HAMILTON MEMORIAL HOSPITAL

MCLEANSBORO, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED JUNE 30, 2014

October 7, 2014

National Government Services, Inc.
P.O. Box 6474
Indianapolis, IN 46206-6474

Re: Provider: Hamilton Memorial Hospital District
Provider Numbers: 14-1326, 14-Z326, 14-3477, 14-8529
Period ended: 6-30-14
Protested amount claimed on original submitted cost report.

Dear Sir or Madam:

The original as filed cost report for Hamilton Memorial Hospital District, for the year ended June 30, 2014, claims additional amounts due the provider for an expense paid by the provider, but currently not classified as a reimbursable cost by National Government Services, Inc. The expense in question relates to the SWAP interest in the amount of $173,442 which we have included as an adjustment to line 1.00 (Cap Rel Cost-Bldg & Fixt) on worksheet A-8. We feel as though the expense should be allowed as a reimbursable cost under Medicare Guidelines.

The calculation of the additional amounts due the provider was calculated by removing the adjustment on worksheet A-8. The protested amounts claimed for the period ended June 30, 2014 are as follows:

Worksheet E, part B, line 44	$ 38,497
Worksheet E-2, line 23	16,874
Worksheet E-3, part V, line 34	24,253
Worksheet M-3, line 30	2,112
Worksheet M-3, line 30	10
Total	$ 81,746

Sincerely,

Randall Dauby, CEO
Hamilton Memorial Hospital
611 South Marshall
McLeansboro, IL 62859
(618) 643-2361

National Government Services, Inc.
Medicare Audit and Reimbursement
PO Box 6474
Indianapolis, IN 46206-6474

Dear Sir or Madam:

The cost report of Hamilton Memorial Hospital for the fiscal year ended June 30, 2014 includes two Level 2000 Error.

20300 Worksheet C, Part I, Line 50, Col 11 should not be more than 100% or less than .1%.

The Hospital's operating room cost to charge ratio was 1.233729 as the number of surgeries in 2014 did not generate enough revenue to cover the expense of the surgeries including allocated overhead. As a rural hospital Hamilton Memorial Hospital qualifies for cost reimbursement for these services. The reimbursement program is designed for rural hospitals with lower surgery volumes

20300 Worksheet C, Part I, Line 53, Col 11 should not be more than 100% or less than .1%.

The Hospital's anesthesiology cost to charge ratio was 1.578867 as the number of surgeries in 2014 did not generate enough revenue to cover the expense of the CRNA's including allocated overhead. As a rural hospital Hamilton Memorial Hospital qualifies for cost reimbursement for these services. The reimbursement program is designed for rural hospitals with lower surgery volumes.

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:55 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 10/07/2014 TIME: 09:55 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED 6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY HAMILTON MEMORIAL HOSPITAL (14-1326) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 07/01/2013 AND ENDING 06/30/2014, AND 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 AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 10/07/2014 09:55
EMFXZLSo45fSE3JNL2oFY1gRDa6uO0
w6gOj0CwwRF9GIpQRv6gYMTx.P9fjh
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PI Encryption: 10/07/2014 09:55
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(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		68,887	461,927	-3,332	1,955,232	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-7,082				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-2,758			10
10.01	HEALTH CLINIC - RHC II			156			10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		61,805	459,325	-3,332	1,955,232	200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 611 SOUTH MARSHALL	P.O. Box:		1
2	City: MCLEANSBORO	State: IL	ZIP Code: 62859	County: HAMILTON	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Prov-ider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	HAMILTON MEMORIAL HOSPITAL	14-1326	99914	1	05/01/2003	N	O	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	HAMILTON MEMORIAL HOSP SWING BED	14-Z326	99914		05/01/2003	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	HAMILTON MEMORIAL FAMILY CLINIC	14-3477	99914		01/11/2006	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	HAMILTON MEMORIAL FAMILY CLINIC NC	14-8529	99914		05/06/2013	N	O	N	15.01
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2013	To: 06 / 30 / 2014	20
21	Type of control (see instructions)	11		21

	Inpatient PPS Information	1	2	
22	Does this facility qualify for and receive disproportionate share hosptial payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N	23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional paymetn exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N	N		57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	
	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hosptial trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
	Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
	Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hosptial. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
Inpatient Psychiatric Faciltiy PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86

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WORKSHEET S-2
PART I

				V	XIX	
Title V and XIX Services				1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.			N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.			N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the appilcable column.				N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.					97
Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hosptial (CAH)?			Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			Y		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Y	Y	Y	N	109
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'		N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.			N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1		118
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:		130,400			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.			N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.			Y		121
Transplant Center Information						
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.			N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.					134

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	N		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
			1	2	3	
155	Hospital	Y	Y		N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Surpvodier - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	118,450			168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2013	06/30/2014	170

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HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
			Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES			1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.		N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?		N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.		N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.		N		11
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	09/05/2014	Y	09/05/2014	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES. ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	Y	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	N	33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	N	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	35

		Y/N	DATE	
HOME OFFICE COSTS		1	2	
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	N		36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N		37
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.	N		38
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.	N		39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N		40

COST REORT PREPARER INFORMATION				
41	FIRST NAME: DAVID	LAST NAME: SCHNAKE	TITLE: PARTNER	41
42	EMPLOYER: KEB			42
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: DAVIDS@KEBCPA.COM		43

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	43,920.00		1,433	155	1,830	1
2	HMO AND OTHER (see instructions)									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						977		977	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								144	6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		25	9,125	43,920.00		2,410	155	2,951	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (see instructions)		25	9,125	43,920.00		2,410	155	2,951	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					1,292		3,835	26
26.01	RHC II	88.01					2		414	26.01
27	TOTAL (sum of lines 14-26)		25							27
28	OBSERVATION BED DAYS							68	397	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

Optimizer Systems, Inc. WinLASH Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					460	69	653	1
2	HMO AND OTHER (see instructions)								2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		109.11			460	69	653	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC		8.30						26
26.01	RHC II		1.13						26.01
27	TOTAL (sum of lines 14-26)		118.54						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

Optimizer Systems, Inc. **WinLASH** Micro System

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200						1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)							10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)							17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT							26
27	ADMINISTRATIVE & GENERAL							27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT							30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING							32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY							34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION							38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY							41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)							1
2	EXCLUDED AREA SALARIES (see instructions)							2
3	SUBTOTAL SALARIES (line 1 minus line 2)							3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)							4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)							5
6	TOTAL (sum of lines 3 through 5)							6
7	TOTAL OVERHEAD COST (see instructions)							7

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3**
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)		8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)		11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE		15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY		17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)		24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE			1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)			2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH			3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)			4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

Optimizer Systems, Inc. WinLASH Micro System

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II			14.01
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

Optimizer Systems, Inc. **WinLASH** Micro System

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	Y	/ /	2

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70

Optimizer Systems, Inc. **WinLASH** Micro System

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA AT BEGINNING OF COST REPORTING PERIOD	CBSA ON/AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable)	
		1	2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable).			201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (see instructions)

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)				207

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER **COMPONENT CCN: 14-3477** **WORKSHEET S-8**
STATISTICAL DATA

CHECK APPLICABLE BOX: **[XX] RHC [ ] FQHC**

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 611 SOUTH MARSHALL	1
2	CITY: MCLEANSBORO STATE: IL ZIP CODE: 62859 COUNTY: HAMILTON	2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN	3

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (Section 330(d), PHS Act)			4
5	MIGRANT HEALTH CENTER (Section 329(d), PHS Act)			5
6	HEALTH SERVICES FOR HOMELESS (Section 340(d), PHS Act)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER			9

		1	2	
10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N		10

FACILITY HOURS OF OPERATIONS(1)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	TYPE OPERATION	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	CLINIC			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (both type and hours of operation). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

		1	2	
12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N		13
14	PROVIDER NAME: CCN NUMBER:			14

		Y/N	V	XVIII	XIX	TOTAL VISITS	
		1	2	3	4	5	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (see instructions)	N					15

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER **COMPONENT CCN: 14-8529** **WORKSHEET S-8**
STATISTICAL DATA

CHECK APPLICABLE BOX: **[XX] RHC [ ] FQHC**

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 110A EAST MAIN	1
2	CITY: NORRIS CITY STATE: IL ZIP CODE: 62869 COUNTY: WHITE	2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN	3

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (Section 330(d), PHS Act)			4
5	MIGRANT HEALTH CENTER (Section 329(d), PHS Act)			5
6	HEALTH SERVICES FOR HOMELESS (Section 340(d), PHS Act)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER (SPECIFY)			9

		1	2	
10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N		10

FACILITY HOURS OF OPERATIONS(1)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	TYPE OPERATION	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	CLINIC			0900	1700	0900	1700	0900	1700	0900	1700					11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (both type and hours of operation). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

		1	2	
12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N		13
14	PROVIDER NAME: CCN NUMBER:			14

		Y/N	V	XVIII	XIX	TOTAL VISITS	
		1	2	3	4	5	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (see instructions)	N					15

Optimizer Systems, Inc. **WinLASH** Micro System

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **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)	0.604345	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	1,594,337	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	5,497,714	6
7	MEDICAID COST (line 1 times line 6)	3,322,516	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	1,728,179	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (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

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	1,728,179	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	215,211	21,626	236,837	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	130,062	13,070	143,132	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	1,763	1,365	3,128	22
23	COST OF CHARITY CARE (line 21 minus line 22)	128,299	11,705	140,004	23

24	DOES THE AMOUNT IN 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?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	1,551,961	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	409,991	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	1,141,970	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	690,144	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	830,148	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	2,558,327	31

Optimizer Systems, Inc. **WinLASH** Micro System

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		1,001,315	1,001,315	1,150,563	2,151,878	-208,331	1,943,547	1
2	00200	CAP REL COSTS-MVBLE EQUIP		357,002	357,002	182,952	539,954	-108,674	431,280	2
3	00300	OTHER CAP REL COSTS		97,569	97,569	-97,569			-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		1,220,750	1,220,750		1,220,750	-26,879	1,193,871	4
5.01	00540	NONPATIENT TELEPHONES		24,209	24,209		24,209		24,209	5.01
5.02	00550	DATA PROCESSING	115,428	13,293	128,721		128,721		128,721	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	42,555	3,241	45,796		45,796	-1,098	44,698	5.03
5.04	00570	ADMITTING				157,504	157,504		157,504	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	235,497	298,922	534,419	-157,504	376,915		376,915	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	441,428	457,561	898,989	70,436	969,425	-192,036	777,389	5.06
7	00700	OPERATION OF PLANT	150,123	575,536	725,659	-2,383	723,276		723,276	7
8	00800	LAUNDRY & LINEN SERVICE		46,097	46,097		46,097		46,097	8
9	00900	HOUSEKEEPING	148,042	21,456	169,498		169,498		169,498	9
10	01000	DIETARY		70,297	70,297		70,297	-171	70,126	10
11	01100	CAFETERIA								11
13	01300	NURSING ADMINISTRATION	263,715	7,657	271,372		271,372	-63,690	207,682	13
14	01400	CENTRAL SERVICES & SUPPLY		25,096	25,096	-6,132	18,964		18,964	14
15	01500	PHARMACY	171,319	238,101	409,420	-219,982	189,438		189,438	15
16	01600	MEDICAL RECORDS & LIBRARY	170,777	40,669	211,446		211,446	-3,086	208,360	16
17	01700	SOCIAL SERVICE	44,933	1,581	46,514		46,514		46,514	17
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	1,076,721	83,623	1,160,344		1,160,344		1,160,344	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	118,899	236,957	355,856	-195,979	159,877		159,877	50
53	05300	ANESTHESIOLOGY	264,605	29,491	294,096	-6,179	287,917		287,917	53
54	05400	RADIOLOGY-DIAGNOSTIC	279,896	313,965	593,861	-105,575	488,286		488,286	54
58	05800	MRI				71,690	71,690		71,690	58
60	06000	LABORATORY	311,247	566,988	878,235	-7,200	871,035		871,035	60
65	06500	RESPIRATORY THERAPY	104,800	27,270	132,070	-4,221	127,849		127,849	65
65.50	06501	SLEEP LAB		29,250	29,250		29,250		29,250	65.50
66	06600	PHYSICAL THERAPY	357,150	164,192	521,342	-232	521,110	-4,005	517,105	66
67	06700	OCCUPATIONAL THERAPY								67
68	06800	SPEECH PATHOLOGY								68
69	06900	ELECTROCARDIOLOGY		17,494	17,494		17,494		17,494	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				73,416	73,416	-25,263	48,153	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				79,695	79,695		79,695	72
73	07300	DRUGS CHARGED TO PATIENTS				202,921	202,921	-7,817	195,104	73
		OUTPATIENT SERVICE COST CENTERS								
88	08800	RURAL HEALTH CLINIC	853,592	186,008	1,039,600	-23,024	1,016,576	-87,438	929,138	88
88.01	08801	RHC II	92,559	23,913	116,472	-7,708	108,764	-4,104	104,660	88.01
90	09000	CLINIC	151,491	141,953	293,444		293,444		293,444	90
90.01	09001	NORRIS CITY CLINIC								90.01
91	09100	EMERGENCY	507,663	1,154,821	1,662,484	-15,214	1,647,270	-629,637	1,017,633	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		1,117,355	1,117,355	-1,117,355				113
117	06950	OTHER SPECIAL PURPOSE COST CENTERS								117
117.02	06952	SUPPLIES AND EXPENSE		18,965	18,965	-18,965				117.02
118		SUBTOTALS (sum of lines 1-117)	5,902,440	8,612,597	14,515,037	3,955	14,518,992	-1,362,229	13,156,763	118
		NONREIMBURSABLE COST CENTERS								
192	19200	PHYSICIANS' PRIVATE OFFICES		84,856	84,856	-3,955	80,901		80,901	192
200		TOTAL (sum of lines 118-199)	5,902,440	8,697,453	14,599,893		14,599,893	-1,362,229	13,237,664	200

Optimizer Systems, Inc. **WinLASH** Micro System

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS INTEREST EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1		1,117,355	1
500	TOTAL RECLASSIFICATIONS					1,117,355	500
	CODE LETTER - A						
1	TO RECLASS RENT EXPENSE	B	CAP REL COSTS-MVBLE EQUIP	2		173,524	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	TOTAL RECLASSIFICATIONS					173,524	500
	CODE LETTER - B						
1	RECLASS INSURANCE COST	C	OTHER ADMINISTRATIVE AND GENE	5.06		54,933	1
500	TOTAL RECLASSIFICATIONS					54,933	500
	CODE LETTER - C						
1	ADMITTING	D	ADMITTING	5.04	78,421	79,083	1
500	TOTAL RECLASSIFICATIONS				78,421	79,083	500
	CODE LETTER - D						
1	RECLASS SUPPLIES SOLD	E	MEDICAL SUPPLIES CHARGED TO P	71		153,111	1
2							2
3							3
4							4
5							5
6							6
7							7
500	TOTAL RECLASSIFICATIONS					153,111	500
	CODE LETTER - E						
1	RECLASS DRUGS TO PHARMACY	F	DRUGS CHARGED TO PATIENTS	73		160,463	1
500	TOTAL RECLASSIFICATIONS					160,463	500
	CODE LETTER - F						
1	RECLASS SUPPLIES SOLD	G	CENTRAL SERVICES & SUPPLY	14		18,965	1
500	TOTAL RECLASSIFICATIONS					18,965	500
	CODE LETTER - G						
1	RECLASS IV COST	H	DRUGS CHARGED TO PATIENTS	73		42,458	1
2							2
500	TOTAL RECLASSIFICATIONS					42,458	500
	CODE LETTER - H						
1	RECLASS MALPRACTICE	I	OTHER ADMINISTRATIVE AND GENE	5.06		23,024	1
500	TOTAL RECLASSIFICATIONS					23,024	500
	CODE LETTER - I						
1	RECLASS IPL DEVICES	J	IMPL. DEV. CHARGED TO PATIENT	72		79,695	1
500	TOTAL RECLASSIFICATIONS					79,695	500
	CODE LETTER - J						
1	RECLASS MRI COST	K	MRI	58		71,690	1
500	TOTAL RECLASSIFICATIONS					71,690	500
	CODE LETTER - K						
1	RECLASS UTLITIES IN PHYS OFFICE	L	OTHER ADMINISTRATIVE AND GENE	5.06		3,955	1
500	TOTAL RECLASSIFICATIONS					3,955	500
	CODE LETTER - L						
	GRAND TOTAL (INCREASES)				78,421	1,978,256	

(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 4, lines as appropriate.

Optimizer Systems, Inc. **WinLASH** Micro System

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	TO RECLASS INTEREST EXPENSE	A	INTEREST EXPENSE	113		1,117,355	11	1
500	TOTAL RECLASSIFICATIONS					1,117,355		500
	CODE LETTER - A							
1	TO RECLASS RENT EXPENSE	B	OTHER ADMINISTRATIVE AND GENE	5.06		11,476	10	1
2			OPERATING ROOM	50		68,738		2
3			RESPIRATORY THERAPY	65		1,325		3
4			RADIOLOGY-DIAGNOSTIC	54		33,880		4
5			LABORATORY	60		7,200		5
6			PHARMACY	15		40,814		6
7			OPERATION OF PLANT	7		2,383		7
8			RHC II	88.01		7,708		8
500	TOTAL RECLASSIFICATIONS					173,524		500
	CODE LETTER - B							
1	RECLASS INSURANCE COST	C	OTHER CAP REL COSTS	3		54,933		1
500	TOTAL RECLASSIFICATIONS					54,933		500
	CODE LETTER - C							
1	ADMITTING	D	CASHIERING/ACCOUNTS RECEIVABL	5.05	78,421	79,083		1
500	TOTAL RECLASSIFICATIONS				78,421	79,083		500
	CODE LETTER - D							
1	RECLASS SUPPLIES SOLD	E	EMERGENCY	91		15,214		1
2			ANESTHESIOLOGY	53		6,179		2
3			OPERATING ROOM	50		127,241		3
4			RESPIRATORY THERAPY	65		2,896		4
5			PHYSICAL THERAPY	66		232		5
6			CENTRAL SERVICES & SUPPLY	14		1,344		6
7			RADIOLOGY-DIAGNOSTIC	54		5		7
500	TOTAL RECLASSIFICATIONS					153,111		500
	CODE LETTER - E							
1	RECLASS DRUGS TO PHARMACY	F	PHARMACY	15		160,463		1
500	TOTAL RECLASSIFICATIONS					160,463		500
	CODE LETTER - F							
1	RECLASS SUPPLIES SOLD	G	SUPPLIES AND EXPENSE	117.02		18,965		1
500	TOTAL RECLASSIFICATIONS					18,965		500
	CODE LETTER - G							
1	RECLASS IV COST	H	PHARMACY	15		18,705		1
2			CENTRAL SERVICES & SUPPLY	14		23,753		2
500	TOTAL RECLASSIFICATIONS					42,458		500
	CODE LETTER - H							
1	RECLASS MALPRACTICE	I	RURAL HEALTH CLINIC	88		23,024		1
500	TOTAL RECLASSIFICATIONS					23,024		500
	CODE LETTER - I							
1	RECLASS IPL DEVICES	J	MEDICAL SUPPLIES CHARGED TO P	71		79,695		1
500	TOTAL RECLASSIFICATIONS					79,695		500
	CODE LETTER - J							
1	RECLASS MRI COST	K	RADIOLOGY-DIAGNOSTIC	54		71,690		1
500	TOTAL RECLASSIFICATIONS					71,690		500
	CODE LETTER - K							
1	RECLASS UTLITIES IN PHYS OFFICE	L	PHYSICIANS' PRIVATE OFFICES	192		3,955		1
500	TOTAL RECLASSIFICATIONS					3,955		500
	CODE LETTER - L							
	GRAND TOTAL (DECREASES)				78,421	1,978,256		

(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 4, lines as appropriate.

Optimizer Systems, Inc. **WinLASH** Micro System

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	69,760					69,760		1
2	LAND IMPROVEMENTS	601,496					601,496		2
3	BUILDINGS AND FIXTURES	21,545,924	15,193		15,193		21,561,117		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	5,638,564	149,549		149,549		5,788,113		6
7	HIT DESIGNATED ASSETS	410,457	118,450		118,450		528,907		7
8	SUBTOTAL (sum of lines 1-7)	28,266,201	283,192		283,192		28,549,393		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	28,266,201	283,192		283,192		28,549,393		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,001,315						1,001,315	1
2	CAP REL COSTS-MVBLE EQUIP	357,002						357,002	2
3	TOTAL (sum of lines 1-2)	1,358,317						1,358,317	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	22,232,373		22,232,373	0.778870	33,208			33,208	1
2	CAP REL COSTS-MVBLE EQU	6,312,020		6,312,020	0.221130	9,428			9,428	2
3	TOTAL (sum of lines 1-2)	28,544,393		28,544,393	1.000000	42,636			42,636	3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,001,315		909,024	33,208			1,943,547	1
2	CAP REL COSTS-MVBLE EQUIP	248,328	173,524		9,428			431,280	2
3	TOTAL (sum of lines 1-2)	1,249,643	173,524	909,024	42,636			2,374,827	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-34,889	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-1,098	PURCHASING RECEIVING AND STORES	5.03		4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-7,090	OTHER ADMINISTRATIVE AND GENERAL	5.06		8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-606,658				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-171	DIETARY	10		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-25,263	MEDICAL SUPPLIES CHARGED TO PATIENTS	71		16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-7,817	DRUGS CHARGED TO PATIENTS	73		17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-3,086	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-1,618	OTHER ADMINISTRATIVE AND GENERAL	5.06		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND	B	-105,229	CAP REL COSTS-MVBLE EQUIP	2	9	32
33	COMMUNITY PROGRAM	B	-8,016	OTHER ADMINISTRATIVE AND GENERAL	5.06		33
34							34
35	PORTION OF LOBBYING DUES	A	-5,630	OTHER ADMINISTRATIVE AND GENERAL	5.06		35
36	WOMENS WELLNESS	B	-72,148	OTHER ADMINISTRATIVE AND GENERAL	5.06		36
37	PHYSICIAN RECRUITMENT	A	-27,460	OTHER ADMINISTRATIVE AND GENERAL	5.06		37
38	ADVERTISING	A	-55,060	OTHER ADMINISTRATIVE AND GENERAL	5.06		38
39	SWAP INTEREST PAYMENTS	A	-173,442	CAP REL COSTS-BLDG & FIXT	1	11	39
40	ER PHYSICIAN SALARY	A	-22,979	EMERGENCY	91		40
41	VNA THERAPHY SERVICES	A	-4,005	PHYSICAL THERAPY	66		41
42	FUNDRAISING	A	-3,445	CAP REL COSTS-MVBLE EQUIP	2	9	42
43	ER PHYSICIAN BENEFITS	A	-4,757	EMPLOYEE BENEFITS DEPARTMENT	4		43
44	NURSING CENTER SERVICES	B	-1,488	OTHER ADMINISTRATIVE AND GENERAL	5.06		44
45	OTHER REVENUE RHC	B	-25,878	RURAL HEALTH CLINIC	88		45
45.06	FUNDRAISING	A	-13,526	OTHER ADMINISTRATIVE AND GENERAL	5.06		45.06
45.09	NON RHC COST SALARY	A	-61,560	RURAL HEALTH CLINIC	88		45.09
45.10	NON RHC COST SALARY	A	-4,104	RHC II	88.01		45.10
45.11	NON RHC BENEFITS	A	-8,109	EMPLOYEE BENEFITS DEPARTMENT	4		45.11
45.13	VNA SEVICES BENEFITS	A	-829	EMPLOYEE BENEFITS DEPARTMENT	4		45.13
46	WHITE OAKS SALARY	A	-63,690	NURSING ADMINISTRATION	13		46
47	WHITE OAKS BENEFITS	A	-13,184	EMPLOYEE BENEFITS DEPARTMENT	4		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-1,362,229				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	

Note: See instructions for column 5 referencing to Worksheet A-7.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12							5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
2	91	EMERGENCY AGGREGATE	1,045,962	606,658	439,304					2
200		TOTAL	1,045,962	606,658	439,304					200

Optimizer Systems, Inc. *WinLASH* Micro System

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
2	91	EMERGENCY AGGREGATE							606,658	2
200		TOTAL							606,658	200

Optimizer Systems, Inc. **WinLASH** Micro System

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)					244	3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		1,881.25	254.25			9
10	AHSEA (see instructions)		70.30	52.73			10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.15	35.15	26.37			11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)	132,252	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)	13,407	16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	145,659	17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	145,659	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)	145,659	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)	8,577	24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	8,577	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)	8,577	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)	8,577	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	145,659	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	8,577	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)	154,236	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	100,040	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)					240	3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		310.75				9
10	AHSEA (see instructions)		74.18				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.09	37.09				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)	23,051	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	23,051	17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	23,051	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	74.18	21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)	57,860	22
23	TOTAL SALARY EQUIVALENCY (see instructions)	57,860	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)	8,902	24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	8,902	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)	8,902	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)	8,902	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	57,860	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	8,902	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)	66,762	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	18,615	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)					240	3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		479.50				9
10	AHSEA (see instructions)		67.56				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	33.78	33.78				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)	32,395	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	32,395	17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	32,395	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	67.56	21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)	52,697	22
23	TOTAL SALARY EQUIVALENCY (see instructions)	52,697	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)	8,107	24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	8,107	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)	8,107	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)	8,107	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	52,697	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	8,107	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)	60,804	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	24,950	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,943,547	1,943,547					1
2	CAP REL COSTS-MVBLE EQUIP	431,280		431,280				2
4	EMPLOYEE BENEFITS DEPARTMENT	1,193,871			1,193,871			4
5.01	NONPATIENT TELEPHONES	24,209	967	215		25,391		5.01
5.02	DATA PROCESSING	128,721			23,983		152,704	5.02
5.03	PURCHASING RECEIVING AND STORES	44,698	54,861	12,174	8,842	289		5.03
5.04	ADMITTING	157,504			16,294			5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	376,915	38,427	8,527	32,636		123,880	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	777,389	238,273	52,874	91,716	4,328	28,824	5.06
7	OPERATION OF PLANT	723,276	172,077	38,184	31,191	577		7
8	LAUNDRY & LINEN SERVICE	46,097	23,105	5,127		144		8
9	HOUSEKEEPING	169,498			30,759			9
10	DIETARY	70,126						10
11	CAFETERIA							11
13	NURSING ADMINISTRATION	207,682	36,252	8,044	41,559	1,010		13
14	CENTRAL SERVICES & SUPPLY	18,964						14
15	PHARMACY	189,438	28,349	6,291	35,595	577		15
16	MEDICAL RECORDS & LIBRARY	208,360	30,138	6,688	35,483	1,010		16
17	SOCIAL SERVICE	46,514	4,640	1,030	9,336	433		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,160,344	329,724	73,166	223,710	4,617		30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	159,877	161,926	35,932	24,704	1,154		50
53	ANESTHESIOLOGY	287,917			54,977			53
54	RADIOLOGY-DIAGNOSTIC	488,286	114,847	25,485	58,154	1,443		54
58	MRI	71,690				144		58
60	LABORATORY	871,035	41,690	9,251	64,668	1,154		60
65	RESPIRATORY THERAPY	127,849	16,918	3,754	21,774	577		65
65.50	SLEEP LAB	29,250	9,063	2,011		433		65.50
66	PHYSICAL THERAPY	517,105	108,635	24,107	73,373	1,154		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	17,494						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,153						71
72	IMPL. DEV. CHARGED TO PATIENTS	79,695						72
73	DRUGS CHARGED TO PATIENTS	195,104						73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	929,138	180,801	40,120	164,561	2,597		88
88.01	RHC II	104,660	85,072	18,878	18,378	577		88.01
90	CLINIC	293,444	56,070	12,442	31,475	721		90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	1,017,633	111,125	24,659	100,703	1,875		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	13,156,763	1,842,960	408,959	1,193,871	24,814	152,704	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	80,901	100,587	22,321		577		192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	13,237,664	1,943,547	431,280	1,193,871	25,391	152,704	202

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING , RECEIVIN G AND STOR	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES	120,864						5.03
5.04	ADMITTING		173,798					5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE			580,385				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,418			1,194,822	1,194,822		5.06
7	OPERATION OF PLANT	3,909			969,214	96,160	1,065,374	7
8	LAUNDRY & LINEN SERVICE	238			74,711	7,412	17,106	8
9	HOUSEKEEPING	1,898			202,155	20,057		9
10	DIETARY	168			70,294	6,974		10
11	CAFETERIA							11
13	NURSING ADMINISTRATION	172			294,719	29,240	26,841	13
14	CENTRAL SERVICES & SUPPLY	4,484			23,448	2,326		14
15	PHARMACY	17,084			277,334	27,515	20,989	15
16	MEDICAL RECORDS & LIBRARY	899			282,578	28,036	22,313	16
17	SOCIAL SERVICE	122			62,075	6,159	3,436	17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	8,146	50,134	43,551	1,893,392	187,855	244,124	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	15,224	3,451	21,991	424,259	42,092	119,888	50
53	ANESTHESIOLOGY	2,611	866	6,303	352,674	34,990		53
54	RADIOLOGY-DIAGNOSTIC	2,125	13,491	109,018	812,849	80,646	85,031	54
58	MRI		2,059	11,193	85,086	8,442		58
60	LABORATORY	49,491	31,013	136,962	1,205,264	119,579	30,867	60
65	RESPIRATORY THERAPY	1,261	16,733	17,615	206,481	20,486	12,526	65
65.50	SLEEP LAB			5,546	46,303	4,594	6,710	65.50
66	PHYSICAL THERAPY	1,145	12,611	33,071	771,201	76,514	80,432	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	131	1,763	11,009	30,397	3,016		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		772	539	49,464	4,908		71
72	IMPL. DEV. CHARGED TO PATIENTS			3,157	82,852	8,220		72
73	DRUGS CHARGED TO PATIENTS		38,886	48,757	282,747	28,052		73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,024	2,019	12,744	1,333,004	132,253	133,863	88
88.01	RHC II			703	228,268	22,647	62,986	88.01
90	CLINIC	1,402		23,235	418,789	41,550	41,513	90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	7,859		94,991	1,358,845	134,816	82,275	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	120,811	173,798	580,385	13,033,225	1,174,539	990,900	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	53			204,439	20,283	74,474	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	120,864	173,798	580,385	13,237,664	1,194,822	1,065,374	202

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		8	9	10	13	14	15	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	99,229						8
9	HOUSEKEEPING		222,212					9
10	DIETARY			77,268				10
11	CAFETERIA							11
13	NURSING ADMINISTRATION		1,098		351,898			13
14	CENTRAL SERVICES & SUPPLY					25,774		14
15	PHARMACY						325,838	15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	52,777	90,711	77,268	251,751			30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,742	24,708		17,657			50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	3,914	10,981					54
58	MRI	385						58
60	LABORATORY		8,236					60
65	RESPIRATORY THERAPY							65
65.50	SLEEP LAB							65.50
66	PHYSICAL THERAPY	12,601	12,354					66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					12,358		71
72	IMPL. DEV. CHARGED TO PATIENTS					13,416		72
73	DRUGS CHARGED TO PATIENTS						325,838	73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	907	32,944					88
88.01	RHC II							88.01
90	CLINIC		5,491					90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	25,903	35,689		82,490			91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	99,229	222,212	77,268	351,898	25,774	325,838	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	99,229	222,212	77,268	351,898	25,774	325,838	202

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	332,927						16
17	SOCIAL SERVICE		71,670					17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	141,067	11,316	2,950,261		2,950,261		30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			631,346		631,346		50
53	ANESTHESIOLOGY			387,664		387,664		53
54	RADIOLOGY-DIAGNOSTIC			993,421		993,421		54
58	MRI			93,913		93,913		58
60	LABORATORY	89,364		1,453,310		1,453,310		60
65	RESPIRATORY THERAPY			239,493		239,493		65
65.50	SLEEP LAB			57,607		57,607		65.50
66	PHYSICAL THERAPY		5,103	958,205		958,205		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			33,413		33,413		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			66,730		66,730		71
72	IMPL. DEV. CHARGED TO PATIENTS			104,488		104,488		72
73	DRUGS CHARGED TO PATIENTS			636,637		636,637		73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		17,751	1,650,722		1,650,722		88
88.01	RHC II			313,901		313,901		88.01
90	CLINIC			507,343		507,343		90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	102,496	37,500	1,860,014		1,860,014		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	332,927	71,670	12,938,468		12,938,468		118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES			299,196		299,196		192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	332,927	71,670	13,237,664		13,237,664		202

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	NONPATIENT TELEPHONES	PURCHASING, RECEIVING AND STOR	
		0	1	2	2A	5.01	5.03	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES		967	215	1,182	1,182		5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES		54,861	12,174	67,035	13	67,048	5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		38,427	8,527	46,954			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		238,273	52,874	291,147	201	786	5.06
7	OPERATION OF PLANT		172,077	38,184	210,261	27	2,169	7
8	LAUNDRY & LINEN SERVICE		23,105	5,127	28,232	7	132	8
9	HOUSEKEEPING						1,053	9
10	DIETARY						93	10
11	CAFETERIA							11
13	NURSING ADMINISTRATION		36,252	8,044	44,296	47	95	13
14	CENTRAL SERVICES & SUPPLY						2,487	14
15	PHARMACY		28,349	6,291	34,640	27	9,477	15
16	MEDICAL RECORDS & LIBRARY		30,138	6,688	36,826	47	499	16
17	SOCIAL SERVICE		4,640	1,030	5,670	20	67	17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		329,724	73,166	402,890	214	4,519	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		161,926	35,932	197,858	54	8,445	50
53	ANESTHESIOLOGY						1,448	53
54	RADIOLOGY-DIAGNOSTIC		114,847	25,485	140,332	67	1,179	54
58	MRI					7		58
60	LABORATORY		41,690	9,251	50,941	54	27,456	60
65	RESPIRATORY THERAPY		16,918	3,754	20,672	27	699	65
65.50	SLEEP LAB		9,063	2,011	11,074	20		65.50
66	PHYSICAL THERAPY		108,635	24,107	132,742	54	635	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY						73	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		180,801	40,120	220,921	121	568	88
88.01	RHC II		85,072	18,878	103,950	27		88.01
90	CLINIC		56,070	12,442	68,512	34	778	90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY		111,125	24,659	135,784	87	4,360	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)		1,842,960	408,959	2,251,919	1,155	67,018	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		100,587	22,321	122,908	27	30	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		1,943,547	431,280	2,374,827	1,182	67,048	202

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CASHIERING /ACCOUNTS RECEIVABLE	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.05	5.06	7	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	46,954						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		292,134					5.06
7	OPERATION OF PLANT		23,511	235,968				7
8	LAUNDRY & LINEN SERVICE		1,812	3,789	33,972			8
9	HOUSEKEEPING		4,904			5,957		9
10	DIETARY		1,705				1,798	10
11	CAFETERIA							11
13	NURSING ADMINISTRATION		7,149	5,945		29		13
14	CENTRAL SERVICES & SUPPLY		569					14
15	PHARMACY		6,728	4,649				15
16	MEDICAL RECORDS & LIBRARY		6,855	4,942				16
17	SOCIAL SERVICE		1,506	761				17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,524	45,929	54,070	18,069	2,433	1,798	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,779	10,292	26,554	939	662		50
53	ANESTHESIOLOGY	510	8,555					53
54	RADIOLOGY-DIAGNOSTIC	8,821	19,718	18,833	1,340	294		54
58	MRI	906	2,064		132			58
60	LABORATORY	11,075	29,237	6,837		221		60
65	RESPIRATORY THERAPY	1,425	5,009	2,774				65
65.50	SLEEP LAB	449	1,123	1,486				65.50
66	PHYSICAL THERAPY	2,676	18,708	17,815	4,314	331		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	891	737					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	44	1,200					71
72	IMPL. DEV. CHARGED TO PATIENTS	255	2,010					72
73	DRUGS CHARGED TO PATIENTS	3,945	6,859					73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,031	32,336	29,649	310	883		88
88.01	RHC II	57	5,537	13,951				88.01
90	CLINIC	1,880	10,159	9,195		147		90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	7,686	32,963	18,223	8,868	957		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	46,954	287,175	219,473	33,972	5,957	1,798	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		4,959	16,495				192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	46,954	292,134	235,968	33,972	5,957	1,798	202

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		13	14	15	16	17	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION	57,561						13
14	CENTRAL SERVICES & SUPPLY		3,056					14
15	PHARMACY			55,521				15
16	MEDICAL RECORDS & LIBRARY				49,169			16
17	SOCIAL SERVICE					8,024		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	41,180			20,834	1,267	596,727	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,888					249,471	50
53	ANESTHESIOLOGY						10,513	53
54	RADIOLOGY-DIAGNOSTIC						190,584	54
58	MRI						3,109	58
60	LABORATORY				13,198		139,019	60
65	RESPIRATORY THERAPY						30,606	65
65.50	SLEEP LAB						14,152	65.50
66	PHYSICAL THERAPY					571	177,846	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY						1,701	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,465				2,709	71
72	IMPL. DEV. CHARGED TO PATIENTS		1,591				3,856	72
73	DRUGS CHARGED TO PATIENTS			55,521			66,325	73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC					1,987	287,806	88
88.01	RHC II						123,522	88.01
90	CLINIC						90,705	90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	13,493			15,137	4,199	241,757	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	57,561	3,056	55,521	49,169	8,024	2,230,408	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES						144,419	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	57,561	3,056	55,521	49,169	8,024	2,374,827	202

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		596,727					30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		249,471					50
53	ANESTHESIOLOGY		10,513					53
54	RADIOLOGY-DIAGNOSTIC		190,584					54
58	MRI		3,109					58
60	LABORATORY		139,019					60
65	RESPIRATORY THERAPY		30,606					65
65.50	SLEEP LAB		14,152					65.50
66	PHYSICAL THERAPY		177,846					66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		1,701					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,709					71
72	IMPL. DEV. CHARGED TO PATIENTS		3,856					72
73	DRUGS CHARGED TO PATIENTS		66,325					73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		287,806					88
88.01	RHC II		123,522					88.01
90	CLINIC		90,705					90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY		241,757					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)		2,230,408					118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		144,419					192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		2,374,827					202

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NONPATIENT TELEPHONES #OF PHONES	DATA PROCESSING MACHINE TIME	PURCHASING, RECEIVING AND STORAGE COSTS SUPPLIES	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	80,418						1
2	CAP REL COSTS-MVBLE EQUIP		80,418					2
4	EMPLOYEE BENEFITS DEPARTMENT			5,746,102				4
5.01	NONPATIENT TELEPHONES	40	40		176			5.01
5.02	DATA PROCESSING			115,428		249		5.02
5.03	PURCHASING RECEIVING AND STORES	2,270	2,270	42,555	2		1,180,708	5.03
5.04	ADMITTING			78,421				5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,590	1,590	157,076		202		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,859	9,859	441,428	30	47	13,850	5.06
7	OPERATION OF PLANT	7,120	7,120	150,123	4		38,189	7
8	LAUNDRY & LINEN SERVICE	956	956		1		2,322	8
9	HOUSEKEEPING			148,042			18,542	9
10	DIETARY						1,638	10
11	CAFETERIA							11
13	NURSING ADMINISTRATION	1,500	1,500	200,025	7		1,681	13
14	CENTRAL SERVICES & SUPPLY						43,802	14
15	PHARMACY	1,173	1,173	171,319	4		166,892	15
16	MEDICAL RECORDS & LIBRARY	1,247	1,247	170,777	7		8,783	16
17	SOCIAL SERVICE	192	192	44,933	3		1,187	17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	13,643	13,643	1,076,721	32		79,577	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	6,700	6,700	118,899	8		148,721	50
53	ANESTHESIOLOGY			264,605			25,508	53
54	RADIOLOGY-DIAGNOSTIC	4,752	4,752	279,896	10		20,760	54
58	MRI				1			58
60	LABORATORY	1,725	1,725	311,247	8		483,477	60
65	RESPIRATORY THERAPY	700	700	104,800	4		12,317	65
65.50	SLEEP LAB	375	375		3			65.50
66	PHYSICAL THERAPY	4,495	4,495	353,145	8		11,184	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY						1,281	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	7,481	7,481	792,032	18		10,008	88
88.01	RHC II	3,520	3,520	88,455	4			88.01
90	CLINIC	2,320	2,320	151,491	5		13,694	90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	4,598	4,598	484,684	13		76,775	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	76,256	76,256	5,746,102	172	249	1,180,188	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	4,162	4,162		4		520	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,943,547	431,280	1,193,871	25,391	152,704	120,864	202
203	UNIT COST MULT-WS B PT I	24.168059	5.362978	0.207771	144.267045	613.269076	0.102366	203
204	COST TO BE ALLOC PER B PT II				1,182		67,048	204
205	UNIT COST MULT-WS B PT II				6.715909		0.056786	205

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	ADMITTING INPATIENT CHARGES	CASHIERING /ACCOUNTS RECEIVABLE GROSS CHARGES	RECON-CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		5.04	5.05	5A.06	5.06	7	8	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING	4,620,043						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		22,929,507					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-1,194,822	12,042,842			5.06
7	OPERATION OF PLANT				969,214	59,539		7
8	LAUNDRY & LINEN SERVICE				74,711	956	18,277	8
9	HOUSEKEEPING				202,155			9
10	DIETARY				70,294			10
11	CAFETERIA							11
13	NURSING ADMINISTRATION				294,719	1,500		13
14	CENTRAL SERVICES & SUPPLY				23,448			14
15	PHARMACY				277,334	1,173		15
16	MEDICAL RECORDS & LIBRARY				282,578	1,247		16
17	SOCIAL SERVICE				62,075	192		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,332,651	1,720,581		1,893,392	13,643	9,721	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	91,747	868,809		424,259	6,700	505	50
53	ANESTHESIOLOGY	23,021	249,031		352,674			53
54	RADIOLOGY-DIAGNOSTIC	358,643	4,306,983		812,849	4,752	721	54
58	MRI	54,737	442,195		85,086		71	58
60	LABORATORY	824,411	5,411,164		1,205,264	1,725		60
65	RESPIRATORY THERAPY	444,811	695,929		206,481	700		65
65.50	SLEEP LAB		219,088		46,303	375		65.50
66	PHYSICAL THERAPY	335,250	1,306,541		771,201	4,495	2,321	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	46,855	434,935		30,397			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,524	21,308		49,464			71
72	IMPL. DEV. CHARGED TO PATIENTS		124,727		82,852			72
73	DRUGS CHARGED TO PATIENTS	1,033,709	1,926,223		282,747			73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	53,684	503,487		1,333,004	7,481	167	88
88.01	RHC II		27,754		228,268	3,520		88.01
90	CLINIC		917,929		418,789	2,320		90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY		3,752,823		1,358,845	4,598	4,771	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	4,620,043	22,929,507	-1,194,822	11,838,403	55,377	18,277	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES				204,439	4,162		192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	173,798	580,385		1,194,822	1,065,374	99,229	202
203	UNIT COST MULT-WS B PT I	0.037618	0.025312		0.099214	17.893717	5.429173	203
204	COST TO BE ALLOC PER B PT II		46,954		292,134	235,968	33,972	204
205	UNIT COST MULT-WS B PT II		0.002048		0.024258	3.963251	1.858730	205

Optimizer Systems, Inc. **WinLASH** Micro System

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	NURSING ADMINIS-TRATION HOURS OF SERVICE	CENTRAL SERVICES & SUPPLY COSTED REQUISITIO	PHARMACY COSTED REQUISITIO	MEDICAL RECORDS & LIBRARY TIME SPENT	
		9	10	13	14	15	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	9,713						9
10	DIETARY		10,833					10
11	CAFETERIA							11
13	NURSING ADMINISTRATION	48		84,862				13
14	CENTRAL SERVICES & SUPPLY				153,111			14
15	PHARMACY					202,921		15
16	MEDICAL RECORDS & LIBRARY						45,686	16
17	SOCIAL SERVICE							17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,965	10,833	60,711			19,358	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,080		4,258				50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	480						54
58	MRI							58
60	LABORATORY	360					12,263	60
65	RESPIRATORY THERAPY							65
65.50	SLEEP LAB							65.50
66	PHYSICAL THERAPY	540						66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				73,416			71
72	IMPL. DEV. CHARGED TO PATIENTS				79,695			72
73	DRUGS CHARGED TO PATIENTS					202,921		73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,440						88
88.01	RHC II							88.01
90	CLINIC	240						90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	1,560		19,893			14,065	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	9,713	10,833	84,862	153,111	202,921	45,686	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	222,212	77,268	351,898	25,774	325,838	332,927	202
203	UNIT COST MULT-WS B PT I	22.877793	7.132650	4.146709	0.168335	1.605738	7.287287	203
204	COST TO BE ALLOC PER B PT II	5,957	1,798	57,561	3,056	55,521	49,169	204
205	UNIT COST MULT-WS B PT II	0.613302	0.165974	0.678289	0.019959	0.273609	1.076238	205

Optimizer Systems, Inc. **WinLASH** Micro System

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME SPENT						
		17						
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE	9,690						17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,530						30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
58	MRI							58
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
65.50	SLEEP LAB							65.50
66	PHYSICAL THERAPY	690						66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	2,400						88
88.01	RHC II							88.01
90	CLINIC							90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	5,070						91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	9,690						118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	71,670						202
203	UNIT COST MULT-WS B PT I	7.396285						203
204	COST TO BE ALLOC PER B PT II	8,024						204
205	UNIT COST MULT-WS B PT II	0.828070						205

Optimizer Systems, Inc. *WinLASH* Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,950,261		2,950,261		2,950,261	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	631,346		631,346		631,346	50
53	ANESTHESIOLOGY	387,664		387,664		387,664	53
54	RADIOLOGY-DIAGNOSTIC	993,421		993,421		993,421	54
58	MRI	93,913		93,913		93,913	58
60	LABORATORY	1,453,310		1,453,310		1,453,310	60
65	RESPIRATORY THERAPY	239,493		239,493		239,493	65
65.50	SLEEP LAB	57,607		57,607		57,607	65.50
66	PHYSICAL THERAPY	958,205		958,205		958,205	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	33,413		33,413		33,413	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,730		66,730		66,730	71
72	IMPL. DEV. CHARGED TO PATIENTS	104,488		104,488		104,488	72
73	DRUGS CHARGED TO PATIENTS	636,637		636,637		636,637	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	1,650,722		1,650,722		1,650,722	88
88.01	RHC II	313,901		313,901		313,901	88.01
90	CLINIC	507,343		507,343		507,343	90
90.01	NORRIS CITY CLINIC						90.01
91	EMERGENCY	1,860,014		1,860,014		1,860,014	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	363,140		363,140		363,140	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
117	OTHER SPECIAL PURPOSE COST CENTERS						117
117.02	SUPPLIES AND EXPENSE						117.02
200	SUBTOTAL (SEE INSTRUCTIONS)	13,301,608		13,301,608		13,301,608	200
201	LESS OBSERVATION BEDS	363,140		363,140		363,140	201
202	TOTAL (SEE INSTRUCTIONS)	12,938,468		12,938,468		12,938,468	202

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,360,226		1,360,226				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	35,435	476,303	511,738	1.233729	1.233729	1.233729	50
53	ANESTHESIOLOGY	22,343	223,190	245,533	1.578867	1.578867	1.578867	53
54	RADIOLOGY-DIAGNOSTIC	347,811	3,871,855	4,219,666	0.235426	0.235426	0.235426	54
58	MRI	54,737	387,458	442,195	0.212379	0.212379	0.212379	58
60	LABORATORY	824,411	4,586,753	5,411,164	0.268576	0.268576	0.268576	60
65	RESPIRATORY THERAPY	107,618	185,978	293,596	0.815723	0.815723	0.815723	65
65.50	SLEEP LAB		219,088	219,088	0.262940	0.262940	0.262940	65.50
66	PHYSICAL THERAPY	335,250	971,291	1,306,541	0.733391	0.733391	0.733391	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	64,355	370,580	434,935	0.076823	0.076823	0.076823	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	432,039	431,850	863,889	0.077244	0.077244	0.077244	71
72	IMPL. DEV. CHARGED TO PATIENTS		137,927	137,927	0.757560	0.757560	0.757560	72
73	DRUGS CHARGED TO PATIENTS	1,033,709	892,514	1,926,223	0.330511	0.330511	0.330511	73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	53,684	449,803	503,487				88
88.01	RHC II		27,754	27,754				88.01
90	CLINIC		917,929	917,929	0.552704	0.552704	0.552704	90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	1,225	2,225,595	2,226,820	0.835278	0.835278	0.835278	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	8,265	352,090	360,355	1.007728	1.007728	1.007728	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
200	SUBTOTAL (SEE INSTRUCTIONS)	4,681,108	16,727,958	21,409,066				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	4,681,108	16,727,958	21,409,066				202

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1326** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1.233729		249,690			308,050		50
53	ANESTHESIOLOGY	1.578867		114,944			181,481		53
54	RADIOLOGY-DIAGNOSTIC	0.235426		1,423,601			335,153		54
58	MRI	0.212379		115,708			24,574		58
60	LABORATORY	0.268576		2,084,637			559,883		60
65	RESPIRATORY THERAPY	0.815723		47,476			38,727		65
65.50	SLEEP LAB	0.262940		70,171			18,451		65.50
66	PHYSICAL THERAPY	0.733391		368,360			270,152		66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.076823		225,345			17,312		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.077244		94,788			7,322		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.757560		122,019			92,437		72
73	DRUGS CHARGED TO PATIENTS	0.330511		320,533			105,940		73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
90	CLINIC	0.552704		905,095			500,250		90
90.01	NORRIS CITY CLINIC								90.01
91	EMERGENCY	0.835278		855,701			714,748		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.007728		174,843			176,194		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)			7,172,911			3,350,674		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			7,172,911			3,350,674		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z326** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [ ] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [XX] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1.233729							50
53	ANESTHESIOLOGY	1.578867							53
54	RADIOLOGY-DIAGNOSTIC	0.235426							54
58	MRI	0.212379							58
60	LABORATORY	0.268576							60
65	RESPIRATORY THERAPY	0.815723							65
65.50	SLEEP LAB	0.262940							65.50
66	PHYSICAL THERAPY	0.733391							66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.076823							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.077244							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.757560							72
73	DRUGS CHARGED TO PATIENTS	0.330511							73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
90	CLINIC	0.552704							90
90.01	NORRIS CITY CLINIC								90.01
91	EMERGENCY	0.835278							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.007728							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES:
[ ] TITLE V [XX] PPS
[ ] TITLE XVIII, PART A [ ] TEFRA
[XX] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	596,727	184,707	412,020	2,227	185.01	155	28,677	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	596,727		412,020	2,227		155	28,677	200

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1326** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	249,471	511,738	0.487498	6,788	3,309	50
53	ANESTHESIOLOGY	10,513	245,533	0.042817	3,450	148	53
54	RADIOLOGY-DIAGNOSTIC	190,584	4,219,666	0.045166	27,785	1,255	54
58	MRI	3,109	442,195	0.007031			58
60	LABORATORY	139,019	5,411,164	0.025691	51,060	1,312	60
65	RESPIRATORY THERAPY	30,606	293,596	0.104245	7,065	736	65
65.50	SLEEP LAB	14,152	219,088	0.064595			65.50
66	PHYSICAL THERAPY	177,846	1,306,541	0.136120	610	83	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	1,701	434,935	0.003911	7,338	29	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,709	863,889	0.003136	18,719	59	71
72	IMPL. DEV. CHARGED TO PATIENTS	3,856	137,927	0.027957			72
73	DRUGS CHARGED TO PATIENTS	66,325	1,926,223	0.034433	104,013	3,581	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	287,806	503,487	0.571625			88
88.01	RHC II	123,522	27,754	4.450602			88.01
90	CLINIC	90,705	917,929	0.098815			90
90.01	NORRIS CITY CLINIC						90.01
91	EMERGENCY	241,757	2,226,820	0.108566	64	7	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	106,377	360,355	0.295201			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	1,740,058	20,048,840		226,892	10,519	200

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [ ] TITLE XVIII, PART A [ ] TEFRA [XX] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

Optimizer Systems, Inc. WinLASH Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [ ] TITLE XVIII, PART A [ ] TEFRA [XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	2,227		155		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	2,227		155		200

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-1326** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
58	MRI							58
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
65.50	SLEEP LAB							65.50
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
90	CLINIC							90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

Optimizer Systems, Inc. *WinLASH* Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1326** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	511,738			6,788				50
53	ANESTHESIOLOGY	245,533			3,450				53
54	RADIOLOGY-DIAGNOSTIC	4,219,666			27,785				54
58	MRI	442,195							58
60	LABORATORY	5,411,164			51,060				60
65	RESPIRATORY THERAPY	293,596			7,065				65
65.50	SLEEP LAB	219,088							65.50
66	PHYSICAL THERAPY	1,306,541			610				66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	434,935			7,338				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	863,889			18,719				71
72	IMPL. DEV. CHARGED TO PATIENTS	137,927							72
73	DRUGS CHARGED TO PATIENTS	1,926,223			104,013				73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC	503,487							88
88.01	RHC II	27,754							88.01
90	CLINIC	917,929							90
90.01	NORRIS CITY CLINIC								90.01
91	EMERGENCY	2,226,820			64				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	360,355							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	20,048,840			226,892				200

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1326** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1.233729		31,372			38,705		50
53	ANESTHESIOLOGY	1.578867		30,064			47,467		53
54	RADIOLOGY-DIAGNOSTIC	0.235426		1,196,135			281,601		54
58	MRI	0.212379		79,910			16,971		58
60	LABORATORY	0.268576		1,155,569			310,358		60
65	RESPIRATORY THERAPY	0.815723		31,618			25,792		65
65.50	SLEEP LAB	0.262940							65.50
66	PHYSICAL THERAPY	0.733391		272,966			200,191		66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.076823		92,405			7,099		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.077244		87,931			6,792		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.757560		15,838			11,998		72
73	DRUGS CHARGED TO PATIENTS	0.330511		335,660			110,939		73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
90	CLINIC	0.552704							90
90.01	NORRIS CITY CLINIC								90.01
91	EMERGENCY	0.835278		942,532			787,276		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.007728		109,199			110,043		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)			4,381,199			1,955,232		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			4,381,199			1,955,232		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1326** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	3,348	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,227	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	1,830	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	489	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	488	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	72	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	72	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,433	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)	489	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	488	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	137.13	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	134.13	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,950,261	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)	9,873	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	9,657	25
26	TOTAL SWING-BED COST (see instructions)	913,202	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,037,059	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,037,059	37

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1326** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] TEFRA [XX] OTHER [ ] PPS

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					914.71	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					1,310,779	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					1,310,779	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					553,112	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					1,863,891	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					447,293	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					446,378	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)					893,671	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1326** **WORKSHEET D-1**
PARTS III & IV

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [ ] PPS [ ] TEFRA [XX] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					397	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					914.71	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					363,140	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	596,727	2,037,059	0.292936	363,140	106,377	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1326** **WORKSHEET D-1 PART I**

CHECK	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**
APPLICABLE	**[ ] TITLE XVIII, PART A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
BOXES:	**[XX] TITLE XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] OTHER**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	3,348	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,227	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	1,830	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	489	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	488	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	72	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	72	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	155	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	137.13	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	134.13	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,950,261	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)	9,873	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	9,657	25
26	TOTAL SWING-BED COST (see instructions)	913,202	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,037,059	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,037,059	37

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1326** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					914.71	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					141,780	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					141,780	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					76,726	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					218,506	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	28,677	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	10,519	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	39,196	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	179,310	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

Optimizer Systems, Inc. WinLASH Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1326** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P
[XX] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF [ ] NF
[ ] ICF/MR
[XX] PPS [ ] TEFRA [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					397	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1326** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		842,096		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	1.233729	10,359	12,780	50
53	ANESTHESIOLOGY	1.578867	9,764	15,416	53
54	RADIOLOGY-DIAGNOSTIC	0.235426	229,328	53,990	54
58	MRI	0.212379	40,279	8,554	58
60	LABORATORY	0.268576	515,848	138,544	60
65	RESPIRATORY THERAPY	0.815723	72,210	58,903	65
65.50	SLEEP LAB	0.262940			65.50
66	PHYSICAL THERAPY	0.733391	81,251	59,589	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.076823	51,943	3,990	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.077244	168,047	12,981	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.757560			72
73	DRUGS CHARGED TO PATIENTS	0.330511	560,606	185,286	73
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
90	CLINIC	0.552704			90
90.01	NORRIS CITY CLINIC				90.01
91	EMERGENCY	0.835278	1,161	970	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.007728	2,093	2,109	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,742,889	553,112	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,742,889		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z326** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [XX] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	1.233729	6,310	7,785	50
53	ANESTHESIOLOGY	1.578867	3,473	5,483	53
54	RADIOLOGY-DIAGNOSTIC	0.235426	31,165	7,337	54
58	MRI	0.212379	10,324	2,193	58
60	LABORATORY	0.268576	116,062	31,171	60
65	RESPIRATORY THERAPY	0.815723	28,339	23,117	65
65.50	SLEEP LAB	0.262940			65.50
66	PHYSICAL THERAPY	0.733391	221,977	162,796	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.076823	4,837	372	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.077244	99,889	7,716	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.757560			72
73	DRUGS CHARGED TO PATIENTS	0.330511	265,224	87,659	73
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
90	CLINIC	0.552704			90
90.01	NORRIS CITY CLINIC				90.01
91	EMERGENCY	0.835278			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.007728			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		787,600	335,629	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		787,600		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1326** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF [XX] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] SWING BED NF [ ] TEFRA
[XX] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		84,475		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	1.233729	6,788	8,375	50
53	ANESTHESIOLOGY	1.578867	3,450	5,447	53
54	RADIOLOGY-DIAGNOSTIC	0.235426	27,785	6,541	54
58	MRI	0.212379			58
60	LABORATORY	0.268576	51,060	13,713	60
65	RESPIRATORY THERAPY	0.815723	7,065	5,763	65
65.50	SLEEP LAB	0.262940			65.50
66	PHYSICAL THERAPY	0.733391	610	447	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.076823	7,338	564	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.077244	18,719	1,446	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.757560			72
73	DRUGS CHARGED TO PATIENTS	0.330511	104,013	34,377	73
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
90	CLINIC	0.552704			90
90.01	NORRIS CITY CLINIC				90.01
91	EMERGENCY	0.835278	64	53	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.007728			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		226,892	76,726	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		226,892		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1326** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	3,350,674			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	3,350,674			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)				17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	3,384,181			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	29,423			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	1,018,007			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	2,336,751			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	2,336,751			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	2,336,751			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	395,778			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	348,285			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	395,778			36
37	SUBTOTAL (see instructions)	2,685,036			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	2,685,036			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	53,701			40.01
41	INTERIM PAYMENTS	2,169,408			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	461,927			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	38,497			44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1326** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,373,946		2,227,321	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	12/30/2013	30,146			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02	06/20/2014	55,900			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51			12/30/2013	12,584	3.51
		PROVIDER	.52			06/20/2014	45,329	3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		86,046		-57,913	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,459,992		2,169,408	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		100,089		515,628	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,560,081		2,685,036	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z326** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [XX] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,114,832			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	12/30/2013	23,246			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02	06/20/2014	54,291			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		77,537			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,192,369			4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		17,108			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,209,477			7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	653	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,433	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,830	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	21,409,066	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	236,837	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	118,450	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	117,467	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	2,349	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	115,118	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	118,450	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-3,332	32

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z326** **WORKSHEET E-2**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX** **[XX] SWING BED - SNF** **[ ] SWING BED - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	902,608		1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (see instructions)			2
3	ANCILLARY SERVICES (from Wkst D-3, col. 3, line 200 for Part A, and sum of Wkst D, Part V, cols. 5 and 7, line 202 for Part B) (for CAH, see instructions)	338,985		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5	PROGRAM DAYS	977		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (sum of lines 1-3 plus lines 6 and 7)	1,241,593		8
9	PRIMARY PAYER PAYMENTS (see instructions)			9
10	SUBTOTAL (line 8 minus line 9)	1,241,593		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12	SUBTOTAL (line 10 minus line 11)	1,241,593		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	32,116		13
14	80% OF PART B COSTS (line 12 x 80%)			14
15	SUBTOTAL (enter the lesser of line 12 minus line 13, or line 14)	1,209,477		15
16	OTHER ADJUSTMENTS (SEQUESTRATION)			16
17	ALLOWABLE BAD DEBTS (see instructions)			17
17.01	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)			17.01
18	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			18
19	TOTAL (see instructions)	1,209,477		19
19.01	SEQUESTRATION ADJUSTMENT (see instructions)	24,190		19.01
20	INTERIM PAYMENTS	1,192,369		20
21	TENTATIVE SETTLEMENT (for contractor use only)			21
22	BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	-7,082		22
23	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	16,874		23

Optimizer Systems, Inc. WinLASH Micro System

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CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3 PART V**

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT

1	INPATIENT SERVICES	1,863,891	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (sum of lines 1-3)	1,863,891	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)	1,882,530	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (not to exceed 1.000000)	0.000000	13
14	TOTAL CUSTOMARY CHARGES (see instructions)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 14 exceeds line 6) (see instructions)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 6 exceeds line 14) (see instructions)		16
17	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)		18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)	1,882,530	19
20	DEDUCTIBLES (exclude professional component)	384,123	20
21	EXCESS REASONABLE COST (from line 16)		21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)	1,498,407	22
23	COINSURANCE	32	23
24	SUBTOTAL (line 22 minus line 23)	1,498,375	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	70,121	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	61,706	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	70,121	27
28	SUBTOTAL (sum of lines 24 and 26)	1,560,081	28
29	OTHER ADJUSTMENTS (SEQUESTRATION)		29
30	SUBTOTAL (line 28 plus or minus line 29)	1,560,081	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)	31,202	30.01
31	INTERIM PAYMENTS	1,459,992	31
32	TENTATIVE SETTLEMENT (for contractor use only)		32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)	68,887	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	24,253	34

Optimizer Systems, Inc. **WinLASH** Micro System

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1326** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XIX | [XX] HOSPITAL [ ] SUB (OTHER) [ ] SNF | [ ] NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES		1,955,232	2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)		1,955,232	4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)		1,955,232	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	226,892	4,381,199	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)			15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)		1,955,232	21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21		1,955,232	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)		1,955,232	31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)		1,955,232	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)		1,955,232	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)		1,955,232	40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)		1,955,232	42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

Optimizer Systems, Inc. **WinLASH** Micro System

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BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,478,763				1
2	TEMPORARY INVESTMENTS	3,512,944				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3,129,816				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-838,000				6
7	INVENTORY	333,128				7
8	PREPAID EXPENSES	193,166				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	8,809,817				11
	FIXED ASSETS					
12	LAND	69,760				12
13	LAND IMPROVEMENTS	601,496				13
14	ACCUMULATED DEPRECIATION	-309,922				14
15	BUILDINGS	21,567,438				15
16	ACCUMULATED DEPRECIATION	-7,394,448				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	5,781,794				23
24	ACCUMULATED DEPRECIATION	-4,644,993				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS	528,907				27
28	ACCUMULATED DEPRECIATION	-446,223				28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	15,753,809				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	687,642		100,101		34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	687,642		100,101		35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	25,251,268		100,101		36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	252,113				37
38	SALARIES, WAGES & FEES PAYABLE	509,900				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	455,000				40
41	DEFERRED INCOME	298,094				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	47,446				43
44	OTHER CURRENT LIABILITIES	92,513				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	1,655,066				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE	20,045,000				46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	20,045,000				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	21,700,066				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	3,551,202				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED			100,101		54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	3,551,202		100,101		59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	25,251,268		100,101		60

Optimizer Systems, Inc. **WinLASH** Micro System

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STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		3,585,641			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-34,439			2
3	TOTAL (sun of line 1 and line 2)		3,551,202			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		3,551,202			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		3,551,202			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD		100,050			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sun of line 1 and line 2)		100,050			3
4	ADDITIONS (credit adjustments)	51				4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		51			10
11	SUBTOTAL (line 3 plus line 10)		100,101			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		100,101			19

Optimizer Systems, Inc. **WinLASH** Micro System

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	1,117,903		1,117,903	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	206,483		206,483	5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	1,324,386		1,324,386	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	1,324,386		1,324,386	17
18	ANCILLARY SERVICES	2,458,501	13,161,155	15,619,656	18
19	OUTPATIENT SERVICES		5,507,907	5,507,907	19
20	RHC		449,803	449,803	20
20.01	RHC II		27,754	27,754	20.01
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	3,782,887	19,146,619	22,929,506	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		14,599,893	29
30	BAD DEBTS	1,566,302		30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		1,566,302	36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		16,166,195	43

Optimizer Systems, Inc. *WinLASH* Micro System

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STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	22,929,506	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	8,783,838	2
3	NET PATIENT REVENUES (line 1 minus line 2)	14,145,668	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	16,166,195	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-2,020,527	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	354,035	6
7	INCOME FROM INVESTMENTS	41,262	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE	7,090	9
10	PURCHASE DISCOUNTS	1,098	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	171	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	25,263	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	7,817	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	3,086	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	1,618	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS	517,496	23
24	OTHER (OTHER)	629,066	24
24.01	OTHER (GAIN ON SWAP)	398,086	24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	1,986,088	25
26	TOTAL (line 5 plus line 25)	-34,439	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-34,439	29

Optimizer Systems, Inc. **WinLASH** Micro System

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CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-1326** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
58	MRI							58
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
65.50	SLEEP LAB							65.50
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
90	CLINIC							90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202

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ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-3477

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	632,533		632,533		632,533	-61,560	570,973	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	59,882		59,882		59,882		59,882	3
4	VISITING NURSE								4
5	OTHER NURSE	65,046		65,046		65,046		65,046	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS								9
10	SUBTOTAL (sum of lines 1-9)	757,461		757,461		757,461	-61,560	695,901	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		24,334	24,334		24,334		24,334	15
16	TRANSPORTATION (Health Care Staff)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSIONAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (sum of lines 15-20)		24,334	24,334		24,334		24,334	21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	757,461	24,334	781,795		781,795	-61,560	720,235	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS	96,131	161,674	257,805	-23,024	234,781	-25,878	208,903	30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	96,131	161,674	257,805	-23,024	234,781	-25,878	208,903	31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	853,592	186,008	1,039,600	-23,024	1,016,576	-87,438	929,138	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3477** **WORKSHEET M-2**

CHECK APPLICABLE BOX: [XX] RHC I [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS	2.18	3,104	4,200	9,156		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	0.55	731	2,100	1,155		3
4	SUBTOTAL (sum of lines 1-3)	2.73	3,835		10,311	10,311	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FQHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FQHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	2.73	3,835			10,311	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)	720,235	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)		11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)	720,235	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)	1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)	208,903	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)	721,584	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)	930,487	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)		17
18	SUBTRACT LINE 17 FROM LINE 16	930,487	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)	930,487	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)	1,650,722	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3477** **WORKSHEET M-3**

CHECK APPLICABLE BOXES: **[XX] RHC I** **[ ] FQHC** **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	1,650,722	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	5,283	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	1,645,439	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	10,311	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	10,311	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	159.58	7

		CALCULATION OF LIMIT (1)			
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)	
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	159.58	159.58	159.58	9
	CALCULATION OF SETTLEMENT				
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		1,292		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		206,177		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)				15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		206,177		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		94,484		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)		600		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)		1,309		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		154,452		16.04
16.05	TOTAL PROGRAM COST (see instructions)		155,761		16.05
17	PRIMARY PAYER PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		11,803		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		16,416		19
20	NET MEDICARE COST EXCUDING VACCINES (see instructions)		155,761		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		4,184		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		159,945		22
23	ALLOWABLE BAD DEBTS (see instructions)				23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				24
25	OTHER ADJUSTMENTS (SEQUESTRATION)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		159,945		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		3,199		26.01
27	INTERIM PAYMENTS		159,504		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		-2,758		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2		2,112		30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

Optimizer Systems, Inc. WinLASH Micro System

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3477** **WORKSHEET M-4**

CHECK APPLICABLE BOXES: **[XX] RHC I** **[ ] FQHC** **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	695,901	695,901	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000068	0.000707	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	47	492	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	649	1,117	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	696	1,609	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	720,235	720,235	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	930,487	930,487	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.000966	0.002234	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	899	2,079	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	1,595	3,688	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	10	104	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	159.50	35.46	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	8	82	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)	1,276	2,908	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		5,283	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		4,184	16

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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-3477

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC I [ ] FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER					162,929	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO						2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01				3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02				3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03				3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04				3.04
		PROVIDER	.05				3.05
			.06				3.06
			.07				3.07
			.08				3.08
			.09				3.09
			.10				3.10
			.50		06/20/2014	3,425	3.50
			.51				3.51
		PROVIDER	.52				3.52
		TO	.53				3.53
		PROGRAM	.54				3.54
			.55				3.55
			.56				3.56
			.57				3.57
			.58				3.58
			.59				3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			-3,425	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)					159,504	
	TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01				5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02				5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03				5.03
		TO	.04				5.04
		PROVIDER	.05				5.05
			.06				5.06
			.07				5.07
			.08				5.08
			.09				5.09
			.10				5.10
			.50				5.50
			.51				5.51
		PROVIDER	.52				5.52
		TO	.53				5.53
		PROGRAM	.54				5.54
			.55				5.55
			.56				5.56
			.57				5.57
			.58				5.58
			.59				5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01			441	6.01
	BASED ON THE COST REPORT (1)		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					159,945	

8	NAME OF CONTRACTOR	CONTRACTOR NUMBER	NPR DATE (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

Optimizer Systems, Inc. WinLASH Micro System

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ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-8529

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC II [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	42,174		42,174	-4,104	38,070		38,070	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	29,308		29,308		29,308		29,308	3
4	VISITING NURSE								4
5	OTHER NURSE	16,370		16,370		16,370		16,370	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS								9
10	SUBTOTAL (sum of lines 1-9)	87,852		87,852	-4,104	83,748		83,748	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES								15
16	TRANSPORTATION (Health Care Staff)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSIONAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (sum of lines 15-20)								21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	87,852		87,852	-4,104	83,748		83,748	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS	4,707	23,913	28,620	-7,708	20,912		20,912	30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	4,707	23,913	28,620	-7,708	20,912		20,912	31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	92,559	23,913	116,472	-11,812	104,660		104,660	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-8529** **WORKSHEET M-2**

CHECK APPLICABLE BOX: [XX] RHC II [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS	0.19	133	4,200	798		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	0.32	281	2,100	672		3
4	SUBTOTAL (sum of lines 1-3)	0.51	414		1,470	1,470	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FQHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FQHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	0.51	414			1,470	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)	83,748	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)		11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)	83,748	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)	1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)	20,912	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)	209,241	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)	230,153	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)		17
18	SUBTRACT LINE 17 FROM LINE 16	230,153	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)	230,153	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)	313,901	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

Optimizer Systems, Inc. **WinLASH** Micro System

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8529** **WORKSHEET M-3**

CHECK APPLICABLE BOXES: **[XX] RHC II** **[ ] FQHC** **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	313,901	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)		2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	313,901	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	1,470	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	1,470	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	213.54	7

		CALCULATION OF LIMIT (1)			
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)	
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	213.54	213.54	213.54	9
	CALCULATION OF SETTLEMENT				
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		2		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		427		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)				15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		427		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		130		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		342		16.04
16.05	TOTAL PROGRAM COST (see instructions)		342		16.05
17	PRIMARY PAYER PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)				18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		26		19
20	NET MEDICARE COST EXCUDING VACCINES (see instructions)		342		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)				21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		342		22
23	ALLOWABLE BAD DEBTS (see instructions)				23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		342		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		7		26.01
27	INTERIM PAYMENTS		179		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		156		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2		10		30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

Optimizer Systems, Inc. **WinLASH** Micro System

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8529** **WORKSHEET M-4**

CHECK APPLICABLE BOXES: **[XX] RHC II** **[ ] FQHC** **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	83,748	83,748	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000000	0.000000	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)			5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	83,748	83,748	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	230,153	230,153	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES			13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)			14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)			15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)			16

Optimizer Systems, Inc. **WinLASH** Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-8529

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC II [ ] FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				179	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03			3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)				179	
	TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01			5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02			5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03			5.03
		TO	.04			5.04
		PROVIDER	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		PROVIDER	.52			5.52
		TO	.53			5.53
		PROGRAM	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		163	6.01
	BASED ON THE COST REPORT (1)		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				342	

8	NAME OF CONTRACTOR	CONTRACTOR NUMBER	NPR DATE (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

Optimizer Systems, Inc. WinLASH Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	Non CMS worksheet **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	64.35		6.96				71.31	30
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	2.02	48.79	1.33	6.13			58.27	50
53	ANESTHESIOLOGY	3.98	46.81	1.41	12.24			64.44	53
54	RADIOLOGY-DIAGNOSTIC	5.43	33.74	0.66	28.35			68.18	54
58	MRI	9.11	26.17		18.07			53.35	58
60	LABORATORY	9.53	38.52	0.94	21.36			70.35	60
65	RESPIRATORY THERAPY	24.60	16.17	2.41	10.77			53.95	65
65.50	SLEEP LAB		32.03					32.03	65.50
66	PHYSICAL THERAPY	6.22	28.19	0.05	20.89			55.35	66
69	ELECTROCARDIOLOGY	11.94	51.81	1.69	21.25			86.69	69
71	MEDICAL SUPPLIES CHARGED TO PAT	19.45	10.97	2.17	10.18			42.77	71
72	IMPL. DEV. CHARGED TO PATIENTS		88.47		11.48			99.95	72
73	DRUGS CHARGED TO PATIENTS	29.10	16.64	5.40	17.43			68.57	73
90	CLINIC		98.60					98.60	90
91	EMERGENCY	0.05	38.43		42.33			80.81	91
92	OBSERVATION BEDS (NON-DISTINCT	0.58	48.52		30.30			79.40	92
200	TOTAL CHARGES	8.69	35.78	1.13	21.85			67.45	200

Optimizer Systems, Inc. WinLASH Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	Non CMS worksheet **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

REPORT 97 - UTILIZATION STATISTICS - SWING-BED SNF / NF

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	1.23						1.23	50
53	ANESTHESIOLOGY	1.41						1.41	53
54	RADIOLOGY-DIAGNOSTIC	0.74						0.74	54
58	MRI	2.33						2.33	58
60	LABORATORY	2.14						2.14	60
65	RESPIRATORY THERAPY	9.65						9.65	65
66	PHYSICAL THERAPY	16.99						16.99	66
69	ELECTROCARDIOLOGY	1.11						1.11	69
71	MEDICAL SUPPLIES CHARGED TO PAT	11.56						11.56	71
73	DRUGS CHARGED TO PATIENTS	13.77						13.77	73
200	TOTAL CHARGES	3.93						3.93	200

Optimizer Systems, Inc. WinLASH Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	Non CMS worksheet **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,943,547	14.68	-1,943,547	-28.76			1
2	CAP REL COSTS-MVBLE EQUIP	431,280	3.26	-431,280	-6.38			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	1,193,871	9.02	-1,193,871	-17.67			4
5.01	NONPATIENT TELEPHONES	24,209	0.18	-24,209	-0.36			5.01
5.02	DATA PROCESSING	128,721	0.97	-128,721	-1.90			5.02
5.03	PURCHASING RECEIVING AND STORES	44,698	0.34	-44,698	-0.66			5.03
5.04	ADMITTING	157,504	1.19	-157,504	-2.33			5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	376,915	2.85	-376,915	-5.58			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	777,389	5.87	-777,389	-11.50			5.06
7	OPERATION OF PLANT	723,276	5.46	-723,276	-10.70			7
8	LAUNDRY & LINEN SERVICE	46,097	0.35	-46,097	-0.68			8
9	HOUSEKEEPING	169,498	1.28	-169,498	-2.51			9
10	DIETARY	70,126	0.53	-70,126	-1.04			10
11	CAFETERIA							11
13	NURSING ADMINISTRATION	207,682	1.57	-207,682	-3.07			13
14	CENTRAL SERVICES & SUPPLY	18,964	0.14	-18,964	-0.28			14
15	PHARMACY	189,438	1.43	-189,438	-2.80			15
16	MEDICAL RECORDS & LIBRARY	208,360	1.57	-208,360	-3.08			16
17	SOCIAL SERVICE	46,514	0.35	-46,514	-0.69			17
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	ADULTS & PEDIATRICS	1,160,344	8.77	1,789,917	26.49	2,950,261	22.29	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	159,877	1.21	471,469	6.98	631,346	4.77	50
53	ANESTHESIOLOGY	287,917	2.17	99,747	1.48	387,664	2.93	53
54	RADIOLOGY-DIAGNOSTIC	488,286	3.69	505,135	7.47	993,421	7.50	54
58	MRI	71,690	0.54	22,223	0.33	93,913	0.71	58
60	LABORATORY	871,035	6.58	582,275	8.62	1,453,310	10.98	60
65	RESPIRATORY THERAPY	127,849	0.97	111,644	1.65	239,493	1.81	65
65.50	SLEEP LAB	29,250	0.22	28,357	0.42	57,607	0.44	65.50
66	PHYSICAL THERAPY	517,105	3.91	441,100	6.53	958,205	7.24	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	17,494	0.13	15,919	0.24	33,413	0.25	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,153	0.36	18,577	0.27	66,730	0.50	71
72	IMPL. DEV. CHARGED TO PATIENTS	79,695	0.60	24,793	0.37	104,488	0.79	72
73	DRUGS CHARGED TO PATIENTS	195,104	1.47	441,533	6.53	636,637	4.81	73
88	RURAL HEALTH CLINIC	929,138	7.02	721,584	10.68	1,650,722	12.47	88
88.01	RHC II	104,660	0.79	209,241	3.10	313,901	2.37	88.01
90	CLINIC	293,444	2.22	213,899	3.17	507,343	3.83	90
90.01	NORRIS CITY CLINIC							90.01
91	EMERGENCY	1,017,633	7.69	842,381	12.46	1,860,014	14.05	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	80,901	0.61	218,295	3.23	299,196	2.26	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	13,237,664	100.00			13,237,664	100.00	202

Optimizer Systems, Inc. WinLASH Micro System

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	Non CMS worksheet **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 10/07/2014 Run Time: 09:50 Version: 2014.03

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	

****** THIS PROVIDER IS NOT A PPS HOSPITAL**

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)

2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)

3. RATIO OF COST TO CHARGES (line 1 / line 2)