HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/15/2017 Time: 14:04 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 07/01/2016 and ending 06/30/2017, 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.

(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		-154,795	-723,568	1	2,481,549	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-203,724				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			141,971			10
10.01	HEALTH CLINIC - RHC II			4,718			10.01
10.02	HEALTH CLINIC - RHC III			15,872			10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-358,519	-561,007	1	2,481,549	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.

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
15.02	Hospital-Based Health Clinic - RHC III	DOWNTOWN FAMILY CLINIC	14-8556	99914		03 / 01 / 2016	N	O	N	15.02
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 / 2016	To: 06 / 30 / 2017	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
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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WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
	Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
	Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS				
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

		1	2	
Rural Providers				
105	Does this hospital qualify as a critical access hospital (CAH)?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	Y		108

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Y	Y	Y	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	130,400			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
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

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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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

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	08/07/2017	Y	08/07/2017	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: PARTNER	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	39,648.00		1,274	197	1,652	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						1,996		2,076	5
6	Hospital Adults & Peds. Swing Bed NF								219	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	39,648.00		3,270	197	3,947	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	39,648.00		3,270	197	3,947	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					2,991		8,076	26
26.01	RHC II	88.01					1,138		7,983	26.01
26.02	RHC III	88.02					664		3,247	26.02
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							32	359	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)					446	59	601	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)		115.62			446	59	601	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		13.71						26
26.01	RHC II		7.23						26.01
26.02	RHC III		4.92						26.02
27	Total (sum of lines 14-26)		141.48						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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3477** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 611 SOUTH MARSHALL	1
2	City: MCLEANSBORO State: IL ZIP Code: 62859 County: HAMILTON	2
3	HOSPITAL-BASED 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 a hospital-based 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	RHC/FQHC 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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-8529** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 110A EAST MAIN	1
2	City: NORRIS CITY State: IL ZIP Code: 62869 County: WHITE	2
3	HOSPITAL-BASED 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 a hospital-based 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	RHC/FQHC 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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-8556** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 206 S. WASHINGTON STREET	1
2	City: MCLEANSBORO State: IL ZIP Code: 62859 County: HAMILTON	2
3	HOSPITAL-BASED 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 a hospital-based 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	1800	0800	1800	0800	1800	0800	1800	0800	1800			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	RHC/FQHC 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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	0.480365	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,169,112	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	7,433,075	6
7	Medicaid cost (line 1 times line 6)	3,570,589	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.	1,401,477	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)	1,401,477	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	53,495	291,852	345,347	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	25,697	140,195	165,892	21
22	Partial payment by patients approved for charity care		510	510	22
23	Cost of charity care (line 21 minus line 22)	25,697	139,685	165,382	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)	1,716,028	26
27	Medicare bad debts for the entire hospital complex (see instructions)	177,555	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,538,473	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	739,029	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	904,411	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,305,888	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		986,779	986,779	984,169	1,970,948	-25,170	1,945,778	1
2	00200	Cap Rel Costs-Mvble Equip		448,612	448,612	322,618	771,230	-68,772	702,458	2
3	00300	Other Cap Rel Costs		65,076	65,076	-65,076			-0-	3
4	00400	Employee Benefits Department		1,190,854	1,190,854		1,190,854	-15,170	1,175,684	4
5.01	00540	NONPATIENT TELEPHONES		25,224	25,224		25,224		25,224	5.01
5.02	00550	DATA PROCESSING	116,096	163,499	279,595		279,595		279,595	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	46,202	2,182	48,384		48,384	-370	48,014	5.03
5.04	00570	ADMITTING				197,029	197,029		197,029	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	292,272	334,688	626,960	-197,029	429,931		429,931	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	438,773	533,488	972,261	52,601	1,024,862	-264,965	759,897	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	126,785	661,507	788,292	-5,026	783,266		783,266	7
8	00800	Laundry & Linen Service		62,429	62,429		62,429		62,429	8
9	00900	Housekeeping	137,816	26,269	164,085		164,085		164,085	9
10	01000	Dietary		114,726	114,726		114,726	-697	114,029	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	219,934	7,884	227,818		227,818		227,818	13
14	01400	Central Services & Supply		73,212	73,212	-68,474	4,738		4,738	14
15	01500	Pharmacy	182,497	491,239	673,736	-312,977	360,759	-83,703	277,056	15
16	01600	Medical Records & Library	190,040	48,388	238,428		238,428	-3,781	234,647	16
17	01700	Social Service	48,682	2,320	51,002		51,002		51,002	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	1,326,525	224,310	1,550,835	-2,579	1,548,256	-94,542	1,453,714	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	158,974	531,519	690,493	-213,657	476,836	-215,600	261,236	50
53	05300	Anesthesiology	248,610	48,372	296,982	-16,786	280,196	-4,500	275,696	53
54	05400	Radiology-Diagnostic	322,704	326,400	649,104	-99,830	549,274		549,274	54
58	05800	MRI				99,830	99,830		99,830	58
60	06000	Laboratory	500,323	768,399	1,268,722		1,268,722		1,268,722	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	93,290	40,049	133,339	-5,096	128,243		128,243	65
65.50	06501	SLEEP LAB		26,550	26,550		26,550	-26,550		65.50
66	06600	Physical Therapy	457,115	213,965	671,080	-12	671,068		671,068	66
69	06900	Electrocardiology		23,302	23,302		23,302	-14,340	8,962	69
71	07100	Medical Supplies Charged to Patients				112,809	112,809	-6,022	106,787	71
72	07200	Impl. Dev. Charged to Patients				67,500	67,500		67,500	72
73	07300	Drugs Charged to Patients				340,872	340,872	-5,477	335,395	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	1,345,089	448,701	1,793,790	-43,186	1,750,604	-129,979	1,620,625	88
88.01	08801	RHC II	485,290	399,401	884,691	-116,195	768,496		768,496	88.01
88.02	08802	RHC III	281,042	130,046	411,088	-61,197	349,891		349,891	88.02
90	09000	Clinic	229,423	178,028	407,451		407,451		407,451	90
90.01	09001	NORRIS CITY CLINIC								90.01
91	09100	Emergency	699,151	1,274,480	1,973,631	-17,158	1,956,473	-889,113	1,067,360	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		950,629	950,629	-950,629				113
117	06950	OTHER SPECIAL PURPOSE COST CENTERS								117
117.02	06952	SUPPLIES AND EXPENSE		2,521	2,521	-2,521				117.02
118		SUBTOTALS (sum of lines 1-117)	7,946,633	10,825,048	18,771,681		18,771,681	-1,848,751	16,922,930	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices								192
200		TOTAL (sum of lines 118-199)	7,946,633	10,825,048	18,771,681		18,771,681	-1,848,751	16,922,930	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS INTEREST EXPENSE	A	Cap Rel Costs-Bldg & Fixt	1		950,629	1
500	Total reclassifications					950,629	500
	Code Letter - A						
1	TO RECLASS RENT EXPENSE	B	Cap Rel Costs-Mvble Equip	2		312,987	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	Total reclassifications					312,987	500
	Code Letter - B						
1	RECLASS INSURANCE COST	C	OTHER ADMINISTRATIVE AND GENE	5.06		21,905	1
500	Total reclassifications					21,905	500
	Code Letter - C						
1	ADMITTING	D	ADMITTING	5.04	97,327	99,702	1
500	Total reclassifications				97,327	99,702	500
	Code Letter - D						
1	RECLASS SUPPLIES SOLD	E	Medical Supplies Charged to P	71		180,309	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					180,309	500
	Code Letter - E						
1	RECLASS DRUGS TO PHARMACY	F	Drugs Charged to Patients	73		253,284	1
500	Total reclassifications					253,284	500
	Code Letter - F						
1	RECLASS SUPPLIES SOLD	G	Central Services & Supply	14		2,521	1
500	Total reclassifications					2,521	500
	Code Letter - G						
1	RECLASS IV COST	H	Drugs Charged to Patients	73		87,588	1
2							2
500	Total reclassifications					87,588	500
	Code Letter - H						
1	RECLASS MALPRACTICE	I	OTHER ADMINISTRATIVE AND GENE	5.06		43,156	1
500	Total reclassifications					43,156	500
	Code Letter - I						
1	RECLASS IPL DEVICES	J	Impl. Dev. Charged to Patient	72		67,500	1
500	Total reclassifications					67,500	500
	Code Letter - J						
1	RECLASS MRI COST	K	MRI	58		99,830	1
500	Total reclassifications					99,830	500
	Code Letter - K						
	GRAND TOTAL (Increases)				97,327	2,119,411	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	TO RECLASS INTEREST EXPENSE	A	Interest Expense	113		950,629	11	1
500	Total reclassifications					950,629		500
	Code letter - A							
1	TO RECLASS RENT EXPENSE	B	OTHER ADMINISTRATIVE AND GENE	5.06		12,460	10	1
2			Adults & Pediatrics	30		2,579		2
3			Operating Room	50		69,062		3
4			Anesthesiology	53		8,285		4
5			Respiratory Therapy	65		1,358		5
6			RHC II	88.01		116,164		6
7			RHC III	88.02		61,197		7
8			Pharmacy	15		36,856		8
9			Operation of Plant	7		5,026		9
500	Total reclassifications					312,987		500
	Code letter - B							
1	RECLASS INSURANCE COST	C	Other Cap Rel Costs	3		21,905		1
500	Total reclassifications					21,905		500
	Code letter - C							
1	ADMITTING	D	CASHIERING/ACCOUNTS RECEIVABL	5.05	97,327	99,702		1
500	Total reclassifications				97,327	99,702		500
	Code letter - D							
1	RECLASS SUPPLIES SOLD	E	Central Services & Supply	14		6,244		1
2			Emergency	91		17,158		2
3			Anesthesiology	53		8,501		3
4			Operating Room	50		144,595		4
5			Respiratory Therapy	65		3,738		5
6			Physical Therapy	66		12		6
7			Rural Health Clinic	88		30		7
8			RHC II	88.01		31		8
500	Total reclassifications					180,309		500
	Code letter - E							
1	RECLASS DRUGS TO PHARMACY	F	Pharmacy	15		253,284		1
500	Total reclassifications					253,284		500
	Code letter - F							
1	RECLASS SUPPLIES SOLD	G	SUPPLIES AND EXPENSE	117.02		2,521		1
500	Total reclassifications					2,521		500
	Code letter - G							
1	RECLASS IV COST	H	Pharmacy	15		22,837		1
2			Central Services & Supply	14		64,751		2
500	Total reclassifications					87,588		500
	Code letter - H							
1	RECLASS MALPRACTICE	I	Rural Health Clinic	88		43,156		1
500	Total reclassifications					43,156		500
	Code letter - I							
1	RECLASS IPL DEVICES	J	Medical Supplies Charged to P	71		67,500		1
500	Total reclassifications					67,500		500
	Code letter - J							
1	RECLASS MRI COST	K	Radiology-Diagnostic	54		99,830		1
500	Total reclassifications					99,830		500
	Code letter - K							
	GRAND TOTAL (Decreases)				97,327	2,119,411		

(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.

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	69,760					69,760		1
2	Land Improvements	499,730					499,730		2
3	Buildings and Fixtures	21,710,218					21,710,218		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	5,164,086	449,059		449,059		5,613,145		6
7	HIT-designated Assets	784,683					784,683		7
8	Subtotal (sum of lines 1-7)	28,228,477	449,059		449,059		28,677,536		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	28,228,477	449,059		449,059		28,677,536		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	986,779						986,779	1
2	Cap Rel Costs-Mvble Equip	448,612						448,612	2
3	Total (sum of lines 1-2)	1,435,391						1,435,391	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	22,279,708		22,279,708	0.776905	33,540			33,540	1
2	Cap Rel Costs-Mvble Equ	6,397,828		6,397,828	0.223095	9,631			9,631	2
3	Total (sum of lines 1-2)	28,677,536		28,677,536	1.000000	43,171			43,171	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	986,779		925,459	33,540			1,945,778	1
2	Cap Rel Costs-Mvble Equip	379,840	312,987		9,631			702,458	2
3	Total (sum of lines 1-2)	1,366,619	312,987	925,459	43,171			2,648,236	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-43,449	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	-370	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	-6,745	OTHER ADMINISTRATIVE AND GENERAL	5.06		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,244,645				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	-697	Dietary	10		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-6,022	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients	B	-5,477	Drugs Charged to Patients	73		17
18	Sale of medical records and abstracts	B	-3,781	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-961	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	-63,174	Cap Rel Costs-Mvble Equip	2	9	32
33	COMMUNITY PROGRAM	B	-252	OTHER ADMINISTRATIVE AND GENERAL	5.06		33
34							34
35	PORTION OF LOBBYING DUES	A	-6,194	OTHER ADMINISTRATIVE AND GENERAL	5.06		35
36	WOMENS WELLNESS	B	-102,150	OTHER ADMINISTRATIVE AND GENERAL	5.06		36
37	PHYSICIAN RECRUITMENT	A	-7,700	OTHER ADMINISTRATIVE AND GENERAL	5.06		37
38	ADVERTISING	A	-2,976	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	-5,598	Cap Rel Costs-Mvble Equip	2	9	42
43							43
44	NURSING CENTER SERVICES	B	-1,117	OTHER ADMINISTRATIVE AND GENERAL	5.06		44
45							45
45.06	FUNDRAISING	A	-136,870	OTHER ADMINISTRATIVE AND GENERAL	5.06		45.06
45.09	NON RHC COST SALARY	A	-129,979	Rural Health Clinic	88		45.09
45.11	NON RHC BENEFITS	A	-15,170	Employee Benefits Department	4		45.11
46							46
47							47
48							48
49	340B	A	-83,703	Pharmacy	15		49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-1,848,751				50

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

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

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

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

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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	94,542	94,542						1
2	91	Emergency AGGREGATE	1,139,888	889,113	250,775					2
3	50	Operating Room AGGREGATE	215,600	215,600						3
4	53	Anesthesiology AGGREGATE	4,500	4,500						4
5	65.50	SLEEP LAB AGGREGATE	26,550	26,550						5
6	69	Electrocardiology AGGREGATE	14,340	14,340						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	1,495,420	1,244,645	250,775					200

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	30	Adults & Pediatrics AGGREGATE							94,542	1
2	91	Emergency AGGREGATE							889,113	2
3	50	Operating Room AGGREGATE							215,600	3
4	53	Anesthesiology AGGREGATE							4,500	4
5	65.50	SLEEP LAB AGGREGATE							26,550	5
6	69	Electrocardiology AGGREGATE							14,340	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							1,244,645	200

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					244	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate						7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		1,853.75				9
10	AHSEA (see instructions)		76.61				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	38.31	38.31				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)	142,016	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)	142,016	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)	142,016	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)	142,016	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)	9,348	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)	9,348	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)	9,348	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)	9,348	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	142,016	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	9,348	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)	151,364	63
64	Total cost of outside supplier services (from provider records)	113,300	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)					250	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		290.75				9
10	AHSEA (see instructions)		80.83				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	40.42	40.42				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	23,501	15
16	Assistants (column 3, line 9 times column 3, line 10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	23,501	17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	23,501	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)	80.83	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	63,047	22
23	Total salary equivalency (see instructions)	63,047	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)	10,105	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)	10,105	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)	10,105	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)	10,105	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	63,047	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	10,105	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)	73,152	63
64	Total cost of outside supplier services (from provider records)	17,495	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 [ ] 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)					226	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		966.00				9
10	AHSEA (see instructions)		73.61				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)	36.81	36.81				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)	71,107	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)	71,107	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)	71,107	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)	71,107	23

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

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)	8,319	24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	8,319	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	8,319	28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [XX] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	71,107	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)	71,107	63
64	Total cost of outside supplier services (from provider records)	52,901	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	1,945,778	1,945,778					1
2	Cap Rel Costs-Mvble Equip	702,458		702,458				2
4	Employee Benefits Department	1,175,684			1,175,684			4
5.01	NONPATIENT TELEPHONES	25,224	906	327		26,457		5.01
5.02	DATA PROCESSING	279,595			17,462		297,057	5.02
5.03	PURCHASING RECEIVING AND STORES	48,014	51,405	18,558	6,949	267	4,274	5.03
5.04	ADMITTING	197,029			14,639			5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	429,931	36,006	12,999	29,321		23,508	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	759,897	223,260	80,601	65,995	4,277	17,097	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	783,266	161,235	58,208	19,069	534	4,274	7
8	Laundry & Linen Service	62,429	21,649	7,816		134		8
9	Housekeeping	164,085			20,729		2,137	9
10	Dietary	114,029						10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	227,818	33,968	12,263	33,080	668	17,097	13
14	Central Services & Supply	4,738						14
15	Pharmacy	277,056	23,076	8,331	27,449	267	4,274	15
16	Medical Records & Library	234,647	28,239	10,195	28,584	1,069	14,960	16
17	Social Service	51,002	4,348	1,570	7,322	401	2,137	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	1,453,714	304,239	109,834	199,516	4,142	32,057	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	261,236	151,724	54,775	23,911	1,336	10,686	50
53	Anesthesiology	275,696			37,393		2,137	53
54	Radiology-Diagnostic	549,274	112,321	40,550	48,537	1,336	8,548	54
58	MRI	99,830				134		58
60	Laboratory	1,268,722	39,063	14,102	75,253	1,203	12,823	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	128,243	19,339	6,982	14,032	802	4,274	65
65.50	SLEEP LAB		8,492	3,066		134		65.50
66	Physical Therapy	671,068	101,791	36,748	68,754	935	19,234	66
69	Electrocardiology	8,962						69
71	Medical Supplies Charged to Patients	106,787						71
72	Impl. Dev. Charged to Patients	67,500						72
73	Drugs Charged to Patients	335,395						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,620,625	169,410	61,160	182,762	2,940	38,467	88
88.01	RHC II	768,496	95,699	34,549	72,991	2,004	29,919	88.01
88.02	RHC III	349,891	108,698	39,242	42,271	802	10,686	88.02
90	Clinic	407,451	77,900	28,123	34,507	935	14,960	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	1,067,360	104,123	37,590	105,158	1,603	23,508	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)	16,922,930	1,876,891	677,589	1,175,684	25,923	297,057	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		68,887	24,869		534		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	16,922,930	1,945,778	702,458	1,175,684	26,457	297,057	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	129,467						5.03
5.04	ADMITTING		211,668					5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE			531,765				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,758			1,152,885	1,152,885		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	3,460			1,030,046	75,303	1,105,349	7
8	Laundry & Linen Service	213			92,241	6,743	16,246	8
9	Housekeeping	1,491			188,442	13,776		9
10	Dietary	275			114,304	8,356		10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	310			325,204	23,774	25,490	13
14	Central Services & Supply	7,040			11,778	861		14
15	Pharmacy	19,679			360,132	26,328	17,316	15
16	Medical Records & Library	903			318,597	23,291	21,191	16
17	Social Service	157			66,937	4,893	3,263	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,342	56,188	28,702	2,196,734	160,598	228,309	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,143	4,263	21,694	546,768	39,972	113,857	50
53	Anesthesiology	2,220	864	6,307	324,617	23,731		53
54	Radiology-Diagnostic	3,630	14,492	113,621	892,309	65,233	84,288	54
58	MRI		764	11,121	111,849	8,177		58
60	Laboratory	46,890	37,854	126,000	1,621,910	118,571	29,314	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,026	15,995	11,535	202,228	14,784	14,513	65
65.50	SLEEP LAB			3,292	14,984	1,095	6,373	65.50
66	Physical Therapy	873	23,805	26,171	949,379	69,405	76,386	66
69	Electrocardiology	66	1,228	7,232	17,488	1,278		69
71	Medical Supplies Charged to Patients		357	694	107,838	7,884		71
72	Impl. Dev. Charged to Patients			2,569	70,069	5,122		72
73	Drugs Charged to Patients		55,858	48,123	439,376	32,121		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	2,698		20,450	2,098,512	153,414	127,129	88
88.01	RHC II	2,326		16,721	1,022,705	74,766	71,815	88.01
88.02	RHC III	1,148		5,044	557,782	40,777	81,569	88.02
90	Clinic	1,567		21,999	587,442	42,946	58,458	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	6,252		60,490	1,406,084	102,793	78,137	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)	129,467	211,668	531,765	16,828,640	1,145,992	1,053,654	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices				94,290	6,893	51,695	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	129,467	211,668	531,765	16,922,930	1,152,885	1,105,349	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	115,230						8
9	Housekeeping		202,218					9
10	Dietary			122,660				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		576		375,044			13
14	Central Services & Supply					12,639		14
15	Pharmacy						403,776	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	74,175	62,274	122,660	257,836			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,455	17,808		23,998			50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,641	10,087					54
58	MRI	163						58
60	Laboratory		7,635					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
65.50	SLEEP LAB							65.50
66	Physical Therapy	13,204	13,926					66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients					7,908		71
72	Impl. Dev. Charged to Patients					4,731		72
73	Drugs Charged to Patients						403,776	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	770	30,582					88
88.01	RHC II							88.01
88.02	RHC III		5,118					88.02
90	Clinic		7,678					90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	21,822	46,534		93,210			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)	115,230	202,218	122,660	375,044	12,639	403,776	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)	115,230	202,218	122,660	375,044	12,639	403,776	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	363,079						16
17	Social Service		75,093					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	97,686	30,395	3,230,667		3,230,667		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			745,858		745,858		50
53	Anesthesiology			348,348		348,348		53
54	Radiology-Diagnostic			1,053,558		1,053,558		54
58	MRI			120,189		120,189		58
60	Laboratory	140,992		1,918,422		1,918,422		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			231,525		231,525		65
65.50	SLEEP LAB			22,452		22,452		65.50
66	Physical Therapy		5,619	1,127,919		1,127,919		66
69	Electrocardiology			18,766		18,766		69
71	Medical Supplies Charged to Patients			123,630		123,630		71
72	Impl. Dev. Charged to Patients			79,922		79,922		72
73	Drugs Charged to Patients			875,273		875,273		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		24,776	2,435,183		2,435,183		88
88.01	RHC II			1,169,286		1,169,286		88.01
88.02	RHC III			685,246		685,246		88.02
90	Clinic			696,524		696,524		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	124,401	14,303	1,887,284		1,887,284		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)	363,079	75,093	16,770,052		16,770,052		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			152,878		152,878		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	363,079	75,093	16,922,930		16,922,930		202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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		906	327	1,233	1,233		5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES		51,405	18,558	69,963	12	69,975	5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		36,006	12,999	49,005			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		223,260	80,601	303,861	201	950	5.06
6	Maintenance & Repairs							6
7	Operation of Plant		161,235	58,208	219,443	25	1,870	7
8	Laundry & Linen Service		21,649	7,816	29,465	6	115	8
9	Housekeeping						806	9
10	Dietary						149	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		33,968	12,263	46,231	31	168	13
14	Central Services & Supply						3,805	14
15	Pharmacy		23,076	8,331	31,407	12	10,636	15
16	Medical Records & Library		28,239	10,195	38,434	50	488	16
17	Social Service		4,348	1,570	5,918	19	85	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		304,239	109,834	414,073	193	4,508	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		151,724	54,775	206,499	62	9,266	50
53	Anesthesiology						1,200	53
54	Radiology-Diagnostic		112,321	40,550	152,871	62	1,962	54
58	MRI					6		58
60	Laboratory		39,063	14,102	53,165	56	25,344	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		19,339	6,982	26,321	37	554	65
65.50	SLEEP LAB		8,492	3,066	11,558	6		65.50
66	Physical Therapy		101,791	36,748	138,539	44	472	66
69	Electrocardiology						36	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		169,410	61,160	230,570	137	1,458	88
88.01	RHC II		95,699	34,549	130,248	93	1,257	88.01
88.02	RHC III		108,698	39,242	147,940	37	620	88.02
90	Clinic		77,900	28,123	106,023	44	847	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency		104,123	37,590	141,713	75	3,379	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)		1,876,891	677,589	2,554,480	1,208	69,975	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		68,887	24,869	93,756	25		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,945,778	702,458	2,648,236	1,233	69,975	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	49,005						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		305,012					5.06
6	Maintenance & Repairs							6
7	Operation of Plant		19,922	241,260				7
8	Laundry & Linen Service		1,784	3,546	34,916			8
9	Housekeeping		3,645			4,451		9
10	Dietary		2,211				2,360	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		6,290	5,564		13		13
14	Central Services & Supply		228					14
15	Pharmacy		6,965	3,780				15
16	Medical Records & Library		6,162	4,625				16
17	Social Service		1,295	712				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	2,644	42,491	49,831	22,477	1,370	2,360	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,999	10,575	24,851	1,047	392		50
53	Anesthesiology	581	6,278					53
54	Radiology-Diagnostic	10,468	17,258	18,397	497	222		54
58	MRI	1,025	2,163		49			58
60	Laboratory	11,620	31,369	6,398		168		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,063	3,911	3,168				65
65.50	SLEEP LAB	303	290	1,391				65.50
66	Physical Therapy	2,411	18,362	16,673	4,001	307		66
69	Electrocardiology	666	338					69
71	Medical Supplies Charged to Patients	64	2,086					71
72	Impl. Dev. Charged to Patients	237	1,355					72
73	Drugs Charged to Patients	4,434	8,498					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	1,884	40,587	27,748	233	673		88
88.01	RHC II	1,541	19,780	15,675				88.01
88.02	RHC III	465	10,788	17,804		113		88.02
90	Clinic	2,027	11,362	12,759		169		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	5,573	27,195	17,055	6,612	1,024		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)	49,005	303,188	229,977	34,916	4,451	2,360	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		1,824	11,283				192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	49,005	305,012	241,260	34,916	4,451	2,360	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	58,297						13
14	Central Services & Supply		4,033					14
15	Pharmacy			52,800				15
16	Medical Records & Library				49,759			16
17	Social Service					8,029		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	40,078			13,388	3,250	596,663	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,730					258,421	50
53	Anesthesiology						8,059	53
54	Radiology-Diagnostic						201,737	54
58	MRI						3,243	58
60	Laboratory				19,322		147,442	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy						35,054	65
65.50	SLEEP LAB						13,548	65.50
66	Physical Therapy					601	181,410	66
69	Electrocardiology						1,040	69
71	Medical Supplies Charged to Patients		2,523				4,673	71
72	Impl. Dev. Charged to Patients		1,510				3,102	72
73	Drugs Charged to Patients			52,800			65,732	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					2,649	305,939	88
88.01	RHC II						168,594	88.01
88.02	RHC III						177,767	88.02
90	Clinic						133,231	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	14,489			17,049	1,529	235,693	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)	58,297	4,033	52,800	49,759	8,029	2,541,348	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices						106,888	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	58,297	4,033	52,800	49,759	8,029	2,648,236	202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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		596,663					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		258,421					50
53	Anesthesiology		8,059					53
54	Radiology-Diagnostic		201,737					54
58	MRI		3,243					58
60	Laboratory		147,442					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		35,054					65
65.50	SLEEP LAB		13,548					65.50
66	Physical Therapy		181,410					66
69	Electrocardiology		1,040					69
71	Medical Supplies Charged to Patients		4,673					71
72	Impl. Dev. Charged to Patients		3,102					72
73	Drugs Charged to Patients		65,732					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		305,939					88
88.01	RHC II		168,594					88.01
88.02	RHC III		177,767					88.02
90	Clinic		133,231					90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency		235,693					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)		2,541,348					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		106,888					192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,648,236					202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NONPATIENT TELEPHONES #OF PHONES	DATA PROCESSING MACHINE TIME	PURCHASING, RECEIVING AND STORAGE COSTS SUPPLIES	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	85,924						1
2	Cap Rel Costs-Mvble Equip		85,924					2
4	Employee Benefits Department			7,816,654				4
5.01	NONPATIENT TELEPHONES	40	40		198			5.01
5.02	DATA PROCESSING			116,096		139		5.02
5.03	PURCHASING RECEIVING AND STORES	2,270	2,270	46,202	2	2	1,766,459	5.03
5.04	ADMITTING			97,327				5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,590	1,590	194,945		11		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,859	9,859	438,773	32	8	23,983	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	7,120	7,120	126,785	4	2	47,210	7
8	Laundry & Linen Service	956	956		1		2,901	8
9	Housekeeping			137,816		1	20,349	9
10	Dietary						3,749	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,500	1,500	219,934	5	8	4,229	13
14	Central Services & Supply						96,049	14
15	Pharmacy	1,019	1,019	182,497	2	2	268,498	15
16	Medical Records & Library	1,247	1,247	190,040	8	7	12,324	16
17	Social Service	192	192	48,682	3	1	2,146	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	13,435	13,435	1,326,525	31	15	113,812	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,700	6,700	158,974	10	5	233,901	50
53	Anesthesiology			248,610		1	30,286	53
54	Radiology-Diagnostic	4,960	4,960	322,704	10	4	49,531	54
58	MRI				1			58
60	Laboratory	1,725	1,725	500,323	9	6	639,798	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	854	854	93,290	6	2	13,997	65
65.50	SLEEP LAB	375	375		1			65.50
66	Physical Therapy	4,495	4,495	457,115	7	9	11,915	66
69	Electrocardiology						904	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	1,215,110	22	18	36,805	88
88.01	RHC II	4,226	4,226	485,290	15	14	31,736	88.01
88.02	RHC III	4,800	4,800	281,042	6	5	15,658	88.02
90	Clinic	3,440	3,440	229,423	7	7	21,378	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	4,598	4,598	699,151	12	11	85,300	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)	82,882	82,882	7,816,654	194	139	1,766,459	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	3,042	3,042		4			192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,945,778	702,458	1,175,684	26,457	297,057	129,467	202
203	Unit Cost Multiplier (Wkst. B, Part I)	22.645338	8.175341	0.150408	133.621212	2,137.100719	0.073292	203
204	Cost to be allocated (Per Wkst. B, Part II)				1,233		69,975	204
205	Unit Cost Multiplier (Wkst. B, Part II)				6.227273		0.039613	205

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	6,958,666						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		35,503,914					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-1,152,885	15,770,045			5.06
6	Maintenance & Repairs							6
7	Operation of Plant				1,030,046	65,045		7
8	Laundry & Linen Service				92,241	956	22,611	8
9	Housekeeping				188,442			9
10	Dietary				114,304			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				325,204	1,500		13
14	Central Services & Supply				11,778			14
15	Pharmacy				360,132	1,019		15
16	Medical Records & Library				318,597	1,247		16
17	Social Service				66,937	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	1,847,257	1,916,270		2,196,734	13,435	14,555	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	140,163	1,448,364		546,768	6,700	678	50
53	Anesthesiology	28,389	421,109		324,617			53
54	Radiology-Diagnostic	476,412	7,585,836		892,309	4,960	322	54
58	MRI	25,121	742,488		111,849		32	58
60	Laboratory	1,244,472	8,413,148		1,621,910	1,725		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	525,824	770,160		202,228	854		65
65.50	SLEEP LAB		219,760		14,984	375		65.50
66	Physical Therapy	782,585	1,747,321		949,379	4,495	2,591	66
69	Electrocardiology	40,360	482,859		17,488			69
71	Medical Supplies Charged to Patients	11,745	46,365		107,838			71
72	Impl. Dev. Charged to Patients		171,504		70,069			72
73	Drugs Charged to Patients	1,836,338	3,212,913		439,376			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		1,365,333		2,098,512	7,481	151	88
88.01	RHC II		1,116,383		1,022,705	4,226		88.01
88.02	RHC III		336,765		557,782	4,800		88.02
90	Clinic		1,468,759		587,442	3,440		90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency		4,038,577		1,406,084	4,598	4,282	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)	6,958,666	35,503,914	-1,152,885	15,675,755	62,003	22,611	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices				94,290	3,042		192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	211,668	531,765		1,152,885	1,105,349	115,230	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.030418	0.014978		0.073106	16.993604	5.096192	203
204	Cost to be allocated (Per Wkst. B, Part II)		49,005		305,012	241,260	34,916	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.001380		0.019341	3.709124	1.544204	205

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	9,482						9
10	Dietary		14,473					10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	27		84,424				13
14	Central Services & Supply				180,309			14
15	Pharmacy					340,872		15
16	Medical Records & Library						36,220	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	2,920	14,473	58,040			9,745	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	835		5,402				50
53	Anesthesiology							53
54	Radiology-Diagnostic	473						54
58	MRI							58
60	Laboratory	358					14,065	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				112,809			71
72	Impl. Dev. Charged to Patients				67,500			72
73	Drugs Charged to Patients					340,872		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	1,434						88
88.01	RHC II							88.01
88.02	RHC III	240						88.02
90	Clinic	360						90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	2,182		20,982			12,410	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)	9,482	14,473	84,424	180,309	340,872	36,220	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)	202,218	122,660	375,044	12,639	403,776	363,079	202
203	Unit Cost Multiplier (Wkst. B, Part I)	21.326513	8.475092	4.442386	0.070096	1.184538	10.024268	203
204	Cost to be allocated (Per Wkst. B, Part II)	4,451	2,360	58,297	4,033	52,800	49,759	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.469416	0.163062	0.690526	0.022367	0.154897	1.373799	205

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	8,820						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,570						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	660						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	2,910						88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	1,680						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
117	OTHER SPECIAL PURPOSE COST CENTERS							117
117.02	SUPPLIES AND EXPENSE							117.02
118	SUBTOTALS (sum of lines 1-117)	8,820						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)	75,093						202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.513946						203
204	Cost to be allocated (Per Wkst. B, Part II)	8,029						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.910317						205

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	3,230,667		3,230,667		3,230,667	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	745,858		745,858		745,858	50
53	Anesthesiology	348,348		348,348		348,348	53
54	Radiology-Diagnostic	1,053,558		1,053,558		1,053,558	54
58	MRI	120,189		120,189		120,189	58
60	Laboratory	1,918,422		1,918,422		1,918,422	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	231,525		231,525		231,525	65
65.50	SLEEP LAB	22,452		22,452		22,452	65.50
66	Physical Therapy	1,127,919		1,127,919		1,127,919	66
69	Electrocardiology	18,766		18,766		18,766	69
71	Medical Supplies Charged to Patients	123,630		123,630		123,630	71
72	Impl. Dev. Charged to Patients	79,922		79,922		79,922	72
73	Drugs Charged to Patients	875,273		875,273		875,273	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	2,435,183		2,435,183		2,435,183	88
88.01	RHC II	1,169,286		1,169,286		1,169,286	88.01
88.02	RHC III	685,246		685,246		685,246	88.02
90	Clinic	696,524		696,524		696,524	90
90.01	NORRIS CITY CLINIC						90.01
91	Emergency	1,887,284		1,887,284		1,887,284	91
92	Observation Beds (Non-Distinct Part)	281,169		281,169		281,169	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)	17,051,221		17,051,221		17,051,221	200
201	Less Observation Beds	281,169		281,169		281,169	201
202	Total (line 200 minus line 201)	16,770,052		16,770,052		16,770,052	202

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	1,716,394		1,716,394				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	133,647	750,264	883,911	0.843816	0.843816	0.843816	50
53	Anesthesiology	23,761	377,089	400,850	0.869023	0.869023	0.869023	53
54	Radiology-Diagnostic	465,651	6,852,023	7,317,674	0.143974	0.143974	0.143974	54
58	MRI	25,121	717,367	742,488	0.161873	0.161873	0.161873	58
60	Laboratory	1,244,472	7,091,573	8,336,045	0.230136	0.230136	0.230136	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	132,729	138,826	271,555	0.852590	0.852590	0.852590	65
65.50	SLEEP LAB		216,008	216,008	0.103941	0.103941	0.103941	65.50
66	Physical Therapy	782,585	909,526	1,692,111	0.666575	0.666575	0.666575	66
69	Electrocardiology	36,472	404,759	441,231	0.042531	0.042531	0.042531	69
71	Medical Supplies Charged to Patients	430,423	723,454	1,153,877	0.107143	0.107143	0.107143	71
72	Impl. Dev. Charged to Patients	2,175	169,329	171,504	0.466007	0.466007	0.466007	72
73	Drugs Charged to Patients	1,836,338	1,364,743	3,201,081	0.273430	0.273430	0.273430	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	10,420	1,254,218	1,264,638				88
88.01	RHC II		1,116,383	1,116,383				88.01
88.02	RHC III		336,765	336,765				88.02
90	Clinic		1,468,759	1,468,759	0.474226	0.474226	0.474226	90
90.01	NORRIS CITY CLINIC							90.01
91	Emergency	4,235	3,864,683	3,868,918	0.487807	0.487807	0.487807	91
92	Observation Beds (Non-Distinct Part)	792	310,064	310,856	0.904499	0.904499	0.904499	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)	6,845,215	28,065,833	34,911,048				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	6,845,215	28,065,833	34,911,048				202

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] Swing Bed SNF **[ ] Swing Bed NF** **[ ] ICF/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	0.843816		378,816			319,651		50
53	Anesthesiology	0.869023		174,433			151,586		53
54	Radiology-Diagnostic	0.143974		2,762,797			397,771		54
58	MRI	0.161873		215,827			34,937		58
60	Laboratory	0.230136		3,528,152			811,955		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.852590		40,204			34,278		65
65.50	SLEEP LAB	0.103941		49,848			5,181		65.50
66	Physical Therapy	0.666575		220,180			146,766		66
69	Electrocardiology	0.042531		235,904			10,033		69
71	Medical Supplies Charged to Pat	0.107143		188,753			20,224		71
72	Impl. Dev. Charged to Patients	0.466007		133,392			62,162		72
73	Drugs Charged to Patients	0.273430		575,835			157,451		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
88.02	RHC III								88.02
90	Clinic	0.474226		1,383,103			655,903		90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	0.487807		1,594,788			777,949		91
92	Observation Beds (Non-Distinct	0.904499		228,146			206,358		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			11,710,178			3,792,205		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			11,710,178			3,792,205		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	0.843816							50
53	Anesthesiology	0.869023							53
54	Radiology-Diagnostic	0.143974							54
58	MRI	0.161873							58
60	Laboratory	0.230136							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.852590							65
65.50	SLEEP LAB	0.103941							65.50
66	Physical Therapy	0.666575							66
69	Electrocardiology	0.042531							69
71	Medical Supplies Charged to Pat	0.107143							71
72	Impl. Dev. Charged to Patients	0.466007							72
73	Drugs Charged to Patients	0.273430							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
88.02	RHC III								88.02
90	Clinic	0.474226							90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	0.487807							91
92	Observation Beds (Non-Distinct	0.904499							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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	596,663	305,777	290,886	2,011	144.65	197	28,496	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	596,663		290,886	2,011		197	28,496	200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	258,421	883,911	0.292361	9,669	2,827	50
53	Anesthesiology	8,059	400,850	0.020105	13,188	265	53
54	Radiology-Diagnostic	201,737	7,317,674	0.027568	62,927	1,735	54
58	MRI	3,243	742,488	0.004368	4,786	21	58
60	Laboratory	147,442	8,336,045	0.017687	117,822	2,084	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	35,054	271,555	0.129086	8,512	1,099	65
65.50	SLEEP LAB	13,548	216,008	0.062720			65.50
66	Physical Therapy	181,410	1,692,111	0.107209	4,727	507	66
69	Electrocardiology	1,040	441,231	0.002357	4,019	9	69
71	Medical Supplies Charged to Pat	4,673	1,153,877	0.004050	22,963	93	71
72	Impl. Dev. Charged to Patients	3,102	171,504	0.018087			72
73	Drugs Charged to Patients	65,732	3,201,081	0.020534	146,483	3,008	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	305,939	1,264,638	0.241918			88
88.01	RHC II	168,594	1,116,383	0.151018			88.01
88.02	RHC III	177,767	336,765	0.527867			88.02
90	Clinic	133,231	1,468,759	0.090710			90
90.01	NORRIS CITY CLINIC						90.01
91	Emergency	235,693	3,868,918	0.060920	837	51	91
92	Observation Beds (Non-Distinct	51,928	310,856	0.167048			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,996,613	33,194,654		395,933	11,699	200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,011		197		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	2,011		197		200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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
88.02	RHC III							88.02
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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	883,911			9,669				50
53	Anesthesiology	400,850			13,188				53
54	Radiology-Diagnostic	7,317,674			62,927				54
58	MRI	742,488			4,786				58
60	Laboratory	8,336,045			117,822				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	271,555			8,512				65
65.50	SLEEP LAB	216,008							65.50
66	Physical Therapy	1,692,111			4,727				66
69	Electrocardiology	441,231			4,019				69
71	Medical Supplies Charged to Pat	1,153,877			22,963				71
72	Impl. Dev. Charged to Patients	171,504							72
73	Drugs Charged to Patients	3,201,081			146,483				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	1,264,638							88
88.01	RHC II	1,116,383							88.01
88.02	RHC III	336,765							88.02
90	Clinic	1,468,759							90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	3,868,918			837				91
92	Observation Beds (Non-Distinct	310,856							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	33,194,654			395,933				200

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	0.843816		192,769			162,662		50
53	Anesthesiology	0.869023		113,006			98,205		53
54	Radiology-Diagnostic	0.143974		2,440,233			351,330		54
58	MRI	0.161873		309,471			50,095		58
60	Laboratory	0.230136		2,039,417			469,343		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.852590		33,365			28,447		65
65.50	SLEEP LAB	0.103941		101,656			10,566		65.50
66	Physical Therapy	0.666575		353,685			235,758		66
69	Electrocardiology	0.042531		123,082			5,235		69
71	Medical Supplies Charged to Pat	0.107143		199,402			21,365		71
72	Impl. Dev. Charged to Patients	0.466007		3,848			1,793		72
73	Drugs Charged to Patients	0.273430		395,862			108,241		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
88.02	RHC III								88.02
90	Clinic	0.474226		13,091			6,208		90
90.01	NORRIS CITY CLINIC								90.01
91	Emergency	0.487807		1,783,293			869,903		91
92	Observation Beds (Non-Distinct	0.904499		68,986			62,398		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			8,171,166			2,481,549		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			8,171,166			2,481,549		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	4,306	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,011	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)	1,652	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,038	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)	1,038	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	110	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)	109	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,274	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)	998	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)	998	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)	3,230,667	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)	15,084	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	14,620	25
26	Total swing-bed cost (see instructions)	1,655,648	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,575,019	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)	1,575,019	37

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] PPS [ ] TEFRA [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)	783.21	38
39	Program general inpatient routine service cost (line 9 x line 38)	997,810	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)	997,810	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)	558,224	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,556,034	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)	781,644	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	781,644	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	1,563,288	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	359	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	783.20	88
89	Observation bed cost (line 87 x line 88) (see instructions)	281,169	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	596,663	3,230,667	0.184687	281,169	51,928	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	4,306	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,011	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)	1,652	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,038	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)	1,038	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	110	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)	109	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	197	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)	3,230,667	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)	15,084	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	14,620	25
26	Total swing-bed cost (see instructions)	1,655,648	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,575,019	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)	1,575,019	37

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	783.21	38
39	Program general inpatient routine service cost (line 9 x line 38)	154,292	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)	154,292	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)	110,070	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	264,362	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	28,496	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,699	51
52	Total Program excludable cost (sum of lines 50 and 51)	40,195	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	224,167	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)					359	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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		875,470		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.843816	50,960	43,001	50
53	Anesthesiology	0.869023	10,573	9,188	53
54	Radiology-Diagnostic	0.143974	275,351	39,643	54
58	MRI	0.161873	9,572	1,549	58
60	Laboratory	0.230136	658,881	151,632	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.852590	59,028	50,327	65
65.50	SLEEP LAB	0.103941			65.50
66	Physical Therapy	0.666575	73,153	48,762	66
69	Electrocardiology	0.042531	22,188	944	69
71	Medical Supplies Charged to Patients	0.107143	176,161	18,874	71
72	Impl. Dev. Charged to Patients	0.466007	2,175	1,014	72
73	Drugs Charged to Patients	0.273430	698,225	190,916	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	0.474226			90
90.01	NORRIS CITY CLINIC				90.01
91	Emergency	0.487807	3,398	1,658	91
92	Observation Beds (Non-Distinct Part)	0.904499	792	716	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,040,457	558,224	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,040,457		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	0.843816	13,016	10,983	50
53	Anesthesiology	0.869023			53
54	Radiology-Diagnostic	0.143974	64,204	9,244	54
58	MRI	0.161873	3,584	580	58
60	Laboratory	0.230136	332,885	76,609	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.852590	62,882	53,613	65
65.50	SLEEP LAB	0.103941			65.50
66	Physical Therapy	0.666575	619,625	413,027	66
69	Electrocardiology	0.042531	9,048	385	69
71	Medical Supplies Charged to Patients	0.107143	159,508	17,090	71
72	Impl. Dev. Charged to Patients	0.466007			72
73	Drugs Charged to Patients	0.273430	801,567	219,172	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
88.02	RHC III				88.02
90	Clinic	0.474226			90
90.01	NORRIS CITY CLINIC				90.01
91	Emergency	0.487807			91
92	Observation Beds (Non-Distinct Part)	0.904499			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,066,319	800,703	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,066,319		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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		142,752		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.843816	9,669	8,159	50
53	Anesthesiology	0.869023	13,188	11,461	53
54	Radiology-Diagnostic	0.143974	62,927	9,060	54
58	MRI	0.161873	4,786	775	58
60	Laboratory	0.230136	117,822	27,115	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.852590	8,512	7,257	65
65.50	SLEEP LAB	0.103941			65.50
66	Physical Therapy	0.666575	4,727	3,151	66
69	Electrocardiology	0.042531	4,019	171	69
71	Medical Supplies Charged to Patients	0.107143	22,963	2,460	71
72	Impl. Dev. Charged to Patients	0.466007			72
73	Drugs Charged to Patients	0.273430	146,483	40,053	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
88.02	RHC III				88.02
90	Clinic	0.474226			90
90.01	NORRIS CITY CLINIC				90.01
91	Emergency	0.487807	837	408	91
92	Observation Beds (Non-Distinct Part)	0.904499			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		395,933	110,070	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		395,933		202

(A) Worksheet A line numbers

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	3,792,205			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)	3,792,205			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)	3,830,127			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)	32,252			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,642,533			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)	2,155,342			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)	2,155,342			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,155,342			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)	227,131			34
35	Adjusted reimbursable bad debts (see instructions)	147,635			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	227,131			36
37	Subtotal (see instructions)	2,302,977			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)	2,302,977			40
40.01	Sequestration adjustment (see instructions)	46,060			40.01
41	Interim payments	2,980,485			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-723,568			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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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				1,283,215		3,120,311	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	12/15/2016	74,156			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			12/15/2016	139,826	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		74,156		-139,826	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)				1,357,371		2,980,485	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-154,795		-723,568	6.02
7	Total Medicare program liability (see instructions)				1,202,576		2,256,917	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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				2,350,633			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	12/15/2016	79,474			3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		79,474			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)				2,430,107			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-203,724			6.02
7	Total Medicare program liability (see instructions)				2,226,383			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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	601	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,274	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)	1,652	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	34,911,048	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	345,347	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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

Check Applicable Boxes:
[ ] Title V **[XX] Swing Bed - SNF**
[XX] Title XVIII **[ ] Swing Bed - NF**
[ ] Title XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	1,578,921		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)	808,710		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	1,996		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)	2,387,631		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	2,387,631		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	2,387,631		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	115,812		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)	2,271,819		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)	2,271,819		19
19.01	Sequestration adjustment (see instructions)	45,436		19.01
20	Interim payments	2,430,107		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	-203,724		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	1,556,034	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,556,034	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,571,594	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)	1,571,594	19
20	Deductibles (exclude professional component)	364,736	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,206,858	22
23	Coinsurance	9,660	23
24	Subtotal (line 22 minus line 23)	1,197,198	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	46,031	25
26	Adjusted reimbursable bad debts (see instructions)	29,920	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	46,031	27
28	Subtotal (sum of lines 24 and 26)	1,227,118	28
29	Other adjustments (SEQUESTRATION)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,227,118	30
30.01	Sequestration adjustment (see instructions)	24,542	30.01
31	Interim payments	1,357,371	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	-154,795	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] NF**	**[XX] PPS**
	[XX] Title XIX	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] TEFRA**
		[ ] SNF		**[ ] 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		2,481,549	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)		2,481,549	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)		2,481,549	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	395,933	8,171,166	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)	395,933	8,171,166	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)	395,933	8,171,166	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)		2,481,549	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)		2,481,549	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)		2,481,549	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)		2,481,549	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)		2,481,549	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)		2,481,549	40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)		2,481,549	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	2,433,731				1
2	Temporary investments	3,087,109				2
3	Notes receivable					3
4	Accounts receivable	4,990,670				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,632,000				6
7	Inventory	417,988				7
8	Prepaid expenses	184,344				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	9,481,842				11
	FIXED ASSETS					
12	Land	69,760				12
13	Land improvements	499,730				13
14	Accumulated depreciation	-251,488				14
15	Buildings	21,710,218				15
16	Accumulated depreciation	-10,268,473				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	5,613,145				23
24	Accumulated depreciation	-4,043,817				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	784,683				27
28	Accumulated depreciation	-736,987				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	13,376,771				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	83,996		101,411		34
35	Total other assets (sum of lines 31-34)	83,996		101,411		35
36	Total assets (sum of lines 11, 30 and 35)	22,942,609		101,411		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	355,938				37
38	Salaries, wages and fees payable	700,147				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	515,000				40
41	Deferred income	40,880				41
42	Accelerated payments					42
43	Due to other funds	1,265,975				43
44	Other current liabilities	86,797				44
45	Total current liabilities (sum of lines 37 thru 44)	2,964,737				45
	LONG TERM LIABILITIES					
46	Mortgage payable	18,565,000				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)	18,565,000				50
51	Total liabilities (sum of lines 45 and 50)	21,529,737				51
	CAPITAL ACCOUNTS					
52	General fund balance	1,412,872				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted			101,411		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)	1,412,872		101,411		59
60	Total liabilities and fund balances (sum of lines 51 and 59)	22,942,609		101,411		60

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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		2,959,122			1
2	Net income (loss) (from Worksheet G-3, line 29)		-1,546,250			2
3	Total (sum of line 1 and line 2)		1,412,872			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)		1,412,872			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,412,872			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period		100,282			1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)		100,282			3
4	Additions (credit adjustments) (specify)	1,129				4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		1,129			10
11	Subtotal (line 3 plus line 10)		101,411			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		101,411			19

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	1,344,564		1,344,564	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	502,693		502,693	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)	1,847,257		1,847,257	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)	1,847,257		1,847,257	17
18	Ancillary services	5,111,409	20,219,431	25,330,840	18
19	Outpatient services		5,861,803	5,861,803	19
20	Rural Health Clinic (RHC)	105,685	1,259,648	1,365,333	20
20.01	RHC II		1,116,383	1,116,383	20.01
20.02	RHC III		336,765	336,765	20.02
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)	7,064,351	28,794,030	35,858,381	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		18,771,681	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			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)		18,771,681	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	35,858,381	1
2	Less contractual allowances and discounts on patients' accounts	20,221,304	2
3	Net patient revenues (line 1 minus line 2)	15,637,077	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	18,771,681	4
5	Net income from service to patients (line 3 minus line 4)	-3,134,604	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	84,329	6
7	Income from investments	42,320	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	370	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	697	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	6,021	16
17	Revenue from sale of drugs to other than patients	5,477	17
18	Revenue from sale of medical records and abstracts	3,781	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	961	21
22	Rental of hosptial space	34,800	22
23	Governmental appropriations	592,185	23
24	Other (EHR INCENTIVE)	122,677	24
24.01	Other (340B DRUG REVENUE)	435,150	24.01
24.02	Other (WELLNESS PROGRAMS)	102,150	24.02
24.03	Other (LAB CONTRACT REVENUE)	21,971	24.03
24.04	Other (HH CONTRACT SERVICES)	158,485	24.04
24.05	Other (MISCELLANEOUS OTHER REVENUE)	19,449	24.05
25	Total other income (sum of lines 6-24)	1,630,823	25
26	Total (line 5 plus line 25)	-1,503,781	26
27	Other expenses (LOSS ON SALE OF ASSETS)	42,469	27
28	Total other expenses (sum of line 27 and subscripts)	42,469	28
29	Net income (or loss) for the period (line 26 minus line 28)	-1,546,250	29

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

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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
88.02	RHC III							88.02
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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	841,923		841,923		841,923	-129,979	711,944	1
2	Physician Assistant								2
3	Nurse Practitioner	191,668		191,668		191,668		191,668	3
4	Visiting Nurse								4
5	Other Nurse	141,685		141,685		141,685		141,685	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)	1,175,276		1,175,276		1,175,276	-129,979	1,045,297	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		41,240	41,240		41,240		41,240	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)		41,240	41,240		41,240		41,240	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,175,276	41,240	1,216,516		1,216,516	-129,979	1,086,537	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
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	169,813	407,461	577,274	-43,186	534,088		534,088	30
31	Total Facility Overhead (sum of lines 29 and 30)	169,813	407,461	577,274	-43,186	534,088		534,088	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,345,089	448,701	1,793,790	-43,186	1,750,604	-129,979	1,620,625	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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	4,632	4,200	7,266		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.16	3,444	2,100	2,436		3
4	Subtotal (sum of lines 1 through 3)	2.89	8,076		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	8,076			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)	1,086,537	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)	1,086,537	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)	534,088	14
15	Parent provider overhead allocated to facility (see instructions)	814,558	15
16	Total overhead (sum of lines 14 and 15)	1,348,646	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,348,646	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,348,646	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	2,435,183	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	2,435,183	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	19,397	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,415,786	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)	249.00	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)	249.00	249.00	249.00	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		2,991		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		744,759		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)		744,759		16
16.01	Total program charges (see instructions)(from contractor's records)		265,585		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,105		16.02
16.03	Total program preventive costs (see instructions)		5,903		16.03
16.04	Total program non-preventive costs (see instructions)		558,490		16.04
16.05	Total program cost (see instructions)		564,393		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		40,743		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		44,547		19
20	Net Medicare cost excluding vaccines (see instructions)		564,393		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,352		21
22	Total reimbursable Program cost (line 20 plus line 21)		572,745		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)		572,745		26
26.01	Sequestration adjustment (see instructions)		11,455		26.01
27	Interim payments		419,319		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		141,971		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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	1,045,297	1,045,297	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000093	0.001899	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	97	1,985	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,181	5,392	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,278	7,377	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,086,537	1,086,537	6
7	Total overhead (from Wkst. M-2, line 16)	1,348,646	1,348,646	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001176	0.006789	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,586	9,156	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	2,864	16,533	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	16	325	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	179.00	50.87	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	10	129	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,790	6,562	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)		19,397	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)		8,352	16

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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

COMPONENT CCN: 14-3477

WORKSHEET M-5

Check applicable box: [XX] RHC I [ ] FQHC

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				395,252	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	12/15/2016	24,067	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		24,067	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				419,319	
	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		141,971	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				561,290	

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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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								1
2	Physician Assistant								2
3	Nurse Practitioner	317,550		317,550		317,550		317,550	3
4	Visiting Nurse								4
5	Other Nurse	96,026		96,026		96,026		96,026	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)	413,576		413,576		413,576		413,576	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		8,656	8,656		8,656		8,656	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)		8,656	8,656		8,656		8,656	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	413,576	8,656	422,232		422,232		422,232	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
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	71,714	390,745	462,459	-116,195	346,264		346,264	30
31	Total Facility Overhead (sum of lines 29 and 30)	71,714	390,745	462,459	-116,195	346,264		346,264	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	485,290	399,401	884,691	-116,195	768,496		768,496	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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			4,200			1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.61	7,983	2,100	3,381		3
4	Subtotal (sum of lines 1 through 3)	1.61	7,983		3,381	7,983	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)	1.61	7,983			7,983	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)	422,232	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)	422,232	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)	346,264	14
15	Parent provider overhead allocated to facility (see instructions)	400,790	15
16	Total overhead (sum of lines 14 and 15)	747,054	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	747,054	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	747,054	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	1,169,286	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	1,169,286	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	4,085	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,165,201	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	7,983	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	7,983	6
7	Adjusted cost per visit (line 3 divided by line 6)	145.96	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)	145.96	145.96	145.96	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		1,138		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		166,102		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)		166,102		16
16.01	Total program charges (see instructions)(from contractor's records)		119,527		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,510		16.02
16.03	Total program preventive costs (see instructions)		3,488		16.03
16.04	Total program non-preventive costs (see instructions)		110,768		16.04
16.05	Total program cost (see instructions)		114,256		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		24,154		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,573		19
20	Net Medicare cost excluding vaccines (see instructions)		114,256		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,733		21
22	Total reimbursable Program cost (line 20 plus line 21)		117,989		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)		117,989		26
26.01	Sequestration adjustment (see instructions)		2,360		26.01
27	Interim payments		110,911		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		4,718		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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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)	413,576	413,576	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000089	0.000521	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	37	215	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	443	780	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	480	995	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	422,232	422,232	6
7	Total overhead (from Wkst. M-2, line 16)	747,054	747,054	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001137	0.002357	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	849	1,761	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	1,329	2,756	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	8	47	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	166.13	58.64	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	8	41	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,329	2,404	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)		4,085	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		3,733	16

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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

COMPONENT CCN: 14-8529

WORKSHEET M-5

Check applicable box: [XX] RHC II [ ] FQHC

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				118,945	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	12/15/2016	8,034	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		-8,034	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				110,911	
	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		4,718	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				115,629	

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.

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 14-8556** **WORKSHEET M-1**

Check applicable box: **[XX] RHC III** **[ ] 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								1
2	Physician Assistant								2
3	Nurse Practitioner	162,849		162,849		162,849		162,849	3
4	Visiting Nurse								4
5	Other Nurse	69,586		69,586		69,586		69,586	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)	232,435		232,435		232,435		232,435	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		1,839	1,839		1,839		1,839	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)		1,839	1,839		1,839		1,839	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	232,435	1,839	234,274		234,274		234,274	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
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	48,607	128,207	176,814	-61,197	115,617		115,617	30
31	Total Facility Overhead (sum of lines 29 and 30)	48,607	128,207	176,814	-61,197	115,617		115,617	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	281,042	130,046	411,088	-61,197	349,891		349,891	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-8556** **WORKSHEET M-2**

Check applicable box: **[XX] RHC III** **[ ] 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			4,200			1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.88	3,247	2,100	1,848		3
4	Subtotal (sum of lines 1 through 3)	0.88	3,247		1,848	3,247	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)	0.88	3,247			3,247	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)	234,274	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)	234,274	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)	115,617	14
15	Parent provider overhead allocated to facility (see instructions)	335,355	15
16	Total overhead (sum of lines 14 and 15)	450,972	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	450,972	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	450,972	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	685,246	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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8556** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC III** **[ ] 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)	685,246	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	2,861	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	682,385	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	3,247	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	3,247	6
7	Adjusted cost per visit (line 3 divided by line 6)	210.16	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)	210.16	210.16	210.16	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		664		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		139,546		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)		139,546		16
16.01	Total program charges (see instructions)(from contractor's records)		54,213		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,170		16.02
16.03	Total program preventive costs (see instructions)		3,012		16.03
16.04	Total program non-preventive costs (see instructions)		101,058		16.04
16.05	Total program cost (see instructions)		104,070		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		10,212		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,566		19
20	Net Medicare cost excluding vaccines (see instructions)		104,070		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,788		21
22	Total reimbursable Program cost (line 20 plus line 21)		105,858		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)		105,858		26
26.01	Sequestration adjustment (see instructions)		2,117		26.01
27	Interim payments		87,869		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		15,872		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: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8556** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC III** **[ ] 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)	232,435	232,435	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000782	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		182	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		796	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		978	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	234,274	234,274	6
7	Total overhead (from Wkst. M-2, line 16)	450,972	450,972	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.004175	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,883	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)		2,861	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)		48	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)		59.60	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries		30	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)		1,788	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)		2,861	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)		1,788	16

HAMILTON MEMORIAL HOSPITAL Provider CCN: 14-1326	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/15/2017 Run Time: 14:04 Version: 2017.01 (07/27/2017)

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

COMPONENT CCN: 14-8556

WORKSHEET M-5

Check applicable box: [XX] RHC III [ ] FQHC

				Part B mm/dd/yyyy 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				87,869	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)				87,869	
	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		15,872	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				103,741	

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.