HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET S-10

Uncompensated and indigent care cost computation			
1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3, divided by line 202, column 8)		1
Medicaid (see instructions for each line)			
2	Net revenue from Medicaid		2
3	Did you receive DSH or supplemental payments from Medicaid?		3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges		6
7	Medicaid cost (line 1 times line 6)		7
8	Difference between net revenue and costs for Medicaid program (line 7 minus lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8
Children's Health Insurance Program (CHIP) (see instructions for each line)			
9	Net revenue from stand-alone CHIP		9
10	Stand-alone CHIP charges		10
11	Stand-alone CHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12
Other state or local government indigent care program (see instructions for each line)			
13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13) If line 15 is less than line 13, then enter zero.		16
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)			
17	Private grants, donations, or endowment income restricted to funding charity care		17
18	Government grants, appropriations or transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs (sum of lines 8, 12, and 16)		19

Uncompensated Care (see instructions for each line)

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)				20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)				21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)				23

24	Does the amount on line 20, column 2, include charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program?		24
25	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-of-stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)		26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		27.01
28	Non-Medicare bad debt expense (see instructions)		28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		29
30	Cost of uncompensated care (line 23 column 3 plus line 29)		30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31