# TAB C

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION
Office of Special Programs

**FORM APPROVED:**
**OMB No. 0915-007**

# UNCOMPENSATED SERVICES ASSURANCE REPORT

## PART A: IDENTIFICATION DATA

| 1. FACILITY NAME AND ADDRESS (Include Zip Code) | 2. FACILITY IDENTIFICATION NUMBER |
|---|---|
| | 3. TELEPHONE NUMBER (Include Area Code) |

## PART B: BASIC INFORMATION

| 4. FISCAL YEAR REPORTED | 5. REASON FOR SUBMISSION (Check All That Apply) |
|---|---|
| FY ____ BEGINNING ________ ENDING ________ | ☐ a. Completion of Obligation |
| ____ ________ ________ | ☐ b. Department Request |

6. FACILITY STATUS

☐ NO CHANGE IN STATUS

(CHECK APPROPRIATE BOX BELOW IF STATUS HAS CHANGED SINCE LAST AUDIT OR REPORT PROVIDED)

____/____

MONTH & YEAR OF CHANGE

☐ a. Transfer of Ownership
☐ b. Merged with ________
☐ c. Closed
☐ d. Converted to ________
☐ e. Management Contract
☐ f. Lease Agreement
☐ g. Other (Specify)

## PART C: ANNUAL COMPLIANCE LEVEL

| | |
|---|---|
| 7. FISCAL YEAR OF MOST RECENT AUDITED FINANCIAL STATEMENT WHICH PROVIDES THE BASIS FOR ANSWERS TO LINES 8, 9, & 10 | FY- |
| 8. TOTAL OPERATING EXPENSE | $ |
| 9. MEDICARE REIMBURSEMENTS | $ |
| 10. MEDICAID REIMBURSEMENTS | $ |
| 11. OPERATING EXPENSE MINUS MEDICARE AND MEDICAID REIMBURSEMENTS (Line 8) - (Line 9 + Line 10) | $ |
| 12. 3% ANNUAL COMPLIANCE LEVEL (Line 11 x 3%) | $ |
| 13. 10% ANNUAL COMPLIANCE LEVEL (Already Adjusted by CPI) | $ |
| 14. ANNUAL COMPLIANCE LEVEL (Lesser of Line 12 or 13) | $ |
| 15. DEFICIT FROM PREVIOUS YEAR | $ |
| 16. CPI INFLATION FACTOR | % |
| 17. ADJUSTED DEFICIT FROM PREVIOUS YEAR (Line 15 x Line 18) | $ |
| 18. PRORATED DEFICIT REQUIRED TO BE MADE UP IN CURRENT YEAR | $ |
| 19. CPI INFLATION FACTOR | % |
| 20. ADJUSTED PRORATED DEFICIT ( Line 18 x Line 19) | $ |
| 21. TOTAL DEFICIT TO BE MADE UP IN REPORTING YEAR (Line 17 + Line 20) | $ |
| 22. EXCESS FROM PREVIOUS YEAR | $ |
| 23. CPI INFLATION FACTOR | % |
| 24. ADJUSTED EXCESS (Line 22 x Line 23) | $ |

| 25. ADJUSTED ANNUAL COMPLIANCE LEVEL (Line 14 + Line 21) or (Line 14 + Line 21) - (Line 24) | |
|---|---|

**PART D: ALLOWABLE CREDIT FACTOR**
**TO BE COMPLETED ONLY BY FACILITIES WHICH PARTICIPATE IN MEDICARE**

| 26. ALLOWABLE CREDIT | |
|---|---|

**PART E: UNCOMPENSATED SERVICES**

| | |
|---|---|
| 27. AMOUNT OF UNCOMPENSATED SERVICES PROVIDED TO ELIGIBLE PATIENTS COMPUTED AT USUAL CHARGES | $ |
| 28. UNCOMPENSATED SERVICES PROVIDED AT ALLOWABLE CREDIT (Line 26 x Line 27) | $ |
| 29. DIFFERENCE BETWEEN COMPLIANCE LEVEL AND SERVICES PROVIDED (Compare Line 25 with Line 28 and Enter the Difference) | |
| a. Deficit.......... | $ |
| b. Excess.......... | $ |

**PART F: ADDITIONAL INFORMATION**

| | |
|---|---|
| 30. ALLOCATION PLAN PUBLISHED IN NEWSPAPER (Attach Copy of Published Notice) | ☐ YES ☐ NO |
| 31. DETERMINATIONS OF ELIGIBILITY | |
| a. Number of Requests for Services at No Charge or Reduced Charge.......... | |
| b. Number of Requests Resulting in Denial.......... | |
| c. Number of Eligibility Determinations Resulting in Provision of Uncompensated Services | |
| 32. POSTED NOTICE OF UNCOMPENSATED SERVICES (Admissions/Business Office and Emergency Room) | ☐ YES ☐ NO |
| 33. INDIVIDUAL NOTICE PROVIDED TO EACH PATIENT (Attach Copy of Written Notice Provided) | ☐ YES ☐ NO |

34. CERTIFICATION

I understand that all the information contained in this report is subject to public disclosure under the Freedom of Information Act. I certify that, in answering all the applicable items, I have not omitted material information reasonably available to me. I further certify that the information given is true and correct to the best of my knowledge. (A willfully false statement is punishable by law [ 18 U.S.C. Sec. 1001])

| a. PREPARER'S NAME | b. PREPARER'S TITLE AND TELEPHONE NO. (Include Area Code) | c. PREPARER'S SIGNATURE | DATE |
|---|---|---|---|
| | | | |

| d. NAME OF FACILITY ADMINISTRATOR | e. FACILITY ADMINISTRATOR'S SIGNATURE | DATE |
|---|---|---|
| | | |

*PLEASE RETAIN A COPY OF THIS FORM FOR YOUR FILES.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
OFFICE OF SPECIAL PROGRAMS

# INSTRUCTIONS FOR COMPLETING THE UNCOMPENSATED SERVICES ASSURANCE REPORT (Section 1627 of the Public Health Service Act, 42 CFR Part 124) (HRSA-710, Rev. 1/2000)

**Purpose:**

Section 1627 of the Public Health Service (PHS) Act requires all health facilities which have been assisted by the Department of Health and Human Services under Title VI and Title XV1 of the PHS Act, to report fulfillment of an assurance guaranteed in the original application for Federal assistance. This assurance requires that each facility make available a reasonable volume of services to persons unable to pay. Facilities having received Federal assistance under Titles VI and XV1 in conjunction with any of the following acts also must provide and report uncompensated services.

- The District of Columbia Medical Facilities Construction Act of 1968, 82 Stat. 631 (Public Law 90-457)
- The Appalachian Regional Development Act of 1965, as amended (40 U.S.C. App.)
- The Public Works Acceleration Act of 1962 (42 U.S.C. 2641, et .seq.)
- The Public Works and Economic Development Act of 1965 (42 U.S.C. 3121, et. seq.)
- The Local Public Works Capital Development and Investment Act of 1976 (Public Law 94-369)

The attached form is provided for reporting these uncompensated services. The form should be completed and returned no later than 90 days after the end of the facility's fiscal year when requested or if the facility believes it has completed its obligation. If an extension is needed, contact the Office of Special Programs, Division of Facilities Compliance and Recovery, 5600 Fishers Lane, Rockville, Maryland 20857, (301) 443-5656.

**PUBLIC BURDEN STATEMENT:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-007. Public reporting burden for the applicant for this collection of information is estimated to average 11, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions, for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-45, Rockville, Maryland 20875.

## GENERAL INSTRUCTIONS FOR COMPLETING FORM

- Please type or print legibly.
- Round financial data to nearest dollar.
- If more space is needed to answer an item, please continue on an extra sheet of paper. Type or print the name of your facility and your facility identification number (as it appears in Part A) at the top of the extra page and identify each answer by number. Enclose the extra page with the form.
- Additional information, if needed, can be obtained in the Provider's Guide to the Hill-Burton Uncompensated Services Regulations, February 1988.
- Some facilities, such as outpatient facilities, will find that certain items, as those relating to inpatient activities, do not apply. If any item does not apply to your facility, please enter "NOT APPLICABLE" or "NA" in the appropriate space.
- Do not complete this form if your have been approved under one of the compliance alternatives identified under 42 CFR section 124.513, 124.514, 124.515, 124.516, or 124.517 or the uncompensated services regulations.

## INSTRUCTIONS

### Part A-IDENTIFICATION DATA

**Items 1-3:** Self- Explanatory.

### Part B-BASIC INFORMATION

**Item 4:** Please enter the fiscal year your facility uses for accounting purposes.

**Item 5:** Check all the appropriate boxes to show if this report is submitted (a) because you believe your facility has completed its obligation or (b) as the result of a specific request by the Department.

**Item 6:** If the status of the facility has not changed since the last audit or report provided, check the "no change" box. If the status of the facility has changed since the last audit or report provided, indicate the month and year of the change and check the appropriate box.

### PART C- ANNUAL COMPLIANCE LEVEL

A facility is in compliance with its assurance to provide a reasonable volume of services to person unable to pay during its fiscal year it provides uncompensated services at a level not less than the lesser of:
(1) Three (3) percent of its operating expenses less Medicare and Medicaid for the most recent fiscal year for which an audited financial statement is available; or
(2) Ten (10) percent of all Federal assistance provided to or on behalf of the facility, adjusted by a percentage change in the National Consumer Price Index for medical care between the year in which the facility received assistance or 1979, whichever is later, and the most recent year for which a published index is available.

At the top of the column, enter the fiscal year being reported (same as that indicated in Item 4).

**Item 7:** Use the Medicare and Medicaid cost reports and the audited financial statement for the year which is 2 years prior to the reporting year, e.g., use the 2000 audited financial statement for the 2002 reporting year. Enter the year of the audited financial statement and the Medicare and Medicaid cost reports used to compute the operating cost for the fiscal year covered by this report.

**Item 8:** Take this figure from the appropriate audited financial statement.

**Item 9 and 10:** Report the amount of reimbursement received from Medicare and Medicaid for the year covered by your financial statement. If reimbursements for the year had not been received prior to the start of the fiscal year for which you are reporting, report the amount claimed in your Medicare cost report for that year.

**Item 11 and 12:** Compute as indicated

**Item 13:** The 10 percent annual compliance level for grants and loans can be found on the Facility Status Report. The amount of Federal assistance under obligation for facilities which received loans or loan guarantees is based on the cumulative interest subsidy amounts and other payments by HHS. (See Provider's Guide, Chapter III, pages 7-11.) These amounts can be found on the Loan History Report.

**Item 14:** Select the lesser of the 3 percent or 10 percent compliance levels for the year and enter amount.

(Over)

UNCOMPENSATED SERVICES ASSURANCE REPORT: LINE-BY-LINE

**Item 15:** Record any deficit from the previous year to be made up in the year covered by the report. Enter the amount of the deficit to be made up and the fiscal year in which the deficit was incurred. If there is no deficit to be made up, enter 0. (See Provider's Guide, Chapter III, Page 9.)

**Item 16:** Adjust the deficit by the appropriate Consumer Price Index for medical care.

**Item 17:** Compute as indicated.

**Items 18:** If your facility had a deficit from a previous audit, and if all or a portion of it is required to be made up in the fiscal year covered by this report, enter the appropriate deficit amount. If none, enter 0. (See Provider's Guide, Chapter III, Page 9.)

**Item 19:** Adjust the prorated deficit by the appropriate Consumer Price Index for medical care.

**Item 20:** Compute as indicated.

**Item 21:** Compute as indicated.

**Item 22:** Record all excess earned in previous year which is to be applied to the year covered by this report. Enter the amount of the excess and the fiscal year in which the excess was earned. If there is no excess to be applied, enter 0. (See Provider's Guide, Chapter III, Page 9-10.)

**Items 23:** Adjust the excess by the appropriate Consumer Price Index for medical care.

**Item 24:** Compute as indicated.

**Item 25:** Compute as indicated.

- If you are reporting your first year under these regulations, there is no deficit or excess to be carried over from the previous year.
- See Provider's Guide, Chapter III, Page 9-10, for an example of the calculation of the amount of the adjustment of excess or deficit due to a change in the Consumer Price Index for medical care.

**PART D-ALLOWABLE CREDIT FACTOR**

**Item 26:** Facilities which participate in Medicare must calculate an allowable credit factor. Use the Medicare cost report for the year which is 2 years prior to the reporting year, e.g., use the 1997 Medicare cost report for the 1999 reporting year. Those which do not participate in Medicare should enter 100 percent.

Use the attached worksheet to calculate the allowable credit factor and enter onto line 26. (Round off percentage to 4 decimals places, i.e. 87.92 percent or .8792). (See Provider's Guide, Chapter III, Page 10-11.)

**PART E-UNCOMPENSATED SERVICES**

**Item 27:** Do not include amounts which are excluded by the regulations. Generally, you may not include: amounts for which reimbursement is available; and services provided 96 hours or more after notification of disapproval by a Peer Review Organization. (See Provider's Guide, Chapter VII, Pages 23-25.) Do not include any payments made by Category B patients.

**Item 28:** Calculate as indicated.

**Item 29:** Calculate as indicated. If line 25 is larger than line 28, enter the difference as a deficit in line 29a. If line 28 is larger, enter the difference as an excess in line 29b.

**PART F- ADDITIONAL INFORMATION**

**Item 30:** Indicate name of newspaper in which notice was published and date of publication. Be sure to attach a copy of your published notice for the fiscal year including proof of the date of publication. If more than one published notice was used during the fiscal year, be sure to attach a copy of each.



**Item 31a, b, and c:** Eligibility determinations must be made in response to requests whenever uncompensated services are available. Determinations of eligibility may result in denials because of failure to meet poverty income criteria, because the individual is not eligible under your allocation plan, because of lack of income verification if required by the facility, or because the individual did not take reasonable action to obtain third party coverage if stated by the facility as a condition of eligibility. Determinations of eligibility are required in these cases. Denials may also be made because the services requested are not offered by your facility, or uncompensated services are no longer available in your facility. In these cases, determinations of eligibility are not required, but denials must be made in writing to the applicant.

In Item 31a, provide the total number of requests for uncompensated services.

In Item 31b, enter the total number of denials.

Item 31c, enter the number of eligibility determinations approved for uncompensated services. (See Provider's Guide, Chapter VI, Pages 17-22, and 42CFR.124.507.)

**Item 32:** Self -Explanatory.

**Item 33:** This is the individual written notice of the availability of uncompensated services provided to each person who seeks services in your facility on behalf of himself or another individual. Be sure to attach a copy of each individual notice used for the fiscal year being reported.

**Item 34:** Check the entire form for completeness and accuracy. Please be sure that this item is completed and signed by the appropriate individuals.