HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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: 11/05/2015 Time: 10:12 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 certification 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

(Signed) _____
Officer or Administrator of Provider(s)

H
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-237,873	-439,906	1	1,806,640	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-158,156				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-7,338			10
10.01	HEALTH CLINIC - RHC II			27,995			10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-396,029	-419,249	1	1,806,640	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 resopnd to a collection of information unless it displays a valid OMB 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.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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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	Provider 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 / 2014	To: 06 / 30 / 2015	20
21	Type of control (see instructions)	11		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital 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
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period 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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
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 column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							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 is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		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 payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. 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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 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 hospital 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 nonprovider 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 nonprovider 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 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	
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, indicate which program year began during this cost reporting period. (see instructions)				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, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

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
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 applicable column.		N	92
93	Does this facility operate an ICF/IID 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

		1	2	
Rural Providers				
105	Does this hospital qualify as a critical access hospital (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	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. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	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
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 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' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	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

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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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.			N	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, chapter 40, §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	4	
155	Hospital	Y	Y	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - 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. (see instructions)		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)	1		168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07 / 01 / 2014	06 / 30 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N	171

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 Accnountant? 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 in 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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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	08/25/2015	Y	08/25/2015	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 Reoprt 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

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 Cost			
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 capitalization 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.	N	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	Are 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 servcies 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 Report Preparer Contact Information				
41	First name: AMBER	Last name: HALSTEAD	Title: MANAGER	41
42	Employer: KEB			42
43	Phone number: 618-529-1040	E-mail Address: AMBERH@KEBCPA.COM		43

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A 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	46,104.00		1,451	134	1,921	1
2	HMO and other (see instructions)						4			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						1,437		1,437	5
6	Hospital Adults & Peds. Swing Bed NF								121	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	46,104.00		2,888	134	3,479	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	46,104.00		2,888	134	3,479	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					1,351		3,842	26
26.01	RHC II	88.01					399		2,132	26.01
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							57	345	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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)					482	63	650	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)		97.47			482	63	650	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		7.99						26
26.01	RHC II		3.38						26.01
27	Total (sum of lines 14-26)		108.84						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 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
71	PD2				71

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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	
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 catetory. 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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 the Homeless (Section 340(d), PHS			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. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	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 by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 the Homeless (Section 340(d), PHS			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. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	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 by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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)	0.539982	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,006,374	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?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	5,404,112	6
7	Medicaid cost (line 1 times line 6)	2,918,124	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.	911,750	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 care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig 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)	911,750	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	66,284	258,080	324,364	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	35,792	139,359	175,151	21
22	Partial payment by patients approved for charity care	1,312	3,105	4,417	22
23	Cost of charity care (line 21 minus line 22)	34,480	136,254	170,734	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)	1,326,713	26
27	Medicare bad debts for the entire hospital complex (see instructions)	206,328	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,120,385	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	604,988	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	775,722	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,687,472	31

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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		984,086	984,086	1,028,964	2,013,050	-17,846	1,995,204	1
2	00200	Cap Rel Costs-Mvble Equip		374,670	374,670	204,642	579,312	-133,245	446,067	2
3	00300	Other Cap Rel Costs		124,286	124,286	-124,286			-0-	3
4	00400	Employee Benefits Department		1,210,807	1,210,807		1,210,807	-21,987	1,188,820	4
5.01	00540	NONPATIENT TELEPHONES		21,301	21,301		21,301		21,301	5.01
5.02	00550	DATA PROCESSING	124,251	69,215	193,466		193,466		193,466	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	43,691	1,302	44,993		44,993	-505	44,488	5.03
5.04	00570	ADMITTING				159,336	159,336		159,336	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	221,014	303,072	524,086	-159,336	364,750		364,750	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	483,088	374,164	857,252	97,424	954,676	-214,624	740,052	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	128,377	616,934	745,311	-3,341	741,970		741,970	7
8	00800	Laundry & Linen Service		49,006	49,006		49,006		49,006	8
9	00900	Housekeeping	126,748	17,867	144,615		144,615		144,615	9
10	01000	Dietary		90,406	90,406		90,406	-37	90,369	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	203,320	9,159	212,479		212,479	-43,122	169,357	13
14	01400	Central Services & Supply		21,952	21,952	-18,568	3,384		3,384	14
15	01500	Pharmacy	172,972	264,100	437,072	-244,863	192,209		192,209	15
16	01600	Medical Records & Library	162,368	35,158	197,526		197,526	-3,544	193,982	16
17	01700	Social Service	45,506	1,173	46,679		46,679		46,679	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,008,199	195,252	1,203,451		1,203,451		1,203,451	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	121,221	182,396	303,617	-143,724	159,893		159,893	50
53	05300	Anesthesiology	253,630	32,995	286,625	-3,903	282,722		282,722	53
54	05400	Radiology-Diagnostic	284,791	344,324	629,115	-110,675	518,440		518,440	54
58	05800	MRI				77,050	77,050		77,050	58
60	06000	Laboratory	366,659	678,716	1,045,375	-7,200	1,038,175		1,038,175	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	71,767	26,214	97,981	-2,770	95,211		95,211	65
65.50	06501	SLEEP LAB		22,950	22,950		22,950		22,950	65.50
66	06600	Physical Therapy	348,797	160,954	509,751		509,751		509,751	66
69	06900	Electrocardiology		17,800	17,800		17,800		17,800	69
71	07100	Medical Supplies Charged to Patients				38,130	38,130	-3,241	34,889	71
72	07200	Impl. Dev. Charged to Patients				69,300	69,300		69,300	72
73	07300	Drugs Charged to Patients				228,136	228,136	-6,220	221,916	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	804,689	190,086	994,775	-26,252	968,523	-106,197	862,326	88
88.01	08801	RHC II	245,067	78,824	323,891	-42,112	281,779	-9,584	272,195	88.01
90	09000	Clinic	174,575	149,534	324,109		324,109		324,109	90
90.01	09001	NORRIS CITY CLINIC								90.01
91	09100	Emergency	536,113	1,463,524	1,999,637	-15,483	1,984,154	-913,246	1,070,908	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		996,583	996,583	-996,583				113
117	06950	OTHER SPECIAL PURPOSE COST CENTERS								117
117.02	06952	SUPPLIES AND EXPENSE		3,250	3,250	-3,250				117.02
118		SUBTOTALS (sum of lines 1-117)	5,926,843	9,112,060	15,038,903	636	15,039,539	-1,473,398	13,566,141	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		171,262	171,262	-636	170,626		170,626	192
200		TOTAL (sum of lines 118-199)	5,926,843	9,283,322	15,210,165		15,210,165	-1,473,398	13,736,767	200

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		996,583	1
500	Total reclassifications					996,583	500
	Code Letter - A						
1	TO RECLASS RENT EXPENSE	B	Cap Rel Costs-Mvble Equip	2		195,069	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					195,069	500
	Code Letter - B						
1	RECLASS INSURANCE COST	C	OTHER ADMINISTRATIVE AND GENE	5.06		82,332	1
500	Total reclassifications					82,332	500
	Code Letter - C						
1	ADMITTING	D	ADMITTING	5.04	73,598	85,738	1
500	Total reclassifications				73,598	85,738	500
	Code Letter - D						
1	RECLASS SUPPLIES SOLD	E	Medical Supplies Charged to P	71		107,430	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications					107,430	500
	Code Letter - E						
1	RECLASS DRUGS TO PHARMACY	F	Drugs Charged to Patients	73		177,316	1
500	Total reclassifications					177,316	500
	Code Letter - F						
1	RECLASS SUPPLIES SOLD	G	Central Services & Supply	14		3,250	1
500	Total reclassifications					3,250	500
	Code Letter - G						
1	RECLASS IV COST	H	Drugs Charged to Patients	73		50,820	1
2							2
500	Total reclassifications					50,820	500
	Code Letter - H						
1	RECLASS MALPRACTICE	I	OTHER ADMINISTRATIVE AND GENE	5.06		26,252	1
500	Total reclassifications					26,252	500
	Code Letter - I						
1	RECLASS IPL DEVICES	J	Impl. Dev. Charged to Patient	72		69,300	1
500	Total reclassifications					69,300	500
	Code Letter - J						
1	RECLASS MRI COST	K	MRI	58		77,050	1
500	Total reclassifications					77,050	500
	Code Letter - K						
1	RECLASS UTLITIES IN PHYS OFFICE	L	OTHER ADMINISTRATIVE AND GENE	5.06		636	1
500	Total reclassifications					636	500
	Code Letter - L						
	GRAND TOTAL (Increases)				73,598	1,871,776	

(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.

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		996,583	11	1
500	Total reclassifications					996,583		500
	Code letter - A							
1	TO RECLASS RENT EXPENSE	B	OTHER ADMINISTRATIVE AND GENE	5.06		11,796	10	1
2			Operating Room	50		59,880		2
3			Respiratory Therapy	65		1,452		3
4			Radiology-Diagnostic	54		33,625		4
5			Laboratory	60		7,200		5
6			Pharmacy	15		35,681		6
7			Operation of Plant	7		3,341		7
8			RHC II	88.01		42,094		8
500	Total reclassifications					195,069		500
	Code letter - B							
1	RECLASS INSURANCE COST	C	Other Cap Rel Costs	3		82,332		1
500	Total reclassifications					82,332		500
	Code letter - C							
1	ADMITTING	D	CASHIERING/ACCOUNTS RECEIVABL	5.05	73,598	85,738		1
500	Total reclassifications				73,598	85,738		500
	Code letter - D							
1	RECLASS SUPPLIES SOLD	E	Emergency	91		15,483		1
2			Anesthesiology	53		3,903		2
3			Operating Room	50		83,844		3
4			Respiratory Therapy	65		1,318		4
5			RHC II	88.01		18		5
6			Central Services & Supply	14		2,864		6
500	Total reclassifications					107,430		500
	Code letter - E							
1	RECLASS DRUGS TO PHARMACY	F	Pharmacy	15		177,316		1
500	Total reclassifications					177,316		500
	Code letter - F							
1	RECLASS SUPPLIES SOLD	G	SUPPLIES AND EXPENSE	117.02		3,250		1
500	Total reclassifications					3,250		500
	Code letter - G							
1	RECLASS IV COST	H	Pharmacy	15		31,866		1
2			Central Services & Supply	14		18,954		2
500	Total reclassifications					50,820		500
	Code letter - H							
1	RECLASS MALPRACTICE	I	Rural Health Clinic	88		26,252		1
500	Total reclassifications					26,252		500
	Code letter - I							
1	RECLASS IPL DEVICES	J	Medical Supplies Charged to P	71		69,300		1
500	Total reclassifications					69,300		500
	Code letter - J							
1	RECLASS MRI COST	K	Radiology-Diagnostic	54		77,050		1
500	Total reclassifications					77,050		500
	Code letter - K							
1	RECLASS UTLITIES IN PHYS OFFICE	L	Physicians' Private Offices	192		636		1
500	Total reclassifications					636		500
	Code letter - L							
	GRAND TOTAL (Decreases)				73,598	1,871,776		

(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.

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	69,760					69,760		1
2	Land Improvements	601,496	30,862		30,862		632,358		2
3	Buildings and Fixtures	21,567,438	96,150		96,150		21,663,588		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	5,784,554	204,432		204,432		5,988,986		6
7	HIT-designated Assets	526,146	96,780		96,780		622,926		7
8	Subtotal (sum of lines 1-7)	28,549,394	428,224		428,224		28,977,618		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	28,549,394	428,224		428,224		28,977,618		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	984,086						984,086	1
2	Cap Rel Costs-Mvble Equip	374,670						374,670	2
3	Total (sum of lines 1-2)	1,358,756						1,358,756	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	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	22,365,706		22,365,706	0.771827	32,381			32,381	1
2	Cap Rel Costs-Mvble Equ	6,611,912		6,611,912	0.228173	9,573			9,573	2
3	Total (sum of lines 1-2)	28,977,618		28,977,618	1.000000	41,954			41,954	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	984,086		978,737	32,381			1,995,204	1
2	Cap Rel Costs-Mvble Equip	241,425	195,069		9,573			446,067	2
3	Total (sum of lines 1-2)	1,225,511	195,069	978,737	41,954			2,441,271	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.)

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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	-36,125	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	-505	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	-7,468	OTHER ADMINISTRATIVE AND GENERAL	5.06		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-913,246				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	-37	Dietary	10		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-3,241	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients	B	-6,220	Drugs Charged to Patients	73		17
18	Sale of medical records and abstracts	B	-3,544	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-1,386	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	B	-128,758	Cap Rel Costs-Mvble Equip	2	9	32
33	COMMUNITY PROGRAM	B	-1,511	OTHER ADMINISTRATIVE AND GENERAL	5.06		33
34							34
35	PORTION OF LOBBYING DUES	A	-5,486	OTHER ADMINISTRATIVE AND GENERAL	5.06		35
36	WOMENS WELLNESS	B	-87,874	OTHER ADMINISTRATIVE AND GENERAL	5.06		36
37	PHYSICIAN RECRUITMENT	A	-30,430	OTHER ADMINISTRATIVE AND GENERAL	5.06		37
38	ADVERTISING	A	-58,028	OTHER ADMINISTRATIVE AND GENERAL	5.06		38
39	BOND ISSUE COSTS	A	18,279	Cap Rel Costs-Bldg & Fixt	1	11	39
40							40
41							41
42	FUNDRAISING	A	-4,487	Cap Rel Costs-Mvble Equip	2	9	42
43							43
44	NURSING CENTER SERVICES	B	-1,040	OTHER ADMINISTRATIVE AND GENERAL	5.06		44
45	OTHER REVENUE RHC	B	2,035	Rural Health Clinic	88		45
45.06	FUNDRAISING	A	-21,401	OTHER ADMINISTRATIVE AND GENERAL	5.06		45.06
45.09	NON RHC COST SALARY	A	-108,232	Rural Health Clinic	88		45.09
45.10	NON RHC COST SALARY	A	-9,584	RHC II	88.01		45.10
45.11	NON RHC BENEFITS	A	-13,190	Employee Benefits Department	4		45.11
46	WHITE OAKS SALARY	A	-43,122	Nursing Administration	13		46
47	WHITE OAKS BENEFITS	A	-8,797	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)		-1,473,398				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.

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 Adjustments (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	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2	91	Emergency AGGREGATE	1,343,009	913,246	429,763					2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,343,009	913,246	429,763					200

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2	91	Emergency AGGREGATE							913,246	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							913,246	200

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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)					249	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		1,964.50	11.00			9
10	AHSEA (see instructions)		73.10	54.83			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)	36.55	36.55	27.42			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)	143,605	15
16	Assistants (column 3, line 9 times column 3, line 10)	603	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	144,208	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)	144,208	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 excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	144,208	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)	9,101	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)	9,101	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)	9,101	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)	9,101	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	Optoinal 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

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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

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem 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 overimte 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)	144,208	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	9,101	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)	153,309	63
64	Total cost of outside supplier services (from provider records)	98,830	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

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)					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		241.00				9
10	AHSEA (see instructions)		77.13				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)	38.57	38.57				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)	18,588	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)	18,588	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)	18,588	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)	77.13	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	60,161	22
23	Total salary equivalency (see instructions)	60,161	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)	9,411	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)	9,411	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)	9,411	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)	9,411	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	Optoinal 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

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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

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem 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 overimte 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)	60,161	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	9,411	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)	69,572	63
64	Total cost of outside supplier services (from provider records)	14,460	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

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)					203	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		540.75				9
10	AHSEA (see instructions)		70.24				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)	35.12	35.12				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)	37,982	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)	37,982	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)	37,982	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)	70.24	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	54,787	22
23	Total salary equivalency (see instructions)	54,787	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)	7,129	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)	7,129	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)	7,129	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)		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	Optoinal 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

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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

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem 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 overimte 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)	54,787	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		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)	54,787	63
64	Total cost of outside supplier services (from provider records)	27,579	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST 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	1,995,204	1,995,204					1
2	Cap Rel Costs-Mvble Equip	446,067		446,067				2
4	Employee Benefits Department	1,188,820			1,188,820			4
5.01	NONPATIENT TELEPHONES	21,301	992	222		22,515		5.01
5.02	DATA PROCESSING	193,466			25,618		219,084	5.02
5.03	PURCHASING RECEIVING AND STORES	44,488	56,320	12,591	9,008	259		5.03
5.04	ADMITTING	159,336			15,175			5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	364,750	39,449	8,819	30,394		177,731	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	740,052	244,606	54,686	99,604	3,753	41,353	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	741,970	176,650	39,494	26,469	518		7
8	Laundry & Linen Service	49,006	23,719	5,303		129		8
9	Housekeeping	144,615			26,133			9
10	Dietary	90,369						10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	169,357	37,216	8,320	33,030	647		13
14	Central Services & Supply	3,384						14
15	Pharmacy	192,209	29,103	6,506	35,664	518		15
16	Medical Records & Library	193,982	30,939	6,917	33,477	906		16
17	Social Service	46,679	4,764	1,065	9,382	388		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,203,451	338,486	75,677	207,873	4,140		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	159,893	166,230	37,164	24,993	1,035		50
53	Anesthesiology	282,722			52,294			53
54	Radiology-Diagnostic	518,440	117,899	26,359	58,718	1,165		54
58	MRI	77,050				129		58
60	Laboratory	1,038,175	42,798	9,568	75,598	1,035		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	95,211	17,367	3,883	14,797	776		65
65.50	SLEEP LAB	22,950	9,304	2,080		388		65.50
66	Physical Therapy	509,751	111,523	24,933	71,915	1,035		66
69	Electrocardiology	17,800						69
71	Medical Supplies Charged to Patients	34,889						71
72	Impl. Dev. Charged to Patients	69,300						72
73	Drugs Charged to Patients	221,916						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	862,326	185,607	41,496	143,596	2,329		88
88.01	RHC II	272,195	87,333	19,525	48,552	518		88.01
90	Clinic	324,109	71,454	15,975	35,994	647		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	1,070,908	114,078	25,504	110,536	1,682		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)	13,566,141	1,905,837	426,087	1,188,820	21,997	219,084	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	170,626	89,367	19,980		518		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	13,736,767	1,995,204	446,067	1,188,820	22,515	219,084	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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	122,666						5.03
5.04	ADMITTING		174,511					5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE			621,143				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,122			1,185,176	1,185,176		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	4,170			989,271	93,411	1,082,682	7
8	Laundry & Linen Service	151			78,308	7,394	17,384	8
9	Housekeeping	1,493			172,241	16,264		9
10	Dietary	183			90,552	8,550		10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	507			249,077	23,519	27,277	13
14	Central Services & Supply	5,132			8,516	804		14
15	Pharmacy	17,486			281,486	26,579	21,330	15
16	Medical Records & Library	963			267,184	25,229	22,676	16
17	Social Service	99			62,377	5,890	3,491	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,729	56,064	42,795	1,937,215	182,924	248,091	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	10,725	2,085	19,696	421,821	39,830	121,836	50
53	Anesthesiology	1,539	758	5,366	342,679	32,357		53
54	Radiology-Diagnostic	2,319	10,197	129,161	864,258	81,607	86,412	54
58	MRI		1,453	12,742	91,374	8,628		58
60	Laboratory	53,281	29,899	151,762	1,402,116	132,393	31,368	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,091	12,390	14,494	160,009	15,109	12,729	65
65.50	SLEEP LAB			4,774	39,496	3,729	6,819	65.50
66	Physical Therapy	895	14,879	29,921	764,852	72,220	81,739	66
69	Electrocardiology	95	1,394	10,457	29,746	2,809		69
71	Medical Supplies Charged to Patients		526	686	36,101	3,409		71
72	Impl. Dev. Charged to Patients			3,440	72,740	6,868		72
73	Drugs Charged to Patients		43,111	54,796	319,823	30,199		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,342	1,755	15,229	1,253,680	118,377	136,038	88
88.01	RHC II	1,324		6,529	435,976	41,167	64,009	88.01
90	Clinic	1,471		18,133	467,783	44,170	52,371	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	8,433		101,162	1,432,303	135,244	83,612	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)	122,550	174,511	621,143	13,456,160	1,158,680	1,017,182	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	116			280,607	26,496	65,500	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	122,666	174,511	621,143	13,736,767	1,185,176	1,082,682	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	103,086						8
9	Housekeeping		188,505					9
10	Dietary			99,102				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		1,067		300,940			13
14	Central Services & Supply					9,320		14
15	Pharmacy						329,395	15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	54,900	63,925	99,102	198,571			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,102	18,566		18,272			50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,054	10,628					54
58	MRI	304						58
60	Laboratory		7,960					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
65.50	SLEEP LAB							65.50
66	Physical Therapy	14,370	14,519					66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients					3,308		71
72	Impl. Dev. Charged to Patients					6,012		72
73	Drugs Charged to Patients						329,395	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	862	31,973					88
88.01	RHC II							88.01
90	Clinic		7,960					90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	27,494	31,907		84,097			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)	103,086	188,505	99,102	300,940	9,320	329,395	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	103,086	188,505	99,102	300,940	9,320	329,395	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	315,089						16
17	Social Service		71,758					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	108,133	20,450	2,913,311		2,913,311		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			622,427		622,427		50
53	Anesthesiology			375,036		375,036		53
54	Radiology-Diagnostic			1,045,959		1,045,959		54
58	MRI			100,306		100,306		58
60	Laboratory	131,409		1,705,246		1,705,246		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			187,847		187,847		65
65.50	SLEEP LAB			50,044		50,044		65.50
66	Physical Therapy		5,803	953,503		953,503		66
69	Electrocardiology			32,555		32,555		69
71	Medical Supplies Charged to Patients			42,818		42,818		71
72	Impl. Dev. Charged to Patients			85,620		85,620		72
73	Drugs Charged to Patients			679,417		679,417		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		20,726	1,561,656		1,561,656		88
88.01	RHC II			541,152		541,152		88.01
90	Clinic			572,284		572,284		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	75,547	24,779	1,894,983		1,894,983		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)	315,089	71,758	13,364,164		13,364,164		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			372,603		372,603		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	315,089	71,758	13,736,767		13,736,767		202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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		992	222	1,214	1,214		5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES		56,320	12,591	68,911	14	68,925	5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		39,449	8,819	48,268			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		244,606	54,686	299,292	202	631	5.06
6	Maintenance & Repairs							6
7	Operation of Plant		176,650	39,494	216,144	28	2,343	7
8	Laundry & Linen Service		23,719	5,303	29,022	7	85	8
9	Housekeeping						839	9
10	Dietary						103	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		37,216	8,320	45,536	35	285	13
14	Central Services & Supply						2,884	14
15	Pharmacy		29,103	6,506	35,609	28	9,825	15
16	Medical Records & Library		30,939	6,917	37,856	49	541	16
17	Social Service		4,764	1,065	5,829	21	56	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		338,486	75,677	414,163	221	4,905	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		166,230	37,164	203,394	56	6,026	50
53	Anesthesiology						865	53
54	Radiology-Diagnostic		117,899	26,359	144,258	63	1,303	54
58	MRI					7		58
60	Laboratory		42,798	9,568	52,366	56	29,935	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		17,367	3,883	21,250	42	613	65
65.50	SLEEP LAB		9,304	2,080	11,384	21		65.50
66	Physical Therapy		111,523	24,933	136,456	56	503	66
69	Electrocardiology						54	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		185,607	41,496	227,103	126	754	88
88.01	RHC II		87,333	19,525	106,858	28	744	88.01
90	Clinic		71,454	15,975	87,429	35	827	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency		114,078	25,504	139,582	91	4,739	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)		1,905,837	426,087	2,331,924	1,186	68,860	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		89,367	19,980	109,347	28	65	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,995,204	446,067	2,441,271	1,214	68,925	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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	48,268						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		300,125					5.06
6	Maintenance & Repairs							6
7	Operation of Plant		23,654	242,169				7
8	Laundry & Linen Service		1,872	3,888	34,874			8
9	Housekeeping		4,118			4,957		9
10	Dietary		2,165				2,268	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		5,956	6,101		28		13
14	Central Services & Supply		204					14
15	Pharmacy		6,731	4,771				15
16	Medical Records & Library		6,389	5,072				16
17	Social Service		1,491	781				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,326	46,326	55,493	18,573	1,682	2,268	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,531	10,086	27,252	711	488		50
53	Anesthesiology	417	8,194					53
54	Radiology-Diagnostic	10,039	20,665	19,328	1,033	279		54
58	MRI	990	2,185		103			58
60	Laboratory	11,786	33,526	7,016		209		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,127	3,826	2,847				65
65.50	SLEEP LAB	371	944	1,525				65.50
66	Physical Therapy	2,326	18,288	18,283	4,861	382		66
69	Electrocardiology	813	711					69
71	Medical Supplies Charged to Patients	53	863					71
72	Impl. Dev. Charged to Patients	267	1,739					72
73	Drugs Charged to Patients	4,259	7,647					73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,184	29,977	30,428	292	841		88
88.01	RHC II	507	10,425	14,317				88.01
90	Clinic	1,409	11,185	11,714		209		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	7,863	34,248	18,702	9,301	839		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)	48,268	293,415	227,518	34,874	4,957	2,268	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		6,710	14,651				192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	48,268	300,125	242,169	34,874	4,957	2,268	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	57,941						13
14	Central Services & Supply		3,088					14
15	Pharmacy			56,964				15
16	Medical Records & Library				49,907			16
17	Social Service					8,178		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	38,232			17,127	2,331	604,647	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,518					253,062	50
53	Anesthesiology						9,476	53
54	Radiology-Diagnostic						196,968	54
58	MRI						3,285	58
60	Laboratory				20,814		155,708	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy						29,705	65
65.50	SLEEP LAB						14,245	65.50
66	Physical Therapy					661	181,816	66
69	Electrocardiology						1,578	69
71	Medical Supplies Charged to Patients		1,096				2,012	71
72	Impl. Dev. Charged to Patients		1,992				3,998	72
73	Drugs Charged to Patients			56,964			68,870	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					2,362	293,067	88
88.01	RHC II						132,879	88.01
90	Clinic						112,808	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	16,191			11,966	2,824	246,346	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)	57,941	3,088	56,964	49,907	8,178	2,310,470	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices						130,801	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	57,941	3,088	56,964	49,907	8,178	2,441,271	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		604,647					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		253,062					50
53	Anesthesiology		9,476					53
54	Radiology-Diagnostic		196,968					54
58	MRI		3,285					58
60	Laboratory		155,708					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		29,705					65
65.50	SLEEP LAB		14,245					65.50
66	Physical Therapy		181,816					66
69	Electrocardiology		1,578					69
71	Medical Supplies Charged to Patients		2,012					71
72	Impl. Dev. Charged to Patients		3,998					72
73	Drugs Charged to Patients		68,870					73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		293,067					88
88.01	RHC II		132,879					88.01
90	Clinic		112,808					90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency		246,346					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)		2,310,470					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		130,801					192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,441,271					202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 STOR 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			5,765,905				4
5.01	NONPATIENT TELEPHONES	40	40		174			5.01
5.02	DATA PROCESSING			124,251		249		5.02
5.03	PURCHASING RECEIVING AND STORES	2,270	2,270	43,691	2		1,286,271	5.03
5.04	ADMITTING			73,598				5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,590	1,590	147,416		202		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,859	9,859	483,088	29	47	11,767	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	7,120	7,120	128,377	4		43,724	7
8	Laundry & Linen Service	956	956		1		1,585	8
9	Housekeeping			126,748			15,655	9
10	Dietary						1,922	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,500	1,500	160,198	5		5,313	13
14	Central Services & Supply						53,818	14
15	Pharmacy	1,173	1,173	172,972	4		183,353	15
16	Medical Records & Library	1,247	1,247	162,368	7		10,093	16
17	Social Service	192	192	45,506	3		1,040	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,643	13,643	1,008,199	32		91,530	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,700	6,700	121,221	8		112,463	50
53	Anesthesiology			253,630			16,143	53
54	Radiology-Diagnostic	4,752	4,752	284,791	9		24,313	54
58	MRI				1			58
60	Laboratory	1,725	1,725	366,659	8		558,696	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	700	700	71,767	6		11,443	65
65.50	SLEEP LAB	375	375		3			65.50
66	Physical Therapy	4,495	4,495	348,797	8		9,381	66
69	Electrocardiology						999	69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	7,481	7,481	696,457	18		14,069	88
88.01	RHC II	3,520	3,520	235,483	4		13,887	88.01
90	Clinic	2,880	2,880	174,575	5		15,427	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	4,598	4,598	536,113	13		88,432	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)	76,816	76,816	5,765,905	170	249	1,285,053	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	3,602	3,602		4		1,218	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,995,204	446,067	1,188,820	22,515	219,084	122,666	202
203	Unit Cost Multiplier (Wkst. B, Part I)	24.810416	5.546855	0.206181	129.396552	879.855422	0.095366	203
204	Cost to be allocated (Per Wkst. B, Part II)				1,214		68,925	204
205	Unit Cost Multiplier (Wkst. B, Part II)				6.977011		0.053585	205

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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	5,469,998						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		25,997,686					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-1,185,176	12,551,591			5.06
6	Maintenance & Repairs							6
7	Operation of Plant				989,271	59,539		7
8	Laundry & Linen Service				78,308	956	18,293	8
9	Housekeeping				172,241			9
10	Dietary				90,552			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				249,077	1,500		13
14	Central Services & Supply				8,516			14
15	Pharmacy				281,486	1,173		15
16	Medical Records & Library				267,184	1,247		16
17	Social Service				62,377	192		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,757,300	1,791,168		1,937,215	13,643	9,742	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	65,346	824,379		421,821	6,700	373	50
53	Anesthesiology	23,752	224,578		342,679			53
54	Radiology-Diagnostic	319,635	5,406,053		864,258	4,752	542	54
58	MRI	45,530	533,297		91,374		54	58
60	Laboratory	937,200	6,351,655		1,402,116	1,725		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	388,354	606,648		160,009	700		65
65.50	SLEEP LAB		199,827		39,496	375		65.50
66	Physical Therapy	466,384	1,252,351		764,852	4,495	2,550	66
69	Electrocardiology	43,697	437,689		29,746			69
71	Medical Supplies Charged to Patients	16,497	28,732		36,101			71
72	Impl. Dev. Charged to Patients		144,000		72,740			72
73	Drugs Charged to Patients	1,351,308	2,293,500		319,823			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	54,995	637,414		1,253,680	7,481	153	88
88.01	RHC II		273,283		435,976	3,520		88.01
90	Clinic		758,956		467,783	2,880		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency		4,234,156		1,432,303	4,598	4,879	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)	5,469,998	25,997,686	-1,185,176	12,270,984	55,937	18,293	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices				280,607	3,602		192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	174,511	621,143		1,185,176	1,082,682	103,086	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.031903	0.023892		0.094424	18.184417	5.635270	203
204	Cost to be allocated (Per Wkst. B, Part II)		48,268		300,125	242,169	34,874	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.001857		0.023911	4.067401	1.906412	205

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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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	8,478						9
10	Dietary		12,928					10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	48		68,217				13
14	Central Services & Supply				107,430			14
15	Pharmacy					228,136		15
16	Medical Records & Library						39,935	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,875	12,928	45,012			13,705	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	835		4,142				50
53	Anesthesiology							53
54	Radiology-Diagnostic	478						54
58	MRI							58
60	Laboratory	358					16,655	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
65.50	SLEEP LAB							65.50
66	Physical Therapy	653						66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients				38,130			71
72	Impl. Dev. Charged to Patients				69,300			72
73	Drugs Charged to Patients					228,136		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,438						88
88.01	RHC II							88.01
90	Clinic	358						90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	1,435		19,063			9,575	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)	8,478	12,928	68,217	107,430	228,136	39,935	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	188,505	99,102	300,940	9,320	329,395	315,089	202
203	Unit Cost Multiplier (Wkst. B, Part I)	22.234607	7.665687	4.411510	0.086754	1.443854	7.890046	203
204	Cost to be allocated (Per Wkst. B, Part II)	4,957	2,268	57,941	3,088	56,964	49,907	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.584690	0.175433	0.849363	0.028744	0.249693	1.249706	205

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	7,790						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,220						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
65.50	SLEEP LAB							65.50
66	Physical Therapy	630						66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,250						88
88.01	RHC II							88.01
90	Clinic							90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	2,690						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)	7,790						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	71,758						202
203	Unit Cost Multiplier (Wkst. B, Part I)	9.211553						203
204	Cost to be allocated (Per Wkst. B, Part II)	8,178						204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.049807						205

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,913,311		2,913,311		2,913,311	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	622,427		622,427		622,427	50
53	Anesthesiology	375,036		375,036		375,036	53
54	Radiology-Diagnostic	1,045,959		1,045,959		1,045,959	54
58	MRI	100,306		100,306		100,306	58
60	Laboratory	1,705,246		1,705,246		1,705,246	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	187,847		187,847		187,847	65
65.50	SLEEP LAB	50,044		50,044		50,044	65.50
66	Physical Therapy	953,503		953,503		953,503	66
69	Electrocardiology	32,555		32,555		32,555	69
71	Medical Supplies Charged to Patients	42,818		42,818		42,818	71
72	Impl. Dev. Charged to Patients	85,620		85,620		85,620	72
73	Drugs Charged to Patients	679,417		679,417		679,417	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	1,561,656		1,561,656		1,561,656	88
88.01	RHC II	541,152		541,152		541,152	88.01
90	Clinic	572,284		572,284		572,284	90
90.01	NORRIS CITY CLINIC						90.01
91	Emergency	1,894,983		1,894,983		1,894,983	91
92	Observation Beds (Non-Distinct Part)	269,897		269,897		269,897	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 (sum of lines 30 thru 199)	13,634,061		13,634,061		13,634,061	200
201	Less Observation Beds	269,897		269,897		269,897	201
202	Total (line 200 minus line 201)	13,364,164		13,364,164		13,364,164	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 SERVICE COST CENTERS							
30	Adults & Pediatrics	1,791,168		1,791,168				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	35,353	476,216	511,569	1.216702	1.216702	1.216702	50
53	Anesthesiology	29,281	188,329	217,610	1.723432	1.723432	1.723432	53
54	Radiology-Diagnostic	310,446	4,983,633	5,294,079	0.197571	0.197571	0.197571	54
58	MRI	45,530	487,767	533,297	0.188087	0.188087	0.188087	58
60	Laboratory	937,200	5,594,455	6,531,655	0.261074	0.261074	0.261074	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	96,031	161,755	257,786	0.728694	0.728694	0.728694	65
65.50	SLEEP LAB		199,827	199,827	0.250437	0.250437	0.250437	65.50
66	Physical Therapy	466,384	785,967	1,252,351	0.761370	0.761370	0.761370	66
69	Electrocardiology	43,697	393,992	437,689	0.074379	0.074379	0.074379	69
71	Medical Supplies Charged to Patients	357,125	457,961	815,086	0.052532	0.052532	0.052532	71
72	Impl. Dev. Charged to Patients		144,000	144,000	0.594583	0.594583	0.594583	72
73	Drugs Charged to Patients	1,351,308	942,192	2,293,500	0.296236	0.296236	0.296236	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	54,995	582,419	637,414				88
88.01	RHC II		273,283	273,283				88.01
90	Clinic		758,956	758,956	0.754041	0.754041	0.754041	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	836	2,491,021	2,491,857	0.760470	0.760470	0.760470	91
92	Observation Beds (Non-Distinct Part)	1,502	306,667	308,169	0.875808	0.875808	0.875808	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 (sum of lines 30 thru 199)	5,520,856	19,228,440	24,749,296				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	5,520,856	19,228,440	24,749,296				202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			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	1.216702		217,802			265,000		50
53	Anesthesiology	1.723432		108,804			187,516		53
54	Radiology-Diagnostic	0.197571		1,817,192			359,024		54
58	MRI	0.188087		155,517			29,251		58
60	Laboratory	0.261074		2,593,967			677,217		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.728694		36,930			26,911		65
65.50	SLEEP LAB	0.250437		66,365			16,620		65.50
66	Physical Therapy	0.761370		137,025			104,327		66
69	Electrocardiology	0.074379		194,695			14,481		69
71	Medical Supplies Charged to Pat	0.052532		98,940			5,198		71
72	Impl. Dev. Charged to Patients	0.594583		105,081			62,479		72
73	Drugs Charged to Patients	0.296236		278,990			82,647		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
90	Clinic	0.754041		728,654			549,435		90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	0.760470		991,890			754,303		91
92	Observation Beds (Non-Distinct	0.875808		160,096			140,213		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			7,691,948			3,274,622		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			7,691,948			3,274,622		202

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[XX] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			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	1.216702							50
53	Anesthesiology	1.723432							53
54	Radiology-Diagnostic	0.197571							54
58	MRI	0.188087							58
60	Laboratory	0.261074							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.728694							65
65.50	SLEEP LAB	0.250437							65.50
66	Physical Therapy	0.761370							66
69	Electrocardiology	0.074379							69
71	Medical Supplies Charged to Pat	0.052532							71
72	Impl. Dev. Charged to Patients	0.594583							72
73	Drugs Charged to Patients	0.296236							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
90	Clinic	0.754041							90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	0.760470							91
92	Observation Beds (Non-Distinct	0.875808							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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX
[XX] PPS
[ ] TEFRA

		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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	604,647	236,726	367,921	2,266	162.37	134	21,758	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)	604,647		367,921	2,266		134	21,758	200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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) 1	Total Charges (from Wkst. C, Part I, (col. 8) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	253,062	511,569	0.494678	6,788	3,358	50
53	Anesthesiology	9,476	217,610	0.043546	3,450	150	53
54	Radiology-Diagnostic	196,968	5,294,079	0.037205	27,785	1,034	54
58	MRI	3,285	533,297	0.006160			58
60	Laboratory	155,708	6,531,655	0.023839	51,060	1,217	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	29,705	257,786	0.115231	7,065	814	65
65.50	SLEEP LAB	14,245	199,827	0.071287			65.50
66	Physical Therapy	181,816	1,252,351	0.145180	610	89	66
69	Electrocardiology	1,578	437,689	0.003605	7,338	26	69
71	Medical Supplies Charged to Pat	2,012	815,086	0.002468	18,719	46	71
72	Impl. Dev. Charged to Patients	3,998	144,000	0.027764			72
73	Drugs Charged to Patients	68,870	2,293,500	0.030028	104,013	3,123	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	293,067	637,414	0.459775			88
88.01	RHC II	132,879	273,283	0.486232			88.01
90	Clinic	112,808	758,956	0.148636			90
90.01	NORRIS CITY CLINIC						90.01
91	Emergency	246,346	2,491,857	0.098860	64	6	91
92	Observation Beds (Non-Distinct	92,058	308,169	0.298726			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,797,881	22,958,128		226,892	9,863	200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 **[ ] Other**

		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 SERVICE 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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,266		134		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)	2,266		134		200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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/IID | [XX] PPS [ ] TEFRA [ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
65.50	SLEEP LAB							65.50
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	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							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

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/IID | [XX] PPS [ ] TEFRA [ ] Other

(A)	Cost Center Description	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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	511,569			6,788				50
53	Anesthesiology	217,610			3,450				53
54	Radiology-Diagnostic	5,294,079			27,785				54
58	MRI	533,297							58
60	Laboratory	6,531,655			51,060				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	257,786			7,065				65
65.50	SLEEP LAB	199,827							65.50
66	Physical Therapy	1,252,351			610				66
69	Electrocardiology	437,689			7,338				69
71	Medical Supplies Charged to Pat	815,086			18,719				71
72	Impl. Dev. Charged to Patients	144,000							72
73	Drugs Charged to Patients	2,293,500			104,013				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	637,414							88
88.01	RHC II	273,283							88.01
90	Clinic	758,956							90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	2,491,857			64				91
92	Observation Beds (Non-Distinct	308,169							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	22,958,128			226,892				200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[XX] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			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	1.216702		31,372			38,170		50
53	Anesthesiology	1.723432		30,064			51,813		53
54	Radiology-Diagnostic	0.197571		1,196,135			236,322		54
58	MRI	0.188087		79,910			15,030		58
60	Laboratory	0.261074		1,155,569			301,689		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.728694		31,618			23,040		65
65.50	SLEEP LAB	0.250437							65.50
66	Physical Therapy	0.761370		272,966			207,828		66
69	Electrocardiology	0.074379		92,405			6,873		69
71	Medical Supplies Charged to Pat	0.052532		87,931			4,619		71
72	Impl. Dev. Charged to Patients	0.594583		15,838			9,417		72
73	Drugs Charged to Patients	0.296236		335,660			99,435		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
90	Clinic	0.754041							90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	0.760470		942,532			716,767		91
92	Observation Beds (Non-Distinct	0.875808		109,199			95,637		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			4,381,199			1,806,640		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			4,381,199			1,806,640		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**	
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**	

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,824	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,266	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)	1,921	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	719	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)	718	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	61	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)	60	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,451	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)	719	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)	718	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 XIX only)		15
16	Nursery days (title V or 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)	2,913,311	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)	8,365	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	8,048	25
26	Total swing-bed cost (see instructions)	1,140,592	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,772,719	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 minus line 36)	1,772,719	37

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [XX] 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)	782.31	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,135,132	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)	1,135,132	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 (Wkst. D-3, col. 3, line 200)	506,974	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,642,106	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. 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 etner 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)	562,481	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	561,699	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	1,124,180	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

Check Applicable Boxes:
[ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [ ] NF [XX] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					345	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					782.31	88
89	Observation bed cost (line 87 x line 88) (see instructions)					269,897	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	604,647	1,772,719	0.341085	269,897	92,058	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[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)	3,824	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,266	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)	1,921	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	719	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)	718	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	61	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)	60	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	134	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 XIX only)		15
16	Nursery days (title V or 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)	2,913,311	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)	8,365	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	8,048	25
26	Total swing-bed cost (see instructions)	1,140,592	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,772,719	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 minus line 36)	1,772,719	37

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] 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)	782.31	38
39	Program general inpatient routine service cost (line 9 x line 38)	104,830	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)	104,830	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 (Wkst. D-3, col. 3, line 200)	71,027	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	175,857	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	21,758	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,863	51
52	Total Program excludable cost (sum of lines 50 and 51)	31,621	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	144,236	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 etner 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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					345	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)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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/IID**
[ ] 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		928,214		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	1.216702	12,341	15,015	50
53	Anesthesiology	1.723432	19,151	33,005	53
54	Radiology-Diagnostic	0.197571	195,795	38,683	54
58	MRI	0.188087	26,010	4,892	58
60	Laboratory	0.261074	529,779	138,312	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.728694	53,656	39,099	65
65.50	SLEEP LAB	0.250437			65.50
66	Physical Therapy	0.761370	59,888	45,597	66
69	Electrocardiology	0.074379	29,605	2,202	69
71	Medical Supplies Charged to Patients	0.052532	149,255	7,841	71
72	Impl. Dev. Charged to Patients	0.594583			72
73	Drugs Charged to Patients	0.296236	613,500	181,741	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
90	Clinic	0.754041			90
90.01	NORRIS CITY CLINIC				90.01
91	Emergency	0.760470	772	587	91
92	Observation Beds (Non-Distinct Part)	0.875808			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,689,752	506,974	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,689,752		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other] [XX] Swing Bed SNF [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/IID [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	1.216702	2,551	3,104	50
53	Anesthesiology	1.723432	6,680	11,513	53
54	Radiology-Diagnostic	0.197571	32,185	6,359	54
58	MRI	0.188087	7,590	1,428	58
60	Laboratory	0.261074	185,752	48,495	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.728694	35,310	25,730	65
65.50	SLEEP LAB	0.250437			65.50
66	Physical Therapy	0.761370	372,029	283,252	66
69	Electrocardiology	0.074379	5,512	410	69
71	Medical Supplies Charged to Patients	0.052532	95,735	5,029	71
72	Impl. Dev. Charged to Patients	0.594583			72
73	Drugs Charged to Patients	0.296236	468,750	138,861	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
90	Clinic	0.754041			90
90.01	NORRIS CITY CLINIC				90.01
91	Emergency	0.760470			91
92	Observation Beds (Non-Distinct Part)	0.875808			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,212,094	524,181	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,212,094		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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/IID**	**[ ] 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	1.216702	6,788	8,259	50
53	Anesthesiology	1.723432	3,450	5,946	53
54	Radiology-Diagnostic	0.197571	27,785	5,490	54
58	MRI	0.188087			58
60	Laboratory	0.261074	51,060	13,330	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.728694	7,065	5,148	65
65.50	SLEEP LAB	0.250437			65.50
66	Physical Therapy	0.761370	610	464	66
69	Electrocardiology	0.074379	7,338	546	69
71	Medical Supplies Charged to Patients	0.052532	18,719	983	71
72	Impl. Dev. Charged to Patients	0.594583			72
73	Drugs Charged to Patients	0.296236	104,013	30,812	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
90	Clinic	0.754041			90
90.01	NORRIS CITY CLINIC				90.01
91	Emergency	0.760470	64	49	91
92	Observation Beds (Non-Distinct Part)	0.875808			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		226,892	71,027	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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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)	3,274,622			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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	3,274,622			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, col. 4, line 69)				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 ressonable 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)	3,307,368			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	25,158			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,020,188			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,262,022			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)	2,262,022			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,262,022			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)	193,994			34
35	Adjusted reimbursable bad debts (see instructions)	147,435			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	193,994			36
37	Subtotal (see instructions)	2,409,457			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,409,457			40
40.01	Sequestration adjustment (see instructions)	48,189			40.01
41	Interim payments	2,801,174			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-439,906			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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				1,506,732		2,582,520	1
2	Interim payments payable on individual bills, eitehr 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	01/02/2015	11,367	01/02/2015	122,406	3.01
	amount based on subsequent revision of the interim		.02	07/25/2015	17,198	07/25/2015	96,248	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		28,565		218,654	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)				1,535,297		2,801,174	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					6.01
	based on the cost report (1)		.02		-237,873		-439,906	6.02
7	Total Medicare program liability (see instructions)				1,297,424		2,361,268	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.

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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				1,750,975			1
2	Interim payments payable on individual bills, eitehr 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	01/02/2015	1,168			3.50
			.51	07/25/2015	2,753			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		-3,921			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)				1,747,054			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					6.01
	based on the cost report (1)		.02		-158,156			6.02
7	Total Medicare program liability (see instructions)				1,588,898			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.

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 (Wkst. S-3, Pt. I, col. 15, line 14)	650	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,451	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	4	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,921	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	24,749,296	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	324,364	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1	7
8	Calculation of the HIT incentive payment (see instructions)	1	8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	1	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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)	1,135,422		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, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	529,423		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	1,437		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 through 3 plus lines 6 and 7)	1,664,845		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,664,845		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,664,845		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	43,521		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)	1,621,324		15
16	Other Adjustments (SEQUESTRATION)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
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)	1,621,324		19
19.01	Sequestration adjustment (see instructions)	32,426		19.01
20	Interim payments	1,747,054		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	-158,156		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

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	1,642,106	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,642,106	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,658,527	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 physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	1,658,527	19
20	Deductibles (exclude professional component)	393,518	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,265,009	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,265,009	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	77,491	25
26	Adjusted reimbursable bad debts (see instructions)	58,893	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	77,491	27
28	Subtotal (sum of lines 24 and 26)	1,323,902	28
29	Other adjustments (SEQUESTRATION)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,323,902	30
30.01	Sequestration adjustment (see instructions)	26,478	30.01
31	Interim payments	1,535,297	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	-237,873	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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/IID [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		1,806,640	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)		1,806,640	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)		1,806,640	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)	226,892	4,381,199	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge 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)	1.000000	1.000000	15
16	Total customary charges (see instructions)	226,892	4,381,199	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 physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)		1,806,640	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	Titles V or XIX (sum of lines 21 and 27)		1,806,640	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)		1,806,640	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)		1,806,640	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)		1,806,640	38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)		1,806,640	40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)		1,806,640	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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	3,461,823				1
2	Temporary investments	3,552,660				2
3	Notes receivable					3
4	Accounts receivable	4,183,461				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-973,000				6
7	Inventory	350,503				7
8	Prepaid expenses	144,736				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	10,720,183				11
	FIXED ASSETS					
12	Land	69,760				12
13	Land improvements	632,359				13
14	Accumulated depreciation	-333,657				14
15	Buildings	21,663,588				15
16	Accumulated depreciation	-8,354,799				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	5,979,409				23
24	Accumulated depreciation	-4,899,221				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	632,504				27
28	Accumulated depreciation	-566,666				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	14,823,277				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	194,000		100,502		34
35	Total other assets (sum of lines 31-34)	194,000		100,502		35
36	Total assets (sum of lines 11, 30 and 35)	25,737,460		100,502		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	378,750				37
38	Salaries, wages and fees payable	569,712				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	470,000				40
41	Deferred income	194,620				41
42	Accelerated payments					42
43	Due to other funds	1,467,484				43
44	Other current liabilities	90,681				44
45	Total current liabilities (sum of lines 37 thru 44)	3,171,247				45
	LONG TERM LIABILITIES					
46	Mortgage payable	19,575,000				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)	19,575,000				50
51	Total liabilities (sum of lines 45 and 50)	22,746,247				51
	CAPITAL ACCOUNTS					
52	General fund balance	2,991,213				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted			100,502		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 thru 58)	2,991,213		100,502		59
60	Total liabilities and fund balances (sum of lines 51 and 59)	25,737,460		100,502		60

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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		3,112,508			1
2	Net income (loss) (from Worksheet G-3, line 29)		-120,894			2
3	Total (sum of line 1 and line 2)		2,991,614			3
4	Additions (credit adjustments) (specify)					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)		2,991,614			11
12	Deductions (debit adjustments) (specify)	401				12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		401			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,991,213			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period		100,101			1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)		100,101			3
4	Additions (credit adjustments) (specify)	401				4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		401			10
11	Subtotal (line 3 plus line 10)		100,502			11
12	Deductions (debit adjustments) (specify)					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)		100,502			19

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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	1,455,603		1,455,603	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	301,697		301,697	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)	1,757,300		1,757,300	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)	1,757,300		1,757,300	17
18	Ancillary services	2,405,659	15,165,540	17,571,199	18
19	Outpatient services		6,301,653	6,301,653	19
20	Rural Health Clinic (RHC)		582,419	582,419	20
20.01	RHC II		273,283	273,283	20.01
21	Federally Qualified Health Center (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)	4,162,959	22,322,895	26,485,854	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		15,210,165	29
30	BAD DEBTS	1,333,969		30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		1,333,969	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)		16,544,134	43

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	26,485,854	1
2	Less contractual allowances and discounts on patients' accounts	11,411,372	2
3	Net patient revenues (line 1 minus line 2)	15,074,482	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	16,544,134	4
5	Net income from service to patients (line 3 minus line 4)	-1,469,652	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	154,267	6
7	Income from investments	36,133	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	505	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	37	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	3,241	16
17	Revenue from sale of drugs to other than patients	6,220	17
18	Revenue from sale of medical records and abstracts	3,544	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	1,386	21
22	Rental of hosptial space		22
23	Governmental appropriations	541,884	23
24	Other (EHR INCENTIVE)	231,359	24
24.01	Other (OTHER)	370,182	24.01
25	Total other income (sum of lines 6-24)	1,348,758	25
26	Total (line 5 plus line 25)	-120,894	26
29	Net income (or loss) for the period (line 26 minus line 28)	-120,894	29

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 (see instructions)		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 (see instructions)		11
12	Total prospective capital payments (see instructions)		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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE 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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
65.50	SLEEP LAB							65.50
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	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 Centers							201
202	TOTAL (sum of lines 118-201)							202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

ANALYSIS OF HOSPITAL-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	555,189		555,189		555,189	-108,232	446,957	1
2	Physician Assistant								2
3	Nurse Practitioner	82,490		82,490		82,490		82,490	3
4	Visiting Nurse								4
5	Other Nurse	69,016		69,016		69,016		69,016	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	706,695		706,695		706,695	-108,232	598,463	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 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		19,512	19,512		19,512		19,512	15
16	Transportation (Health Care Staff)								16
17	Deperciation-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 through 20)		19,512	19,512		19,512		19,512	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	706,695	19,512	726,207		726,207	-108,232	617,975	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 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs	97,994	170,574	268,568	-26,252	242,316	2,035	244,351	30
31	Total Facility Overhead (sum of lines 29 and 30)	97,994	170,574	268,568	-26,252	242,316	2,035	244,351	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	804,689	190,086	994,775	-26,252	968,523	-106,197	862,326	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.

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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	2.08	2,868	4,200	8,736		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.73	974	2,100	1,533		3
4	Subtotal (sum of lines 1 through 3)	2.81	3,842		10,269	10,269	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 through 7)	2.81	3,842			10,269	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	617,975	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	617,975	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	244,351	14
15	Parent provider overhead allocated to facility (see instructions)	699,330	15
16	Total overhead (sum of lines 14 and 15)	943,681	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	943,681	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	943,681	19
20	Total allowable cost of RHC/FQHC sservices(sum of lines 10 and 19)	1,561,656	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.

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 Wkst. M-2, line 20)	1,561,656	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	12,427	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,549,229	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	10,269	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	10,269	6
7	Adjusted cost per visit (line 3 divided by line 6)	150.86	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)	150.86	150.86	150.86	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		1,351		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		203,812		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 (see instructions)		203,812		16
16.01	Total program charges (see instructions)(from contractor's records)		112,265		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		190		16.02
16.03	Total program preventive costs (see instructions)		345		16.03
16.04	Total program non-preventive costs (see instructions)		151,776		16.04
16.05	Total program cost (see instructions)		152,121		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		13,747		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19,666		19
20	Net Medicare cost excluding vaccines (see instructions)		152,121		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,684		21
22	Total reimbursable Program cost (line 20 plus line 21)		155,805		22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (SEQUESTRATION)				25
26	Net reimbursable amount (see instructions)		155,805		26
26.01	Sequestration adjustment (see instructions)		3,116		26.01
27	Interim payments		160,027		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		-7,338		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 Wkst. M-1, col. 7, line 10)	598,463	598,463	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000065	0.001059	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	39	634	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	867	3,378	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	906	4,012	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	617,975	617,975	6
7	Total overhead (from Wkst. M-2, line 16)	943,681	943,681	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001466	0.006492	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,383	6,126	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	2,289	10,138	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	13	211	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	176.08	48.05	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	7	51	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,233	2,451	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		12,427	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		3,684	16

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				160,027	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 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 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. M-3, line 27)				160,027	
	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 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	Determine net settlement amount (balance due)		.01			6.01
	based on the cost report (1)		.02		-7,338	6.02
7	Total Medicare program liability (see instructions)				152,689	

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.

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

ANALYSIS OF HOSPITAL-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	42,205		42,205		42,205	-9,584	32,621	1
2	Physician Assistant								2
3	Nurse Practitioner	129,431		129,431		129,431		129,431	3
4	Visiting Nurse								4
5	Other Nurse	47,313		47,313		47,313		47,313	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	218,949		218,949		218,949	-9,584	209,365	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 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Deperciation-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 through 20)								21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	218,949		218,949		218,949	-9,584	209,365	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 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs	26,118	78,824	104,942	-42,112	62,830		62,830	30
31	Total Facility Overhead (sum of lines 29 and 30)	26,118	78,824	104,942	-42,112	62,830		62,830	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	245,067	78,824	323,891	-42,112	281,779	-9,584	272,195	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.

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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	0.18	412	4,200	756		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.95	1,720	2,100	1,995		3
4	Subtotal (sum of lines 1 through 3)	1.13	2,132		2,751	2,751	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 through 7)	1.13	2,132			2,751	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	209,365	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	209,365	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	62,830	14
15	Parent provider overhead allocated to facility (see instructions)	268,957	15
16	Total overhead (sum of lines 14 and 15)	331,787	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	331,787	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	331,787	19
20	Total allowable cost of RHC/FQHC sservices(sum of lines 10 and 19)	541,152	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.

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 Wkst. M-2, line 20)	541,152	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	11,205	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	529,947	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	2,751	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	2,751	6
7	Adjusted cost per visit (line 3 divided by line 6)	192.64	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)	192.64	192.64	192.64	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		399		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		76,863		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 (see instructions)		76,863		16
16.01	Total program charges (see instructions)(from contractor's records)		49,527		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)		58,395		16.04
16.05	Total program cost (see instructions)		58,395		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		3,869		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,869		19
20	Net Medicare cost excluding vaccines (see instructions)		58,395		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,056		21
22	Total reimbursable Program cost (line 20 plus line 21)		64,451		22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		64,451		26
26.01	Sequestration adjustment (see instructions)		1,289		26.01
27	Interim payments		35,167		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		27,995		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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 Wkst. M-1, col. 7, line 10)	209,365	209,365	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000036	0.000392	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	8	82	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	867	3,378	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	875	3,460	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	209,365	209,365	6
7	Total overhead (from Wkst. M-2, line 16)	331,787	331,787	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004179	0.016526	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,387	5,483	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	2,262	8,943	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	3	33	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	754.00	271.00	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	3	14	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,262	3,794	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		11,205	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		6,056	16

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 10:12 Version: 2015.10 (10/27/2015)

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

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				35,167	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 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 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. M-3, line 27)				35,167	
	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 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	Determine net settlement amount (balance due)		.01		27,995	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				63,162	

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.