EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	7.25	5/3/2018

D. General Cost Report Year Information 10/1/2016 - 9/30/2017

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:	HAMILTON MEDICAL CENTER			
	10/1/2016 through 9/30/2017			
2. Select Cost Report Year Covered by this Survey:	X			
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted			
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/7/2018			

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	HAMILTON MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000899A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110001	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number	See attached listing	
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2016 - 09/30/2017)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 250,318	$ 1,055,986	$1,306,304
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,688,318	$ 8,781,839	$10,470,157
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$1,938,636	$9,837,825	$11,776,461
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	12.91%	10.73%	11.09%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ -
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	$ -
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2016 - 09/30/2017)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	45,495

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2.	Inpatient Hospital Subsidies	1,285,579
3.	Outpatient Hospital Subsidies	2,714,421
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 4,000,000
7.	Inpatient Hospital Charity Care Charges	19,327,455
8.	Outpatient Hospital Charity Care Charges	25,680,484
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 45,007,939

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 92,943,370	$ -	$ -	$ 69,800,034	$ -	$ -	$ 23,143,336
12.	Psych Subprovider	$ 6,621,850	$ -	$ -	$ 4,972,978	$ -	$ -	$ 1,648,872
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 281,034,102	$ 446,098,084	$ -	$ 211,055,290	$ 335,017,565	$ -	$ 181,059,331
20.	Outpatient Services		$ 110,234,954	$ -		$ 82,785,933	$ -	$ 27,449,021
21.	Home Health Agency			$ 7,200,460			$ 5,407,512	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ 2,467,611			$ 1,853,164	
26.	Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27.	Total	$ 380,599,322	$ 556,333,038	$ 9,668,071	$ 285,828,303	$ 417,803,498	$ 7,260,676	$ 233,300,560
28.	Total Hospital and Non Hospital		Total from Above	$ 946,600,431		Total from Above	$ 710,892,476	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 946,600,431	Total Contractual Adj. (G-3 Line 2)	$ 709,215,755
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+ $ -
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+ $ 1,676,721
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				- $ -
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"				- $ -
35.	Adjusted Contractual Adjustments				710,892,476
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) | HAMILTON MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 32,029,801	$ -	$ -	$ -	**$ 32,029,801**	37,831	$ 45,876,429		**$ 846.65**
2	03100 INTENSIVE CARE UNIT	$ 10,004,107	$ -	$ -		**$ 10,004,107**	7,011	$ 20,797,435		**$ 1,426.92**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,295,001	$ -	$ -		**$ 3,295,001**	2,271	$ 7,045,355		**$ 1,450.90**
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ 1,505,337	$ -	$ -		**$ 1,505,337**	3,117	$ 2,550,193		**$ 482.94**
11	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
12	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
13	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
14	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
15	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
16	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
17	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18	Total Routine	$ 46,834,246	$ -	$ -	$ -	$ 46,834,246	50,230	$ 76,269,412		
19	Weighted Average									$ 932.39

Line #			*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)									
20	09200	Observation (Non-Distinct)	4,735	-	-	**$ 4,008,888**	$ 33,122	$ 7,140,559	$ 7,173,681	**0.558833**

Line #			*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21	5000	OPERATING ROOM	$ 9,445,090	$ -	$ -		**$ 9,445,090**	$ 20,742,880	$ 38,620,983	$ 59,363,863	**0.159105**
22	5100	RECOVERY ROOM	$ 1,406,253	$ -	$ -		**$ 1,406,253**	$ 2,787,692	$ 2,722,678	$ 5,510,370	**0.255201**
23	5200	DELIVERY ROOM & LABOR ROOM	$ 4,540,026	$ -	$ -		**$ 4,540,026**	$ 17,702,449	$ 713,198	$ 18,415,647	**0.246531**
24	5300	ANESTHESIOLOGY	$ 572,697	$ -	$ -		**$ 572,697**	$ 1,872,023	$ 2,522,923	$ 4,394,946	**0.130308**
25	5400	RADIOLOGY-DIAGNOSTIC	$ 15,190,617	$ -	$ -		**$ 15,190,617**	$ 14,279,002	$ 79,363,676	$ 93,642,678	**0.162219**
26	5700	CT SCAN	$ 2,283,580	$ -	$ -		**$ 2,283,580**	$ 17,636,113	$ 55,349,183	$ 72,985,296	**0.031288**
27	5800	MRI	$ 1,399,152	$ -	$ -		**$ 1,399,152**	$ 7,874,680	$ 21,392,434	$ 29,267,114	**0.047806**
28	5900	CARDIAC CATHETERIZATION	$ 5,700,278	$ -	$ -		**$ 5,700,278**	$ 27,327,702	$ 31,110,060	$ 58,437,762	**0.097544**
29	6000	LABORATORY	$ 10,906,525	$ -	$ -		**$ 10,906,525**	$ 64,892,365	$ 95,770,662	$ 160,663,027	**0.067884**
30	6500	RESPIRATORY THERAPY	$ 3,491,350	$ -	$ -		**$ 3,491,350**	$ 28,772,827	$ 10,094,612	$ 38,867,439	**0.089827**
31	6600	PHYSICAL THERAPY	$ 5,763,877	$ -	$ -		**$ 5,763,877**	$ 4,287,671	$ 8,290,786	$ 12,578,457	**0.458234**
32	6900	ELECTROCARDIOLOGY	$ 2,421,173	$ -	$ -		**$ 2,421,173**	$ 11,577,923	$ 23,024,832	$ 34,602,755	**0.069971**

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) HAMILTON MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 9,598,315	$ -	$ -		$ 9,598,315	$ 16,575,575	$ 19,715,810	$ 36,291,385	0.264479
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 11,215,175	$ -	$ -		$ 11,215,175	$ 12,371,897	$ 9,380,544	$ 21,752,441	0.515582
35	7300	DRUGS CHARGED TO PATIENTS	$ 18,168,414	$ -	$ -		$ 18,168,414	$ 29,340,706	$ 66,860,290	$ 96,200,996	0.188859
36	7400	RENAL DIALYSIS	$ 744,762	$ -	$ -		$ 744,762	$ 3,245,378	$ 229,557	$ 3,474,935	0.214324
37	7501	PSYCHIATRIC ANCILLARY	$ 911,761	$ -	$ -		$ 911,761	$ 1,643,564	$ 1,458,923	$ 3,102,487	0.293881
38	9000	CLINIC	$ 3,616,821	$ -	$ -		$ 3,616,821	$ 25,908	$ 7,875,857	$ 7,901,765	0.457723
39	9100	EMERGENCY	$ 13,109,122	$ -	$ -		$ 13,109,122	$ 16,705,929	$ 51,284,027	$ 67,989,956	0.192810
40			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
41			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
42			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
43			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
44			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
45			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
46			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
47			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
48			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
49			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
50			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
51			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
52			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
53			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
54			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
55			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
56			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
57			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
58			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
59			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
60			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
61			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
62			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
63			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
64			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
65			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
66			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
67			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
68			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
69			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
70			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
71			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
72			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
73			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
74			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
75			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
76			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
77			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
78			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
79			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
80			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
81			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
82			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
83			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
84			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
85			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
86			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
87			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
88			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
89			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
90			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
91			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
92			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
93			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) HAMILTON MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
94		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
95		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
96		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
97		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
98		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
99		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
100		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
101		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
102		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
103		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
104		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
105		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
106		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
107		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
108		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
109		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
110		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
111		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
112		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
113		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
114		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
115		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
116		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
117		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
118		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
119		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
120		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
121		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
122		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
123		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
124		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
125		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
126	**Total Ancillary**	$ 120,484,988	$ -	$ -		$ 120,484,988	$ 299,695,406	$ 532,921,594	$ 832,617,000	
127	**Weighted Average**									0.149521
128	**Sub Totals**	$ 167,319,234	$ -	$ -		$ 167,319,234	$ 375,964,818	$ 532,921,594	$ 908,886,412	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)					$ -				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)					$ -				
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)					$ -				
131.01	Other Cost Adjustments (support must be submitted)					$ -				
132	**Grand Total**					**$ 167,319,234**				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data

Cost Report Year (10/01/2016-09/30/2017 | HAMILTON MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 846.65		2,935		3,474		3,061		848		2,604		**10,318**		41.52%
2	03100 INTENSIVE CARE UNIT	$ 1,426.92		1,174		2,678		534		227		871		**4,613**		82.33%
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-		**-**		
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		**-**		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 1,450.90		-		-		-		-		-		**-**		0.00%
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-		**-**		
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-		**-**		
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-		**-**		
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-		**-**		
10	04300 NURSERY	$ 482.94		400		1,750		-		167		71		**2,317**		77.96%
11	0	$ -		-		-		-		-		-		**-**		
12	0	$ -		-		-		-		-		-		**-**		
13	0	$ -		-		-		-		-		-		**-**		
14	0	$ -		-		-		-		-		-		**-**		
15	0	$ -		-		-		-		-		-		**-**		
16	0	$ -		-		-		-		-		-		**-**		
17	0	$ -		-		-		-		-		-		**-**		
18			**Total Days**	4,509		7,902		3,595		1,242		3,546		17,248		48.23%
19	Total Days per PS&R or Exhibit Detail			4,509		7,902		3,595		1,242		3,546				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 6,980,263		$ 10,481,849		$ 6,872,615		$ 1,800,926		$ 5,637,489		$ 26,135,653		44.26%
21.01	Calculated Routine Charge Per Dien			$ 1,548.07		$ 1,326.48		$ 1,911.71		$ 1,450.02		$ 1,589.82		$ 1,515.29		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct		0.558833	$ 35,292	$ 614,232	$ 61,496	$ 522,111	$ 264,501	$ 769,140	$ 34,111	$ 98,711	$ -	$ 734,843	$ 395,400	$ 2,004,194	51.24%
23	5000 OPERATING ROOM		0.159105	$ 1,859,090	$ 2,169,771	$ 3,866,711	$ 2,011,244	$ 3,034,317	$ 6,210,460	$ 702,893	$ 540,615	$ 2,084,675	$ 2,432,386	$ 9,463,011	$ 10,932,090	45.18%
24	5100 RECOVERY ROOM		0.255201	$ 167,593	$ 155,955	$ 382,216	$ 146,212	$ 294,847	$ 178,905	$ 71,588	$ 23,583	$ 222,211	$ 216,892	$ 916,244	$ 504,655	37.37%
25	5200 DELIVERY ROOM & LABOR ROOM		0.246531	$ 1,453,089	$ 15,775	$ 5,956,491	$ 151,366	$ 32,548	$ 3,416	$ 554,157	$ 22,849	$ 239,865	$ 28,138	$ 7,996,285	$ 193,406	46.97%
26	5300 ANESTHESIOLOGY		0.130308	$ 92,465	$ 173,340	$ 51,281	$ 107,164	$ 226,737	$ 322,393	$ 27,688	$ 33,162	$ 170,948	$ 221,967	$ 398,171	$ 636,059	35.75%
27	5400 RADIOLOGY-DIAGNOSTIC		0.162219	$ 987,641	$ 4,053,262	$ 445,532	$ 3,524,151	$ 2,082,754	$ 8,417,554	$ 244,205	$ 961,891	$ 936,244	$ 7,062,401	$ 3,760,132	$ 16,956,858	32.01%
28	5700 CT SCAN		0.031288	$ 1,231,845	$ 2,742,244	$ 322,808	$ 2,110,460	$ 2,438,301	$ 5,521,158	$ 119,710	$ 837,512	$ 617,228	$ 9,066,029	$ 4,112,664	$ 11,211,374	37.67%
29	5800 MRI		0.047806	$ 414,015	$ 1,039,351	$ 93,431	$ 902,480	$ 1,205,735	$ 3,076,477	$ 111,007	$ 285,862	$ 686,013	$ 989,848	$ 1,824,188	$ 5,304,170	30.08%
30	5900 CARDIAC CATHETERIZATION		0.097544	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
31	6000 LABORATORY		0.067884	$ 5,978,061	$ 6,870,982	$ 3,284,865	$ 6,056,933	$ 10,234,988	$ 7,812,954	$ 1,096,406	$ 1,214,095	$ 4,867,682	$ 11,166,149	$ 20,594,320	$ 21,954,964	39.39%
32	6500 RESPIRATORY THERAPY		0.089827	$ 2,314,470	$ 299,610	$ 1,278,796	$ 187,495	$ 3,938,835	$ 622,684	$ 587,459	$ 54,300	$ 1,826,538	$ 470,868	$ 8,119,560	$ 1,164,089	30.29%
33	6600 PHYSICAL THERAPY		0.458234	$ 302,359	$ 39,003	$ 155,467	$ 113,197	$ 579,521	$ 614,082	$ 130,251	$ 12,475	$ 179,062	$ 140,814	$ 1,167,598	$ 778,757	19.62%
34	6900 ELECTROCARDIOLOGY		0.069971	$ 1,768,303	$ 2,250,864	$ 454,154	$ 948,187	$ 4,177,837	$ 5,888,409	$ 505,650	$ 699,430	$ 1,863,300	$ 2,477,664	$ 6,905,944	$ 9,786,890	63.12%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.264479	$ 1,159,885	$ 946,673	$ 1,450,438	$ 713,010	$ 2,279,869	$ 1,819,703	$ 341,990	$ 180,033	$ 1,272,751	$ 1,306,956	$ 5,232,182	$ 3,659,419	33.57%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.515582	$ 336,761	$ 529,947	$ -	$ -	$ 1,686,627	$ 1,069,527	$ 193,214	$ 89,100	$ 404,491	$ 229,850	$ 2,216,602	$ 1,688,574	22.53%
37	7300 DRUGS CHARGED TO PATIENTS		0.188859	$ 3,063,173	$ 4,885,329	$ 3,155,233	$ 3,040,175	$ 4,471,984	$ 6,257,996	$ 481,315	$ 527,937	$ 1,872,720	$ 5,866,843	$ 11,171,705	$ 14,711,437	37.22%
38	7400 RENAL DIALYSIS		0.214324	$ 282,957	$ -	$ 93,915	$ 623	$ 728,115	$ 19,418	$ 114,226	$ -	$ 180,198	$ 47,298	$ 1,219,213	$ 20,041	42.21%
39	7501 PSYCHIATRIC ANCILLARY		0.293881	$ 240,037	$ 11,497	$ 81,072	$ 7,737	$ 134,221	$ 93,672	$ 20,772	$ 3,354	$ 79,868	$ 67,003	$ 476,102	$ 116,260	26.63%
40	9000 CLINIC		0.457723	$ 12,823	$ 12,700	$ 42,914	$ 186,449	$ 2,820	$ 282,923	$ 2,443	$ 7,608	$ 7,427	$ 109,167	$ 61,000	$ 489,680	8.58%
41	9100 EMERGENCY		0.192810	$ 918,707	$ 3,999,466	$ 224,228	$ 7,872,295	$ 1,648,887	$ 4,547,609	$ -	$ 736,009	$ 4,040	$ 13,313,769	$ 2,791,822	$ 17,155,379	52.55%
42			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
43			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
44			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
45			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
46			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
47			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
48			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
49			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
50			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
51			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
52			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
53			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
54			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
55			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
56			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
57			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
58			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
59			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
60			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
61			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
62			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
63			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
64			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
65			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
66			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
67			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
68			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
69			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
70			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
71			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
72			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
73			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
74			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
75			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
76			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
77			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
78			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
79			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
80			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
81			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
82			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
83			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
84			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data

Cost Report Year (10/01/2016-09/30/2017 | HAMILTON MEDICAL CENTER

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
85			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
86			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
87			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
88			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
89			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
90			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
91			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
92			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
93			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
94			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
95			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
96			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
97			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
98			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
99			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
100			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
101			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
102			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
103			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
104			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
105			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
106			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
107			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
108			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
109			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
110			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
111			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
112			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
113			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
114			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
115			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
116			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
117			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
118			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
119			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
120			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
121			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
122			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
123			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
124			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
125			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
126			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
127			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
				22,618,566	30,810,001	21,401,048	28,601,289	39,463,444	53,528,480	5,339,085	6,328,526	17,515,261	55,948,885			
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***			**$ 29,598,829**	**$ 30,810,001**	**$ 31,882,897**	**$ 28,601,289**	**$ 46,336,059**	**$ 53,528,480**	**$ 7,140,011**	**$ 6,328,526**	**$ 23,152,750** (Agrees to Exhibit A)	**$ 55,948,885** (Agrees to Exhibit A)	**$ 114,957,796**	**$ 119,268,296**	36.72%
129	Total Charges per PS&R or Exhibit Detail			$ 29,598,829	$ 30,810,001	$ 31,882,897	$ 28,601,289	$ 46,336,059	$ 53,528,480	$ 7,140,011	$ 6,328,526	$ 23,152,750	$ 55,948,885			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			**$ 7,549,500**	**$ 4,443,038**	**$ 11,444,015**	**$ 4,295,801**	**$ 9,007,112**	**$ 7,724,068**	**$ 1,995,514**	**$ 834,646**	**$ 5,827,652**	**$ 7,622,695**	$ 29,996,141	$ 17,297,553	38.64%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 6,775,072	$ 3,997,801	$ -	$ -	$ 848,598	$ 628,188	$ 661,257	$ 220,024			$ 8,284,927	$ 4,846,013	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 7,697,039	$ 4,569,496	$ -	$ -	$ -	$ -			$ 7,697,039	$ 4,569,496	
134	Private Insurance (including primary and third party liability)			$ 339,214	$ 321,254	$ -	$ -	$ 12,774	$ 9,592	$ 1,360,582	$ 729,053			$ 1,712,570	$ 1,059,899	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 9,057	$ -	$ -	$ -	$ -	$ -	$ -			$ -	$ 9,057	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 7,114,286	$ 4,328,112	$ 7,697,039	$ 4,569,496									
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ -	$ -	$ -							$ -	$ -	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 7,454,103	$ 5,652,974	$ -	$ -			$ 7,454,103	$ 5,652,974	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments							$ 96,206	$ 225,938	$ -	$ -			$ 96,206	$ 225,938	
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 250,318	$ 1,055,986			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 435,214	$ 114,926	$ 3,746,976	$ (273,695)	$ 595,431	$ 1,207,376	$ (26,325)	$ (114,431)	$ 5,577,334	$ 6,566,709	$ 4,751,296	$ 934,176	
146	**Calculated Payments as a Percentage of Cost**			94%	97%	67%	106%	93%	84%	101%	114%	4%	14%	84%	95%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6**							20,531								
148	**Percent of cross-over days to total Medicare days from the cost report**							18%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with s
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education pay
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation pa

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) HAMILTON MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 846.65		819		-		-		1		820	
2	03100 INTENSIVE CARE UNIT	$ 1,426.92		288		-		-		-		288	
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 1,450.90		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ 482.94		42		-		-		-		42	
11		$ -		-		-		-		-		-	
12		$ -		-		-		-		-		-	
13		$ -		-		-		-		-		-	
14		$ -		-		-		-		-		-	
15		$ -		-		-		-		-		-	
16		$ -		-		-		-		-		-	
17		$ -		-		-		-		-		-	
18			Total Days	1,149		-		-		1		1,150	
19	Total Days per PS&R or Exhibit Detail			1,149		-		-		1			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 1,975,440		$ -		$ -		$ 6,600		$ 1,982,040	
21.01	Calculated Routine Charge Per Diem			$ 1,719.27		$ -		$ -		$ 6,600.00		$ 1,723.51	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.558833	-	540,538	-	-	-	-	-	1,050	$ -	$ 541,588
23	5000 OPERATING ROOM		0.159105	768,592	1,110,966	-	-	-	-	-	30,665	$ 768,592	$ 1,141,631
24	5100 RECOVERY ROOM		0.255201	67,524	129,450	-	-	-	-	-	2,096	$ 67,524	$ 131,546
25	5200 DELIVERY ROOM & LABOR ROOM		0.246531	188,130	4,380	-	-	-	-	-	-	$ 188,130	$ 4,380
26	5300 ANESTHESIOLOGY		0.130308	54,828	88,188	-	-	-	-	-	1,082	$ 54,828	$ 89,270
27	5400 RADIOLOGY-DIAGNOSTIC		0.162219	261,693	995,437	-	-	-	-	377	6,243	$ 262,070	$ 1,001,680
28	5700 CT SCAN		0.031288	45,780	2,430,723	-	-	-	-	-	10,340	$ 45,780	$ 2,441,063
29	5800 MRI		0.047806	-	-	-	-	-	-	-	-	$ -	$ -
30	5900 CARDIAC CATHETERIZATION		0.097544	-	-	-	-	-	-	-	-	$ -	$ -
31	6000 LABORATORY		0.067884	1,419,608	3,259,700	-	-	-	-	7,122	10,294	$ 1,426,730	$ 3,269,994
32	6500 RESPIRATORY THERAPY		0.089827	191,844	-	-	-	-	-	-	1,302	$ 191,844	$ 1,302
33	6600 PHYSICAL THERAPY		0.458234	47,004	155,162	-	-	-	-	-	-	$ 47,004	$ 155,162
34	6900 ELECTROCARDIOLOGY		0.069971	350,559	455,135	-	-	-	-	3,129	360	$ 353,688	$ 455,495
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.264479	211,392	494,902	-	-	-	-	440	6,182	$ 211,832	$ 501,084
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.515582	-	361,258	-	-	-	-	-	-	$ -	$ 361,258
37	7300 DRUGS CHARGED TO PATIENTS		0.188859	541,238	1,628,454	-	-	-	-	2,326	7,175	$ 543,564	$ 1,635,629
38	7400 RENAL DIALYSIS		0.214324	-	-	-	-	-	-	-	-	$ -	$ -
39	7501 PSYCHIATRIC ANCILLARY		0.293881	78,564	8,404	-	-	-	-	-	-	$ 78,564	$ 8,404
40	9000 CLINIC		0.457723	3,339	3,369	-	-	-	-	-	4,290	$ 3,339	$ 7,659
41	9100 EMERGENCY		0.192810	-	2,453,746	-	-	-	-	-	7,833	$ -	$ 2,461,579
42			-	-	-	-	-	-	-	-	-	$ -	$ -
43			-	-	-	-	-	-	-	-	-	$ -	$ -
44			-	-	-	-	-	-	-	-	-	$ -	$ -
45			-	-	-	-	-	-	-	-	-	$ -	$ -
46			-	-	-	-	-	-	-	-	-	$ -	$ -
47			-	-	-	-	-	-	-	-	-	$ -	$ -
48			-	-	-	-	-	-	-	-	-	$ -	$ -
49			-	-	-	-	-	-	-	-	-	$ -	$ -
50			-	-	-	-	-	-	-	-	-	$ -	$ -
51			-	-	-	-	-	-	-	-	-	$ -	$ -
52			-	-	-	-	-	-	-	-	-	$ -	$ -
53			-	-	-	-	-	-	-	-	-	$ -	$ -
54			-	-	-	-	-	-	-	-	-	$ -	$ -
55			-	-	-	-	-	-	-	-	-	$ -	$ -
56			-	-	-	-	-	-	-	-	-	$ -	$ -
57			-	-	-	-	-	-	-	-	-	$ -	$ -
58			-	-	-	-	-	-	-	-	-	$ -	$ -
59			-	-	-	-	-	-	-	-	-	$ -	$ -
60			-	-	-	-	-	-	-	-	-	$ -	$ -
61			-	-	-	-	-	-	-	-	-	$ -	$ -
62			-	-	-	-	-	-	-	-	-	$ -	$ -
63			-	-	-	-	-	-	-	-	-	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) HAMILTON MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
64			-	-	-	-	-	-	-	-	-	$ -	$ -
65			-	-	-	-	-	-	-	-	-	$ -	$ -
66			-	-	-	-	-	-	-	-	-	$ -	$ -
67			-	-	-	-	-	-	-	-	-	$ -	$ -
68			-	-	-	-	-	-	-	-	-	$ -	$ -
69			-	-	-	-	-	-	-	-	-	$ -	$ -
70			-	-	-	-	-	-	-	-	-	$ -	$ -
71			-	-	-	-	-	-	-	-	-	$ -	$ -
72			-	-	-	-	-	-	-	-	-	$ -	$ -
73			-	-	-	-	-	-	-	-	-	$ -	$ -
74			-	-	-	-	-	-	-	-	-	$ -	$ -
75			-	-	-	-	-	-	-	-	-	$ -	$ -
76			-	-	-	-	-	-	-	-	-	$ -	$ -
77			-	-	-	-	-	-	-	-	-	$ -	$ -
78			-	-	-	-	-	-	-	-	-	$ -	$ -
79			-	-	-	-	-	-	-	-	-	$ -	$ -
80			-	-	-	-	-	-	-	-	-	$ -	$ -
81			-	-	-	-	-	-	-	-	-	$ -	$ -
82			-	-	-	-	-	-	-	-	-	$ -	$ -
83			-	-	-	-	-	-	-	-	-	$ -	$ -
84			-	-	-	-	-	-	-	-	-	$ -	$ -
85			-	-	-	-	-	-	-	-	-	$ -	$ -
86			-	-	-	-	-	-	-	-	-	$ -	$ -
87			-	-	-	-	-	-	-	-	-	$ -	$ -
88			-	-	-	-	-	-	-	-	-	$ -	$ -
89			-	-	-	-	-	-	-	-	-	$ -	$ -
90			-	-	-	-	-	-	-	-	-	$ -	$ -
91			-	-	-	-	-	-	-	-	-	$ -	$ -
92			-	-	-	-	-	-	-	-	-	$ -	$ -
93			-	-	-	-	-	-	-	-	-	$ -	$ -
94			-	-	-	-	-	-	-	-	-	$ -	$ -
95			-	-	-	-	-	-	-	-	-	$ -	$ -
96			-	-	-	-	-	-	-	-	-	$ -	$ -
97			-	-	-	-	-	-	-	-	-	$ -	$ -
98			-	-	-	-	-	-	-	-	-	$ -	$ -
99			-	-	-	-	-	-	-	-	-	$ -	$ -
100			-	-	-	-	-	-	-	-	-	$ -	$ -
101			-	-	-	-	-	-	-	-	-	$ -	$ -
102			-	-	-	-	-	-	-	-	-	$ -	$ -
103			-	-	-	-	-	-	-	-	-	$ -	$ -
104			-	-	-	-	-	-	-	-	-	$ -	$ -
105			-	-	-	-	-	-	-	-	-	$ -	$ -
106			-	-	-	-	-	-	-	-	-	$ -	$ -
107			-	-	-	-	-	-	-	-	-	$ -	$ -
108			-	-	-	-	-	-	-	-	-	$ -	$ -
109			-	-	-	-	-	-	-	-	-	$ -	$ -
110			-	-	-	-	-	-	-	-	-	$ -	$ -
111			-	-	-	-	-	-	-	-	-	$ -	$ -
112			-	-	-	-	-	-	-	-	-	$ -	$ -
113			-	-	-	-	-	-	-	-	-	$ -	$ -
114			-	-	-	-	-	-	-	-	-	$ -	$ -
115			-	-	-	-	-	-	-	-	-	$ -	$ -
116			-	-	-	-	-	-	-	-	-	$ -	$ -
117			-	-	-	-	-	-	-	-	-	$ -	$ -
118			-	-	-	-	-	-	-	-	-	$ -	$ -
119			-	-	-	-	-	-	-	-	-	$ -	$ -
120			-	-	-	-	-	-	-	-	-	$ -	$ -
121			-	-	-	-	-	-	-	-	-	$ -	$ -
122			-	-	-	-	-	-	-	-	-	$ -	$ -
123			-	-	-	-	-	-	-	-	-	$ -	$ -
124			-	-	-	-	-	-	-	-	-	$ -	$ -
125			-	-	-	-	-	-	-	-	-	$ -	$ -
126			-	-	-	-	-	-	-	-	-	$ -	$ -
127			-	-	-	-	-	-	-	-	-	$ -	$ -
				4,230,095	14,119,812	-	-	-	-	13,394	88,912		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 6,205,535	$ 14,119,812	$ -	$ -	$ -	$ -	$ 19,994	$ 88,912	$ 6,225,529	$ 14,208,724
129	Total Charges per PS&R or Exhibit Detail	$ 6,205,535	$ 14,119,812	$ -	$ -	$ -	$ -	$ 19,994	$ 88,912		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)									$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 1,703,983	$ 2,188,013	$ -	$ -	$ -	$ -	$ 2,166	$ 14,783	$ 1,706,149	$ 2,202,796
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 43,306	$ 87,676	$ -	$ -	$ -	$ -	$ 1,300	$ 2,537	$ 44,606	$ 90,213
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 43,306	$ 87,676	$ -	$ -						

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) HAMILTON MEDICAL CENTER

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 5,462	$ 10,029	$ 5,462	$ 10,029
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -	$ -	$ -
143.02	**Calculated Payment Shortfall / (Longfall)**	$ 1,660,677	$ 2,100,337	$ -	$ -	$ -	$ -	$ (4,596)	$ 2,217	$ 1,656,081	$ 2,102,554
144	**Calculated Payments as a Percentage of Cost**	3%	4%	0%	0%	0%	0%	312%	85%	3%	5%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (10/01/2016-09/30/2017) HAMILTON MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section D as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (10/01/2016-09/30/2017) HAMILTON MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primar		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey
Note B: Enter Organ Acquisition Payments in Section E as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (10/01/2016-09/30/2017) HAMILTON MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 2,629,356		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	55000-560100	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ -	5.01	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ 2,629,356		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ 2,629,356

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*

DSH Examination Eligibility Summary

Hospital Name	**HAMILTON MEDICAL CENTER**
Hospital Medicaid Number	**000000899A**
Cost Report Period	From **10/1/2016** To **9/30/2017**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 25,532,294	$ 669,525	$ 26,201,819
2	Hospital Cash Subsidies	Survey F-2	$ 4,000,000	$ -	$ 4,000,000
3	Total		$ 29,532,294	$ 669,525	$ 30,201,819
4	Net Hospital Patient Revenue	Survey F-3	$ 233,300,560	$ -	$ 233,300,560
5	Medicaid Fraction		12.45%	0.28%	12.73%
6	Inpatient Charity Care Charges	Survey F-2	$ 19,327,455	$ -	$ 19,327,455
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ 1,285,579	$ -	$ 1,285,579
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 18,041,876	$ -	$ 18,041,876
10	Inpatient Hospital Charges	Survey F-3	$ 380,599,322	$ -	$ 380,599,322
11	Inpatient Charity Fraction		4.74%	0.00%	4.74%
12	LIUR		17.19%	0.28%	17.47%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	17,248	-	17,248
14	Out-of-State Medicaid Eligible Days	Survey I	1,150	-	1,150
15	Total Medicaid Eligible Days		18,398	-	18,398
16	Total Hospital Days (excludes swing-bed)	Survey F-1	45,495	-	45,495
17	MIUR		40.44%	0.00%	40.44%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **HAMILTON MEDICAL CENTER**
Hospital Medicaid Number: **000000899A**
Cost Report Period: From **10/1/2016** To **9/30/2017**

As-Reported:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	7,534,265	6,775,072	-	-	-	-	-	-	-	-	-			6,775,072	759,193	89.92%
2	Medicaid Fee for Service	Outpatient	4,440,950	3,997,801	-	-	-	-	-	-	-	-	-			3,997,801	443,149	90.02%
3	Medicaid Managed Care	Inpatient	11,425,915	-	7,697,039	-	-	-	-							7,697,039	3,728,876	67.36%
4	Medicaid Managed Care	Outpatient	4,294,026	-	4,569,496	-	-	-	-							4,569,496	(275,470)	106.42%
5	Medicare Cross-over (FFS)	Inpatient	9,009,953	848,598	-	12,774	-		-	7,454,103	-	96,206	-			8,411,681	598,272	93.36%
6	Medicare Cross-over (FFS)	Outpatient	7,721,454	628,188	-	9,592	-		-	5,652,974	-	225,938	-			6,516,692	1,204,762	84.40%
7	Other Medicaid Eligibles	Inpatient	1,994,291	661,257	-	1,360,582	-			-	-	-	-			2,021,839	(27,548)	101.38%
8	Other Medicaid Eligibles	Outpatient	834,310	220,024	-	729,053	-			-	-	-	-			949,077	(114,767)	113.76%
9	Uninsured	Inpatient	5,823,640	-	-	-	-	-	-	-	-	-	-	250,318	-	250,318	5,573,322	4.30%
10	Uninsured	Outpatient	7,620,197	-	-	-	-	-	-	-	-	-	-	1,055,986	-	1,055,986	6,564,211	13.86%
11	In-State Sub-total	Inpatient	35,788,064	8,284,927	7,697,039	1,373,356	-	-	-	7,454,103	-	96,206	-	250,318	-	25,155,949	10,632,115	70.29%
12	In-State Sub-total	Outpatient	24,910,937	4,846,013	4,569,496	738,645	-	-	-	5,652,974	-	225,938	-	1,055,986	-	17,089,052	7,821,885	68.60%
13	Out-of-State Medicaid	Inpatient	1,715,128	44,606	-	-	-	-	-	5,462	-	-	-			50,068	1,665,060	2.92%
14	Out-of-State Medicaid	Outpatient	2,200,955	90,213	-	-	-	-	-	10,029	-	-	-			100,242	2,100,713	4.55%
15	Sub-Total	I/P and O/P	64,615,084	13,265,759	12,266,535	2,112,001	-	-	-	13,122,568	-	322,144	-	1,306,304	-	42,395,311	22,219,773	65.61%
15.01	Provider Tax Assessment Adjustment to UCC																965,554	

Adjustments:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
1	Medicaid Fee for Service	Inpatient	15,235	-	-	339,214	-	-	-	-	-	-	-			339,214	(323,979)	4.31%
2	Medicaid Fee for Service	Outpatient	2,088	-	-	321,254	9,057	-	-	-	-	-	-			330,311	(328,223)	7.39%
3	Medicaid Managed Care	Inpatient	18,100	-	-	-	-	-	-							-	18,100	-0.11%
4	Medicaid Managed Care	Outpatient	1,775	-	-	-	-	-	-							-	1,775	-0.04%
5	Medicare Cross-over (FFS)	Inpatient	(2,841)	-	-	-	-		-	-	-	-	-			-	(2,841)	0.03%
6	Medicare Cross-over (FFS)	Outpatient	2,614	-	-	-	-		-	-	-	-	-			-	2,614	-0.03%
7	Other Medicaid Eligibles	Inpatient	1,223	-	-	-	-			-	-	-	-			-	1,223	-0.06%
8	Other Medicaid Eligibles	Outpatient	336	-	-	-	-			-	-	-	-			-	336	-0.05%
9	Uninsured	Inpatient	4,012	-	-	-	-	-	-	-	-	-	-	-	-	-	4,012	0.00%
10	Uninsured	Outpatient	2,498	-	-	-	-	-	-	-	-	-	-	-	-	-	2,498	0.00%
11	In-State Sub-total	Inpatient	35,729	-	-	339,214	-	-	-	-	-	-	-	-	-	339,214	(303,485)	0.88%
12	In-State Sub-total	Outpatient	9,311	-	-	321,254	9,057	-	-	-	-	-	-	-	-	330,311	(321,000)	1.30%
13	Out-of-State Medicaid	Inpatient	(8,979)	-	-	-	-	-	-	-	-	-	-			-	(8,979)	0.02%
14	Out-of-State Medicaid	Outpatient	1,841	-	-	-	-	-	-	-	-	-	-			-	1,841	0.00%
15	Sub-Total	I/P and O/P	37,902	-	-	660,468	9,057	-	-	-	-	-	-	-	-	669,525	(631,623)	1.00%
15.01	Provider Tax Assessment Adjustment to UCC																	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **HAMILTON MEDICAL CENTER**
Hospital Medicaid Number: **000000899A**
Cost Report Period: From **10/1/2016** To **9/30/2017**

As-Adjusted:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	7,549,500	6,775,072	-	339,214	-	-	-	-	-	-	-			7,114,286	435,214	94.24%
2	Medicaid Fee for Service	Outpatient	4,443,038	3,997,801	-	321,254	9,057	-	-	-	-	-	-			4,328,112	114,926	97.41%
3	Medicaid Managed Care	Inpatient	11,444,015	-	7,697,039	-	-	-	-							7,697,039	3,746,976	67.26%
4	Medicaid Managed Care	Outpatient	4,295,801	-	4,569,496	-	-	-	-							4,569,496	(273,695)	106.37%
5	Medicare Cross-over (FFS)	Inpatient	9,007,112	848,598	-	12,774	-		-	7,454,103	-	96,206	-			8,411,681	595,431	93.39%
6	Medicare Cross-over (FFS)	Outpatient	7,724,068	628,188	-	9,592	-		-	5,652,974	-	225,938	-			6,516,692	1,207,376	84.37%
7	Other Medicaid Eligibles	Inpatient	1,995,514	661,257	-	1,360,582	-			-	-	-	-			2,021,839	(26,325)	101.32%
8	Other Medicaid Eligibles	Outpatient	834,646	220,024	-	729,053	-			-	-	-	-			949,077	(114,431)	113.71%
9	Uninsured	Inpatient	5,827,652	-	-	-	-	-	-	-	-	-	-	250,318	-	250,318	5,577,334	4.30%
10	Uninsured	Outpatient	7,622,695	-	-	-	-	-	-	-	-	-	-	1,055,986	-	1,055,986	6,566,709	13.85%
11	In-State Sub-total	Inpatient	35,823,793	8,284,927	7,697,039	1,712,570	-	-	-	7,454,103	-	96,206	-	250,318	-	25,495,163	10,328,630	71.17%
12	In-State Sub-total	Outpatient	24,920,248	4,846,013	4,569,496	1,059,899	9,057	-	-	5,652,974	-	225,938	-	1,055,986	-	17,419,363	7,500,885	69.90%
13	Out-of-State Medicaid	Inpatient	1,706,149	44,606	-	-	-	-	-	5,462	-	-	-			50,068	1,656,081	2.93%
14	Out-of-State Medicaid	Outpatient	2,202,796	90,213	-	-	-	-	-	10,029	-	-	-			100,242	2,102,554	4.55%
15	Cost Report Year Sub-Total	I/P and O/P	64,652,986	13,265,759	12,266,535	2,772,469	9,057	-	-	13,122,568	-	322,144	-	1,306,304	-	43,064,836	21,588,150	66.61%
15.01																		
															Provider Tax Assessment Adjustment to UCC		965,554	
16															Less: Out of State DSH Payments from Adjusted Survey		-	
17															Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments		22,553,704	

Medicaid DSH Survey Adjustments

PROVIDER: HAMILTON MEDICAL CENTER
FROM: 10/1/2016 TO: 9/30/2017
Mcaid Number: 000000899A
Mcare Number: 110001

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
	G - CR Data	1	ADULTS & PEDIATRICS	3.00	Total Allowable Cost	Adjust to cost report.	$ 28,812,873.00	$ 3,216,928	$ 32,029,801.00	
	G - CR Data	7	SUBPROVIDER I	3.00	Total Allowable Cost	Adjust to cost report.	$ 3,216,928.00	$ (3,216,928)	$ -	
	G - CR Data	1	ADULTS & PEDIATRICS	8.00	Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjust to cost report.	34,240	3,591	37,831	
	G - CR Data	7	SUBPROVIDER I	8.00	Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjust to cost report.	3,591	(3,591)	-	
	G - CR Data	1	ADULTS & PEDIATRICS	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Adjust to cost report.	$ 41,241,111.00	$ 4,635,318	$ 45,876,429.00	
	G - CR Data	7	SUBPROVIDER I	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Adjust to cost report.	$ 4,635,318.00	$ (4,635,318)	$ -	
	H - In-State	134	Private Insurance (including primary and third party liability)	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to include payments for even HS&R types	$ -	$ 339,214	$ 339,214	HS&R
	H - In-State	134	Private Insurance (including primary and third party liability)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to include payments for even HS&R types	$ -	$ 321,254	$ 321,254	HS&R
	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to include payments for even HS&R types	$ -	$ 9,057	$ 9,057	HS&R

Medicaid DSH Report Notes

PROVIDER: HAMILTON MEDICAL CENTER Mcaid Number: 000000899A
FROM: 10/1/2016 TO: 9/30/2017 Mcare Number: 110001

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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