HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 10/20/2016 Time: 12:45 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 HAMILTON MEMORIAL HOSPITAL (14-1326) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 10/20/2016 12:45
BHxY6Pr17EwqjXt4mdq:OUJUXg.ed0
k2IWi01MUOb9flPKYFcxKxfze:HY44
lLty0QZ9vL0qp7vc

PI Encryption: 10/20/2016 12:45
N5Ixrs:UYXPNvbmOl9Ueq3j0IkaAN0
ZxPnV0yzGv83usgoUyZtpsw6Ky6OXK
LvcJ0yBW0H0HbgXZ

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		247,246	-482,195	1	2,209,976	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		228,842				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			96,943			10
10.01	HEALTH CLINIC - RHC II			-38,643			10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		476,088	-423,895	1	2,209,976	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 / 2015	To: 06 / 30 / 2016	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
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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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

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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

Rural Providers				1	2	
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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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

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
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those 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	08/08/2016	Y	08/08/2016	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 services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost 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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	9,150	36,936.00		1,047	218	1,539	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						1,327		1,327	5
6	Hospital Adults & Peds. Swing Bed NF								314	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,150	36,936.00		2,374	218	3,180	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	9,150	36,936.00		2,374	218	3,180	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					2,261		8,022	26
26.01	RHC II	88.01					744		5,533	26.01
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							50	301	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)					373	92	562	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)		110.76			373	92	562	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		12.79						26
26.01	RHC II		6.50						26.01
27	Total (sum of lines 14-26)		130.05						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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	0.519816	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,175,616	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	6,593,336	6
7	Medicaid cost (line 1 times line 6)	3,427,322	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	1,251,706	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)	1,251,706	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	41,592	778,006	819,598	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	21,620	404,420	426,040	21
22	Partial payment by patients approved for charity care		1,540	1,540	22
23	Cost of charity care (line 21 minus line 22)	21,620	402,880	424,500	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)	1,524,507	26
27	Medicare bad debts for the entire hospital complex (see instructions)	181,589	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,342,918	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	698,070	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,122,570	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,374,276	31

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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		986,993	986,993	1,008,859	1,995,852	-18,157	1,977,695	1
2	00200	Cap Rel Costs-Mvble Equip		413,592	413,592	264,942	678,534	-100,474	578,060	2
3	00300	Other Cap Rel Costs		68,945	68,945	-68,945			-0-	3
4	00400	Employee Benefits Department		1,426,868	1,426,868		1,426,868	-33,403	1,393,465	4
5.01	00540	NONPATIENT TELEPHONES		24,362	24,362		24,362		24,362	5.01
5.02	00550	DATA PROCESSING	119,227	75,518	194,745		194,745		194,745	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	44,924	3,179	48,103		48,103	-534	47,569	5.03
5.04	00570	ADMITTING				173,618	173,618		173,618	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	249,417	319,550	568,967	-173,618	395,349		395,349	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	400,659	384,591	785,250	39,275	824,525	-262,420	562,105	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	125,587	628,300	753,887	-4,759	749,128		749,128	7
8	00800	Laundry & Linen Service		54,461	54,461		54,461		54,461	8
9	00900	Housekeeping	138,725	19,239	157,964		157,964		157,964	9
10	01000	Dietary		94,113	94,113		94,113	-120	93,993	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	214,658	7,296	221,954		221,954	-46,929	175,025	13
14	01400	Central Services & Supply		33,918	33,918	-26,939	6,979		6,979	14
15	01500	Pharmacy	182,397	348,457	530,854	-287,168	243,686		243,686	15
16	01600	Medical Records & Library	171,666	34,835	206,501		206,501	-4,559	201,942	16
17	01700	Social Service	48,420	880	49,300		49,300		49,300	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	1,164,285	185,270	1,349,555		1,349,555		1,349,555	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	137,062	361,482	498,544	-174,813	323,731		323,731	50
53	05300	Anesthesiology	252,606	42,270	294,876	-13,014	281,862		281,862	53
54	05400	Radiology-Diagnostic	322,908	373,308	696,216	-128,610	567,606		567,606	54
58	05800	MRI				82,410	82,410		82,410	58
60	06000	Laboratory	466,235	707,412	1,173,647	-6,000	1,167,647		1,167,647	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	90,333	33,419	123,752	-4,430	119,322		119,322	65
65.50	06501	SLEEP LAB		32,850	32,850		32,850		32,850	65.50
66	06600	Physical Therapy	420,220	207,954	628,174	-12	628,162		628,162	66
69	06900	Electrocardiology		17,864	17,864		17,864		17,864	69
71	07100	Medical Supplies Charged to Patients				78,042	78,042	-13,643	64,399	71
72	07200	Impl. Dev. Charged to Patients				75,537	75,537		75,537	72
73	07300	Drugs Charged to Patients				270,813	270,813	-5,044	265,769	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	1,180,656	264,551	1,445,207	-22,774	1,422,433	-203,941	1,218,492	88
88.01	08801	RHC II	389,496	120,112	509,608	-60,434	449,174	-6,859	442,315	88.01
90	09000	Clinic	223,442	177,436	400,878		400,878		400,878	90
90.01	09001	NORRIS CITY CLINIC								90.01
91	09100	Emergency	503,285	1,729,975	2,233,260	-17,124	2,216,136	-1,156,323	1,059,813	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		976,771	976,771	-976,771				113
117	06950	OTHER SPECIAL PURPOSE COST CENTERS								117
117.02	06952	SUPPLIES AND EXPENSE		6,833	6,833	-6,833				117.02
118		SUBTOTALS (sum of lines 1-117)	6,846,208	10,162,604	17,008,812	21,252	17,030,064	-1,852,406	15,177,658	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices	78,915	122,929	201,844	-21,252	180,592		180,592	192
200		TOTAL (sum of lines 118-199)	6,925,123	10,285,533	17,210,656		17,210,656	-1,852,406	15,358,250	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		976,771	1
500	Total reclassifications					976,771	500
	Code Letter - A						
1	TO RECLASS RENT EXPENSE	B	Cap Rel Costs-Mvble Equip	2		254,757	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	Total reclassifications					254,757	500
	Code Letter - B						
1	RECLASS INSURANCE COST	C	OTHER ADMINISTRATIVE AND GENE	5.06		26,672	1
500	Total reclassifications					26,672	500
	Code Letter - C						
1	ADMITTING	D	ADMITTING	5.04	83,056	90,562	1
500	Total reclassifications				83,056	90,562	500
	Code Letter - D						
1	RECLASS SUPPLIES SOLD	E	Medical Supplies Charged to P	71		153,579	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					153,579	500
	Code Letter - E						
1	RECLASS DRUGS TO PHARMACY	F	Drugs Charged to Patients	73		186,916	1
500	Total reclassifications					186,916	500
	Code Letter - F						
1	RECLASS SUPPLIES SOLD	G	Central Services & Supply	14		6,833	1
500	Total reclassifications					6,833	500
	Code Letter - G						
1	RECLASS IV COST	H	Drugs Charged to Patients	73		83,897	1
2							2
500	Total reclassifications					83,897	500
	Code Letter - H						
1	RECLASS MALPRACTICE	I	OTHER ADMINISTRATIVE AND GENE	5.06		22,751	1
500	Total reclassifications					22,751	500
	Code Letter - I						
1	RECLASS IPL DEVICES	J	Impl. Dev. Charged to Patient	72		75,537	1
500	Total reclassifications					75,537	500
	Code Letter - J						
1	RECLASS MRI COST	K	MRI	58		82,410	1
500	Total reclassifications					82,410	500
	Code Letter - K						
1	RECLASS UTLITIES IN PHYS OFFICE	L	OTHER ADMINISTRATIVE AND GENE	5.06		1,162	1
500	Total reclassifications					1,162	500
	Code Letter - L						
	GRAND TOTAL (Increases)				83,056	1,961,847	

(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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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		976,771	11	1
500	Total reclassifications					976,771		500
	Code letter - A							
1	TO RECLASS RENT EXPENSE	B	OTHER ADMINISTRATIVE AND GENE	5.06		11,310	10	1
2			Operating Room	50		68,630		2
3			Respiratory Therapy	65		1,717		3
4			Radiology-Diagnostic	54		46,200		4
5			Laboratory	60		6,000		5
6			Pharmacy	15		35,681		6
7			Operation of Plant	7		4,759		7
8			RHC II	88.01		60,370		8
9			Physicians' Private Offices	192		20,090		9
500	Total reclassifications					254,757		500
	Code letter - B							
1	RECLASS INSURANCE COST	C	Other Cap Rel Costs	3		26,672		1
500	Total reclassifications					26,672		500
	Code letter - C							
1	ADMITTING	D	CASHIERING/ACCOUNTS RECEIVABL	5.05	83,056	90,562		1
500	Total reclassifications				83,056	90,562		500
	Code letter - D							
1	RECLASS SUPPLIES SOLD	E	Emergency	91		17,124		1
2			Anesthesiology	53		13,014		2
3			Operating Room	50		106,183		3
4			Respiratory Therapy	65		2,713		4
5			RHC II	88.01		64		5
6			Central Services & Supply	14		14,446		6
7			Physical Therapy	66		12		7
8			Rural Health Clinic	88		23		8
500	Total reclassifications					153,579		500
	Code letter - E							
1	RECLASS DRUGS TO PHARMACY	F	Pharmacy	15		186,916		1
500	Total reclassifications					186,916		500
	Code letter - F							
1	RECLASS SUPPLIES SOLD	G	SUPPLIES AND EXPENSE	117.02		6,833		1
500	Total reclassifications					6,833		500
	Code letter - G							
1	RECLASS IV COST	H	Pharmacy	15		64,571		1
2			Central Services & Supply	14		19,326		2
500	Total reclassifications					83,897		500
	Code letter - H							
1	RECLASS MALPRACTICE	I	Rural Health Clinic	88		22,751		1
500	Total reclassifications					22,751		500
	Code letter - I							
1	RECLASS IPL DEVICES	J	Medical Supplies Charged to P	71		75,537		1
500	Total reclassifications					75,537		500
	Code letter - J							
1	RECLASS MRI COST	K	Radiology-Diagnostic	54		82,410		1
500	Total reclassifications					82,410		500
	Code letter - K							
1	RECLASS UTLITIES IN PHYS OFFICE	L	Physicians' Private Offices	192		1,162		1
500	Total reclassifications					1,162		500
	Code letter - L							
	GRAND TOTAL (Decreases)				83,056	1,961,847		

(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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	632,358				25,246	607,112		2
3	Buildings and Fixtures	21,656,164	56,270		56,270	961,747	20,750,687		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	5,996,409	884,142		884,142	702,561	6,177,990		6
7	HIT-designated Assets	622,926					622,926		7
8	Subtotal (sum of lines 1-7)	28,977,617	940,412		940,412	1,689,554	28,228,475		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	28,977,617	940,412		940,412	1,689,554	28,228,475		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	986,993						986,993	1
2	Cap Rel Costs-Mvble Equip	413,592						413,592	2
3	Total (sum of lines 1-2)	1,400,585						1,400,585	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	21,427,559		21,427,559	0.759076	32,088			32,088	1
2	Cap Rel Costs-Mvble Equ	6,800,916		6,800,916	0.240924	10,185			10,185	2
3	Total (sum of lines 1-2)	28,228,475		28,228,475	1.000000	42,273			42,273	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	986,993		958,614	32,088			1,977,695	1
2	Cap Rel Costs-Mvble Equip	313,118	254,757		10,185			578,060	2
3	Total (sum of lines 1-2)	1,300,111	254,757	958,614	42,273			2,555,755	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	-36,436	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	-534	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	-7,344	OTHER ADMINISTRATIVE AND GENERAL	5.06		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,156,323				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	-120	Dietary	10		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-13,643	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients	B	-5,044	Drugs Charged to Patients	73		17
18	Sale of medical records and abstracts	B	-4,559	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-1,454	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	-96,071	Cap Rel Costs-Mvble Equip	2	9	32
33	COMMUNITY PROGRAM	B	-2,894	OTHER ADMINISTRATIVE AND GENERAL	5.06		33
34							34
35	PORTION OF LOBBYING DUES	A	-5,630	OTHER ADMINISTRATIVE AND GENERAL	5.06		35
36	WOMENS WELLNESS	B	-97,312	OTHER ADMINISTRATIVE AND GENERAL	5.06		36
37	PHYSICIAN RECRUITMENT	A	-30,067	OTHER ADMINISTRATIVE AND GENERAL	5.06		37
38	ADVERTISING	A	-98,652	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	-4,403	Cap Rel Costs-Mvble Equip	2	9	42
43							43
44	NURSING CENTER SERVICES	B	-960	OTHER ADMINISTRATIVE AND GENERAL	5.06		44
45							45
45.06	FUNDRAISING	A	-18,107	OTHER ADMINISTRATIVE AND GENERAL	5.06		45.06
45.09	NON RHC COST SALARY	A	-203,941	Rural Health Clinic	88		45.09
45.10	NON RHC COST SALARY	A	-6,859	RHC II	88.01		45.10
45.11	NON RHC BENEFITS	A	-23,729	Employee Benefits Department	4		45.11
46	WHITE OAKS SALARY	A	-46,929	Nursing Administration	13		46
47	WHITE OAKS BENEFITS	A	-9,674	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)		-1,852,406				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.

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	1,584,004	1,156,323	427,681					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	1,584,004	1,156,323	427,681					200

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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							1,156,323	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							1,156,323	200

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)					259	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		2,000.00	13.25			9
10	AHSEA (see instructions)		75.07	56.30			10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.54	37.54	28.15			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)	150,140	15
16	Assistants (column 3, line 9 times column 3, line 10)	746	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	150,886	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)	150,886	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)	150,886	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)	9,723	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)	9,723	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)	9,723	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)	9,723	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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	150,886	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	9,723	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)	160,609	63
64	Total cost of outside supplier services (from provider records)	120,631	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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)					248	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		285.25				9
10	AHSEA (see instructions)		79.21				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)	39.61	39.61				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)	22,595	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)	22,595	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)	22,595	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)	79.21	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	61,784	22
23	Total salary equivalency (see instructions)	61,784	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)	9,823	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)	9,823	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)	9,823	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)	9,823	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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	61,784	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	9,823	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)	71,607	63
64	Total cost of outside supplier services (from provider records)	17,105	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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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)					196	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		601.00				9
10	AHSEA (see instructions)		72.14				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)	36.07	36.07				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)	43,356	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)	43,356	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)	43,356	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)	72.14	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	56,269	22
23	Total salary equivalency (see instructions)	56,269	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)	7,070	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)	7,070	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)	7,070	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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	56,269	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)	56,269	63
64	Total cost of outside supplier services (from provider records)	29,887	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	1,977,695	1,977,695					1
2	Cap Rel Costs-Mvble Equip	578,060		578,060				2
4	Employee Benefits Department	1,393,465			1,393,465			4
5.01	NONPATIENT TELEPHONES	24,362	965	282		25,609		5.01
5.02	DATA PROCESSING	194,745			24,905		219,650	5.02
5.03	PURCHASING RECEIVING AND STORES	47,569	54,736	15,999	9,384	289		5.03
5.04	ADMITTING	173,618			17,350			5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	395,349	38,340	11,206	34,751		178,190	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	562,105	237,729	69,486	83,694	4,196	41,460	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	749,128	171,684	50,182	26,234	579		7
8	Laundry & Linen Service	54,461	23,052	6,738		145		8
9	Housekeeping	157,964			28,978			9
10	Dietary	93,993						10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	175,025	36,169	10,572	35,037	723		13
14	Central Services & Supply	6,979						14
15	Pharmacy	243,686	28,284	8,267	38,101	579		15
16	Medical Records & Library	201,942	30,069	8,789	35,859	1,013		16
17	Social Service	49,300	4,630	1,353	10,115	434		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	1,349,555	328,972	96,153	243,211	4,631		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	323,731	161,557	47,221	28,631	1,157		50
53	Anesthesiology	281,862			52,767			53
54	Radiology-Diagnostic	567,606	114,585	33,492	67,453	1,302		54
58	MRI	82,410				145		58
60	Laboratory	1,167,647	41,595	12,158	97,392	1,157		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	119,322	16,879	4,934	18,870	868		65
65.50	SLEEP LAB	32,850	9,042	2,643		434		65.50
66	Physical Therapy	628,162	108,388	31,681	87,780	1,157		66
69	Electrocardiology	17,864						69
71	Medical Supplies Charged to Patients	64,399						71
72	Impl. Dev. Charged to Patients	75,537						72
73	Drugs Charged to Patients	265,769						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	1,218,492	180,389	52,726	204,721	2,604		88
88.01	RHC II	442,315	84,878	24,809	79,940	579		88.01
90	Clinic	400,878	69,445	20,298	46,675	723		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	1,059,813	110,871	32,407	105,132	1,881		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)	15,177,658	1,852,259	541,396	1,376,980	24,596	219,650	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	180,592	125,436	36,664	16,485	1,013		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	15,358,250	1,977,695	578,060	1,393,465	25,609	219,650	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING, RECEIVING AND STOR	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMINISTRATIVE 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	127,977						5.03
5.04	ADMITTING		190,968					5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE			657,836				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,504			1,000,174	1,000,174		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	4,057			1,001,864	69,789	1,071,653	7
8	Laundry & Linen Service	221			84,617	5,894	16,757	8
9	Housekeeping	1,527			188,469	13,129		9
10	Dietary	231			94,224	6,564		10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	178			257,704	17,951	26,292	13
14	Central Services & Supply	8,208			15,187	1,058		14
15	Pharmacy	16,622			335,539	23,373	20,561	15
16	Medical Records & Library	631			278,303	19,386	21,858	16
17	Social Service	63			65,895	4,590	3,365	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	7,422	52,911	33,025	2,115,880	147,395	239,136	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,821	1,992	21,514	600,624	41,839	117,439	50
53	Anesthesiology	2,660	948	7,003	345,240	24,049		53
54	Radiology-Diagnostic	2,856	10,243	137,121	934,658	65,107	83,294	54
58	MRI		1,374	13,178	97,107	6,764		58
60	Laboratory	47,623	39,236	160,949	1,567,757	109,208	30,236	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	928	13,703	12,558	188,062	13,100	12,270	65
65.50	SLEEP LAB			5,743	50,712	3,533	6,573	65.50
66	Physical Therapy	1,378	16,089	30,793	905,428	63,071	78,789	66
69	Electrocardiology	97	1,187	10,682	29,830	2,078		69
71	Medical Supplies Charged to Patients		437	742	65,578	4,568		71
72	Impl. Dev. Charged to Patients			3,127	78,664	5,480		72
73	Drugs Charged to Patients		49,833	52,730	368,332	25,658		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	2,723	3,015	21,644	1,686,314	117,467	131,128	88
88.01	RHC II	2,981		13,761	649,263	45,227	61,699	88.01
90	Clinic	1,811		30,371	570,201	39,720	50,481	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	7,762		102,895	1,420,761	98,969	80,594	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)	126,304	190,968	657,836	14,996,387	974,967	980,472	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,673			361,863	25,207	91,181	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	127,977	190,968	657,836	15,358,250	1,000,174	1,071,653	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	107,268						8
9	Housekeeping		201,598					9
10	Dietary			100,788				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		587		302,534			13
14	Central Services & Supply					16,245		14
15	Pharmacy						379,473	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	67,218	63,642	100,788	208,089			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,817	18,149		17,752			50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,663	10,390					54
58	MRI	165						58
60	Laboratory		7,781					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
65.50	SLEEP LAB							65.50
66	Physical Therapy	12,581	14,193					66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients					8,915		71
72	Impl. Dev. Charged to Patients					7,330		72
73	Drugs Charged to Patients						379,473	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	734	31,256					88
88.01	RHC II							88.01
90	Clinic		7,781					90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	22,090	47,471		76,693			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)	107,268	201,250	100,788	302,534	16,245	379,473	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		348					192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	107,268	201,598	100,788	302,534	16,245	379,473	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	319,547						16
17	Social Service		73,850					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	88,046	22,817	3,053,011		3,053,011		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			798,620		798,620		50
53	Anesthesiology			369,289		369,289		53
54	Radiology-Diagnostic			1,095,112		1,095,112		54
58	MRI			104,036		104,036		58
60	Laboratory	118,905		1,833,887		1,833,887		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			213,432		213,432		65
65.50	SLEEP LAB			60,818		60,818		65.50
66	Physical Therapy		6,379	1,080,441		1,080,441		66
69	Electrocardiology			31,908		31,908		69
71	Medical Supplies Charged to Patients			79,061		79,061		71
72	Impl. Dev. Charged to Patients			91,474		91,474		72
73	Drugs Charged to Patients			773,463		773,463		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		19,383	1,986,282		1,986,282		88
88.01	RHC II			756,189		756,189		88.01
90	Clinic			668,183		668,183		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	112,596	25,271	1,884,445		1,884,445		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)	319,547	73,850	14,879,651		14,879,651		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			478,599		478,599		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	319,547	73,850	15,358,250		15,358,250		202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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		965	282	1,247	1,247		5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES		54,736	15,999	70,735	14	70,749	5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		38,340	11,206	49,546			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		237,729	69,486	307,215	204	832	5.06
6	Maintenance & Repairs							6
7	Operation of Plant		171,684	50,182	221,866	28	2,243	7
8	Laundry & Linen Service		23,052	6,738	29,790	7	122	8
9	Housekeeping						844	9
10	Dietary						128	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		36,169	10,572	46,741	35	99	13
14	Central Services & Supply						4,538	14
15	Pharmacy		28,284	8,267	36,551	28	9,189	15
16	Medical Records & Library		30,069	8,789	38,858	49	349	16
17	Social Service		4,630	1,353	5,983	21	35	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		328,972	96,153	425,125	229	4,103	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		161,557	47,221	208,778	56	8,193	50
53	Anesthesiology						1,470	53
54	Radiology-Diagnostic		114,585	33,492	148,077	63	1,579	54
58	MRI					7		58
60	Laboratory		41,595	12,158	53,753	56	26,326	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		16,879	4,934	21,813	42	513	65
65.50	SLEEP LAB		9,042	2,643	11,685	21		65.50
66	Physical Therapy		108,388	31,681	140,069	56	762	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		180,389	52,726	233,115	127	1,505	88
88.01	RHC II		84,878	24,809	109,687	28	1,648	88.01
90	Clinic		69,445	20,298	89,743	35	1,001	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency		110,871	32,407	143,278	92	4,291	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)		1,852,259	541,396	2,393,655	1,198	69,824	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		125,436	36,664	162,100	49	925	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,977,695	578,060	2,555,755	1,247	70,749	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	49,546						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		308,251					5.06
6	Maintenance & Repairs							6
7	Operation of Plant		21,509	245,646				7
8	Laundry & Linen Service		1,817	3,841	35,577			8
9	Housekeeping		4,046			4,890		9
10	Dietary		2,023				2,151	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		5,533	6,027		14		13
14	Central Services & Supply		326					14
15	Pharmacy		7,204	4,713				15
16	Medical Records & Library		5,975	5,010				16
17	Social Service		1,415	771				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	2,488	45,421	54,816	22,294	1,545	2,151	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,621	12,895	26,919	934	440		50
53	Anesthesiology	528	7,412					53
54	Radiology-Diagnostic	10,329	20,066	19,093	552	252		54
58	MRI	993	2,085		55			58
60	Laboratory	12,113	33,658	6,931		189		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	946	4,038	2,812				65
65.50	SLEEP LAB	433	1,089	1,507				65.50
66	Physical Therapy	2,320	19,439	18,060	4,173	344		66
69	Electrocardiology	805	640					69
71	Medical Supplies Charged to Patients	56	1,408					71
72	Impl. Dev. Charged to Patients	236	1,689					72
73	Drugs Charged to Patients	3,972	7,908					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	1,630	36,203	30,057	243	758		88
88.01	RHC II	1,037	13,939	14,143				88.01
90	Clinic	2,288	12,242	11,571		189		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	7,751	30,502	18,474	7,326	1,151		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)	49,546	300,482	224,745	35,577	4,882	2,151	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		7,769	20,901		8		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	49,546	308,251	245,646	35,577	4,890	2,151	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	58,449						13
14	Central Services & Supply		4,864					14
15	Pharmacy			57,685				15
16	Medical Records & Library				50,241			16
17	Social Service					8,225		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	40,202			13,843	2,541	614,758	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,430					263,266	50
53	Anesthesiology						9,410	53
54	Radiology-Diagnostic						200,011	54
58	MRI						3,140	58
60	Laboratory				18,695		151,721	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy						30,164	65
65.50	SLEEP LAB						14,735	65.50
66	Physical Therapy					710	185,933	66
69	Electrocardiology						1,499	69
71	Medical Supplies Charged to Patients		2,669				4,133	71
72	Impl. Dev. Charged to Patients		2,195				4,120	72
73	Drugs Charged to Patients			57,685			69,565	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					2,159	305,797	88
88.01	RHC II						140,482	88.01
90	Clinic						117,069	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	14,817			17,703	2,815	248,200	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)	58,449	4,864	57,685	50,241	8,225	2,364,003	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices						191,752	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	58,449	4,864	57,685	50,241	8,225	2,555,755	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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		614,758					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		263,266					50
53	Anesthesiology		9,410					53
54	Radiology-Diagnostic		200,011					54
58	MRI		3,140					58
60	Laboratory		151,721					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		30,164					65
65.50	SLEEP LAB		14,735					65.50
66	Physical Therapy		185,933					66
69	Electrocardiology		1,499					69
71	Medical Supplies Charged to Patients		4,133					71
72	Impl. Dev. Charged to Patients		4,120					72
73	Drugs Charged to Patients		69,565					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		305,797					88
88.01	RHC II		140,482					88.01
90	Clinic		117,069					90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency		248,200					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)		2,364,003					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		191,752					192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,555,755					202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	82,018						1
2	Cap Rel Costs-Mvble Equip		82,018					2
4	Employee Benefits Department			6,670,765				4
5.01	NONPATIENT TELEPHONES	40	40		177			5.01
5.02	DATA PROCESSING			119,227		249		5.02
5.03	PURCHASING RECEIVING AND STORES	2,270	2,270	44,924	2		1,535,616	5.03
5.04	ADMITTING			83,056				5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,590	1,590	166,361		202		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,859	9,859	400,659	29	47	18,050	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	7,120	7,120	125,587	4		48,684	7
8	Laundry & Linen Service	956	956		1		2,654	8
9	Housekeeping			138,725			18,325	9
10	Dietary						2,770	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,500	1,500	167,729	5		2,139	13
14	Central Services & Supply						98,489	14
15	Pharmacy	1,173	1,173	182,397	4		199,446	15
16	Medical Records & Library	1,247	1,247	171,666	7		7,577	16
17	Social Service	192	192	48,420	3		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	13,643	13,643	1,164,285	32		89,053	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,700	6,700	137,062	8		177,841	50
53	Anesthesiology			252,606			31,912	53
54	Radiology-Diagnostic	4,752	4,752	322,908	9		34,268	54
58	MRI				1			58
60	Laboratory	1,725	1,725	466,235	8		571,437	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	700	700	90,333	6		11,139	65
65.50	SLEEP LAB	375	375		3			65.50
66	Physical Therapy	4,495	4,495	420,220	8		16,529	66
69	Electrocardiology						1,163	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	980,036	18		32,671	88
88.01	RHC II	3,520	3,520	382,687	4		35,767	88.01
90	Clinic	2,880	2,880	223,442	5		21,733	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	4,598	4,598	503,285	13		93,132	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	6,591,850	170	249	1,515,537	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	5,202	5,202	78,915	7		20,079	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,977,695	578,060	1,393,465	25,609	219,650	127,977	202
203	Unit Cost Multiplier (Wkst. B, Part I)	24.112939	7.047965	0.208891	144.683616	882.128514	0.083339	203
204	Cost to be allocated (Per Wkst. B, Part II)				1,247		70,749	204
205	Unit Cost Multiplier (Wkst. B, Part II)				7.045198		0.046072	205

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	5,381,114						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		30,289,790					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-1,000,174	14,358,076			5.06
6	Maintenance & Repairs							6
7	Operation of Plant				1,001,864	61,139		7
8	Laundry & Linen Service				84,617	956	21,478	8
9	Housekeeping				188,469			9
10	Dietary				94,224			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				257,704	1,500		13
14	Central Services & Supply				15,187			14
15	Pharmacy				335,539	1,173		15
16	Medical Records & Library				278,303	1,247		16
17	Social Service				65,895	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	1,491,021	1,520,618		2,115,880	13,643	13,459	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	56,123	990,621		600,624	6,700	564	50
53	Anesthesiology	26,711	322,441		345,240			53
54	Radiology-Diagnostic	288,637	6,313,709		934,658	4,752	333	54
58	MRI	38,721	606,790		97,107		33	58
60	Laboratory	1,105,577	7,410,741		1,567,757	1,725		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	386,115	578,226		188,062	700		65
65.50	SLEEP LAB		264,424		50,712	375		65.50
66	Physical Therapy	453,339	1,417,860		905,428	4,495	2,519	66
69	Electrocardiology	33,438	491,851		29,830			69
71	Medical Supplies Charged to Patients	12,302	34,177		65,578			71
72	Impl. Dev. Charged to Patients		144,000		78,664			72
73	Drugs Charged to Patients	1,404,185	2,427,924		368,332			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	84,945	996,606		1,686,314	7,481	147	88
88.01	RHC II		633,607		649,263	3,520		88.01
90	Clinic		1,398,433		570,201	2,880		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency		4,737,762		1,420,761	4,598	4,423	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)	5,381,114	30,289,790	-1,000,174	13,996,213	55,937	21,478	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices				361,863	5,202		192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	190,968	657,836		1,000,174	1,071,653	107,268	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.035489	0.021718		0.069659	17.528141	4.994320	203
204	Cost to be allocated (Per Wkst. B, Part II)		49,546		308,251	245,646	35,577	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.001636		0.021469	4.017828	1.656439	205

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	9,275						9
10	Dietary		12,090					10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	27		78,788				13
14	Central Services & Supply				153,579			14
15	Pharmacy					270,813		15
16	Medical Records & Library						31,303	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	2,928	12,090	54,192			8,625	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	835		4,623				50
53	Anesthesiology							53
54	Radiology-Diagnostic	478						54
58	MRI							58
60	Laboratory	358					11,648	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				84,279			71
72	Impl. Dev. Charged to Patients				69,300			72
73	Drugs Charged to Patients					270,813		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	2,184		19,973			11,030	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	9,259	12,090	78,788	153,579	270,813	31,303	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	16						192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	201,598	100,788	302,534	16,245	379,473	319,547	202
203	Unit Cost Multiplier (Wkst. B, Part I)	21.735633	8.336476	3.839849	0.105776	1.401236	10.208191	203
204	Cost to be allocated (Per Wkst. B, Part II)	4,890	2,151	58,449	4,864	57,685	50,241	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.527224	0.177916	0.741852	0.031671	0.213007	1.604990	205

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	9,030						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	2,790						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	780						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	2,370						88
88.01	RHC II							88.01
90	Clinic							90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	3,090						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	9,030						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)	73,850						202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.178295						203
204	Cost to be allocated (Per Wkst. B, Part II)	8,225						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.910853						205

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	3,053,011		3,053,011		3,053,011	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	798,620		798,620		798,620	50
53	Anesthesiology	369,289		369,289		369,289	53
54	Radiology-Diagnostic	1,095,112		1,095,112		1,095,112	54
58	MRI	104,036		104,036		104,036	58
60	Laboratory	1,833,887		1,833,887		1,833,887	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	213,432		213,432		213,432	65
65.50	SLEEP LAB	60,818		60,818		60,818	65.50
66	Physical Therapy	1,080,441		1,080,441		1,080,441	66
69	Electrocardiology	31,908		31,908		31,908	69
71	Medical Supplies Charged to Patients	79,061		79,061		79,061	71
72	Impl. Dev. Charged to Patients	91,474		91,474		91,474	72
73	Drugs Charged to Patients	773,463		773,463		773,463	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	1,986,282		1,986,282		1,986,282	88
88.01	RHC II	756,189		756,189		756,189	88.01
90	Clinic	668,183		668,183		668,183	90
90.01	NORRIS CITY CLINIC						90.01
91	Emergency	1,884,445		1,884,445		1,884,445	91
92	Observation Beds (Non-Distinct Part)	286,119		286,119		286,119	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)	15,165,770		15,165,770		15,165,770	200
201	Less Observation Beds	286,119		286,119		286,119	201
202	Total (line 200 minus line 201)	14,879,651		14,879,651		14,879,651	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	1,520,618		1,520,618				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	49,627	798,729	848,356	0.941374	0.941374	0.941374	50
53	Anesthesiology	40,339	253,554	293,893	1.256542	1.256542	1.256542	53
54	Radiology-Diagnostic	282,520	5,870,667	6,153,187	0.177975	0.177975	0.177975	54
58	MRI	38,721	568,069	606,790	0.171453	0.171453	0.171453	58
60	Laboratory	1,105,577	6,305,164	7,410,741	0.247463	0.247463	0.247463	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	253,069	120,465	373,534	0.571386	0.571386	0.571386	65
65.50	SLEEP LAB		264,424	264,424	0.230002	0.230002	0.230002	65.50
66	Physical Therapy	453,339	964,521	1,417,860	0.762022	0.762022	0.762022	66
69	Electrocardiology	33,538	458,313	491,851	0.064873	0.064873	0.064873	69
71	Medical Supplies Charged to Patients	203,333	353,646	556,979	0.141946	0.141946	0.141946	71
72	Impl. Dev. Charged to Patients		164,808	164,808	0.555034	0.555034	0.555034	72
73	Drugs Charged to Patients	1,404,185	1,023,739	2,427,924	0.318570	0.318570	0.318570	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	84,945	911,661	996,606				88
88.01	RHC II		633,607	633,607				88.01
90	Clinic		1,398,433	1,398,433	0.477808	0.477808	0.477808	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	3,000	2,749,433	2,752,433	0.684647	0.684647	0.684647	91
92	Observation Beds (Non-Distinct Part)	1,705	311,099	312,804	0.914691	0.914691	0.914691	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)	5,474,516	23,150,332	28,624,848				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	5,474,516	23,150,332	28,624,848				202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	0.941374		298,615			281,108		50
53	Anesthesiology	1.256542		151,933			190,910		53
54	Radiology-Diagnostic	0.177975		2,325,333			413,851		54
58	MRI	0.171453		179,773			30,823		58
60	Laboratory	0.247463		2,909,607			720,020		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.571386		32,836			18,762		65
65.50	SLEEP LAB	0.230002		74,020			17,025		65.50
66	Physical Therapy	0.762022		252,694			192,558		66
69	Electrocardiology	0.064873		247,641			16,065		69
71	Medical Supplies Charged to Pat	0.141946		122,294			17,359		71
72	Impl. Dev. Charged to Patients	0.555034		127,008			70,494		72
73	Drugs Charged to Patients	0.318570		417,145			132,890		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	0.477808		1,256,409			600,322		90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	0.684647		1,062,848			727,676		91
92	Observation Beds (Non-Distinct	0.914691		176,644			161,575		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			9,634,800			3,591,438		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			9,634,800			3,591,438		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	0.941374							50
53	Anesthesiology	1.256542							53
54	Radiology-Diagnostic	0.177975							54
58	MRI	0.171453							58
60	Laboratory	0.247463							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.571386							65
65.50	SLEEP LAB	0.230002							65.50
66	Physical Therapy	0.762022							66
69	Electrocardiology	0.064873							69
71	Medical Supplies Charged to Pat	0.141946							71
72	Impl. Dev. Charged to Patients	0.555034							72
73	Drugs Charged to Patients	0.318570							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	0.477808							90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	0.684647							91
92	Observation Beds (Non-Distinct	0.914691							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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	614,758	262,571	352,187	1,840	191.41	218	41,727	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)	614,758		352,187	1,840		218	41,727	200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[XX] PPS** **[ ] TEFRA**

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	263,266	848,356	0.310325	7,797	2,420	50
53	Anesthesiology	9,410	293,893	0.032018	12,543	402	53
54	Radiology-Diagnostic	200,011	6,153,187	0.032505	25,882	841	54
58	MRI	3,140	606,790	0.005175			58
60	Laboratory	151,721	7,410,741	0.020473	111,957	2,292	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	30,164	373,534	0.080753	9,206	743	65
65.50	SLEEP LAB	14,735	264,424	0.055725			65.50
66	Physical Therapy	185,933	1,417,860	0.131136	1,293	170	66
69	Electrocardiology	1,499	491,851	0.003048	11,351	35	69
71	Medical Supplies Charged to Pat	4,133	556,979	0.007420	20,132	149	71
72	Impl. Dev. Charged to Patients	4,120	164,808	0.024999			72
73	Drugs Charged to Patients	69,565	2,427,924	0.028652	149,667	4,288	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	305,797	996,606	0.306838			88
88.01	RHC II	140,482	633,607	0.221718			88.01
90	Clinic	117,069	1,398,433	0.083714			90
90.01	NORRIS CITY CLINIC						90.01
91	Emergency	248,200	2,752,433	0.090175	1,239	112	91
92	Observation Beds (Non-Distinct	57,613	312,804	0.184182			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,806,858	27,104,230		351,067	11,452	200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	1,840		218		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)	1,840		218		200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	848,356			7,797				50
53	Anesthesiology	293,893			12,543				53
54	Radiology-Diagnostic	6,153,187			25,882				54
58	MRI	606,790							58
60	Laboratory	7,410,741			111,957				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	373,534			9,206				65
65.50	SLEEP LAB	264,424							65.50
66	Physical Therapy	1,417,860			1,293				66
69	Electrocardiology	491,851			11,351				69
71	Medical Supplies Charged to Pat	556,979			20,132				71
72	Impl. Dev. Charged to Patients	164,808							72
73	Drugs Charged to Patients	2,427,924			149,667				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	996,606							88
88.01	RHC II	633,607							88.01
90	Clinic	1,398,433							90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	2,752,433			1,239				91
92	Observation Beds (Non-Distinct	312,804							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	27,104,230			351,067				200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	0.941374		91,006			85,671		50
53	Anesthesiology	1.256542		69,889			87,818		53
54	Radiology-Diagnostic	0.177975		1,975,347			351,562		54
58	MRI	0.171453		204,678			35,093		58
60	Laboratory	0.247463		1,659,564			410,681		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.571386		31,643			18,080		65
65.50	SLEEP LAB	0.230002							65.50
66	Physical Therapy	0.762022		289,559			220,650		66
69	Electrocardiology	0.064873		112,489			7,297		69
71	Medical Supplies Charged to Pat	0.141946		124,702			17,701		71
72	Impl. Dev. Charged to Patients	0.555034		10,578			5,871		72
73	Drugs Charged to Patients	0.318570		440,920			140,464		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	0.477808		52			25		90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	0.684647		1,089,446			745,886		91
92	Observation Beds (Non-Distinct	0.914691		90,934			83,177		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			6,190,807			2,209,976		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			6,190,807			2,209,976		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	3,481	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,840	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)	1,539	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	664	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)	663	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	157	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)	157	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,047	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)	664	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)	663	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)	3,053,011	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)	21,529	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	21,058	25
26	Total swing-bed cost (see instructions)	1,303,980	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,749,031	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)	1,749,031	37

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)					950.56	38
39	Program general inpatient routine service cost (line 9 x line 38)					995,236	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)					995,236	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)					461,005	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,456,241	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)	631,172	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	630,221	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	1,261,393	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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**	**[ ] 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)					301	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					950.56	88
89	Observation bed cost (line 87 x line 88) (see instructions)					286,119	89
		Cost	Routine Cost (from line 21)	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	614,758	3,053,011	0.201361	286,119	57,613	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	3,481	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,840	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)	1,539	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	664	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)	663	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	157	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)	157	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	218	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)	3,053,011	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)	21,529	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	21,058	25
26	Total swing-bed cost (see instructions)	1,303,980	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,749,031	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)	1,749,031	37

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	950.56	38
39	Program general inpatient routine service cost (line 9 x line 38)	207,222	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)	207,222	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)	113,778	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	321,000	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	41,727	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,452	51
52	Total Program excludable cost (sum of lines 50 and 51)	53,179	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	267,821	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)					301	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 21)	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] 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		684,777		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.941374	10,802	10,169	50
53	Anesthesiology	1.256542	19,178	24,098	53
54	Radiology-Diagnostic	0.177975	143,635	25,563	54
58	MRI	0.171453	31,884	5,467	58
60	Laboratory	0.247463	540,375	133,723	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.571386	51,469	29,409	65
65.50	SLEEP LAB	0.230002			65.50
66	Physical Therapy	0.762022	51,119	38,954	66
69	Electrocardiology	0.064873	18,582	1,205	69
71	Medical Supplies Charged to Patients	0.141946	103,305	14,664	71
72	Impl. Dev. Charged to Patients	0.555034			72
73	Drugs Charged to Patients	0.318570	556,278	177,213	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	0.477808			90
90.01	NORRIS CITY CLINIC				90.01
91	Emergency	0.684647	788	540	91
92	Observation Beds (Non-Distinct Part)	0.914691			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,527,415	461,005	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,527,415		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	0.941374	917	863	50
53	Anesthesiology	1.256542	7,970	10,015	53
54	Radiology-Diagnostic	0.177975	41,332	7,356	54
58	MRI	0.171453	6,837	1,172	58
60	Laboratory	0.247463	238,866	59,110	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.571386	31,325	17,899	65
65.50	SLEEP LAB	0.230002			65.50
66	Physical Therapy	0.762022	306,264	233,380	66
69	Electrocardiology	0.064873	3,594	233	69
71	Medical Supplies Charged to Patients	0.141946	79,221	11,245	71
72	Impl. Dev. Charged to Patients	0.555034			72
73	Drugs Charged to Patients	0.318570	469,256	149,491	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	0.477808			90
90.01	NORRIS CITY CLINIC				90.01
91	Emergency	0.684647	786	538	91
92	Observation Beds (Non-Distinct Part)	0.914691			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,186,368	491,302	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,186,368		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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		138,635		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.941374	7,797	7,340	50
53	Anesthesiology	1.256542	12,543	15,761	53
54	Radiology-Diagnostic	0.177975	25,882	4,606	54
58	MRI	0.171453			58
60	Laboratory	0.247463	111,957	27,705	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.571386	9,206	5,260	65
65.50	SLEEP LAB	0.230002			65.50
66	Physical Therapy	0.762022	1,293	985	66
69	Electrocardiology	0.064873	11,351	736	69
71	Medical Supplies Charged to Patients	0.141946	20,132	2,858	71
72	Impl. Dev. Charged to Patients	0.555034			72
73	Drugs Charged to Patients	0.318570	149,667	47,679	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	0.477808			90
90.01	NORRIS CITY CLINIC				90.01
91	Emergency	0.684647	1,239	848	91
92	Observation Beds (Non-Distinct Part)	0.914691			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		351,067	113,778	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		351,067		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	3,591,438			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)	3,591,438			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)	3,627,352			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)	34,388			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,344,265			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)	2,248,699			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)	2,248,699			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,248,699			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)	236,665			34
35	Adjusted reimbursable bad debts (see instructions)	153,832			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	236,665			36
37	Subtotal (see instructions)	2,402,531			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)	2,402,531			40
40.01	Sequestration adjustment (see instructions)	48,051			40.01
41	Interim payments	2,836,675			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-482,195			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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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				1,032,056		3,165,471	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	02/12/2016	72,545	02/12/2016	242,693	3.50
			.51	06/21/2016	32,310	06/21/2016	86,103	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		-104,855		-328,796	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)				927,201		2,836,675	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		247,246			6.01
	based on the cost report (1)		.02				-482,195	6.02
7	Total Medicare program liability (see instructions)				1,174,447		2,354,480	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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				1,513,590			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	02/12/2016	36,485			3.50
			.51	06/21/2016	23,799			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		-60,284			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)				1,453,306			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		228,842			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,682,148			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.

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)	562	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,047	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,539	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	28,624,848	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	819,598	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	1,274,007		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)	496,215		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	1,327		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)	1,770,222		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,770,222		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,770,222		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	53,744		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)	1,716,478		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)	1,716,478		19
19.01	Sequestration adjustment (see instructions)	34,330		19.01
20	Interim payments	1,453,306		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	228,842		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	1,456,241	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,456,241	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,470,803	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)	1,470,803	19
20	Deductibles (exclude professional component)	297,611	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,173,192	22
23	Coinsurance	2,534	23
24	Subtotal (line 22 minus line 23)	1,170,658	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	42,703	25
26	Adjusted reimbursable bad debts (see instructions)	27,757	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	42,703	27
28	Subtotal (sum of lines 24 and 26)	1,198,415	28
29	Other adjustments (SEQUESTRATION)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,198,415	30
30.01	Sequestration adjustment (see instructions)	23,968	30.01
31	Interim payments	927,201	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	247,246	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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		2,209,976	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)		2,209,976	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)		2,209,976	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	351,067	6,190,807	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)	351,067	6,190,807	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)	351,067	6,190,807	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)		2,209,976	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)		2,209,976	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)		2,209,976	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)		2,209,976	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)		2,209,976	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)		2,209,976	40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)		2,209,976	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	1,986,285				1
2	Temporary investments	3,102,941				2
3	Notes receivable					3
4	Accounts receivable	4,909,703				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,280,000				6
7	Inventory	394,965				7
8	Prepaid expenses	124,001				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	9,237,895				11
	FIXED ASSETS					
12	Land	69,760				12
13	Land improvements	499,729				13
14	Accumulated depreciation	-226,274				14
15	Buildings	21,710,219				15
16	Accumulated depreciation	-9,306,907				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	5,316,264				23
24	Accumulated depreciation	-3,765,526				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)	14,363,103				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	117,590		100,282		34
35	Total other assets (sum of lines 31-34)	117,590		100,282		35
36	Total assets (sum of lines 11, 30 and 35)	23,718,588		100,282		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	328,851				37
38	Salaries, wages and fees payable	606,129				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	495,000				40
41	Deferred income	104,055				41
42	Accelerated payments					42
43	Due to other funds	56,642				43
44	Other current liabilities	88,789				44
45	Total current liabilities (sum of lines 37 thru 44)	1,679,466				45
	LONG TERM LIABILITIES					
46	Mortgage payable	19,080,000				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)	19,080,000				50
51	Total liabilities (sum of lines 45 and 50)	20,759,466				51
	CAPITAL ACCOUNTS					
52	General fund balance	2,959,122				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted			100,282		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)	2,959,122		100,282		59
60	Total liabilities and fund balances (sum of lines 51 and 59)	23,718,588		100,282		60

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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		2,991,213			1
2	Net income (loss) (from Worksheet G-3, line 29)		-31,690			2
3	Total (sum of line 1 and line 2)		2,959,523			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)		2,959,523			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)		2,959,122			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period		100,502			1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)		100,502			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)		100,502			11
12	Deductions (debit adjustments) (specify)	220				12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		220			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		100,282			19

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	1,162,512		1,162,512	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	328,509		328,509	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)	1,491,021		1,491,021	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)	1,491,021		1,491,021	17
18	Ancillary services	2,405,659	23,366,371	25,772,030	18
19	Outpatient services		1,794,275	1,794,275	19
20	Rural Health Clinic (RHC)		1,036,003	1,036,003	20
20.01	RHC II		633,607	633,607	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)	3,896,680	26,830,256	30,726,936	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		17,210,656	29
30	BAD DEBTS	1,584,444		30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		1,584,444	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)		18,795,100	43

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	30,726,936	1
2	Less contractual allowances and discounts on patients' accounts	13,427,790	2
3	Net patient revenues (line 1 minus line 2)	17,299,146	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	18,795,100	4
5	Net income from service to patients (line 3 minus line 4)	-1,495,954	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	285,571	6
7	Income from investments	36,436	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	534	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	120	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	13,643	16
17	Revenue from sale of drugs to other than patients	5,044	17
18	Revenue from sale of medical records and abstracts	4,559	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	1,454	21
22	Rental of hosptial space		22
23	Governmental appropriations	565,610	23
24	Other (EHR INCENTIVE)	111,815	24
24.01	Other (OTHER)	439,478	24.01
25	Total other income (sum of lines 6-24)	1,464,264	25
26	Total (line 5 plus line 25)	-31,690	26
29	Net income (or loss) for the period (line 26 minus line 28)	-31,690	29

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	730,657		730,657		730,657	-203,941	526,716	1
2	Physician Assistant								2
3	Nurse Practitioner	157,750		157,750		157,750		157,750	3
4	Visiting Nurse								4
5	Other Nurse	142,652		142,652		142,652		142,652	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)	1,031,059		1,031,059		1,031,059	-203,941	827,118	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		42,573	42,573		42,573		42,573	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)		42,573	42,573		42,573		42,573	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,031,059	42,573	1,073,632		1,073,632	-203,941	869,691	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	149,597	221,978	371,575	-22,774	348,801		348,801	30
31	Total Facility Overhead (sum of lines 29 and 30)	149,597	221,978	371,575	-22,774	348,801		348,801	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,180,656	264,551	1,445,207	-22,774	1,422,433	-203,941	1,218,492	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	1.73	4,349	4,200	7,266		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.16	3,673	2,100	2,436		3
4	Subtotal (sum of lines 1 through 3)	2.89	8,022		9,702	9,702	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)	2.89	8,022			9,702	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)	869,691	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)	869,691	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)	348,801	14
15	Parent provider overhead allocated to facility (see instructions)	767,790	15
16	Total overhead (sum of lines 14 and 15)	1,116,591	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,116,591	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,116,591	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	1,986,282	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	1,986,282	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	13,032	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,973,250	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	9,702	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	9,702	6
7	Adjusted cost per visit (line 3 divided by line 6)	203.39	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)	203.39	203.39	203.39	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		2,261		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		459,865		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)		459,865		16
16.01	Total program charges (see instructions)(from contractor's records)		187,687		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		313		16.02
16.03	Total program preventive costs (see instructions)		767		16.03
16.04	Total program non-preventive costs (see instructions)		348,222		16.04
16.05	Total program cost (see instructions)		348,989		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		23,821		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		32,425		19
20	Net Medicare cost excluding vaccines (see instructions)		348,989		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,161		21
22	Total reimbursable Program cost (line 20 plus line 21)		354,150		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)		354,150		26
26.01	Sequestration adjustment (see instructions)		7,083		26.01
27	Interim payments		250,124		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		96,943		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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	827,118	827,118	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000075	0.001441	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	62	1,192	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	800	3,652	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	862	4,844	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	869,691	869,691	6
7	Total overhead (from Wkst. M-2, line 16)	1,116,591	1,116,591	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000991	0.005570	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,107	6,219	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	1,969	11,063	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	12	230	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	164.08	48.10	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	8	80	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,313	3,848	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)		13,032	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)		5,161	16

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				256,030	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	06/21/2016	5,906	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		-5,906	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				250,124	
	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		96,943	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				347,067	

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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	23,884		23,884		23,884	-6,859	17,025	1
2	Physician Assistant								2
3	Nurse Practitioner	249,218		249,218		249,218		249,218	3
4	Visiting Nurse								4
5	Other Nurse	85,055		85,055		85,055		85,055	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)	358,157		358,157		358,157	-6,859	351,298	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)	358,157		358,157		358,157	-6,859	351,298	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	31,339	120,112	151,451	-60,434	91,017		91,017	30
31	Total Facility Overhead (sum of lines 29 and 30)	31,339	120,112	151,451	-60,434	91,017		91,017	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	389,496	120,112	509,608	-60,434	449,174	-6,859	442,315	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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	0.07	371	4,200	294		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.32	5,162	2,100	2,772		3
4	Subtotal (sum of lines 1 through 3)	1.39	5,533		3,066	5,533	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)	1.39	5,533			5,533	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)	351,298	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)	351,298	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)	91,017	14
15	Parent provider overhead allocated to facility (see instructions)	313,874	15
16	Total overhead (sum of lines 14 and 15)	404,891	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	404,891	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	404,891	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	756,189	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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	756,189	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	4,878	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	751,311	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	5,533	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	5,533	6
7	Adjusted cost per visit (line 3 divided by line 6)	135.79	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)	135.79	135.79	135.79	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		744		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		101,028		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)		101,028		16
16.01	Total program charges (see instructions)(from contractor's records)		68,368		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,265		16.02
16.03	Total program preventive costs (see instructions)		1,869		16.03
16.04	Total program non-preventive costs (see instructions)		75,555		16.04
16.05	Total program cost (see instructions)		77,424		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		4,715		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,458		19
20	Net Medicare cost excluding vaccines (see instructions)		77,424		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,085		21
22	Total reimbursable Program cost (line 20 plus line 21)		79,509		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)		79,509		26
26.01	Sequestration adjustment (see instructions)		1,590		26.01
27	Interim payments		116,562		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		-38,643		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: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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)	351,298	351,298	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000061	0.001426	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	21	501	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	267	1,477	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	288	1,978	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	351,298	351,298	6
7	Total overhead (from Wkst. M-2, line 16)	404,891	404,891	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000820	0.005631	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	332	2,280	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	620	4,258	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	4	93	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	155.00	45.78	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	4	32	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	620	1,465	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)		4,878	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)		2,085	16

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 10/20/2016 Run Time: 12:45 Version: 2016.05 (09/08/2016)

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 1	Part B Amount 2	
1	Total interim payments paid to provider				116,562	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)				116,562	
	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		-38,643	6.02
7	Total Medicare program liability (see instructions)				77,919	

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.