DSH Version 7.30 3/26/2019

D. General Cost Report Year Information 10/1/2017 - 9/30/2018

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

	10/1/2017 through 9/30/2018		
2. Select Cost Report Year Covered by this Survey (enter "X"):	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:	3/12/2019		

	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		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110001	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
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		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2017 - 09/30/2018)

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)	$ 138,466	$ 1,404,434	$1,542,900
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,884,476	$ 10,211,238	$12,095,714
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$2,022,942	$11,615,672	$13,638,614
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.84%	12.09%	11.31%

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 (10/01/2017 - 09/30/2018)

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)	43,342 (See Note in Section F-3, below)

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	1,320,312
3.	Outpatient Hospital Subsidies	2,679,688
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	19,498,091
8.	Outpatient Hospital Charity Care Charges	28,446,583
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 47,944,674

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$97,256,760.00			$ 73,245,903	$ -	$ -	$ 24,010,857
12.	Subprovider I (Psych or Rehab)	$6,333,534.00			$ 4,769,904	$ -	$ -	$ 1,563,630
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$300,815,359.00	$490,148,173.00		$ 226,549,727	$ 369,139,845	$ -	$ 195,273,960
20.	Outpatient Services		$122,007,318.00			$ 91,886,015	$ -	$ 30,121,303
21.	Home Health Agency			$7,601,404.00			$ 5,724,761	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$2,200,331.00			$ 1,657,111	
26.	Other	$0.00	$0.00	$0.00	$ -	$ -	$ -	$ -
27.	Total	$ 404,405,653	$ 612,155,491	$ 9,801,735	$ 304,565,534	$ 461,025,860	$ 7,381,872	$ 250,969,750
28.	Total Hospital and Non Hospital		Total from Above	$ 1,026,362,879		Total from Above	$ 772,973,266	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,026,362,879	Total Contractual Adj. (G-3 Line 2)	770,888,204
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)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs 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)			+	2,085,062
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
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				772,973,266

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) HAMILTON MEDICAL CENTER

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total 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	$ 29,252,374	$ -	$ -	$0.00	$ 29,252,374	32,665	$42,966,823.00		$ 895.53
2	03100 INTENSIVE CARE UNIT	$ 10,514,619	$ -	$ -		$ 10,514,619	6,344	$23,403,787.00		$ 1,657.41
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,409,855	$ -	$ -		$ 3,409,855	2,260	$7,615,264.00		$ 1,508.79
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ 3,269,674	$ -	$ -		$ 3,269,674	3,241	$4,396,932.00		$ 1,008.85
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 1,602,330	$ -	$ -		$ 1,602,330	2,976	$2,840,065.00		$ 538.42
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 48,048,852	$ -	$ -	$ -	$ 48,048,852	47,486	$ 81,222,871		
19	Weighted Average									$ 1,011.86

		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)	4,144	-	-	$ 3,711,076	$49,633.00	$7,149,545.00	$ 7,199,178	0.515486

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total 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*		*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	$8,743,179.00	$ -	$0.00		$ 8,743,179	$22,213,017.00	$45,299,019.00	$ 67,512,036	0.129505
22	5100 RECOVERY ROOM	$1,534,085.00	$ -	$0.00		$ 1,534,085	$2,945,107.00	$3,424,269.00	$ 6,369,376	0.240853
23	5200 DELIVERY ROOM & LABOR ROOM	$4,483,897.00	$ -	$0.00		$ 4,483,897	$17,592,629.00	$969,522.00	$ 18,562,151	0.241561
24	5300 ANESTHESIOLOGY	$529,023.00	$ -	$0.00		$ 529,023	$2,057,805.00	$3,032,964.00	$ 5,090,769	0.103918
25	5400 RADIOLOGY-DIAGNOSTIC	$14,861,962.00	$ -	$0.00		$ 14,861,962	$13,463,492.00	$82,572,406.00	$ 96,035,898	0.154754
26	5700 CT SCAN	$2,101,019.00	$ -	$0.00		$ 2,101,019	$19,278,871.00	$57,095,798.00	$ 76,374,669	0.027509
27	5800 MRI	$1,441,459.00	$ -	$0.00		$ 1,441,459	$8,240,326.00	$21,482,689.00	$ 29,723,015	0.048496
28	5900 CARDIAC CATHETERIZATION	$5,670,845.00	$ -	$0.00		$ 5,670,845	$33,029,638.00	$37,554,707.00	$ 70,584,345	0.080341
29	6000 LABORATORY	$11,348,742.00	$ -	$0.00		$ 11,348,742	$68,466,344.00	$101,172,454.00	$ 169,638,798	0.066899

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) HAMILTON MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total 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
30	6500	RESPIRATORY THERAPY	$3,587,581.00	$ -	$0.00	$ 3,587,581	$29,612,166.00	$8,616,357.00	$ 38,228,523	0.093846
31	6600	PHYSICAL THERAPY	$5,872,843.00	$ -	$0.00	$ 5,872,843	$4,594,080.00	$9,469,022.00	$ 14,063,102	0.417607
32	6900	ELECTROCARDIOLOGY	$2,704,867.00	$ -	$0.00	$ 2,704,867	$12,603,290.00	$25,586,772.00	$ 38,190,062	0.070826
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$10,481,254.00	$ -	$0.00	$ 10,481,254	$18,694,121.00	$20,262,274.00	$ 38,956,395	0.269051
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$13,385,683.00	$ -	$0.00	$ 13,385,683	$14,191,470.00	$12,317,785.00	$ 26,509,255	0.504944
35	7300	DRUGS CHARGED TO PATIENTS	$20,905,480.00	$ -	$0.00	$ 20,905,480	$31,322,291.00	$78,392,459.00	$ 109,714,750	0.190544
36	7400	RENAL DIALYSIS	$808,592.00	$ -	$0.00	$ 808,592	$3,328,185.00	$242,280.00	$ 3,570,465	0.226467
37	7501	PSYCHIATRIC ANCILLARY	$876,746.00	$ -	$0.00	$ 876,746	$1,639,809.00	$1,379,413.00	$ 3,019,222	0.290388
38	9000	CLINIC	$4,764,373.00	$ -	$0.00	$ 4,764,373	$25,429.00	$9,550,344.00	$ 9,575,773	0.497544
39	9100	EMERGENCY	$13,187,949.00	$ -	$0.00	$ 13,187,949	$18,650,378.00	$59,461,417.00	$ 78,111,795	0.168834
40			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) HAMILTON MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total 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
90		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 127,289,579	$ -	$ -		$ 127,289,579	$ 321,998,081	$ 585,031,496	$ 907,029,577	
127	**Weighted Average**									0.144428
128	**Sub Totals**	$ 175,338,431	$ -	$ -		$ 175,338,431	$ 403,220,952	$ 585,031,496	$ 988,252,448	
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)*					$0.00				
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)*					$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01	Other Cost Adjustments (support must be submitted)									
132	**Grand Total**					$ 175,338,431				
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 (10/01/2017-09/30/2018) | 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	$ 895.53		3,273		2,307		2,621		753		2,293		8,954		39.54%
2	03100 INTENSIVE CARE UNIT	$ 1,657.41		861		1,246		716		360		1,009		3,183		66.17%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 1,508.79												-		0.00%
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ 1,008.85						335		50		230		385		20.49%
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 538.42		739		1,960				224		31		2,923		99.33%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	4,873		5,513		3,672		1,387		3,563		15,445		40.21%
19	Total Days per PS&R or Exhibit Detail			4,873		5,513		3,672		1,387		3,563				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 8,684,870		$ 10,556,024		$ 7,614,129		$ 3,177,769		$ 6,672,027		$ 30,032,792		45.33%
21.01	Calculated Routine Charge Per Diem			$ 1,782.24		$ 1,914.75		$ 2,073.56		$ 2,291.11		$ 1,872.59		$ 1,944.50		
	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)		0.515486	49,633	710,914	28,075	935,649	191,986	742,904	-	80,582	-	830,111	$ 269,694	$ 2,470,049	49.95%
23	5000 OPERATING ROOM		0.129505	3,147,245	2,485,997	3,045,601	2,561,617	3,148,212	7,485,807	739,030	601,496	77,496	4,376,673	$ 10,080,088	$ 13,134,917	41.09%
24	5100 RECOVERY ROOM		0.240853	282,773	171,390	290,823	319,436	281,928	207,676	70,732	33,832	243,417	374,211	$ 926,256	$ 732,334	35.92%
25	5200 DELIVERY ROOM & LABOR ROOM		0.241561	1,620,944	10,438	4,645,732	137,171	50,377	2,164	743,417	22,488	44,974	24,755	$ 7,060,470	$ 172,261	39.38%
26	5300 ANESTHESIOLOGY		0.103918	156,482	198,965	32,985	271,339	238,315	374,650	28,110	46,417	37,370	354,727	$ 455,892	$ 891,371	34.23%
27	5400 RADIOLOGY-DIAGNOSTIC		0.154754	1,147,013	3,586,491	329,107	3,861,733	1,997,010	8,623,319	249,760	1,208,813	2,427,631	7,563,532	$ 3,722,890	$ 17,280,356	32.42%
28	5700 CT SCAN		0.027509	1,464,303	3,301,828	234,081	2,940,629	2,586,017	6,173,477	112,227	1,203,684	695,319	10,934,273	$ 4,396,628	$ 13,619,618	39.05%
29	5800 MRI		0.048496	573,047	1,056,348	89,636	657,412	995,907	2,981,695	133,288	446,948	2,303,178	1,370,963	$ 1,791,878	$ 5,142,403	35.86%
30	5900 CARDIAC CATHETERIZATION		0.080341	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
31	6000 LABORATORY		0.066899	6,903,509	8,088,136	2,538,675	8,056,489	10,559,979	8,013,199	1,557,332	1,368,620	6,139,305	14,872,569	$ 21,559,495	$ 25,526,444	40.38%
32	6500 RESPIRATORY THERAPY		0.093846	2,958,798	401,406	990,509	425,774	3,956,655	698,247	759,326	60,824	252,245	612,270	$ 8,665,288	$ 1,586,251	29.14%
33	6600 PHYSICAL THERAPY		0.417607	377,327	82,979	392,758	142,480	533,110	651,455	176,787	28,740	2,351,382	190,584	$ 1,479,982	$ 905,654	35.08%
34	6900 ELECTROCARDIOLOGY		0.070826	1,553,310	2,029,231	401,971	1,280,885	4,195,324	5,699,728	406,287	748,609	657,433	4,321,416	$ 6,556,892	$ 9,758,453	56.07%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.269051	1,527,800	953,176	1,011,172	1,289,495	2,517,048	1,909,354	473,121	217,018	1,370,503	1,917,110	$ 5,529,141	$ 4,369,043	33.94%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.504944	663,759	332,230	-	-	1,670,444	1,546,420	128,195	37,399	531,872	520,220	$ 2,462,398	$ 1,916,049	20.51%
37	7300 DRUGS CHARGED TO PATIENTS		0.190544	3,118,914	6,196,028	1,913,066	3,269,130	4,340,023	7,182,033	602,920	870,357	1,991,092	7,978,041	$ 9,974,923	$ 17,517,548	34.32%
38	7400 RENAL DIALYSIS		0.226467	85,695	-	29,610	-	741,195	40,380	37,239	4,038	162,452	117,102	$ 893,739	$ 44,418	34.11%
39	7501 PSYCHIATRIC ANCILLARY		0.290388	296,677	1,399	59,827	15,571	169,323	97,637	36,575	402	392,953	71,063	$ 562,402	$ 115,009	38.51%
40	9000 CLINIC		0.497544	12,595	30,787	26,680	190,971	3,016	288,265	2,752	27,672	152,147	178,458	$ 45,043	$ 537,695	9.59%
41	9100 EMERGENCY		0.168834	1,226,244	4,962,896	228,180	8,656,579	1,871,057	5,556,927	5,245	1,245,562	56,673	16,651,799	$ 3,330,726	$ 20,421,964	52.26%
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
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81			-											$ -	$ -	
82			-											$ -	$ -	

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

Cost Report Year (10/01/2017-09/30/2018) | 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		%
83–127			-											$ -	$ -	
	Totals / Payments			$ 27,166,068	$ 34,600,639	$ 16,288,488	$ 35,012,360	$ 40,046,926	$ 58,275,337	$ 6,262,343	$ 8,253,501	$ 19,887,442	$ 73,259,877			
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 35,850,938	$ 34,600,639	$ 26,844,512	$ 35,012,360	$ 47,661,055	$ 58,275,337	$ 9,440,112	$ 8,253,501	$ 26,559,469 (Agrees to Exhibit A)	$ 73,259,877 (Agrees to Exhibit A)	$ 119,796,617	$ 136,141,837	36.18%
129	Total Charges per PS&R or Exhibit Detail			$ 35,850,938	$ 34,600,639	$ 26,844,512	$ 35,012,360	$ 47,661,055	$ 58,275,337	$ 9,440,112	$ 8,253,501	$ 26,559,469	$ 73,259,877			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 8,577,126	$ 4,665,565	$ 8,020,471	$ 4,922,785	$ 9,391,470	$ 8,150,327	$ 2,391,762	$ 1,010,193	$ 7,280,184	$ 9,349,511	$ 28,380,829	$ 18,748,870	36.54%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 7,702,101	$ 4,317,329	$ -	$ -	$ 737,495	$ 696,235	$ 1,013,115	$ 295,859			$ 9,452,711	$ 5,309,423	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 5,334,137	$ 3,839,818	$ -	$ -	$ -	$ -			$ 5,334,137	$ 3,839,818	
134	Private Insurance (including primary and third party liability)			$ -	$ -	$ -	$ -	$ 1,072	$ 389	$ 1,996,576	$ 985,967			$ 1,997,648	$ 986,356	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ -	$ 388	$ 9,552	$ -	$ -			$ 388	$ 9,552	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 7,702,101	$ 4,317,329	$ 5,334,137	$ 3,839,818									
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)							$ 8,217,884	$ 6,110,378	$ -	$ -			$ 8,217,884	$ 6,110,378	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments							$ 158,550	$ 238,038	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 158,550	$ 238,038	
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -	$ -	$ -			$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 138,466	$ 1,404,434			
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)**			$ 875,025	$ 348,236	$ 2,686,334	$ 1,082,967	$ 276,081	$ 1,095,735	$ (617,929)	$ (271,633)	$ 7,141,718	$ 7,945,077	$ 3,219,511	$ 2,255,305	
146	**Calculated Payments as a Percentage of Cost**			90%	93%	67%	78%	97%	87%	126%	127%	2%	15%	89%	88%	
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)**							20,285								
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 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.

NOTE: Inpatient uninsured payment rate is outside normal ranges, please verify this is correct.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) 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	$ 895.53		26						4		30	
2	03100 INTENSIVE CARE UNIT	$ 1,657.41		6								6	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 1,508.79										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ 1,008.85		49								49	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 538.42		2								2	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	83		-		-		4		87	
19	Total Days per PS&R or Exhibit Detail			83		-		-		4			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 108,856						$ 5,346		$ 114,202	
21.01	Calculated Routine Charge Per Diem			$ 1,311.52		$ -		$ -		$ 1,336.50		$ 1,312.67	
	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)		0.515486	-	24,604					-	1,628	$ -	$ 26,232
23	5000 OPERATING ROOM		0.129505	28,465	16,987					-	27,041	$ 28,465	$ 44,028
24	5100 RECOVERY ROOM		0.240853	7,749	3,700					-	-	$ 7,749	$ 3,700
25	5200 DELIVERY ROOM & LABOR ROOM		0.241561	6,170	290					-	-	$ 6,170	$ 290
26	5300 ANESTHESIOLOGY		0.103918	1,701	1,674					-	-	$ 1,701	$ 1,674
27	5400 RADIOLOGY-DIAGNOSTIC		0.154754	15,438	116,997					-	10,754	$ 15,438	$ 127,751
28	5700 CT SCAN		0.027509	4,841	172,101					-	1,298	$ 4,841	$ 173,399
29	5800 MRI		0.048496	6,027	41,574					-	4,095	$ 6,027	$ 45,669
30	5900 CARDIAC CATHETERIZATION		0.080341	-	-					-	-	$ -	$ -
31	6000 LABORATORY		0.066899	86,890	288,922					6,590	14,143	$ 93,480	$ 303,065
32	6500 RESPIRATORY THERAPY		0.093846	18,055	6,921					-	469	$ 18,055	$ 7,390
33	6600 PHYSICAL THERAPY		0.417607	578	3,839					-	827	$ 578	$ 4,666
34	6900 ELECTROCARDIOLOGY		0.070826	72,458	38,418					3,507	3,752	$ 75,965	$ 42,170
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.269051	17,755	15,110					141	1,982	$ 17,896	$ 17,092
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.504944	5,520	-					-	-	$ 5,520	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.190544	19,216	165,520					1,079	6,724	$ 20,295	$ 172,244
38	7400 RENAL DIALYSIS		0.226467	-	-					-	-	$ -	$ -
39	7501 PSYCHIATRIC ANCILLARY		0.290388	19,137	2,010					-	-	$ 19,137	$ 2,010
40	9000 CLINIC		0.497544	-	1,428					-	3,440	$ -	$ 4,868
41	9100 EMERGENCY		0.168834	-	349,616					-	8,617	$ -	$ 358,233
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) 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	
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			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) 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	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 310,000	$ 1,249,711	$ -	$ -	$ -	$ -	$ 11,317	$ 84,770		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ 418,856	$ 1,249,711	$ -	$ -	$ -	$ -	$ 16,663	$ 84,770	$ 435,519	$ 1,334,481
129	Total Charges per PS&R or Exhibit Detail			$ 418,856	$ 1,249,711	$ -	$ -	$ -	$ -	$ 16,663	$ 84,770		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 123,437	$ 161,102	$ -	$ -	$ -	$ -	$ 4,515	$ 12,822	$ 127,952	$ 173,924
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 26,398	$ 108,170					$ 155	$ 1,355	$ 26,553	$ 109,525
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)			$ 26,398	$ 108,170	$ -	$ -						
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)									$ 9,075	$ 12,096	$ 9,075	$ 12,096
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	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 97,039	$ 52,932	$ -	$ -	$ -	$ -	$ (4,715)	$ (629)	$ 92,324	$ 52,303
144	**Calculated Payments as a Percentage of Cost**			21%	67%	0%	0%	0%	0%	204%	105%	28%	70%

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 (10/01/2017-09/30/2018) 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 Acquisition 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	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		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 H 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 (10/01/2017-09/30/2018) 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 Primary		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 Acquisition 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								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	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 I 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 (10/01/2017-09/30/2018) 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)*		$ 2,872,751		
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 ---------->)		$ 2,872,751		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(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*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
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		$ 2,872,751
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	257,708,454
19	Uninsured Hospital	**Charges Sec. G**	99,819,346
20	Total Hospital	**Charges Sec. G**	988,252,448
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		26.08%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.10%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 749,133
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 290,165
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 1,039,298**

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

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*