing in the next 12 months?

Is the hospital enrolled in a Regional Healthcare Partnership under the TPI you are requesting the application under (RHP)?

RHP Hospital is Enrolled in (1-20):

If privately owned, does the hospital have an active affiliation with a government entity on file?

To update your TPI or to enroll in an RHP plan, you will need to contact the anchor of your RHP.

SIGNATURE OF PRIMARY HOSPITAL CONTACT

PRINT NAME OF PRIMARY HOSPITAL CONTACT

TITLE

EMAIL

STREET 1

STREET 2

CITY

STATE

ZIP CODE

COUNTY

PHONE NUMBER

DATE

DSH/UC APPLICATION PREPARER CONTACT

TITLE

EMAIL

PHONE NUMBER

DATE

PROVIDER NAME: 0
MEDICARE PROVIDER NO.: 0
TPI: 0

ADJUSTMENTS SUMMARY TO REFLECT DEMONSTRATION YEAR COSTS

Schedule 1

Line Number	Cost Center	IP Uninsured Charity Costs	OP Uninsured Charity Costs	Explanation	Supporting Documentation File Name
	Total	-	-		

Schedule 2

Line Number	Cost Center	Uninsured Charity Costs	Explanation	Supporting Documentation File Name
	Total	-		

Schedule 3

Line Number	Cost Center	IP Uninsured Charity Costs	OP Uninsured Charity Costs	Explanation	Supporting Documentation File Name
	Total	-	-		

PROVIDER NAME: -
MEDICARE PROVIDER NO.: 0
TPI: -

PLEASE FILL IN THE YELLOW HIGHLIGHTED CELLS

Line Number	0 COST CENTER DESCRIPTION (Revise as needed)	Source of Column 1 data	1 Total Physician and Mid-Level Professional Costs	1a Total Allocation Statistics	1b Allocation Statistical Basis	2 Cost Ratio	2a Uninsured Charity Inpatient Charges	2b Uninsured Charity Outpatient Charges	2c Uninsured Charity Inpatient Physician and Mid Level Professional Costs	2d Uninsured Charity Outpatient Physician and Mid-Level Professional Costs
1.00	GENERAL SERVICES					NA			NA	NA
5.01 & 5.05	Indigent Care				Hospital Charges	NA			NA	NA
5.01	Medical Services- SponsoredCare				Hospital Charges	NA			NA	NA
5.01	Medical Services- CMA Carelink				Hospital Charges	NA			NA	NA
5.01	Medical Services- General				Hospital Charges	NA			NA	NA
5.01	Medical Services- UPG Carelink				Hospital Charges	NA			NA	NA
	GENERAL SERVICES (specify)					NA			NA	NA
	GENERAL SERVICES (specify)					NA			NA	NA
30.00	ADULTS AND PEDIATRICS			-	Hospital Charges	NA	-		NA	NA
31.00	INTENSIVE CARE UNIT			-	Hospital Charges	NA	-		NA	NA
32.00	CORONARY CARE UNIT			-	Hospital Charges	NA	-		NA	NA
33.00	BURN INTENSIVE CARE UNIT			-	Hospital Charges	NA	-		NA	NA
34.00	SURGICAL INTENSIVE CARE UNIT			-	Hospital Charges	NA	-		NA	NA
35.00	OTHER SPECIAL CARE UNIT			-	Hospital Charges	NA	-		NA	NA
40.00	SUBPROVIDER IPF			-	Hospital Charges	NA	-		NA	NA
41.00	SUBPROVIDER IRF			-	Hospital Charges	NA	-		NA	NA
42.00	SUBPROVIDER (OTHER)			-	Hospital Charges	NA	-		NA	NA
43.00	NURSERY			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
-	0			-	Hospital Charges	NA	-		NA	NA
50.00	OPERATING ROOM			-	Hospital Charges	NA	-	-	NA	NA
51.00	RECOVERY ROOM			-	Hospital Charges	NA	-	-	NA	NA
52.00	DELIVERY ROOM & LABOR ROOM			-	Hospital Charges	NA	-	-	NA	NA
53.00	ANESTHESIOLOGY			-	Hospital Charges	NA	-	-	NA	NA
54.00	RADIOLOGY-DIAGNOSTIC			-	Hospital Charges	NA	-	-	NA	NA
55.00	RADIOLOGY-THERAPUTIC			-	Hospital Charges	NA	-	-	NA	NA
56.00	RADIOISOTOPE			-	Hospital Charges	NA	-	-	NA	NA
57.00	COMPUTED TOMOGRAPHY (CT) SCAN			-	Hospital Charges	NA	-	-	NA	NA
58.00	MAGNETIC RESONANCE IMAGING (MRI)			-	Hospital Charges	NA	-	-	NA	NA
59.00	CARDIAC CATHETERIZATION			-	Hospital Charges	NA	-	-	NA	NA
60.00	LABORATORY			-	Hospital Charges	NA	-	-	NA	NA
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY			-	Hospital Charges	NA	-	-	NA	NA
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS			-	Hospital Charges	NA	-	-	NA	NA
63.00	BLOOD STORING, PROCESSING & TRANS.			-	Hospital Charges	NA	-	-	NA	NA
64.00	INTRAVENOUS THERAPY			-	Hospital Charges	NA	-	-	NA	NA
65.00	RESPIRATORY THERAPY			-	Hospital Charges	NA	-	-	NA	NA
66.00	PHYSICAL THERAPY			-	Hospital Charges	NA	-	-	NA	NA
67.00	OCCUPATIONAL THERAPY			-	Hospital Charges	NA	-	-	NA	NA
68.00	SPEECH PATHOLOGY			-	Hospital Charges	NA	-	-	NA	NA
69.00	ELECTROCARDIOLOGY			-	Hospital Charges	NA	-	-	NA	NA
70.00	ELECTROENCEPHALOGRAPHY			-	Hospital Charges	NA	-	-	NA	NA
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS			-	Hospital Charges	NA	-	-	NA	NA
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS			-	Hospital Charges	NA	-	-	NA	NA
73.00	DRUGS CHARGED TO PATIENTS			-	Hospital Charges	NA	-	-	NA	NA
74.00	RENAL DIALYSIS			-	Hospital Charges	NA	-	-	NA	NA
75.00	ASC (NON-DISTINCT PART)			-	Hospital Charges	NA	-	-	NA	NA
76.00	OTHER ANCILLARY			-	Hospital Charges	NA	-	-	NA	NA
90.00	CLINIC			-	Hospital Charges	NA	-	-	NA	NA
91.00	EMERGENCY			-	Hospital Charges	NA	-	-	NA	NA
92.00	OBSERVATION BEDS (NON-DISTINCT)			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
-	0			-	Hospital Charges	NA	-	-	NA	NA
					Hospital Charges	NA				
					Hospital Charges	NA				
	TOTAL COST			-			-	-	-	-
102.00	LESS: SERVICE & OTHER REVENUES (enter as a positive number)									
103.00	NET COST								-	-

Drop-down Options
A-8
A-8-2 (Column 4)
(A-8) + (A-8-2)
B Part I

In order for Schedule 1 costs to be allowed, providers MUST enter all revenues associated with costs claimed. If you do not have revenue for the costs you are claiming, please provide the cost center number and reason for the lack of revenue below.

Cost Center Number	Title of Supporting Documentation File OR Reason for Lack of Revenue in Cost Center

TEXAS HOSPITAL UNCOMPENSATED CARE APPLICATION

PROVIDER NAME: -
MEDICARE PROVIDER NO.: 0
TPI: -

		A	B	1	1a	1b	2	3b	3d
Line Number	COST CENTER DESCRIPTION (Revise as needed)	Pharmacy Name	Pharmacy NPI	Total Pharmacy Costs	Total Charges	Allocation Statistical Basis	Cost-to-Charge Ratio	Uninsured Charity Outpatient Pharmacy Charges	Uninsured Charity Outpatient Pharmacy Costs
1.00	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	SELF-PAY PHARMACY					Hospital Charges	NA		NA
	Total			-	-			-	-
2.00	Service and Other Revenues (enter as positive)								
3.00	NET COST								-

Hospital Data
Program Year 2020
Program Year (10-1-2019 through 9-30-2020)
DSH Data Year (10-1-2017 through 9-30-2018); S-10 Data from Cost Report for period ending in Calendar Year 2018

Hospital Name: 0
TPI # 0

Section 1: Identifying Information

	Hospital IDENTIFYING NUMBERS:	ID Number
1.1	Other Associated TPI: Ambulatory Surgical Center (ASC)	
1.2	Other Associated TPI: Hospital Ambulatory Surgical Center (HASC)	
1.3	Tax Payer ID	
1.4	Prior TPI	
1.5	Prior TPI	
1.6	Prior TPI	
1.7	Facility ID Number (Determined by TX Department of State Health Services)	

NOTE: EVEN IF YOU BELIEVE YOUR HOSPITAL WILL NOT PARTICIPATE IN DSH, PLEASE COMPLETE SECTIONS 2 AND 3

Section 2: PHYSICIAN CERTIFICATION - Check one of the following:

Please select "1" if your Hospital has at least two licensed PHYSICIANs (doctor of medicine or osteopathy) who have Hospital staff privileges and who have agreed, as of the date the application is submitted and through the program year, to provide nonemergency obstetrical services to individuals who are entitled to Medicaid reimbursement for such services, Otherwise "2."

		Specialty Type	Texas Medical License #	Texas Medicaid Provider #
1.	PHYSICIAN Name:			
2.	PHYSICIAN Name:			

Please select "1" if claiming exemption as a Children's Hospital or a Hospital that serves inpatients who are predominantly under 18 years of age, Otherwise select "2."

Please select "1" if claiming exemption because your Hospital was operating and ceased to perform non-emergency obstetrical services (doing deliveries) to the general public as of December 22, 1987. Supporting documentation such as newspaper announcement, Board of Directors statement, etc. must be submitted by mail with the certification page, Otherwise select "2."

Please select "1" if your Hospital does NOT meet the two PHYSICIAN requirement, or you do not wish to participate in DSH, Otherwise select "2."

Section 3: TRAUMA CERTIFICATION

Please select "1" to acknowledge your Hospital is "in active pursuit" of, or has obtained and will maintain, a trauma facility designation as defined in §§773.111 - 773.120, Health and Safety Code, and consistent with 25 TAC §157.125 (relating to Requirements for Trauma Facility Designation). A Hospital that has obtained its trauma facility designation must maintain that designation for the entire program year, Otherwise select "2."

Section 4: OUT OF STATE INPATIENT DATA FOR DATA YEAR 2016 (10-1-2015 through 9-30-2016)

	Out of State Medicaid Data	CHARGES $	PAYMENTS $	DAYS
4.1	Out of State Adjudicated Medicaid Inpatient Data (Excluding Managed Care Organization data)			
4.2	Out of State Adjudicated Medicaid Outpatient Data (Excluding Managed Care Organization data)			
4.3	Out of State Managed Care Organization Inpatient Data			
4.4	Out of State Managed Care Organization Outpatient Data			

	Out of State Supplemental Payments	PAYMENTS $
4.5	Upper Payment Limit Program Payments	$0
4.6	Graduate Medical Education	$0
4.7	Other Supplemental Programs	$0

	Out of State Insurance	PAYMENTS $
4.8	Out of State Insurance Inpatient Payments	
4.9	Out of State Insurance Outpatient Payments	

This section's data is based on the adjudicated date, which is the date a Hospital claim for payment for a covered Medicaid service is paid or adjusted by the appropriate State or State Fiscal Intermediary. Data should include all claims for patients who are dually eligible for Medicare and Medicaid.

Section 5: CALCULATION DATA FOR DATA YEAR 2018 (10-1-2017 through 9-30-2018) Sections 5.1 and 5.2 Use Cost Report Ending in Calendar Year 2018

	Inpatient Days	DAYS
5.1	Total Hospital Inpatient Days (Include days used solely for acute care (e.g. Newborn Nursery))	
5.2	Swing bed inpatient days (Exclude days for acute care: e.g.; routine medical/surgical)	0
	Total Hospital Inpatient Census	0

The purpose of the sections below are to collect data that is used for the Low Income Utilization Rate calculation. All state and local payments, tax appropriations, and charges listed below in the remainder of section 5 should be limited to those associated with inpatient care unless otherwise specified.

5.3	Tax Revenue for inpatient charity care received by the hospital for inpatient services	

5.4 Identify locally-funded programs and the amount of funds used for inpatient care. Group program names under $10,000 should be included on one line.

	City & County Programs:	PAYMENTS $
5.5a		
5.5b		
5.5c		
5.5d		
5.5e		
5.5f		
5.5g		
5.5h		
5.5i		
5.5j		
5.5k		
5.5l		
5.5m		
5.5n		
5.5o		
5.5p		
5.5	Total, City & County Programs	$0

Identify state-only funded programs and amounts used for inpatient care. These amounts will likely differ from other state surveys

	State Programs:	PAYMENTS $
5.6a		
5.6b		
5.6c		
5.6d		
5.6e		
5.6f		
5.6g		
5.6h		
5.6i		
5.6j		
5.6k		

5.6l		
5.6m		
5.6n		
5.6o		
5.6p		
5.6	Total, State Funded:	$0

Charity Charges

Charity charges must be consistent with §311.031 of the Texas Health and Safety Code, 1 Texas Administrative Code §355.8065(b) and the hospital's financial reports (excluding under-insured charges, bad debt charges, contractual allowances and other discounts given to other legally liable third-party payers).

	CHARGES $
5.7 Inpatient Charity Charges	
5.8 Outpatient Charity Charges	

Section 6: COST REPORT DATA FOR INPATIENT RATIO OF COST TO CHARGES (Hospital Fiscal Year Data that Ended in Calendar Year 2018)

Using your facility's most recently filed or audited Medicare Cost Report for the hospital fiscal year that ended in the calendar year 2018, please provide the information requested below. Hospitals should report costs and charges for nonhospital services and non-reimbursable cost centers in Column #2 below. Non-hospital services and non-reimbursable cost centers (Column #2) will be subtracted from Total Patient Services (Column #1). Non-hospital services include Skilled Nursing Facility, Nursing Facility, Other Long Term Care, Rural Health Clinic(s), Ambulance Services, Primary Home Care, CORF, Home Health Agency, and Hospice. Non-reimbursable cost centers include Wellness, Assisted Living, Lifeline, Swing Bed, Free-standing ASC, Retail Pharmacy, and Professional Fees.

	Cost Report		
	Beginning Date	**Ending Date**	**Status**
6.1 2018 Cost Report	1/0/1900	1/0/1900	0

The following column headings apply for items number 7.2 through 7.7 of this section. The requested information must match the specified worksheet, column and line from the CMS 2552-10 cost report used for this application. Ensure this information matches the cost center worksheet. Provide pertinent copies of the cost report worksheets with your application.

#1: Total of Patient Services from each worksheet
#2: Total of Non-Hospital Services
#3: Difference of #1 minus #2

2018 COST REPORT WORKSHEET INFORMATION		#1	#2	#3
	CMS 2552-10	Total Patient Services	Total Non-Hospital Services	Difference equals Allowable Services
6.2	Worksheet B, Part 1, Costs (Column 24, Line 118)	$0		$0
6.3	Worksheet G-2, Gross Inpatient Revenue (GIR) (Column 1, Line 28)	$0		$0
6.4	Worksheet G-2, Total Revenue (Column 3, Line 28)	$0		$0

6.5 Hospitals with Transplant costs, please list total charges from W/S D-4, Part III. Summary of Costs and Charges

Medicaid Eligible Organ Acquisition Costs:

	Organ Acquisition Cost	Revenue from Organs Sold	Total Useable Organs (Count)	Medicaid Eligible Organs (Count)	Organ RCC	Net Cost	Final Eligible Organ Cost
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 66	Cost Report Worksheet D-4, Pt. III, Col 2, Line 62	From Paid Claims Data or Provider Logs (Note A)	Calculation	Calculation	Calculation
Organ Acquisition Cost Centers (list below):							
Lung Acquisition	$0.00	$0.00		3	0	$0.00	$0.00
Kidney Acquisition	$0.00	$0.00		32	0	$0.00	$0.00
Liver Acquisition	$0.00	$0.00		18	0	$0.00	$0.00
Heart Acquisition	$0.00	$0.00		0	0	$0.00	$0.00
Pancreas Acquisition	$0.00	$0.00		0	0	$0.00	$0.00
Intestinal Acquisition	$0.00	$0.00		0	0	$0.00	$0.00
Islet Acquisition	$0.00	$0.00		0	0	$0.00	$0.00

MEDICAID ELIGIBLE CHARGES AND ORGANS WILL INCLUDE FFS, MCO, CROSSOVERS, SECONDARY NON-BILLED, AND UNINSURED.

Note A: These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into Uninsured patients (but where organs were included in the Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

Uninsured Organ Acquisition Costs

	Organ Acquisition Cost	Revenue from Organs Sold	Total Useable Organs (Count)	Uninsured Eligible Organs (Count)	Charity Eligible Organ (Count)	Duplicate Organ (Count)	Uninsured Organ RCC	Uninsured Net Cost
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 66	Cost Report Worksheet D-4, Pt. III, Col 2, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note B)	From Paid Claims Data or Provider Logs (Note C)	Calculation	Calculation
Organ Acquisition Cost Centers (list below):								
Lung Acquisition	$0.00	$0.00					0	$0.00
Kidney Acquisition	$0.00	$0.00					0	$0.00
Liver Acquisition	$0.00	$0.00					0	$0.00
Heart Acquisition	$0.00	$0.00					0	$0.00
Pancreas Acquisition	$0.00	$0.00					0	$0.00
Intestinal Acquisition	$0.00	$0.00					0	$0.00
Islet Acquisition	$0.00	$0.00					0	$0.00

UNINSURED ELIGIBLE COSTS AND ORGANS

Note A: These amounts must agree to your inpatient and outpatient Uninsured paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: This organ count should be limited to organ acquisition counts that meet the hospital's charity care policy.
Note C: Duplicate means the organ count that is included in the DSH Uninsured and UC Charity counts.

Medicaid Organ Costs	Total	$0.00
Uninsured Organ Costs	Total	$0.00
Charity Organ Costs	Total	$0.00
Duplicate Organ Costs	Total	$0.00

6.6 Hospital's Medicaid Secondary (Non-Billed)
Medicaid-eligible patient services where Medicaid did not receive the claim and therefore are not included in the State's data.□

	Days	Charges	Payments
IP			
OP			
		Total	0

LPPF Costs

Medicaid/Uninsured

6.7 Local Provider Participation Fund

Hospitals required to make a mandatory payment to a local jurisdiction that administers a Local Provider Participation Fund (LPPF) may claim a portion of the mandatory payment as an allowable cost. To calculate the portion of the mandatory payment that can be claimed, hospitals may use a ratio based on Medicaid and uninsured charges to total charges, Medicaid and uninsured payments to total payments, or Medicaid and uninsured days to total days. In the LPPF Costs - Charity Care Costs cell (K195), please calculate the LPPF costs that are associated with charity care using the same methodology (e.g., charity charges/total charges X amount paid to LPPF). In the LPPF Costs - Duplicate cell (L195), please identify the claims that appear in the Uninsured LPPF Costs as well as the claims that appear in the Charity Care LPPF costs also using the same method to calculate cost (e.g., duplicated charges/total charges X amount paid to LPPF). The hospital must provide documented support of its cost in the form of quarterly tax statements and the

Provider Name
Provider NPI Number
Program Year (CY) (2018 through 9999)
State Fiscal Year (SFY) (2017 through 9999)

Section C - UNINSURED CHARGES & PAYMENTS (DHS uses CHARITY CHARGES & PAYMENTS ONLY FOR DATA TO BE REPORTED ON LINES 7 AND 8)

The following instance is meant to help a hospital determine its uninsured charges and payments for the DSH program. This is not an preference but and PPDH, accommodate hospitals Medicaid Charity Care Rate, additional Parameter for state Federal Register pages Patients Order, which attempt information information material be submitted uninsured claim and as much data.

Uninsured Discounted Charges Only. The uninsured section of the program refers to the charges associated with any inpatient and outpatient hospital care to uninsured patients who were given a discount from the hospital's gross charges. Uninsured patients are those who do not have any form of health insurance, including managed care plans with the definition under 40 CFR Parts 144 and 146, as well as, including those on a public Sales Print only, payer. Hospitals should make every effort to document as much data as possible about the facts in order to maximize funding the patient in the uninsured program.

Uninsured Discounted Charges Only Instructions. Report inpatient and outpatient hospital charges for services to uninsured patients **discounted** during the Rate year. Charges are based on the hospital's gross charges for the services provided to uninsured patients. Do not report charges for any discounts provided by the hospital during the Rate year or any payments from or made on behalf of an uninsured patient received by the hospital during the Rate year or before the last uninsured month. Net-loss price data for the uninsured should be reported on the Hospital Specific Limit Calculation Report "Medicaid Rate Plus."

Providers must exclude charges for ESRD Uninsured:

- Non-covered charges or other misclassified costs/charges;
- Professional fees;
- Pro-rata **and** organizational services not billed under the hospital's TPI;
- Non-cost basis with costs, charges, and fees associated with Medicaid Rate Plus and services that or that always medical errors in the uninsured/charity care Rate;
- Non-cost basis with costs, charges, and fees associated with Medicaid Rate Plus and services that or that always medical errors in the uninsured/charity care Rate;
- Charges associated with bad debts (payor discounts, self-pay accounts, uninsured patients with unpaid charges). Bad debtors for other bad debt or payor discounts, subject to such rules fumished to individuals who have any health insurance or other third party payor;
- Charges for services that are not reimbursable under 1886 (d)(5)(F)(vi)(III) and 1886 (d)(5)(F)(vi)(III) that are not to:
- Medicaid or ESRD address and charges; and
- Non-cost that would not be incurred under the Texas Medicaid Rules Plan had the individual been Medicaid-eligible.

Providers must exclude charges for ESRD Uninsured:

- Pro-rata discounts for uninsured patients (Navy discounts and not revenue, but not discounted rates);
- Non-cost allocated to undocumented residents;
- Charges associated with bad debts (payor discounts, self-pay patients);
- All other charges for care provided to uninsured patients;
- Charges for services that are not reimbursable under 1886 (d)(5)(F)(vi)(III) and 1886 (d)(5)(F)(vi)(III) that are not to:
- Medicaid or ESRD address and charges; and
- Non-cost that would not be incurred under the Texas Medicaid Rules Plan had the individual been Medicaid-eligible.

Uninsured - Charity. Include **ONLY** charges for uninsured patients who have completed sentenced to A-G of their Medicare Inter Report! Uninsured any charges reported in are to be associated with the hospital charges **Discounted rates are not required, reduced to the full price rates for charity, indigent or prompt pay, as well as charges that were written off to bad debt.**

- Enter the total charges, or the portion of the total charges, written off for charity care, for uninsured patients, and patients who uncharge from an entity, that does not have a financial relationship with the hospital, such as a church-operated mission. Charity care charges are those charges for services provided to patients who have no source of payment, including third-party coverage, and who meet the hospital's charity care criteria. Charity care charges are those charges for services provided to patients who have no source of payment, including third-party coverage, and who meet the hospital's charity care criteria. Do not include charges for patients who have insurance that pays for the entire charge. Also exclude charges for services provided to patients who do not meet the hospital's charity care criteria. Charges for the uninsured patient that are written off as bad debt because the patient qualified but (1) the patient failed to complete the application process or (2) the patient qualified but (2) the patient failed discount.
- Charges for inpatient and outpatient services that have been written off with no expectation of payment. Write-off payments received during the corresponding patient accounts. Charges written off as charity care should be those charges for services you have decided not to collect because of the patient's financial circumstances. Write-off charges for the entire charity, except any known or other professional write-off. Write-off pay-hourly rates and from uninsured patients and patients with coverage from an entity that does not have a financial relationship with the hospital, such as a church-operated mission. Charity care charges are those charges for services provided to patients who have no source of payment, including third-party coverage, and who meet the hospital's charity care criteria. Do not include charges for patients who have insurance that pays for the entire charge. Also exclude charges for services provided to patients who do not meet the hospital's charity care criteria. Charges for the uninsured patient that are written off as bad debt because the patient qualified but (1) the patient failed to complete the application process or (2) the patient qualified but (2) the patient failed discount.
- Charges for inpatient and outpatient services that have been written off with no expectation of payment. Write-off payments received during the corresponding patient accounts. Charges written off as charity care should be those charges for services you have decided not to collect because of the patient's financial circumstances. Write-off charges for the entire charity, except any known or other professional write-off. Write-off pay-hourly rates and from uninsured patients and patients with coverage from an entity that does not have a financial relationship with the hospital, such as a church-operated mission. Charity care charges are those charges for services provided to patients who have no source of payment, including third-party coverage, and who meet the hospital's charity care criteria. Do not include charges for patients who have insurance that pays for the entire charge. Also exclude charges for services provided to patients who do not meet the hospital's charity care criteria. Charges for the uninsured patient that are written off as bad debt because the patient qualified but (1) the patient failed to complete the application process or (2) the patient qualified but (2) the patient failed discount.
- If you are participating in ERP and DY, of the charges, days, and pay-hurtis that are reported in ERP Total Uninsured, please report the charges, days, and pay-hurtis that are duplicated in the DH Charity Care data.

	ERP Total Uninsured	DH Charity Care Charges and Days (L5-L6, Column 1, Use per Rate Instructions for Rate Year Reporting)	DH Medicaid Rate Plus Hurtis for ESRD Uninsured (L5-L6, Column 2, Use Instructions for Rate Year Reporting)	Charges and Days Discounted to ESRD and UC	Percent to Uninsured at ESRD and UC	Charges and Rate Plus Medicaid Audit Services Uninsured (L5-L6, Column 3, Use Instructions for Rate Year Reporting)	Payments for Reconciled Charges and Days (L5-L6, Column 4, Use Instructions for Rate Year Reporting)
7 Charges							
7 a Days							
8 Charges							
8 a Days							

Section D - UNINSURED DISCOUNTS & PAYMENTS (DHS uses CHARITY CHARGES & PAYMENTS ONLY FOR DATA TO BE REPORTED ON LINES 9 AND 10)

Uninsured - Payments. Report all payments received for patient **discharges** during the Rate year, including pay-hurtis received to date. Pay-hurtis will not include insurance pay-hurtis for insured patients as they are not considered uninsured. **Exception:** Medicaid payments are pay payment from all uninsured patients as from a third party, and the patient's behalf (see Uninsured Discounted Charges Only). Payments may include after and uninsured pay-hurt for uninsured and as over a and Federal ERP Final (page 47870, column 2).

Hospitals must exclude **ONLY** the following pay-hurtis for ESRD Uninsured Rate:

- Pay-hurtis made by Uninsured, or Insurance, (pre-uninsured programs, for indigent patients (e.g., County, Indigent Health Care Program).

Providers must include the following pay-hurtis for ESRD Uninsured Rate based on Uninsured:

- Pharmacy, health and was furnished to uninsured where under Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173;
- Other allowable Rules and Federal Payment such as TRICARE, Medicaid and Other Health Services laws;
- Payments made by Uninsured, or Insurance, (pre-uninsured programs;
- All other investor services provided for;
- All other investor services provided for; and
- All other investor services one-time for

	ERP Total Uninsured
9 Payments	
9 a Days	
10 Payments	
10 a Days	

For Section 7 a, please complete the following form:

	ERP Total Uninsured
11 Inpatient Routine Charges	
11 a Inpatient routine days (see Worksheet S-3, line 14, column 7)	
12 Inpatient Ancillary Charges	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	

Section E - UNINSURED DISCOUNTS & PAYMENTS (PHYSICIAN SERVICES) LEFTOVER (and ordering, reimbursed WORTH) - DSH ONLY

DSH ONLY TEMPLATE TO CAPTURE PHYSICIAN CHARITY

DSH-not-see this uninsured definition to calm certain reports and claims for the uninsured calculation of the DSH hospital specific limit. Please complete this section as an addition to Section A.

Uninsured. DSH-organized the uninsured definition used in DSH is charity-hospital and outpatient hospital services. For DSH-should, and must to health insurance or other sources of third party payment for the Rate year. This includes charges for certain patients that have uninsured charity and private insurance benefits. In addition, include hospital services provided to a patient with health insurance that pays for only a portion of the charges for the hospital stay.

Hospitals must exclude or exclude the following charges for DSH Uninsured Rate:

- Costs associated with bad debt (payor discounts, and unpaid coinsurance and deductibles);
- All other charges for care provided to uninsured patients; and
- Non-cost that would not be incurred under the Texas Medicaid Rules Plan had the individual been Medicaid-eligible.

	ERP Total Uninsured
26 Charges	
26 a Days	
27 Charges	
27 a Days	

Uninsured. Provider must include any pay-hurtis made by or on behalf of patient who has uninsured benefits or receive any services that was not or was based of the Discounts Hospital had for

	ERP Total Uninsured
28 Payments	
28 a Days	
29 Payments	
29 a Days	

Total Uninsured for Sections C and E

	ERP Total Uninsured		DH Charity Care Charges and Days (L5-L6, Column 1, Use per Rate Instructions for Rate Year Reporting)		DH Medicaid Rate Plus Hurtis for ESRD Uninsured (L5-L6, Column 2, Use Instructions for Rate Year Reporting)	
	Charges	Days	Charges	Days	Charges	Days
Inpatient						
Outpatient						

Provider Name: - Provider TPI: 0
Provider Year End (MM/DD/YY) 01/00/00
Federal Fiscal Year 2018 (October 1, 2017 - September 30, 2018)

	Start	End	Status	
Cost Report Period	1/0/1900	1/0/1900	0	100.00%

Routine Services

List All Subscripted/Additional Cost Center Data in the Yellow Lines. DO NOT INSERT LINES.

S-3/B Part I	Description	Form S-3, Part I, Col 8 Days	Total Cost B Part I Col 24	RCE Add-back C Part I Col 4	Allowed Cost	Per Diems	D-1, Col 1, Line 26
	Sum of F12 & F13	-				-	-
S-3 Part I Line # / B Part I Cost Center #	Observation Days - S-3 Part I, Col 8, Line 28	-					
1/30	HOSPITAL ADULTS AND PEDIATRICS	-	-	-	-	0	
8/31	INTENSIVE CARE UNIT	-	-	-	-	0	
9/32	CORONARY CARE UNIT	-	-	-	-	0	
10/33	BURN INTENSIVE CARE UNIT	-	-	-	-	0	
11/34	SURGICAL INTENSIVE CARE UNIT	-	-	-	-	0	
12/35	OTHER SPECIAL CARE UNIT	-	-	-	-	0	
13/43	NURSERY	-	-	-	-	0	
16/40	SUBPROVIDER IPF	-	-	-	-	0	
17/41	SUBPROVIDER IRF	-	-	-	-	0	
18/42	SUBPROVIDER (OTHER)	-	-	-	-	0	
					-	0	
					-	0	
					-	0	
	Total Days	-	-	-	-	-	

Hospital Ancillary Services

List All Subscripted/ Additional Cost Center Data in the Yellow Lines. DO NOT INSERT LINES.

2552-10 Line Reference	Cost Center	IP CHGS	OP CHGS	TOTAL CHGS	Total Cost	RCE Add-back	Total Allowed Cost	CCR
30.00	ADULTS AND PEDIATRICS	-	-	-	[redacted]			
31.00	INTENSIVE CARE UNIT	-	-	-				
32.00	CORONARY CARE UNIT	-	-	-				
33.00	BURN INTENSIVE CARE UNIT	-	-	-				
34.00	SURGICAL INTENSIVE CARE UNIT	-	-	-				
35.00	OTHER SPECIAL CARE UNIT	-	-	-				
40.00	SUBPROVIDER IPF	-	-	-				
41.00	SUBPROVIDER IRF	-	-	-				
42.00	SUBPROVIDER (OTHER)	-	-	-				
43.00	NURSERY	-	-	-				
				-				
				-				
				-				
				-				
				-				
				-				
				-				
				-				
				-				
				-				
				-				
				-				
				-				
50.00	OPERATING ROOM	-	-	-	-	-	-	0
51.00	RECOVERY ROOM	-	-	-	-	-	-	0
52.00	DELIVERY ROOM & LABOR ROOM	-	-	-	-	-	-	0
53.00	ANESTHESIOLOGY	-	-	-	-	-	-	0
54.00	RADIOLOGY-DIAGNOSTIC	-	-	-	-	-	-	0
55.00	RADIOLOGY-THERAPUTIC	-	-	-	-	-	-	0
56.00	RADIOISOTOPE	-	-	-	-	-	-	0
57.00	COMPUTED TOMOGRAPHY (CT) SCAN	-	-	-	-	-	-	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	-	-	-	-	-	-	0
59.00	CARDIAC CATHETERIZATION	-	-	-	-	-	-	0
60.00	LABORATORY	-	-	-	-	-	-	0
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	-	-	-	-	-	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	-	-	-	-	-	0
63.00	BLOOD STORING, PROCESSING & TRANS.	-	-	-	-	-	-	0
64.00	INTRAVENOUS THERAPY	-	-	-	-	-	-	0
65.00	RESPIRATORY THERAPY	-	-	-	-	-	-	0
66.00	PHYSICAL THERAPY	-	-	-	-	-	-	0
67.00	OCCUPATIONAL THERAPY	-	-	-	-	-	-	0
68.00	SPEECH PATHOLOGY	-	-	-	-	-	-	0
69.00	ELECTROCARDIOLOGY	-	-	-	-	-	-	0
70.00	ELECTROENCEPHALOGRAPHY	-	-	-	-	-	-	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	-	-	-	-	-	0
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENT	-	-	-	-	-	-	0
73.00	DRUGS CHARGED TO PATIENTS	-	-	-	-	-	-	0
74.00	RENAL DIALYSIS	-	-	-	-	-	-	0
75.00	ASC (NON-DISTINCT PART)	-	-	-	-	-	-	0
76.00	OTHER ANCILLARY	-	-	-	-	-	-	0
90.00	CLINIC	-	-	-	-	-	-	0
91.00	EMERGENCY	-	-	-	-	-	-	0
92.00	OBSERVATION BEDS (NON-DISTINCT)	-	-	-	-	-	-	0
							-	0
							-	0
							-	0
							-	0
							-	0
							-	0
							-	0
							-	0
							-	0
							-	0
							-	0
							-	0
							-	0
							-	0
							-	0
	Total Inpatient							

TOTAL CHECK   Total Inpatient

TPI: 0
Provider Name: 0

Uninsured Charity Patient Uncompensated Care
S-10 Data from Cost Report for period ending in Calendar Year 2018
1/0/1900

0

Results:	Cost Report Period:	From	To	Status
		1/0/1900	1/0/1900	0

Inpatient Days					A	B	(A*B)
S-3/B Part I	CR Line	Description	Form S-3, Part I, Col 8 Days	Days Submitted on IP Charity Care Detail	Allocated Days	Per Diems	IP Routine Cost
				0	*Linked to Form Page * % of days*		
1/30		HOSPITAL ADULTS AND PEDIATRICS	-	-	-	0	$ -
8/31		INTENSIVE CARE UNIT	-	-	-	0	$ -
9/32		CORONARY CARE UNIT	-	-	-	0	$ -
10/33		BURN INTENSIVE CARE UNIT	-	-	-	0	$ -
11/34		SURGICAL INTENSIVE CARE UNIT	-	-	-	0	$ -
12/35		OTHER SPECIAL CARE UNIT	-	-	-	0	$ -
13/43		NURSERY	-	-	-	0	$ -
16/40		SUBPROVIDER IPF	-	-	-	0	$ -
17/41		SUBPROVIDER IRF	-	-	-	0	$ -
18/42		SUBPROVIDER (OTHER)	-	-	-	0	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	0	$ -
0		0	-	-	-	0	$ -
0		0	-	-	-	0	$ -
	Total Patient Days		**-**		**-**		**-**

		(A)	(B)	(C)	(D) (B*C)
2552-10 Line Reference	Cost Center	WS C, Part 1, Column 6	Percent to Total	IP Uninsured Charges	Allocated Charges
		Inpatient Routine Charges & Cost			
30	ADULTS AND PEDIATRICS	-	0.00%	$0	$ -
31	INTENSIVE CARE UNIT	-	0.00%	$0	$ -
32	CORONARY CARE UNIT	-	0.00%	$0	$ -
33	BURN INTENSIVE CARE UNIT	-	0.00%	$0	$ -
34	SURGICAL INTENSIVE CARE UNIT	-	0.00%	$0	$ -
35	OTHER SPECIAL CARE UNIT	-	0.00%	$0	$ -
40	SUBPROVIDER IPF	-	0.00%	$0	$ -
41	SUBPROVIDER IRF	-	0.00%	$0	$ -
42	SUBPROVIDER (OTHER)	-	0.00%	$0	$ -
43	NURSERY	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
	Subtotal	-	0.00%		$ -

		(A)	(B)	(C)	(D) (B*C)	(E)	(F) (D *E)
2552-10 Line Reference	Cost Center	WS C, Part 1, Column 6	Percent to Total	IP Charity Charges	Allocated Charges	CCR	IP Ancillary Cost
		Inpatient Ancillary Charges & Cost					
50	OPERATING ROOM	-	0.00%	$0	$ -	0	$ -
51	RECOVERY ROOM	-	0.00%	$0	$ -	0	$ -
52	DELIVERY ROOM & LABOR ROOM	-	0.00%	$0	$ -	0	$ -
53	ANESTHESIOLOGY	-	0.00%	$0	$ -	0	$ -
54	RADIOLOGY-DIAGNOSTIC	-	0.00%	$0	$ -	0	$ -
55	RADIOLOGY-THERAPUTIC	-	0.00%	$0	$ -	0	$ -
56	RADIOISOTOPE	-	0.00%	$0	$ -	0	$ -
57	COMPUTED TOMOGRAPHY (CT) SCAN	-	0.00%	$0	$ -	0	$ -
58	MAGNETIC RESONANCE IMAGING (MRI)	-	0.00%	$0	$ -	0	$ -
59	CARDIAC CATHETERIZATION	-	0.00%	$0	$ -	0	$ -
60	LABORATORY	-	0.00%	$0	$ -	0	$ -
61	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	0.00%	$0	$ -	0	$ -
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	0.00%	$0	$ -	0	$ -
63	BLOOD STORING, PROCESSING & TRANS.	-	0.00%	$0	$ -	0	$ -
64	INTRAVENOUS THERAPY	-	0.00%	$0	$ -	0	$ -
65	RESPIRATORY THERAPY	-	0.00%	$0	$ -	0	$ -
66	PHYSICAL THERAPY	-	0.00%	$0	$ -	0	$ -
67	OCCUPATIONAL THERAPY	-	0.00%	$0	$ -	0	$ -
68	SPEECH PATHOLOGY	-	0.00%	$0	$ -	0	$ -
69	ELECTROCARDIOLOGY	-	0.00%	$0	$ -	0	$ -
70	ELECTROENCEPHALOGRAPHY	-	0.00%	$0	$ -	0	$ -
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
72	IMPLANTABLE DEVICES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
73	DRUGS CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
74	RENAL DIALYSIS	-	0.00%	$0	$ -	0	$ -
75	ASC (NON-DISTINCT PART)	-	0.00%	$0	$ -	0	$ -
76	OTHER ANCILLARY	-	0.00%	$0	$ -	0	$ -
90	CLINIC	-	0.00%	$0	$ -	0	$ -
91	EMERGENCY	-	0.00%	$0	$ -	0	$ -
92	OBSERVATION BEDS (NON-DISTINCT)	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -

0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
	Subtotal	-	0.00%		$ -		$ -
	Total Inpatient	-	0.00%		$ -		$ -

Make sure this equal 100%

2552-10 Line Reference	Cost Center	(A) WS C, Part 1, Column 7	(B) Percent to Total	(C) OP Charity Care Charges	(D) (B*C) Allocated Charges	(E) CCR	(F) (D*E) OP Cost
		Outpatient Charges & Cost					
50	OPERATING ROOM	-	0.00%	$0	$ -	0	$ -
51	RECOVERY ROOM	-	0.00%	$0	$ -	0	$ -
52	DELIVERY ROOM & LABOR ROOM	-	0.00%	$0	$ -	0	$ -
53	ANESTHESIOLOGY	-	0.00%	$0	$ -	0	$ -
54	RADIOLOGY-DIAGNOSTIC	-	0.00%	$0	$ -	0	$ -
55	RADIOLOGY-THERAPUTIC	-	0.00%	$0	$ -	0	$ -
56	RADIOISOTOPE	-	0.00%	$0	$ -	0	$ -
57	COMPUTED TOMOGRAPHY (CT) SCAN	-	0.00%	$0	$ -	0	$ -
58	MAGNETIC RESONANCE IMAGING (MRI)	-	0.00%	$0	$ -	0	$ -
59	CARDIAC CATHETERIZATION	-	0.00%	$0	$ -	0	$ -
60	LABORATORY	-	0.00%	$0	$ -	0	$ -
61	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	0.00%	$0	$ -	0	$ -
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	0.00%	$0	$ -	0	$ -
63	BLOOD STORING, PROCESSING & TRANS.	-	0.00%	$0	$ -	0	$ -
64	INTRAVENOUS THERAPY	-	0.00%	$0	$ -	0	$ -
65	RESPIRATORY THERAPY	-	0.00%	$0	$ -	0	$ -
66	PHYSICAL THERAPY	-	0.00%	$0	$ -	0	$ -
67	OCCUPATIONAL THERAPY	-	0.00%	$0	$ -	0	$ -
68	SPEECH PATHOLOGY	-	0.00%	$0	$ -	0	$ -
69	ELECTROCARDIOLOGY	-	0.00%	$0	$ -	0	$ -
70	ELECTROENCEPHALOGRAPHY	-	0.00%	$0	$ -	0	$ -
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
72	IMPLANTABLE DEVICES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
73	DRUGS CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
74	RENAL DIALYSIS	-	0.00%	$0	$ -	0	$ -
75	ASC (NON-DISTINCT PART)	-	0.00%	$0	$ -	0	$ -
76	OTHER ANCILLARY	-	0.00%	$0	$ -	0	$ -
90	CLINIC	-	0.00%	$0	$ -	0	$ -
91	EMERGENCY	-	0.00%	$0	$ -	0	$ -
92	OBSERVATION BEDS (NON-DISTINCT)	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
	Totals	-	0.00%		$ -		$ -

1

	Total Charity Costs	-	-	-
Conclusion:	Hospital Incurred Charity Costs	-	-	-

TPI: 0
Provider Name: 0

Duplicated Patients in Disproportionate Share Hospital and Uncompensated Care 0

1/0/1900

Results:	Cost Report Period:	From	To	Status
		1/0/1900	1/0/1900	0

Inpatient Days					A	B	(A*B)
S-3/B Part I	CR Line	Description	Form S-3, Part I, Col 8 Days	Days Submitted on IP Charity Care Detail	Allocated Days	Per Diems	IP Routine Cost
				0	*Linked to Form Page * % of days*		
1/30		HOSPITAL ADULTS AND PEDIATRICS	-	-	-	0	$ -
8/31		INTENSIVE CARE UNIT	-	-	-	0	$ -
9/32		CORONARY CARE UNIT	-	-	-	0	$ -
10/33		BURN INTENSIVE CARE UNIT	-	-	-	0	$ -
11/34		SURGICAL INTENSIVE CARE UNIT	-	-	-	0	$ -
12/35		OTHER SPECIAL CARE UNIT	-	-	-	0	$ -
13/43		NURSERY	-	-	-	0	$ -
16/40		SUBPROVIDER IPF	-	-	-	0	$ -
17/41		SUBPROVIDER IRF	-	-	-	0	$ -
18/42		SUBPROVIDER (OTHER)	-	-	-	0	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	0	$ -
0		0	-	-	-	0	$ -
0		0	-	-	-	0	$ -
	Total Patient Days		**-**		**-**		**-**

		(A)	(B)	(C)	(D) (B*C)
2552-10 Line Reference	Cost Center	WS C, Part 1, Column 6	Percent to Total	IP Uninsured Charges	Allocated Charges
		Inpatient Routine Charges & Cost			
30	ADULTS AND PEDIATRICS	-	0.00%	$ -	$ -
31	INTENSIVE CARE UNIT	-	0.00%	$0	$ -
32	CORONARY CARE UNIT	-	0.00%	$0	$ -
33	BURN INTENSIVE CARE UNIT	-	0.00%	$0	$ -
34	SURGICAL INTENSIVE CARE UNIT	-	0.00%	$0	$ -
35	OTHER SPECIAL CARE UNIT	-	0.00%	$0	$ -
40	SUBPROVIDER IPF	-	0.00%	$0	$ -
41	SUBPROVIDER IRF	-	0.00%	$0	$ -
42	SUBPROVIDER (OTHER)	-	0.00%	$0	$ -
43	NURSERY	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
	Subtotal	-	0.00%		$ -

		(A)	(B)	(C)	(D) (B*C)	(E)	(F) (D *E)
2552-10 Line Reference	Cost Center	WS C, Part 1, Column 6	Percent to Total	IP Charity Charges	Allocated Charges	CCR	IP Ancillary Cost
		Inpatient Ancillary Charges & Cost					
50	OPERATING ROOM	-	0.00%	$0	$ -	0	$ -
51	RECOVERY ROOM	-	0.00%	$0	$ -	0	$ -
52	DELIVERY ROOM & LABOR ROOM	-	0.00%	$0	$ -	0	$ -
53	ANESTHESIOLOGY	-	0.00%	$0	$ -	0	$ -
54	RADIOLOGY-DIAGNOSTIC	-	0.00%	$0	$ -	0	$ -
55	RADIOLOGY-THERAPUTIC	-	0.00%	$0	$ -	0	$ -
56	RADIOISOTOPE	-	0.00%	$0	$ -	0	$ -
57	COMPUTED TOMOGRAPHY (CT) SCAN	-	0.00%	$0	$ -	0	$ -
58	MAGNETIC RESONANCE IMAGING (MRI)	-	0.00%	$0	$ -	0	$ -
59	CARDIAC CATHETERIZATION	-	0.00%	$0	$ -	0	$ -
60	LABORATORY	-	0.00%	$0	$ -	0	$ -
61	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	0.00%	$0	$ -	0	$ -
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	0.00%	$0	$ -	0	$ -
63	BLOOD STORING, PROCESSING & TRANS.	-	0.00%	$0	$ -	0	$ -
64	INTRAVENOUS THERAPY	-	0.00%	$0	$ -	0	$ -
65	RESPIRATORY THERAPY	-	0.00%	$0	$ -	0	$ -
66	PHYSICAL THERAPY	-	0.00%	$0	$ -	0	$ -
67	OCCUPATIONAL THERAPY	-	0.00%	$0	$ -	0	$ -
68	SPEECH PATHOLOGY	-	0.00%	$0	$ -	0	$ -
69	ELECTROCARDIOLOGY	-	0.00%	$0	$ -	0	$ -
70	ELECTROENCEPHALOGRAPHY	-	0.00%	$0	$ -	0	$ -
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
72	IMPLANTABLE DEVICES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
73	DRUGS CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
74	RENAL DIALYSIS	-	0.00%	$0	$ -	0	$ -
75	ASC (NON-DISTINCT PART)	-	0.00%	$0	$ -	0	$ -
76	OTHER ANCILLARY	-	0.00%	$0	$ -	0	$ -
90	CLINIC	-	0.00%	$0	$ -	0	$ -
91	EMERGENCY	-	0.00%	$0	$ -	0	$ -
92	OBSERVATION BEDS (NON-DISTINCT)	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -

0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
	Subtotal	-	0.00%		$ -		$ -
	Total Inpatient	-	0.00%		$ -		$ -

Make sure this equal 100%

2552-10 Line Reference	Cost Center	(A) WS C, Part 1, Column 7	(B) Percent to Total	(C) OP Charity Care Charges	(D) (B*C) Allocated Charges	(E) CCR	(F) (D*E) OP Cost
		Outpatient Charges & Cost					
50	OPERATING ROOM	-	0.00%	$ -	$ -	0	$ -
51	RECOVERY ROOM	-	0.00%	$0	$ -	0	$ -
52	DELIVERY ROOM & LABOR ROOM	-	0.00%	$0	$ -	0	$ -
53	ANESTHESIOLOGY	-	0.00%	$0	$ -	0	$ -
54	RADIOLOGY-DIAGNOSTIC	-	0.00%	$0	$ -	0	$ -
55	RADIOLOGY-THERAPUTIC	-	0.00%	$0	$ -	0	$ -
56	RADIOISOTOPE	-	0.00%	$0	$ -	0	$ -
57	COMPUTED TOMOGRAPHY (CT) SCAN	-	0.00%	$0	$ -	0	$ -
58	MAGNETIC RESONANCE IMAGING (MRI)	-	0.00%	$0	$ -	0	$ -
59	CARDIAC CATHETERIZATION	-	0.00%	$0	$ -	0	$ -
60	LABORATORY	-	0.00%	$0	$ -	0	$ -
61	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	0.00%	$0	$ -	0	$ -
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	0.00%	$0	$ -	0	$ -
63	BLOOD STORING, PROCESSING & TRANS.	-	0.00%	$0	$ -	0	$ -
64	INTRAVENOUS THERAPY	-	0.00%	$0	$ -	0	$ -
65	RESPIRATORY THERAPY	-	0.00%	$0	$ -	0	$ -
66	PHYSICAL THERAPY	-	0.00%	$0	$ -	0	$ -
67	OCCUPATIONAL THERAPY	-	0.00%	$0	$ -	0	$ -
68	SPEECH PATHOLOGY	-	0.00%	$0	$ -	0	$ -
69	ELECTROCARDIOLOGY	-	0.00%	$0	$ -	0	$ -
70	ELECTROENCEPHALOGRAPHY	-	0.00%	$0	$ -	0	$ -
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
72	IMPLANTABLE DEVICES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
73	DRUGS CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
74	RENAL DIALYSIS	-	0.00%	$0	$ -	0	$ -
75	ASC (NON-DISTINCT PART)	-	0.00%	$0	$ -	0	$ -
76	OTHER ANCILLARY	-	0.00%	$0	$ -	0	$ -
90	CLINIC	-	0.00%	$0	$ -	0	$ -
91	EMERGENCY	-	0.00%	$0	$ -	0	$ -
92	OBSERVATION BEDS (NON-DISTINCT)	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
	Totals	-	0.00%		$ -		$ -

				1	
	Total Charity Costs	-	-	-	
Conclusion:	Hospital Incurred Charity Costs	-	-	-	

TPI: 0
Provider Name: 0

S-10 Data from Cost Report for period ending in Calendar Year 2018
Data Year 2018
1/0/1900

0

Results:	Cost Report Period:	From	To	Status
		1/0/1900	1/0/1900	0

Inpatient Days

S-3/B Part I	CR Line	Description	Form S-3, Part I, Col 8 Days	Days Submitted on IP Charity Care Detail	A Allocated Days	B Per Diems	(A*B) IP Routine Cost
					0 *Linked to Form Page * % of days*		
1/30		HOSPITAL ADULTS AND PEDIATRICS	-	-	-	0	$ -
8/31		INTENSIVE CARE UNIT	-	-	-	0	$ -
9/32		CORONARY CARE UNIT	-	-	-	0	$ -
10/33		BURN INTENSIVE CARE UNIT	-	-	-	0	$ -
11/34		SURGICAL INTENSIVE CARE UNIT	-	-	-	0	$ -
12/35		OTHER SPECIAL CARE UNIT	-	-	-	0	$ -
13/43		NURSERY	-	-	-	0	$ -
16/40		SUBPROVIDER IPF	-	-	-	0	$ -
17/41		SUBPROVIDER IRF	-	-	-	0	$ -
18/42		SUBPROVIDER (OTHER)	-	-	-	0	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	0	$ -
0		0	-	-	-	0	$ -
0		0	-	-	-	0	$ -
	Total Patient Days		**-**		**-**		**-**

2552-10 Line Reference	Cost Center	(A) WS C, Part 1, Column 6	(B) Percent to Total	(C) IP Uninsured Charges	(D) (B*C) Allocated Charges
			Inpatient Routine Charges & Cost		
30	ADULTS AND PEDIATRICS	-	0.00%	$ -	$ -
31	INTENSIVE CARE UNIT	-	0.00%	$0	$ -
32	CORONARY CARE UNIT	-	0.00%	$0	$ -
33	BURN INTENSIVE CARE UNIT	-	0.00%	$0	$ -
34	SURGICAL INTENSIVE CARE UNIT	-	0.00%	$0	$ -
35	OTHER SPECIAL CARE UNIT	-	0.00%	$0	$ -
40	SUBPROVIDER IPF	-	0.00%	$0	$ -
41	SUBPROVIDER IRF	-	0.00%	$0	$ -
42	SUBPROVIDER (OTHER)	-	0.00%	$0	$ -
43	NURSERY	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
	Subtotal	-	0.00%		$ -

2552-10 Line Reference	Cost Center	(A) WS C, Part 1, Column 6	(B) Percent to Total	(C) IP Charity Charges	(D) (B*C) Allocated Charges	(E) CCR	(F) (D *E) IP Ancillary Cost
			Inpatient Ancillary Charges & Cost				
50	OPERATING ROOM	-	0.00%	$0	$ -	0	$ -
51	RECOVERY ROOM	-	0.00%	$0	$ -	0	$ -
52	DELIVERY ROOM & LABOR ROOM	-	0.00%	$0	$ -	0	$ -
53	ANESTHESIOLOGY	-	0.00%	$0	$ -	0	$ -
54	RADIOLOGY-DIAGNOSTIC	-	0.00%	$0	$ -	0	$ -
55	RADIOLOGY-THERAPUTIC	-	0.00%	$0	$ -	0	$ -
56	RADIOISOTOPE	-	0.00%	$0	$ -	0	$ -
57	COMPUTED TOMOGRAPHY (CT) SCAN	-	0.00%	$0	$ -	0	$ -
58	MAGNETIC RESONANCE IMAGING (MRI)	-	0.00%	$0	$ -	0	$ -
59	CARDIAC CATHETERIZATION	-	0.00%	$0	$ -	0	$ -
60	LABORATORY	-	0.00%	$0	$ -	0	$ -
61	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	0.00%	$0	$ -	0	$ -
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	0.00%	$0	$ -	0	$ -
63	BLOOD STORING, PROCESSING & TRANS.	-	0.00%	$0	$ -	0	$ -
64	INTRAVENOUS THERAPY	-	0.00%	$0	$ -	0	$ -
65	RESPIRATORY THERAPY	-	0.00%	$0	$ -	0	$ -
66	PHYSICAL THERAPY	-	0.00%	$0	$ -	0	$ -
67	OCCUPATIONAL THERAPY	-	0.00%	$0	$ -	0	$ -
68	SPEECH PATHOLOGY	-	0.00%	$0	$ -	0	$ -
69	ELECTROCARDIOLOGY	-	0.00%	$0	$ -	0	$ -
70	ELECTROENCEPHALOGRAPHY	-	0.00%	$0	$ -	0	$ -
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
72	IMPLANTABLE DEVICES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
73	DRUGS CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
74	RENAL DIALYSIS	-	0.00%	$0	$ -	0	$ -
75	ASC (NON-DISTINCT PART)	-	0.00%	$0	$ -	0	$ -
76	OTHER ANCILLARY	-	0.00%	$0	$ -	0	$ -
90	CLINIC	-	0.00%	$0	$ -	0	$ -
91	EMERGENCY	-	0.00%	$0	$ -	0	$ -
92	OBSERVATION BEDS (NON-DISTINCT)	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -

0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
	Subtotal	-	0.00%		$ -		$ -
	Total Inpatient	-	0.00%		$ -		$ -

Make sure this equal 100%

		(A)	(B)	(C)	(D) (B*C)	(E)	(F) (D*E)
2552-10 Line Reference	Cost Center	WS C, Part 1, Column 7	Percent to Total	OP Charity Care Charges	Allocated Charges	CCR	OP Cost
		Outpatient Charges & Cost					
50	OPERATING ROOM	-	0.00%	$ -	$ -	0	$ -
51	RECOVERY ROOM	-	0.00%	$0	$ -	0	$ -
52	DELIVERY ROOM & LABOR ROOM	-	0.00%	$0	$ -	0	$ -
53	ANESTHESIOLOGY	-	0.00%	$0	$ -	0	$ -
54	RADIOLOGY-DIAGNOSTIC	-	0.00%	$0	$ -	0	$ -
55	RADIOLOGY-THERAPUTIC	-	0.00%	$0	$ -	0	$ -
56	RADIOISOTOPE	-	0.00%	$0	$ -	0	$ -
57	COMPUTED TOMOGRAPHY (CT) SCAN	-	0.00%	$0	$ -	0	$ -
58	MAGNETIC RESONANCE IMAGING (MRI)	-	0.00%	$0	$ -	0	$ -
59	CARDIAC CATHETERIZATION	-	0.00%	$0	$ -	0	$ -
60	LABORATORY	-	0.00%	$0	$ -	0	$ -
61	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	0.00%	$0	$ -	0	$ -
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	0.00%	$0	$ -	0	$ -
63	BLOOD STORING, PROCESSING & TRANS.	-	0.00%	$0	$ -	0	$ -
64	INTRAVENOUS THERAPY	-	0.00%	$0	$ -	0	$ -
65	RESPIRATORY THERAPY	-	0.00%	$0	$ -	0	$ -
66	PHYSICAL THERAPY	-	0.00%	$0	$ -	0	$ -
67	OCCUPATIONAL THERAPY	-	0.00%	$0	$ -	0	$ -
68	SPEECH PATHOLOGY	-	0.00%	$0	$ -	0	$ -
69	ELECTROCARDIOLOGY	-	0.00%	$0	$ -	0	$ -
70	ELECTROENCEPHALOGRAPHY	-	0.00%	$0	$ -	0	$ -
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
72	IMPLANTABLE DEVICES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
73	DRUGS CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
74	RENAL DIALYSIS	-	0.00%	$0	$ -	0	$ -
75	ASC (NON-DISTINCT PART)	-	0.00%	$0	$ -	0	$ -
76	OTHER ANCILLARY	-	0.00%	$0	$ -	0	$ -
90	CLINIC	-	0.00%	$0	$ -	0	$ -
91	EMERGENCY	-	0.00%	$0	$ -	0	$ -
92	OBSERVATION BEDS (NON-DISTINCT)	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
	Totals	-	0.00%		$ -		$ -

1

Total Charity Costs - - -

Conclusion: Hospital Incurred Charity Costs - - -

TPI	Charity COSTS	Charity PAYMENTS	Charity SHORTFALL
0	$ -	$ -	$ -

INFLATOR	1.053355

Schedule 3 Charity UCC	$ -

IP FFS DAYS	IP MCO DAYS	IP MCO CHARGES	IP FFS CHARGES	OP MCO CHARGES	OP FFS CHARGES	UNINSURED DAYS	UNINSURED CHARGES	OOS DAYS	OOS CHARGES	OOS PAYMENTS
-	-	$ -	$ -	$ -	$ -	-	$ -	-	$ -	$ -

TPI	Charity COSTS	Charity PAYMENTS	Charity SHORTFALL
0	$ -	$ -	$ -

INFLATOR	1.053355

Schedule 3 Charity UCC	$ -

IP FFS DAYS	IP MCO DAYS	IP MCO CHARGES	IP FFS CHARGES	OP MCO CHARGES	OP FFS CHARGES	UNINSURED DAYS	UNINSURED CHARGES	OOS DAYS	OOS CHARGES	OOS PAYMENTS
-	-	$ -	$ -	$ -	$ -	-	$ -	-	$ -	$ -

TPI	Charity COSTS	Charity PAYMENTS	Charity SHORTFALL
0	$ -	$ -	$ -

INFLATOR	1.053355

Schedule 3 Charity UCC	$ -

IP FFS DAYS	IP MCO DAYS	IP MCO CHARGES	IP FFS CHARGES	OP MCO CHARGES	OP FFS CHARGES	UNINSURED DAYS	UNINSURED CHARGES	OOS DAYS	OOS CHARGES	OOS PAYMENTS
-	-	$ -	$ -	$ -	$ -	-	$ -	-	$ -	$ -

TPI: 0
Provider Name: 0

Medicaid Cost of Care
Data Year 2018
1/0/1900

0

	From	To	Status
Cost Report Period:	1/0/1900	1/0/1900	0

THIS SECTION IS PER DIEM COSTS PER HOSPITAL DAYS AND PER DIEM

Inpatient Days				A	B	(C) (A*B)	D	E	(F) (E*B)		H	(I) (H*B)			
S-3/B Part I	Description	Form S-3, Part I, Col 8 Days	TMHP/PCCM Days	FFS Allocated Days	Per Diems	FFS IP Routine Cost	MCO Days Submitted	MCO Allocated Days	MCO IP Routine Cost	OOS Days	OOS Allocated Days	OOS IP Routine Cost	Medicaid Secondary (Non-	Medicaid Secondary (Non-	Medicaid Secondary (Non-
			-				-			-			-		
1/30	HOSPITAL ADULTS AND PEDIATRICS	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
8/31	INTENSIVE CARE UNIT	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
9/32	CORONARY CARE UNIT	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
10/33	BURN INTENSIVE CARE UNIT	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
11/34	SURGICAL INTENSIVE CARE UNIT	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
12/35	OTHER SPECIAL CARE UNIT	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
13/43	NURSERY	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
16/40	SUBPROVIDER IPF	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
17/41	SUBPROVIDER IRF	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
18/42	SUBPROVIDER (OTHER)	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
0	0	-	-	-	$0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
0	0	-	-	-	$0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
0	0	-	-	-	$0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
0	0	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
0	0	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
0	0	-	-	-	0	$ -	-	-	$ -	-	-	$ -	-	-	$ -
	Total	-		-		$ -		0	$ -		0	$ -		-	$ -

THIS BELONGS TO SECTION ABOVE - TOTAL IP CHARGES

		(A)	(B)	(C)	(D) (B*C)	(E)	(F) (B*E)	(G)	(H) (B*G)		
2552-10 Line Reference		C part I, Col 6	Percent to Total	FFS IP Medicaid Charges	FFS Allocated Charges	MCO IP Medicaid Charges	MCO Allocated Charges	OOS IP Medicaid Charges	OOS Allocated Charges	Medicaid Secondary (Non-Billed) Charges	Medicaid Secondary (Non-
30	ADULTS AND PEDIATRICS	-	0.00%	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
31	INTENSIVE CARE UNIT	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
32	CORONARY CARE UNIT	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
33	BURN INTENSIVE CARE UNIT	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
34	SURGICAL INTENSIVE CARE UNIT	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
35	OTHER SPECIAL CARE UNIT	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
40	SUBPROVIDER IPF	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
41	SUBPROVIDER IRF	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
42	SUBPROVIDER (OTHER)	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
43	NURSERY	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
0	0	-	0.00%	0	$ -	0	$ -	0	$ -	$ -	$ -
	Total	-	0.00%		-		-		-		-

ANCILLARY SECTION

C PART I COL 9

		(A)	(B)	(C)	(D) (B*C)	(E)	(F) (D *E)	(G)	(H) (B*G)	(I) (E*H)	(J)	(K) (B*J)	(L) (E*K)			
2552-10 Line Reference		C part I, Col 6	Percent to Total Inpatient Ancillary Charges & Cost	FFS IP Medicaid Charges	FFS Allocated Charges	CCR	FFS IP Ancillary Cost	MCO IP Medicaid Charges	MCO Allocated Charges	MCO IP Ancillary Cost	OOS IP Medicaid Charges	OOS Allocated Charges	OOS IP Ancillary Cost	Medicaid Secondary (Non-	Medicaid Secondary (Non-	Medicaid Secondary (Non-
50	OPERATING ROOM	-	0.00%	$ -	$0	0	$ -	$0	$0	-	$ -	$0	$ -	$ -	$0	$ -
51	RECOVERY ROOM	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
52	DELIVERY ROOM & LABOR ROOM	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
53	ANESTHESIOLOGY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
54	RADIOLOGY-DIAGNOSTIC	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
55	RADIOLOGY-THERAPUTIC	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
56	RADIOISOTOPE	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
57	COMPUTED TOMOGRAPHY (CT) SCAN	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
58	MAGNETIC RESONANCE IMAGING (MRI)	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
59	CARDIAC CATHETERIZATION	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
60	LABORATORY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
61	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
63	BLOOD STORING, PROCESSING & TRANS.	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
64	INTRAVENOUS THERAPY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
65	RESPIRATORY THERAPY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
66	PHYSICAL THERAPY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
67	OCCUPATIONAL THERAPY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
68	SPEECH PATHOLOGY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
69	ELECTROCARDIOLOGY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
70	ELECTROENCEPHALOGRAPHY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
72	IMPLANTABLE DEVICES CHARGED TO PATIENTS	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
73	DRUGS CHARGED TO PATIENTS	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
74	RENAL DIALYSIS	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
75	ASC (NON-DISTINCT PART)	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
76	OTHER ANCILLARY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
90	CLINIC	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
91	EMERGENCY	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
92	OBSERVATION BEDS (NON-DISTINCT)	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	-	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	-	$0	0	$ -	$0	$0	-	$0	$0	$ -	$ -	$0	$ -
	Subtotal	-	0.00%	0	$0	-	$ -	0	$0	-	0	$0	$ -	$ -	$0	$ -
	Total Inpatient	-	0.00%		$0		$ -		$0	-		$0	$ -		$0	$ -

ANCILLARY SECTION

C PART I COL 9

		(A)	(B)	(C)	(D) (B*C)	(E)	(F) (D*E)	(G)	(H) (B*G)	(I) (E*H)	(J)	(K) (B*J)	(L) (E*K)	(M)	(N) (B*M)	(O) (E*N)
2552-10 Line Reference		C part I, Col 7									OOS OP	OOS Allocated		Medicaid	Medicaid	Medicaid

Outpatient Charges & Cost

			Percent to Total	FFS OP Medicaid Charges	FFS Allocated Charges	CCR	FFS OP Cost	MCO OP Medicaid Charges	MCO Allocated Charges	MCO OP Cost	Medicaid Charges	Charges	OOS OP Cost	Secondary (Non-	Secondary (Non-	Secondary (Non-
50	OPERATING ROOM	-	0.00%	$ -	$0	0	$ -	$ -	$0	$ -	$ -	$0	$ -	$ -	$0	$ -
51	RECOVERY ROOM	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
52	DELIVERY ROOM & LABOR ROOM	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
53	ANESTHESIOLOGY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
54	RADIOLOGY-DIAGNOSTIC	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
55	RADIOLOGY-THERAPUTIC	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
56	RADIOISOTOPE	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
57	COMPUTED TOMOGRAPHY (CT) SCAN	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
58	MAGNETIC RESONANCE IMAGING (MRI)	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
59	CARDIAC CATHETERIZATION	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
60	LABORATORY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
61	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
63	BLOOD STORING, PROCESSING & TRANS.	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
64	INTRAVENOUS THERAPY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
65	RESPIRATORY THERAPY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
66	PHYSICAL THERAPY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
67	OCCUPATIONAL THERAPY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
68	SPEECH PATHOLOGY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
69	ELECTROCARDIOLOGY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
70	ELECTROENCEPHALOGRAPHY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
72	IMPLANTABLE DEVICES CHARGED TO PATIENTS	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
73	DRUGS CHARGED TO PATIENTS	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
74	RENAL DIALYSIS	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
75	ASC (NON-DISTINCT PART)	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
76	OTHER ANCILLARY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
90	CLINIC	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
91	EMERGENCY	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
92	OBSERVATION BEDS (NON-DISTINCT)	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	-	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
0	0	-	0.00%	$0	$0	0	$ -	$0	$0	$ -	$0	$0	$ -	$ -	$0	$ -
	Total Outpatient	-			$0		$ -		$0	$ -		$0	$ -		$0	-

			x % Adj Factor		Adj Factor	Outpatient
Total Medicaid FFS Costs		-	$	-	1	-
Total Medicaid MCO Costs		-	$	-		-
Total Medicaid OOS Costs		-	$	-		-
Total Medicaid Secondary (Non-Billed)	$	-	$	-		-
Hospital incurred		-	$	-		-

TPI: 0
Provider Name: 0

Uninsured Patient Uncompensated Care
Data Year 2018
1/0/1900

0

Results:	Cost Report Period:	From	To	Status
		1/0/1900	1/0/1900	0

Inpatient Days					A	B	(A*B)
S-3/B Part I	CR Line	Description	Form S-3, Part I, Col 8 Days	Days Submitted on IP Uninsured Detail	Allocated Days	Per Diems	IP Routine Cost
				0	*Linked to Form Page * % of days*		
1/30		HOSPITAL ADULTS AND PEDIATRICS	-	-	-	0	$ -
8/31		INTENSIVE CARE UNIT	-	-	-	0	$ -
9/32		CORONARY CARE UNIT	-	-	-	0	$ -
10/33		BURN INTENSIVE CARE UNIT	-	-	-	0	$ -
11/34		SURGICAL INTENSIVE CARE UNIT	-	-	-	0	$ -
12/35		OTHER SPECIAL CARE UNIT	-	-	-	0	$ -
13/43		NURSERY	-	-	-	0	$ -
16/40		SUBPROVIDER IPF	-	-	-	0	$ -
17/41		SUBPROVIDER IRF	-	-	-	0	$ -
18/42		SUBPROVIDER (OTHER)	-	-	-	0	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	-	$ -
0		0	-	-	-	0	$ -
0		0	-	-	-	0	$ -
0		0	-	-	-	0	$ -
	Total Patient Days		**-**		**-**		**-**

		(A)	(B)	(C)	(D) (B*C)
2552-10 Line Reference	Cost Center	WS C, Part 1, Column 6	Percent to Total	IP Uninsured Charges	Allocated Charges
		Inpatient Routine Charges & Cost			
30	ADULTS AND PEDIATRICS	-	0.00%	$0	$ -
31	INTENSIVE CARE UNIT	-	0.00%	$0	$ -
32	CORONARY CARE UNIT	-	0.00%	$0	$ -
33	BURN INTENSIVE CARE UNIT	-	0.00%	$0	$ -
34	SURGICAL INTENSIVE CARE UNIT	-	0.00%	$0	$ -
35	OTHER SPECIAL CARE UNIT	-	0.00%	$0	$ -
40	SUBPROVIDER IPF	-	0.00%	$0	$ -
41	SUBPROVIDER IRF	-	0.00%	$0	$ -
42	SUBPROVIDER (OTHER)	-	0.00%	$0	$ -
43	NURSERY	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
0	0	-	0.00%	$0	$ -
	Subtotal	-	0.00%		$ -

		(A)	(B)	(C)	(D) (B*C)	(E)	(F) (D *E)
2552-10 Line Reference	Cost Center	WS C, Part 1, Column 6	Percent to Total	IP Uninsured Charges	Allocated Charges	CCR	IP Ancillary Cost
		Inpatient Ancillary Charges & Cost					
50	OPERATING ROOM	-	0.00%	$0	$ -	0	$ -
51	RECOVERY ROOM	-	0.00%	$0	$ -	0	$ -
52	DELIVERY ROOM & LABOR ROOM	-	0.00%	$0	$ -	0	$ -
53	ANESTHESIOLOGY	-	0.00%	$0	$ -	0	$ -
54	RADIOLOGY-DIAGNOSTIC	-	0.00%	$0	$ -	0	$ -
55	RADIOLOGY-THERAPUTIC	-	0.00%	$0	$ -	0	$ -
56	RADIOISOTOPE	-	0.00%	$0	$ -	0	$ -
57	COMPUTED TOMOGRAPHY (CT) SCAN	-	0.00%	$0	$ -	0	$ -
58	MAGNETIC RESONANCE IMAGING (MRI)	-	0.00%	$0	$ -	0	$ -
59	CARDIAC CATHETERIZATION	-	0.00%	$0	$ -	0	$ -
60	LABORATORY	-	0.00%	$0	$ -	0	$ -
61	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	0.00%	$0	$ -	0	$ -
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	0.00%	$0	$ -	0	$ -
63	BLOOD STORING, PROCESSING & TRANS.	-	0.00%	$0	$ -	0	$ -
64	INTRAVENOUS THERAPY	-	0.00%	$0	$ -	0	$ -
65	RESPIRATORY THERAPY	-	0.00%	$0	$ -	0	$ -
66	PHYSICAL THERAPY	-	0.00%	$0	$ -	0	$ -
67	OCCUPATIONAL THERAPY	-	0.00%	$0	$ -	0	$ -
68	SPEECH PATHOLOGY	-	0.00%	$0	$ -	0	$ -
69	ELECTROCARDIOLOGY	-	0.00%	$0	$ -	0	$ -
70	ELECTROENCEPHALOGRAPHY	-	0.00%	$0	$ -	0	$ -
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
72	IMPLANTABLE DEVICES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
73	DRUGS CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
74	RENAL DIALYSIS	-	0.00%	$0	$ -	0	$ -
75	ASC (NON-DISTINCT PART)	-	0.00%	$0	$ -	0	$ -
76	OTHER ANCILLARY	-	0.00%	$0	$ -	0	$ -
90	CLINIC	-	0.00%	$0	$ -	0	$ -
91	EMERGENCY	-	0.00%	$0	$ -	0	$ -
92	OBSERVATION BEDS (NON-DISTINCT)	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -

0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
	Subtotal	-	0.00%		$ -		$ -
	Total Inpatient	-	0.00%		$ -		$ -

Make sure this equal 100%

2552-10 Line Reference	Cost Center	(A) WS C, Part 1, Column 7	(B) Percent to Total	(C) OP Uninsured Charges	(D) (B*C) Allocated Charges	(E) CCR	(F) (D*E) OP Cost
		Outpatient Charges & Cost					
50	OPERATING ROOM	-	0.00%	$0	$ -	0	$ -
51	RECOVERY ROOM	-	0.00%	$0	$ -	0	$ -
52	DELIVERY ROOM & LABOR ROOM	-	0.00%	$0	$ -	0	$ -
53	ANESTHESIOLOGY	-	0.00%	$0	$ -	0	$ -
54	RADIOLOGY-DIAGNOSTIC	-	0.00%	$0	$ -	0	$ -
55	RADIOLOGY-THERAPUTIC	-	0.00%	$0	$ -	0	$ -
56	RADIOISOTOPE	-	0.00%	$0	$ -	0	$ -
57	COMPUTED TOMOGRAPHY (CT) SCAN	-	0.00%	$0	$ -	0	$ -
58	MAGNETIC RESONANCE IMAGING (MRI)	-	0.00%	$0	$ -	0	$ -
59	CARDIAC CATHETERIZATION	-	0.00%	$0	$ -	0	$ -
60	LABORATORY	-	0.00%	$0	$ -	0	$ -
61	PBP CLINICAL LAB SERVICES-PRGM ONLY	-	0.00%	$0	$ -	0	$ -
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	-	0.00%	$0	$ -	0	$ -
63	BLOOD STORING, PROCESSING & TRANS.	-	0.00%	$0	$ -	0	$ -
64	INTRAVENOUS THERAPY	-	0.00%	$0	$ -	0	$ -
65	RESPIRATORY THERAPY	-	0.00%	$0	$ -	0	$ -
66	PHYSICAL THERAPY	-	0.00%	$0	$ -	0	$ -
67	OCCUPATIONAL THERAPY	-	0.00%	$0	$ -	0	$ -
68	SPEECH PATHOLOGY	-	0.00%	$0	$ -	0	$ -
69	ELECTROCARDIOLOGY	-	0.00%	$0	$ -	0	$ -
70	ELECTROENCEPHALOGRAPHY	-	0.00%	$0	$ -	0	$ -
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
72	IMPLANTABLE DEVICES CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
73	DRUGS CHARGED TO PATIENTS	-	0.00%	$0	$ -	0	$ -
74	RENAL DIALYSIS	-	0.00%	$0	$ -	0	$ -
75	ASC (NON-DISTINCT PART)	-	0.00%	$0	$ -	0	$ -
76	OTHER ANCILLARY	-	0.00%	$0	$ -	0	$ -
90	CLINIC	-	0.00%	$0	$ -	0	$ -
91	EMERGENCY	-	0.00%	$0	$ -	0	$ -
92	OBSERVATION BEDS (NON-DISTINCT)	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0.000000	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
0	0	-	0.00%	$0	$ -	0	$ -
	Totals	-	0.00%		$ -		$ -

1

	Total Uninsured Costs	-	-	-
Conclusion:	Uninsured Hospital incurred	-	-	-

TPI	MEDICAID COSTS	IP FFS & MCO PAYMENTS	IP SDA ADJUSTMENT	IP CROSSOVER PAYMENTS	IP TOTAL	OP FFS & MCO PAYMENTS	OP ADJUSTMENT	OP CROSSOVER PAYMENTS	OP TOTAL	GME PAYMENTS	OTHER INSURANCE PAYMENTS	MEDICARE PAYMENTS	OOS PAYMENTS	COST REPORT SETTLEMENTS	MEDICAID SHORTFALL (COSTS - PAYMENTS)
0	$ -	$ -	0%	$ -	$ -	$ -	100%	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

UNINSURED COSTS	UNINSURED PAYMENTS	UNINSURED SHORTFALL
$ -	$ -	$ -

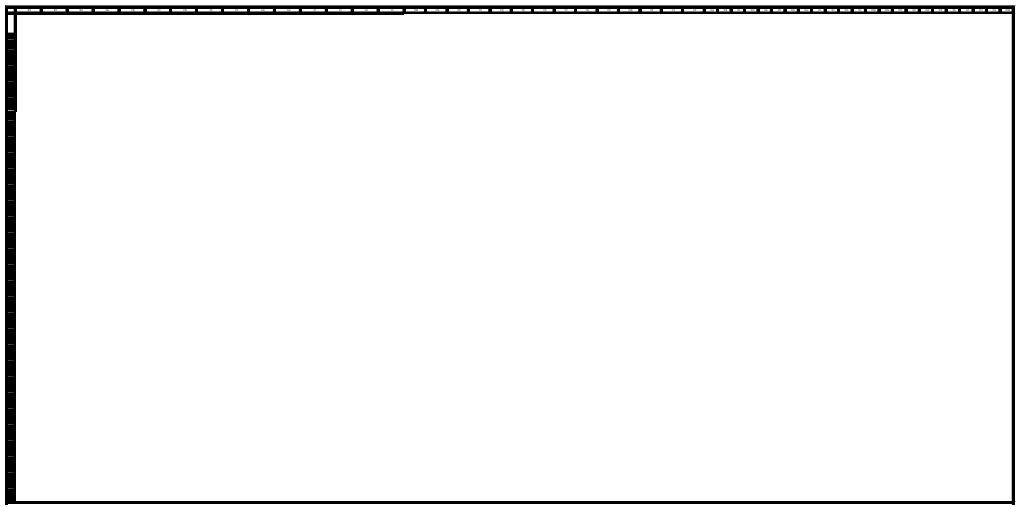
$ -

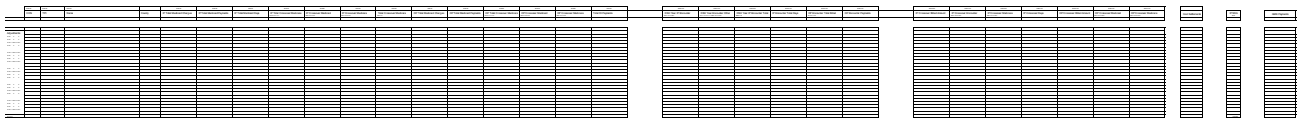
IP FFS DAYS	IP MCO DAYS	IP MCO CHARGES	IP FFS CHARGES	OP MCO CHARGES	OP FFS CHARGES	UNINSURED DAYS	UNINSURED CHARGES	OOS DAYS	OOS CHARGES	OOS PAYMENTS
-	-	$ -	$ -	$ -	$ -	-	$ -	-	$ -	$ -

DSH INFLATOR	1.053355

UNADJUSTED HSL	$ -

CCN	MASTER TPI	PROVIDER NAME	IP FFS & MCO PAYMENTS	IP SDA ADJUSTMENT	IP FFS & MCO CROSSOVER PAYMENTS	OP FFS & MCO PAYMENTS	OP ADJUSTMENT	OP FFS & MCO CROSSOVER PAYMENTS	OTHER INSURANCE PAYMENTS	MEDICARE PAYMENTS	COST REPORT SETTLEMENTS	FFS and FFS Crossover Days	MCO and MCO Crossover Days	IP MCO & IP MCO Crossover CHARGES	IP FFS & IP FFS Crossover CHARGES	OP MCO & OP MCO Crossover CHARGES	OP FFS & OP FFS Crossover CHARGES





Sched3-Cost Rept Collection (Cell K11)	Hospital Application (Cell C143)	Hospital Application (Cell C144)	Hospital Application (Cell C145)	Hospital Application (Cell C146)	Hospital Application (Cell C147)	Hospital Application (Cell C148)	Hospital Application (Cell C149)	Hospital Application (Cell D143)	Hospital Application (Cell D144)	Hospital Application (Cell D145)	Hospital Application (Cell D146)	Hospital Application (Cell D147)	Hospital Application (Cell D148)	Hospital Application (Cell D149)	Hospital Application (Cell E143)	Hospital Application (Cell E144)	Hospital Application (Cell E145)	Hospital Application (Cell E146)	Hospital Application (Cell E147)	Hospital Application (Cell E148)	Hospital Application (Cell E149)	Sched3-Cost Rept Collection (Cell F13)			Sched3-Cost Rept Collection (Cell F14)	Sched3-Cost Rept Collection (Cell F15)	Sched3-Cost Rept Collection (Cell F16)	Sched3-Cost Rept Collection (Cell F17)	Sched3-Cost Rept Collection (Cell F18)	Sched3-Cost Rept Collection (Cell F19)		Sched3-Cost Rept Collection (Cell F20)	Sched3-Cost Rept Collection (Cell F21)	Sched3-Cost Rept Collection (Cell F22)	Sched3-Cost Rept Collection (Cell F12)
Swing Bed Costs	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61 Lung Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61 Kidney Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61 Liver Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61 Heart Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61 Pancreas Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61 Intestinal Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61 Islet Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 66 Lung Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 66 Kidney Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 66 Liver Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 66 Heart Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 66 Pancreas Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 66 Intestinal Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 66 Islet Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 2, Line 62 Lung Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 2, Line 62 Kidney Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 2, Line 62 Liver Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 2, Line 62 Heart Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 2, Line 62 Pancreas Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 2, Line 62 Intestinal Acquisition	Cost Report Worksheet D-4, Pt. III, Col. 2, Line 62 Islet Acquisition	Adults And Pediatrics	Hospital Adults & Peds Swing Bed SNF	Hospital Adults & Peds Swing Bed NF	Intensive Care Unit	Coronary Care Unit	Burn Intensive Care Unit	Surgical Intensive Care Unit	Other Special Care Unit	Nursery	Total	Subprovider IPF	Subprovider IRF	Subprovider (Other)	Observation Bed Days
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Hospital Data (Cell J60)	Hospital Data (Cell J61)	Hospital Data (Cell J62)
Total Days (Plus Observation Days)	Swing Bed Days	Total Days (Plus Observation Beds minus Swing Beds)
[redacted]	[redacted]	[redacted]

179,407

Swing Beds SNF & NF Total

TEXAS AMBULANCE SERVICES COST REPORT

Revised 5/6/2019

Complete Shaded Areas Only

COST REPORT FOR:	**FFY 2020**
Beginning of Reporting Period:	**10/1/2019**
End of Reporting Period:	**9/30/2020**
9-Digit TPI:	
10-Digit NPI:	

PROVIDER INFORMATION

Provider Name:	
Street Address:	
Mailing Address:	
Phone Number:	
FAX Number:	
Email:	

BUSINESS MANAGER / FINANCIAL DIRECTOR

Name:	
Title:	
Agency Name:	
Mailing Address:	
Phone Number:	
FAX Number:	
Email:	

REPORT PREPARER IDENTIFICATION

Name:	
Title:	
Agency/Business Name:	
Mailing Address:	
Phone Number:	
FAX Number:	
Email:	

LOCATION OF ACCOUNTING RECORDS THAT SUPPORT THIS REPORT

Physical Address:	

TEXAS AMBULANCE SERVICES COST REPORT

COST REPORT for FFY 2020

0

9-Digit TPI: 0

10-Digit NPI: 0

Complete Shaded Areas Only

GENERAL AND STATISTICAL INFORMATION

GENERAL PROVIDER INFORMATION

1.00	**Reporting Period - Beginning**	**10/1/2019**
1.01	**Reporting Period - Ending**	**9/30/2020**
1.02	**Is Reporting Period less than a full year?**	

Cost Allocation Information

1.03	**Does your agency have an approved Cost Allocation Plan (CAP)? If yes, see additional detail on Exhibit 7 Worksheet C.**	
1.04	**If yes, please provide the name of the Cognizant Agency who approved the CAP.**	
1.05	**If your agency has an approved Indirect Cost Rate that it would like to use in this cost report, please enter the value. (see Exhibit 7 Worksheet C for additional requirements)**	
1.06	**If you entered an Indirect Cost Rate in 1.05, please provide the name of the Cognizant Agency who approved the rate.**	

Information on Charges Incurred/Payments Received by the Ambulance Service During the Reporting Period

1.07	**Total Uninsured Charity Charges**	
1.08	**Uninsured Charity Reimbursements - Total Payments Received**	
1.09	**Uninsured Billed Amount (Do Not Include Uninsured Charity Charges)**	
1.10	**Total Billed Charges Associated with Medicaid FFS Paid Claims**	
1.11	**Total Billed Charges Associated with MCO Paid Claims**	
1.12	**Medicare Charges**	
1.13	**Other Third Party Coverage**	
1.14	**Charges for Self Pay, County/City Indigent Recipient Programs**	

To be completed by HHSC Staff only.
Reviewed by:
Approved by:
Settlement Date:

TEXAS AMBULANCE SERVICES COST REPORT

COST REPORT for FFY 2020

0

9-Digit TPI: 0

10-Digit NPI: 0

Complete Shaded Areas Only

AMBULANCE SERVICES

PAYROLL EXPENSES

		Amount
2.00	Employee Gross Salary (Enter on Exhibit 6 Schedule B)	$ -
2.01	Employee Benefits (Describe in External Support)	$ -
2.02	Employer Retirement Contribution	$ -
2.03	Employer FICA Payroll Taxes	$ -
2.04	Employer Medicare Payroll Taxes	$ -
2.05	State Unemployment Payroll Taxes	$ -
2.06	Federal Unemployment Payroll Taxes	$ -
2.07	Unemployment Compensation (Reimbursing Employer)	$ -
2.08	Total Staff Costs (sum items 2.00 thru 2.07)	$ -

OTHER COSTS

2.09	Supplies & Materials:	
209.a.	Supplies & Materials Non-Medical	$ -
2.09.b.	Supplies & Materials Medical	$ -
2.10	Equipment:	
2.10.a.	Equipment Non-Medical	
2.10.b.	Equipment Medical	
2.11	Support Services (IT, Dispatch, 9-1-1 CALL TECHNICIANS, Call Handling, etc.)	
2.12	Depreciation (Exhibit 5 Schedule A)	$ -
2.13	Other Costs (Provide additional support for all other costs)	
2.14	Total Direct Medical / Other Costs (sum items 2.09 through 2.13, or indirect costs as percent of staff costs)	$ -
2.15	TOTAL Staff and Direct Medical Other Costs (sum items 2.08 and 2.14)	$ -

REDUCTIONS:

2.16	Other Federal Funds and Grants (Non-Medicaid, Enter on Exhibit 6 Schedule B)	$ -
2.17	Other (Describe in External Support)	$ -
2.18	TOTAL Reductions (sum items 2.16 and 2.17)	$ -

COST SETTLEMENT CALCULATION:

2.19	Total Allowable Costs for Period of Service	$ -
2.2	Total Billed Charges for Period of Service	$ -
2.21	Cost to Charge Ratio	0.00%
2.22	Total Billed Charges Associated with Uninsured Charity Care Claims	$ -
2.23	Uninsured Charity Care Cost	0
2.24	Charity Care Reimbursement	$ -
2.25	Equals Settlement Amount	$ -
2.26	Multiplied by FMAP for appropriate fiscal year	56.18%
2.27	Federal Funds	0
2.28	Non-Federal Share Funds (CPE amount)	$ -
2.29	**Equals Amount due to Provider (Before Proportionate Reduction)**	$ -

TEXAS AMBULANCE SERVICES COST REPORT
COST REPORT for FFY 2020
0
9-Digit TPI: 0
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Complete Shaded Areas Only

t Report Certification

AS SIGNER OF THIS COST REPORT, I HEREBY CERTIFY THAT:

- **The cost report will include only allocable expenditures related to Uninsured Charity Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program.**
- **I have read the note below, the cover letter and all the instructions applicable to this cost report.**
- **I have reviewed this entire cost report after its preparation.**
- **To the best of my knowledge and belief, this cost report is true, correct and complete, and was prepared in accordance with and all the instructions applicable to this cost report.**
- **This cost report was prepared from the books and records of the Ambulance Services provider.**
- **The expenditures on this cost report have not been claimed on any other cost report.**
- **I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that falsification and concealment of a material fact may be prosecuted under Federal and State civil or criminal law.**

NOTE: This COST REPORT CERTIFICATION must be signed by an individual legally responsible for the authorized agent, i.e., ambulance service provider representative, such as Chief Financial Officer or other official of the Governmental Entity. Misrepresentation or falsification of any information contained in this report may be punishable by fine and/or imprisonment under federal and/or state law.

SIGNER IDENTIFICATION

Printed/Typed Name of Report Preparer/Contracted Vendor	Title of Preparer/Contracted Vendor	Vendor Company Name (if applicable)

Printed/Typed Name of Signer (Agency Representative)	Title of Signer

Name of Provider:

Address of Signer (street or P.O. Box, city, state, 9-digit zip):

Phone Number (including area code)	FAX Number (including area code)	Email:

SIGNATURE OF SIGNER DATE

SIGNER AUTHORITY: (check one)
- CFO
- Business Officer
- Director
- Other Officer (describe)

Subscribed and sworn before me, _____, a notary public on _____ (month / day / year)

NOTARY SEAL

NOTARY SIGNATURE

NOTARY PUBLIC, STATE OF

COMMISSION EXPIRES

TEXAS AMBULANCE SERVICES COST REPORT
COST REPORT for FFY 2020
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Certification Of Funds

This statement is of expenditures that the undersigned certifies are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act (the Act), and in accordance with all procedures, instructions and guidance issued by the single state agency and in effect during the cost report federal fiscal year.

Expenditures submitted to the Texas HHSC for FFY ____ Ambulance Medicaid/Medical Services — Total Computable $ **0**

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/STATE LAW.

CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER

I HEREBY CERTIFY that for the reporting period: From: **10/1/2019** To: **9/30/2020**

1. I have examined this statement, the accompanying supporting exhibits, the allocation of expenses and services, and the worksheets for the above indicated reporting period and to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the Provider in accordance with applicable instructions.
2. The expenditures included in this statement are based on the actual cost of recorded expenditures.
3. The required amount of state and/or local funds were available and used to pay for total computable allowable expenditures included in this statement, and such state and/or local funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures (including that the funds were not Federal funds in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed expenditures were not used to meet matching requirements under other Federally funded programs).
4. The expenditures on this cost report have not been claimed on any other cost report.
5. I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that falsification and concealment of a material fact may be prosecuted under Federal and State civil or criminal law.
6. Federal matching funds are being claimed on this report in accordance with the cost report instructions provided by the Texas Health and Human Services Commission effective for the above indicated reporting period.
7. I am the officer authorized by the referenced government agency to submit this form and I have made a good faith effort to assure that all information reported is true and accurate.
8. I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that falsification and concealment of a material fact may be prosecuted under Federal or State civil or criminal law.

SIGNATURE _____ DATE _____

Printed/Typed Name of Signer _____ Title of Signer _____

Address of Signer (street or P.O. Box, city, state, 9-digit zip): _____

Phone Number (including area code) _____ FAX Number (including area code) _____ Email: _____

CERTIFIER AUTHORITY: (check one) ☐ CFO ☐ Business Officer ☐ Director ☐ Other Agent/Representative (describe) _____

Subscribed and sworn before me, _____, a notary public on _____ month / day / year

NOTARY SEAL

_____ Notary Signature _____ Notary Public, State Of _____ Commission Expires

TEXAS AMBULANCE SERVICES COST REPORT
COST REPORT for FFY 2020
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***Providers should use the allocation statistic to reduce the total depreciation to reflect the ambulance portion only**
-If EMS and Fire share the same station, please input the percentage of the building that can be allocated to just ambulance.
-If a provider has a medical utilization rate for its equipment, this can be entered in the allocation statisic column.
-If 100% of the asset's depreciation is attributable to ambulance, please enter 100%.

Beginning of Fiscal Year 10/1/2019
End of Fiscal Year 9/30/2020

SCHEDULE A
DEPRECIATION -- AMBULANCE SERVICES -- (Straight-Line Method Only)

A Description of Asset	B Month/Day/Year Placed in Service	C Years of Useful Life	D Cost	E Prior Period Accumulated Depreciation	F When Asset Will Meet Useful Life	G Asset Disposed of in FFY? (Y/N)	H Month/Day/Year of Disposal (if Y in Column G)	I Allocation Statistic*	J HHSC Allowable Depreciation For Reporting Period
BUILDINGS:									
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
								TOTAL	0
VEHICLES:									
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
								TOTAL	0
EQUIPMENT:									
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
					1/0/1900				-
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					1/0/1900				-
					1/0/1900				-
									0
Total Ambulance Services Depreciation									0

TEXAS AMBULANCE SERVICES COST REPORT
COST REPORT for FFY 2020
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9-Digit TPI: 0
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Beginning of Fiscal Year 10/1/2019
End of Fiscal Year 9/30/2020

A Description of Asset	B Salvage Value	C Maximum Months Depreciation	D Months Since Acquired	E Months Left of Useful Life	F Months Used Before Disposal	G Allowable Depreciation Months	H Capitalization Threshold	I Is the Value of the Asset Less than the Threshold?	J Allowable Depreciation Before Allocation For Reporting Period	K HHSC Allowable Depreciation
BUILDING:										
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
VEHICLES:										
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
EQUIPMENT:										
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
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0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
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0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-

TEXAS AMBULANCE SERVICES COST REPORT

COST REPORT for FFY 2020

9-Digit TPI: 0
10-Digit NPI: 0

Complete Shaded Areas Only

WORKSHEET B PAYROLL AND BENEFITS

EMPLOYEE INFORMATION					PAYROLL AND BENEFITS										FED FUNDING REDUCTION			
Employee #	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Medicare Payroll Taxes	State Unemployment Payroll Taxes	Federal Unemployment Payroll Taxes	Unemployment Compensation (Reimbursing Employer)	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
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																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
9-1-1 Call Technicians																		$ -
TOTAL					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
PARAMEDICS																		
																		$ -
																		$ -
																		$ -
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																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
All Other Paramedics																		$ -
TOTAL					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
TRAINING COORDINATORS																		
																		$ -

TEXAS AMBULANCE SERVICES COST REPORT

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WORKSHEET B PAYROLL AND BENEFITS

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
10	EMPLOYEE INFORMATION					PAYROLL AND BENEFITS										FED FUNDING REDUCTION			
11	Employee #	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Medicare Payroll Taxes	State Unemployment Payroll Taxes	Federal Unemployment Payroll Taxes	Unemployment Compensation (Reimbursing Employer)	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
67																			$ -
68																			$ -
69																			$ -
70																			$ -
71																			$ -
72																			$ -
73																			$ -
74																			$ -
75																			$ -
76																			$ -
77																			$ -
78																			$ -
79																			$ -
80																			$ -
81																			$ -
82																			$ -
83																			$ -
84																			$ -
85																			$ -
86																			$ -
87																			$ -
88	All Other Training Coordinators																		$ -
89	**TOTAL**					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
90																			
91	**QUALITY ASSURANCE TECHS**																		
92																			$ -
93																			$ -
94																			$ -
95																			$ -
96																			$ -
97																			$ -
98																			$ -
99																			$ -
100																			$ -
101																			$ -
102																			$ -
103																			$ -
104																			$ -
105																			$ -
106																			$ -
107																			$ -
108																			$ -
109																			$ -
110																			$ -
111																			$ -
112																			$ -
113																			$ -
114	All Other Quality Assurance Techs																		$ -
115	**TOTAL**					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
116																			
117	**SAFETY OFFICER**																		
118																			$ -
119																			$ -
120																			$ -

TEXASAMBULANCE SERVICES COST REPORT

COST REPORT for FFY 2020

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WORKSHEET B PAYROLL AND BENEFITS

10	EMPLOYEE INFORMATION					PAYROLL AND BENEFITS										FED FUNDING REDUCTION			
11	Employee #	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Medicare Payroll Taxes	State Unemployment Payroll Taxes	Federal Unemployment Payroll Taxes	Unemployment Compensation (Reimbursing Employer)	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
121																			$ -
122																			$ -
123																			$ -
124																			$ -
125																			$ -
126																			$ -
127																			$ -
128																			$ -
129																			$ -
130																			$ -
131																			$ -
132																			$ -
133																			$ -
134																			$ -
135																			$ -
136																			$ -
137																			$ -
138																			$ -
139																			$ -
140	All Other Safety Officer																		$ -
141	**TOTAL**					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
142																			
143	**BILLING / ACCOUNT REPS**																		
144																			$ -
145																			$ -
146																			$ -
147																			$ -
148																			$ -
149																			$ -
150																			$ -
151																			$ -
152																			$ -
153																			$ -
154																			$ -
155																			$ -
156																			$ -
157																			$ -
158																			$ -
159																			$ -
160																			$ -
161																			$ -
162																			$ -
163																			$ -
164																			$ -
165																			$ -
166	All Other Billing / Account Reps																		$ -
167	**TOTAL**					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
168																			
169	**CPR TECHNICIANS**																		
170																			$ -
171																			$ -
172																			$ -
173																			$ -
174																			$ -

TEXAS AMBULANCE SERVICES COST REPORT

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WORKSHEET B PAYROLL AND BENEFITS

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
10	EMPLOYEE INFORMATION					PAYROLL AND BENEFITS										FED FUNDING REDUCTION			
11	Employee #	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Medicare Payroll Taxes	State Unemployment Payroll Taxes	Federal Unemployment Payroll Taxes	Unemployment Compensation (Reimbursing Employer)	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
175																			$ -
176																			$ -
177																			$ -
178																			$ -
179																			$ -
180																			$ -
181																			$ -
182																			$ -
183																			$ -
184																			$ -
185																			$ -
186																			$ -
187																			$ -
188																			$ -
189																			$ -
190																			$ -
191																			$ -
192	All Other CPR Technicians																		$ -
193	**TOTAL**					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
194																			
195	**MEDICAL DIRECTOR**																		
196																			$ -
197																			$ -
198																			$ -
199																			$ -
200																			$ -
201																			$ -
202																			$ -
203																			$ -
204																			$ -
205																			$ -
206																			$ -
207																			$ -
208																			$ -
209																			$ -
210																			$ -
211																			$ -
212																			$ -
213																			$ -
214																			$ -
215																			$ -
216																			$ -
217																			$ -
218	All Other Medical Director																		$ -
219	**TOTAL**					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
220																			
221	**DIRECTOR**																		
222																			$ -
223																			$ -
224																			$ -
225																			$ -
226																			$ -
227																			$ -
228																			$ -

TEXAS AMBULANCE SERVICES COST REPORT

COST REPORT for FFY 2020

9-Digit TPI: 0

10-Digit NPI: 0

Complete Shaded Areas Only

WORKSHEET B PAYROLL AND BENEFITS

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
10	EMPLOYEE INFORMATION					PAYROLL AND BENEFITS										FED FUNDING REDUCTION			
11	Employee #	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Medicare Payroll Taxes	State Unemployment Payroll Taxes	Federal Unemployment Payroll Taxes	Unemployment Compensation (Reimbursing Employer)	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
229																			$ -
230																			$ -
231																			$ -
232																			$ -
233																			$ -
234																			$ -
235																			$ -
236																			$ -
237																			$ -
238																			$ -
239																			$ -
240																			$ -
241																			$ -
242																			$ -
243																			$ -
244	All Other Director																		$ -
245	TOTAL					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
246																			
247	PUBLIC INFORMATION OFFICER																		
248																			$ -
249																			$ -
250																			$ -
251																			$ -
252																			$ -
253																			$ -
254																			$ -
255																			$ -
256																			$ -
257																			$ -
258																			$ -
259																			$ -
260																			$ -
261																			$ -
262																			$ -
263																			$ -
264																			$ -
265																			$ -
266																			$ -
267																			$ -
268																			$ -
269																			$ -
270	All Other Public Information Officer																		$ -
271	TOTAL					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
272																			
273	Other (Identify)																		
274																			$ -
275																			$ -
276																			$ -
277																			$ -
278																			$ -
279																			$ -
280																			$ -
281																			$ -
282																			$ -

TEXAS AMBULANCE SERVICES COST REPORT

COST REPORT for FFY 2020

9-Digit TPI: 0

10-Digit NPI: 0

Complete Shaded Areas Only

WORKSHEET B PAYROLL AND BENEFITS

EMPLOYEE INFORMATION					PAYROLL AND BENEFITS										FED FUNDING REDUCTION			
Employee #	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Medicare Payroll Taxes	State Unemployment Payroll Taxes	Federal Unemployment Payroll Taxes	Unemployment Compensation (Reimbursing Employer)	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
																		$ -
TOTAL					$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
TOTAL BENEFITS AND REDUCTIONS					0	-	0	0	0	0	0	0	0	0		0	0	0

TEXAS AMBULANCE SERVICES COST REPORT

COST REPORT for FFY 2020

0

9-Digit TPI: 0

10-Digit NPI: 0

Complete Shaded Areas Only

Cost Allocation Methodologies Employed by the Governmental Entity

A. If you entered "yes" on Page 2 Line 1.03 and your agency has an approved Cost Allocation Plan (CAP), please provide a copy of the approval letter received from the Cognizant Agency

B. If you entered an Indirect Cost Rate in Exhibit 1 Line 1.05 please provide a copy of the certificate of indirect costs received from the Cognizant Agency

received from the Cognizant Agency

C. Please provide a list of personnel cost worksheets that support your CAP or IDCR

(Examples: Allocation of Personnel Worksheet, Time Distribution Report, Statement of Employee Benefits, etc.)

D. If you do not have an approved CAP or IDCR but are using another cost allocation methodology, please provide a copy of your methodology and the supporting documentation.

Attach Detailed Explanation Externally

Information on Charges Incurred/Payment Received by the Dental Service During the Reporting Period			
1.07	**Uninsured Charity Care Charges Amount (Total Charges)**	$	
1.08	**Uninsured Charity Care Reimbursement - Total Payments Received**	$	
1.09	**Uninsured Billed Amount (Do Not Include Uninsured Charity Charges)**	$	
1.10	**Total Billed Charges Associated With Medicaid FFS Paid Claims**	$	
1.11	**Total MCO Billed Charges Amount Associated with Paid Claims**	$	
1.12	**Medicare Charges for Reporting Period**	$	
1.13	**Charges for Other Third Party Claims for Reporting Period**	$	
1.14	**Charges for Self Pay, County/City Indigent Recipient Programs for Reporting Period**	$	

TEXAS GOVERNMENTALLY OWNED DENTAL PROVIDER SERVICES COST REPORT

Revised 2-22-2019

Complete Shaded Areas Only

Federal Fiscal Year (FFY)	
Reporting Period Start Date:	10/1/2019
Reporting Period End Date:	9/30/2020
9-Digit TPI:	
10-Digit NPI:	

PROVIDER INFORMATION

Provider Name:	
Provider Contact Name:	
Street Address:	
Mailing Address:	
Phone Number:	
FAX Number:	
Email:	

CHIEF FINANCIAL OFFICER / BUSINESS MANAGER

Name:	
Title:	
Business Name:	
Mailing Address:	
Phone Number:	
FAX Number:	
Email:	

REPORT PREPARER

Name:	
Title:	
Business Name:	
Mailing Address:	
Phone Number:	
FAX Number:	
Email:	

LOCATION OF ACCOUNTING RECORDS THAT SUPPORT THIS REPORT

Physical Address:	

TEXAS DENTAL SERVICES COST REPORT

COST REPORT for 0

0

9-Digit TPI: 0

10-Digit NPI: 0

Complete Shaded Areas Only

DENTAL SERVICES

PAYROLL EXPENSES

		Amount
2.00	Employee Gross Salary (Enter on Exhibit 5 Schedule B)	$ -
2.01	Employee Benefits (Describe in External Support)	$ -
2.02	Employer Retirement Contribution	$ -
2.03	Employer FICA Payroll Taxes	$ -
2.04	Employer Medicare Payroll Taxes	$ -
2.05	State Unemployment Payroll Taxes	$ -
2.06	Federal Unemployment Payroll Taxes	$ -
2.07	Unemployment Compensation (Reimbursing Employer)	$ -
2.08	Total Staff Costs (sum items 2.00 thru 2.07)	$ -

OTHER COSTS

2.09	Supplies & Materials:	
2.09 a	Supplies & Materials Non-Clinical (Provide External Support)	
2.09 b	Supplies & Materials Clinical (Provide External Support)	
2.10	Equipment:	
2.10 a	Equipment Non-Clinical (Provide External Support)	
2.10 b	Equipment Clinical (Provide External Support)	
2.11	Support Services (IT, Dispatch, Call Handling, etc.)	
2.12	Depreciation (Exhibit 4 Schedule A)	$ -
2.13	Other Costs (Provide External Support)	
2.14	Total Direct Clinical / Other Costs (sum items 2.09 through 2.13)	$ -
2.15	TOTAL Staff and Direct, and Indirect Dental Other Costs (sum items 2.08 and 2.14)	$ -

REDUCTIONS:

2.16	Other Federal Funds and Grants (Non-Medicaid, Enter on Exhibit 5 Schedule B)	$ -
2.17	Other (Give External Support For)	$ -
2.18	TOTAL Reductions (sum items 2.16 and 2.17)	$ -

COST SETTLEMENT CALCULATION:

			HHSC Review
2.19	Total Allowable Costs for Period of Service	$ -	
2.20	Total Billed Charges For Period of Service	#REF!	
2.21	Cost to Charge Ratio	0.00%	
2.22	Total Billed Charges Associated with Uninsured Charity Care Claims	$ -	
2.23	Uninsured Charity Care Cost	0	
2.24	Charity Care Reimbursement	$ -	
2.25	Equals Settlement Amount	$ -	
2.26	Multiplied by FMAP for appropriate fiscal year	56.18%	
2.27	Federal Funds	0.00%	
2.28	Non-Federal Share Funds (IGT Amount)	$ -	
2.29	**Equals Amount due to Provider (Before Proportionate Reduction)**	$ -	

Federal Fiscal Year (FFY) **0**

Reporting Period Start Date: **10/1/2019**
Reporting Period End Date: **9/30/2020**

Complete Shaded Areas Only

9-Digit TPI: 0

10-Digit NPI: 0

Cost Report Certification

AS SIGNER OF THIS COST REPORT, I HEREBY CERTIFY THAT:

- The cost report will include only allocable expenditures related to Uninsured Charity Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program.
- My office has completed the appropriate documentation required by HHSC and the Texas Comptroller's Office regarding the Intergovernmental Transfer (IGT) process.
- I have read the note below, the cover letter and all the instructions applicable to this cost report.
- I have reviewed this entire cost report after its preparation.
- To the best of my knowledge and belief, this cost report is true, correct and complete, and was prepared in accordance with State and Federal audit and cost principle standards as well as all the instructions applicable to this cost report.
- This cost report was prepared from the books and records of the Dental Services provider.
- The expenditures on this cost report have not been claimed on any other cost report.
- I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that falsification and concealment of a material fact may be prosecuted under Federal and State civil or criminal law.

NOTE: This COST REPORT CERTIFICATION must be signed by an individual legally responsible for the authorized agent and/or dental services provider representative, such as the Chief Financial Officer, Business Officer, Director, or other official. Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under federal and/or state law.

SIGNER IDENTIFICATION

Printed/Typed Name of Signer	Title of Signer

Name of Provider:

Address of Signer (street or P.O. Box, city, state, 9-digit zip):

Phone Number (including area code)	FAX Number (including area code)	Email:

SIGNATURE OF SIGNER

DATE

TEXAS AMBULANCE SERVICES COST REPORT
COST REPORT for 0
0

9-Digit TPI: 0
10-Digit NPI: 0

Complete Shaded Areas Only

Beginning of Fiscal Year 10/1/2019
End of Fiscal Year 9/30/2020

SCHEDULE A
DEPRECIATION -- DENTAL SERVICES -- (Straight-Line Method Only)

A	B	C	D	E	F	G	H	J
Description of Asset	Month/Day/Year Placed in Service	Years of Useful Life	Cost	Prior Period Accumulated Depreciation	When Asset Will Meet Useful Life	Asset Disposed of in FFY? (Y/N)	Month/Day/Year of Disposal (if Y in Column G)	HHSC Allowable Depreciation For Reporting Period
BUILDINGS:								
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
							TOTAL	0
VEHICLES:								
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
							TOTAL	0
EQUIPMENT:								
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
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					1/0/1900			-
					1/0/1900			-
					1/0/1900			-
							Total.	0

Total Dental Services Depreciation 0

TEXAS AMBULANCE SERVICES COST REPORT
COST REPORT for 0
0
9-Digit TPI: 0
10-Digit NPI: 0

Beginning of Fiscal Year 10/1/2019
End of Fiscal Year 9/30/2020

A Description of Asset	B Salvage Value	C Maximum Months Depreciation	D Months Since Acquired	E Months Left of Useful Life	F Months Used Before Disposal	G Allowable Depreciation Months	H Capitalization Threshold	I Is the Value of the Asset Less than the Threshold?	J Allowable Depreciation For Reporting Period	K HHSC Allowable Depreciation
BUILDING:										
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	-	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
VEHICLES:										
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
EQUIPMENT:										
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-
0	0	12	1449	#NUM!		#NUM!	0	N	#NUM!	-

TEXAS GOVERNMENTALLY OWNED DENTAL PROVIDER SERVICES COST REPORT

Federal Fiscal Year (FFY) **0**

Reporting Period Start Date: **10/1/2019**
Reporting Period End Date: **9/30/2020**

Complete Shaded Areas Only

9-Digit TPI: 0
0-Digit NPI: 0

Exhibit 5 Worksheet B Payroll and Benefits

EMPLOYEE INFORMATION					PAYROLL AND BENEFITS							FED FUNDING REDUCTION			
Employee #	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Medicare Payroll Taxes	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
Director															
															$ -
															$ -
All Other														$ -	$ -
TOTAL					$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
Dental Director															
															$ -
															$ -
All Other													$ -	$ -	$ -
TOTAL					$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
Dentists															
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
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															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
All Other													$ -	$ -	$ -
TOTAL					$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
Dental Assistants															
															$ -
															$ -

Federal Fiscal Year (FFY) 0

Reporting Period Start Date: 10/1/2019
Reporting Period End Date: 9/30/2020

Complete Shaded Areas Only

9-Digit TPI: 0 0-Digit NPI: 0

Exhibit 5 Worksheet B Payroll and Benefits

EMPLOYE E INFORMATION					PAYROLL AND BENEFITS							FED FUNDING REDUCTION			
Employee #	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Medicare Payroll Taxes	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
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															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
All Other													$ -	$ -	$ -
TOTAL					$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
Safety Officer															
															$ -
															$ -
All Other													$ -	$ -	$ -
TOTAL					$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
Billing/Account Reps															
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															$ -
All Other													$ -	$ -	$ -
TOTAL					$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -

Federal Fiscal Year (FFY) 0

Reporting Period Start Date: 10/1/2019
Reporting Period End Date: 9/30/2020

Complete Shaded Areas Only

9-Digit TPI: 0 0-Digit NPI: 0

Exhibit 5 Worksheet B Payroll and Benefits

EMPLOYEE INFORMATION					PAYROLL AND BENEFITS							FED FUNDING REDUCTION			
Employee #	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Medicare Payroll Taxes	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
Quality Assurance Techs															
															$ -
															$ -
All Other													$ -	$ -	$ -
TOTAL					$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
Contracted Staff															
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															$ -
All Other													$ -	$ -	$ -
TOTAL					$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
Other Staff															
															$ -
															$ -
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Federal Fiscal Year (FFY) 0

Reporting Period Start Date: 10/1/2019
Reporting Period End Date: 9/30/2020

Complete Shaded Areas Only

9-Digit TPI: 0 0-Digit NPI: 0

Exhibit 5 Worksheet B Payroll and Benefits

EMPLOYEE INFORMATION					PAYROLL AND BENEFITS							FED FUNDING REDUCTION			
Employee #	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Medicare Payroll Taxes	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
															$ -
All Other													$ -	$ -	$ -
TOTAL					$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
Gross Salary, Hours,and Contract Payments					$ -	$ -	$ -								
TOTAL BENEFITS AND REDUCTIONS								$ -	$ -	$ -	$ -		$ -	$ -	$ -

TEXAS GOVERNMENTALLY OWNED DENTAL PROVIDER SERVICES COST REPORT

Federal Fiscal Year **0**

Reporting Period Start Date: **10/1/2019**
Reporting Period End Date: **9/30/2020**

Complete Shaded Areas O

9-Digit TPI: 0

10-Digit NPI: 0

Cost Allocation Methodologies Employed by the Governmental Entity

A. If you entered "yes" on Page 2 Line 1.06 and your agency has an approved Cost Allocation Plan (CAP), please provide a copy of the approval letter received from the Cognizant Agency.

B. If you entered "yes" on Page 2, Line 1.08 and 1.10 and your agency has an approved Indirect Cost Rate (IDCR), please provide a copy of the certificate of indirect costs received from the Cognizant Agency.

C. If you do not have an approved CAP or IDCR but are using another cost allocation methodology, please provide a copy of your methodology and the supporting documentation.

D. Please provide a list of personnel cost worksheets that support your CAP or IDCR
(Examples: Allocation of Personnel Worksheet, Time Distribution Report, Sattement of Employee Benefits, etc)

Attach Detailed Explanation Externally