DSH Version 8.10 7/5/2022

D. General Cost Report Year Information 10/1/2020 - 9/30/2021

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		
	10/1/2020 through 9/30/2021		
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:	3/9/2022		

	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	
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: (10/01/2020 - 09/30/2021)

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)	$ 234,386	$ 612,369	$846,755
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,539,785	$ 4,466,867	$7,006,652
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)	$2,774,171	$5,079,236	$7,853,407
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	8.45%	12.06%	10.78%

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 (10/01/2020 - 09/30/2021)

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)	43,128	**(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	168,078
3.	Outpatient Hospital Subsidies	169,893
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 337,971
7.	Inpatient Hospital Charity Care Charges	23,730,433
8.	Outpatient Hospital Charity Care Charges	39,190,580
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 62,921,013

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	$129,842,677.00			$ 100,238,783	$ -	$ -	$ 29,603,894
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
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	$380,891,852.00	$615,819,598.00		$ 294,049,202	$ 475,413,849	$ -	$ 227,248,398
20.	Outpatient Services		$118,491,301.00			$ 91,475,500	$ -	$ 27,015,801
21.	Home Health Agency			$4,566,398.00			$ 3,525,268	
22.	Ambulance	-	-	$ -	-	-	$ -	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$3,316,647.00			$ 2,560,458	
26.	Other	$25,420,655.00	$17,931,478.00	$0.00	$ 19,624,792	$ 13,843,134	$ -	$ 9,884,207
27.	Total	$ 536,155,184	$ 752,242,377	$ 7,883,045	$ 413,912,777	$ 580,732,483	$ 6,085,725	$ 293,752,301
28.	Total Hospital and Non Hospital		Total from Above	$ 1,296,280,606		Total from Above	$ 1,000,730,985	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,296,280,606	Total Contractual Adj. (G-3 Line 2)		1,000,730,985
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)				+	
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					1,000,730,985
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) 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	$ 32,203,225	$ 3,376,814	$ -	$0.00	$ 35,580,039	31,914	$86,014,483.00		$ 1,114.87
2	03100 INTENSIVE CARE UNIT	$ 11,271,984	$ 962,109	$ -		$ 12,234,093	6,911	$28,684,154.00		$ 1,770.23
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,953,036	$ -	$ -		$ 3,953,036	2,059	$9,321,548.00		$ 1,919.88
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 4,753,561	$ -	$ -		$ 4,753,561	4,634	$11,173,058.00		$ 1,025.80
11	3201 NEONATAL INTENSIVE CARE UNIT	$ 2,492,854	$ -	$ -		$ 2,492,854	1,053	$5,822,492.00		$ 2,367.38
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 54,674,660	$ 4,338,923	$ -	$ -	$ 59,013,583	46,571	$ 141,015,735		
19	Weighted Average									$ 1,267.17

Line #	Observation Data (Non-Distinct)	*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*
20	09200 Observation (Non-Distinct)	3,443	-	-	$ 3,838,497	$1,961,444.00	$5,570,171.00	$ 7,531,615	0.509651

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	$10,133,758.00	$ 867,785	$ 81,041		$ 11,082,584	$29,758,091.00	$69,557,146.00	$ 99,315,237	0.111590
22	5100 RECOVERY ROOM	$1,574,565.00	$ -	$ -		$ 1,574,565	$2,731,286.00	$5,406,050.00	$ 8,137,336	0.193499
23	5200 DELIVERY ROOM & LABOR ROOM	$4,713,558.00	$ -	$ -		$ 4,713,558	$21,178,070.00	$911,777.00	$ 22,089,847	0.213381
24	5300 ANESTHESIOLOGY	$286,928.00	$ -	$ -		$ 286,928	$3,893,158.00	$10,509,298.00	$ 14,402,456	0.019922
25	5400 RADIOLOGY-DIAGNOSTIC	$22,299,660.00	$ 565,947	$ -		$ 22,865,607	$15,319,811.00	$98,167,870.00	$ 113,487,681	0.201481
26	5700 CT SCAN	$2,903,588.00	$ -	$ -		$ 2,903,588	$27,739,581.00	$64,857,733.00	$ 92,597,314	0.031357
27	5800 MRI	$1,762,229.00	$ -	$ -		$ 1,762,229	$5,091,974.00	$19,023,341.00	$ 24,115,315	0.073075
28	5900 CARDIAC CATHETERIZATION	$5,207,259.00	$ -	$ -		$ 5,207,259	$30,352,410.00	$39,472,543.00	$ 69,824,953	0.074576
29	6000 LABORATORY	$17,569,485.00	$ -	$ -		$ 17,569,485	$86,904,935.00	$111,219,366.00	$ 198,124,301	0.088679

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) 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	$6,907,877.00	$ 264,109	$ -	$ 7,171,986	$56,368,818.00	$31,633,289.00	$ 88,002,107	0.081498
31	6600	PHYSICAL THERAPY	$7,054,413.00	$ -	$ -	$ 7,054,413	$7,055,222.00	$12,487,680.00	$ 19,542,902	0.360971
32	6900	ELECTROCARDIOLOGY	$1,143,786.00	$ 584,811	$ -	$ 1,728,597	$232,091.00	$6,335,724.00	$ 6,567,815	0.263192
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$16,301,472.00	$ -	$ -	$ 16,301,472	$24,810,677.00	$15,026,513.00	$ 39,837,190	0.409202
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$16,353,799.00	$ -	$ -	$ 16,353,799	$12,039,944.00	$20,019,513.00	$ 32,059,457	0.510108
35	7300	DRUGS CHARGED TO PATIENTS	$42,921,927.00	$ -	$ -	$ 42,921,927	$53,127,697.00	$109,469,170.00	$ 162,596,867	0.263978
36	7400	RENAL DIALYSIS	$819,039.00	$ 396,162	$ -	$ 1,215,201	$4,288,087.00	$1,722,584.00	$ 6,010,671	0.202174
37	9000	CLINIC	$4,010,090.00	$ -	$ -	$ 4,010,090	$0.00	$9,404,120.00	$ 9,404,120	0.426418
38	9100	EMERGENCY	$17,648,356.00	$ 622,541	$ -	$ 18,270,897	$19,964,606.00	$81,590,959.00	$ 101,555,565	0.179910
39			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) 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	$ -	-
91		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
92		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 179,611,789	$ 3,301,355	$ 81,041		$ 182,994,185	$ 402,817,902	$ 712,384,847	$ 1,115,202,749	
127	**Weighted Average**									0.167532
128	**Sub Totals**	$ 234,286,449	$ 7,640,278	$ 81,041		$ 242,007,768	$ 543,833,637	$ 712,384,847	$ 1,256,218,484	
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**					$ 242,007,768				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					3.26%				

* 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 (10/01/2020-09/30/2021) 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	$ 1,114.87		2,231		2,304		3,241		1,908		2,711		9,684		43.81%
2	03100 INTENSIVE CARE UNIT	$ 1,770.23		425		724		815		619		1,004		2,583		52.24%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 1,919.88												-		0.00%
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 1,025.80		703		1,764				142		80		2,609		58.03%
11	3201 NEONATAL INTENSIVE CARE UNIT	$ 2,367.38		219		802								1,021		96.96%
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	3,578		5,594		4,056		2,669		3,795		15,897		42.50%
19	Total Days per PS&R or Exhibit Detail			3,578		5,594		4,056		2,669		3,795				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 8,509,583		$ 12,854,351		$ 8,553,775		$ 6,114,534		$ 9,241,948		$ 36,032,243		32.25%
21.01	Calculated Routine Charge Per Diem			$ 2,378.31		$ 2,297.88		$ 2,108.92		$ 2,290.95		$ 2,435.30		$ 2,266.61		
	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)		0.509651	178,510	586,287	349,873	609,388	326,698	605,508	118,019	396,772	190,898	647,972	$ 973,100	$ 2,197,955	53.29%
23	5000 OPERATING ROOM		0.111590	3,334,755	3,571,953	4,087,444	3,158,025	4,628,563	8,704,130	3,269,156	3,738,482	4,131,282	6,181,353	$ 15,319,918	$ 19,172,590	45.23%
24	5100 RECOVERY ROOM		0.193499	216,069	320,967	364,223	449,531	262,617	308,667	228,797	-	364,706	510,687	$ 1,071,706	$ 1,079,165	37.42%
25	5200 DELIVERY ROOM & LABOR ROOM		0.213381	1,566,478	-	6,990,143	7,618	26,817	-	1,870,806	-	339,219	-	$ 10,454,244	$ 7,618	48.93%
26	5300 ANESTHESIOLOGY		0.019922	273,400	407,142	431,657	449,607	357,618	740,900	307,006	366,425	437,209	650,926	$ 1,369,681	$ 1,964,074	30.81%
27	5400 RADIOLOGY-DIAGNOSTIC		0.201481	972,808	3,588,039	419,944	5,231,950	1,940,747	8,724,369	908,880	3,097,665	1,646,294	6,704,278	$ 4,242,379	$ 20,642,023	29.37%
28	5700 CT SCAN		0.031357	1,724,687	3,015,627	428,143	3,973,880	3,311,036	5,739,239	1,405,386	2,856,933	3,096,226	10,515,223	$ 6,869,252	$ 15,585,679	39.17%
29	5800 MRI		0.073075	268,070	1,061,370	95,524	877,848	664,750	2,195,550	262,779	956,010	682,233	1,098,650	$ 1,291,123	$ 5,090,778	33.88%
30	5900 CARDIAC CATHETERIZATION		0.074576	2,372,396	1,573,057	365,668	484,503	5,518,668	3,848,740	2,433,779	1,917,933	4,273,683	3,126,234	$ 10,690,511	$ 7,824,233	37.20%
31	6000 LABORATORY		0.088679	6,840,763	7,409,640	3,302,142	10,811,189	11,138,285	6,943,333	5,409,916	4,995,559	10,443,678	14,848,248	$ 26,691,106	$ 30,159,721	41.66%
32	6500 RESPIRATORY THERAPY		0.081498	2,686,855	320,815	1,014,744	176,437	3,931,572	464,284	2,135,310	184,358	2,377,505	302,271	$ 9,768,481	$ 1,145,894	15.45%
33	6600 PHYSICAL THERAPY		0.360971	532,646	190,278	721,701	608,572	840,337	803,830	470,515	337,764	2,070,506	790,033	$ 2,565,199	$ 1,940,444	37.75%
34	6900 ELECTROCARDIOLOGY		0.263192	31,216	87,852	188,001	568,156	31,262	167,382	10,036	66,520	16,548	77,522	$ 260,515	$ 889,910	18.95%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.409202	1,625,824	531,893	1,141,281	931,070	2,656,661	1,183,801	1,569,939	584,405	1,711,354	1,212,066	$ 6,993,705	$ 3,231,169	33.10%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.510108	476,604	639,176	-	-	1,165,703	2,023,256	520,263	683,578	508,135	452,745	$ 2,162,570	$ 3,346,010	20.26%
37	7300 DRUGS CHARGED TO PATIENTS		0.263978	3,895,712	9,547,649	2,974,799	5,128,637	5,604,576	17,016,547	2,909,885	3,268,747	5,758,204	10,774,065	$ 15,384,972	$ 34,961,580	41.22%
38	7400 RENAL DIALYSIS		0.202174	239,536	-	-	-	844,322	38,160	266,696	26,288	291,281	1,477,300	$ 1,350,554	$ 64,448	52.97%
39	9000 CLINIC		0.426418	36,935	30,694	99,350	64,297	-	4,412	20,500	144,779	-	-	$ 156,785	$ 244,182	4.43%
40	9100 EMERGENCY		0.179910	1,009,886	3,537,977	259,564	10,954,861	2,003,138	4,616,426	881,035	2,929,907	1,850,361	16,787,731	$ 4,153,623	$ 22,039,171	44.50%
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
54			-											$ -	$ -	
55			-											$ -	$ -	
56			-											$ -	$ -	
57			-											$ -	$ -	
58			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (10/01/2020-09/30/2021) 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		%
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			-											$ -	$ -	
110			-											$ -	$ -	
111			-											$ -	$ -	
112			-											$ -	$ -	
113			-											$ -	$ -	
114			-											$ -	$ -	
115			-											$ -	$ -	
116			-											$ -	$ -	
117			-											$ -	$ -	
118			-											$ -	$ -	
119			-											$ -	$ -	
120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 28,283,150	$ 36,420,416	$ 23,234,201	$ 44,485,569	$ 45,253,370	$ 64,128,534	$ 24,998,703	$ 26,552,125	$ 40,189,322	$ 76,157,304			

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

Cost Report Year (10/01/2020-09/30/2021) HAMILTON MEDICAL CENTER

	Totals / Payments	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		%
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 36,792,733	$ 36,420,416	$ 36,088,552	$ 44,485,569	$ 53,807,145	$ 64,128,534	$ 31,113,237	$ 26,552,125	$ 49,431,270 (Agrees to Exhibit A)	$ 76,157,304 (Agrees to Exhibit A)	$ 157,801,667	$ 171,586,644	36.36%
129	Total Charges per PS&R or Exhibit Detail	$ 36,792,733	$ 36,420,416	$ 36,088,552	$ 44,485,569	$ 53,807,145	$ 64,128,534	$ 31,113,237	$ 26,552,125	$ 49,431,270	$ 76,157,304			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 8,979,178	$ 6,268,676	$ 11,922,697	$ 7,115,039	$ 12,069,709	$ 11,576,005	$ 7,394,418	$ 4,195,633	$ 11,132,071	$ 11,662,680	$ 40,366,002	$ 29,155,353	38.29%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 5,864,733	$ 4,267,104	$ -	$ -	$ 277,784	$ 688,707	$ 327,420	$ 290,056			$ 6,469,937	$ 5,245,867	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 6,935,954	$ 5,151,488	$ -	$ -	$ -	$ -			$ 6,935,954	$ 5,151,488	
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ 75	$ 7,077,284	$ 3,933,009			$ 7,077,284	$ 3,933,084	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			$ -	$ -	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 5,864,733	$ 4,267,104	$ 6,935,954	$ 5,151,488									
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)					$ 8,612,044	$ 7,322,382	$ -	$ -			$ 8,612,044	$ 7,322,382	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 255,031	$ 288,634	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 255,031	$ 288,634	
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -			$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 234,386	$ 612,369			
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)**	$ 3,114,445	$ 2,001,572	$ 4,986,743	$ 1,963,551	$ 2,924,850	$ 3,276,207	$ (10,286)	$ (27,432)	$ 10,897,685	$ 11,050,311	$ 11,015,752	$ 7,213,898	
146	**Calculated Payments as a Percentage of Cost**	65%	68%	58%	72%	76%	72%	100%	101%	2%	5%	73%	75%	
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)**					18,610								
148	**Percent of cross-over days to total Medicare days from the cost report**					22%								

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.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) 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	$ 1,114.87		67						11		78	
2	03100 INTENSIVE CARE UNIT	$ 1,770.23		23								23	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 1,919.88										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,025.80										-	
11	3201 NEONATAL INTENSIVE CARE UNIT	$ 2,367.38										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	90		-		-		11		101	
19	Total Days per PS&R or Exhibit Detail			90		-		-		11			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 191,808						$ 17,215		$ 209,023	
21.01	Calculated Routine Charge Per Diem			$ 2,131.20		$ -		$ -		$ 1,565.00		$ 2,069.53	
	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)		0.509651	445	2,254					840	-	$ 1,285	$ 2,254
23	5000 OPERATING ROOM		0.111590	20,755	60,508					28,017	7,416	$ 48,772	$ 67,924
24	5100 RECOVERY ROOM		0.193499	3,101	9,671					3,987	2,330	$ 7,088	$ 12,001
25	5200 DELIVERY ROOM & LABOR ROOM		0.213381	7,807	-					-	-	$ 7,807	$ -
26	5300 ANESTHESIOLOGY		0.019922	2,880	7,617					3,472	1,279	$ 6,352	$ 8,896
27	5400 RADIOLOGY-DIAGNOSTIC		0.201481	21,265	64,785					5,029	8,455	$ 26,294	$ 73,240
28	5700 CT SCAN		0.031357	39,308	99,305					-	63,513	$ 39,308	$ 162,818
29	5800 MRI		0.073075	7,433	-					-	-	$ 7,433	$ -
30	5900 CARDIAC CATHETERIZATION		0.074576	34,255	17,750					3,560	2,261	$ 37,815	$ 20,011
31	6000 LABORATORY		0.088679	140,867	197,280					45,415	13,450	$ 186,282	$ 210,730
32	6500 RESPIRATORY THERAPY		0.081498	493	4,346					-	518	$ 493	$ 4,864
33	6600 PHYSICAL THERAPY		0.360971	1,952	1,282					7,786	-	$ 9,738	$ 1,282
34	6900 ELECTROCARDIOLOGY		0.263192	-	-					-	-	$ -	$ -
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.409202	8,543	20,796					8,149	931	$ 16,692	$ 21,727
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.510108	6,000	9,105					10,315	85	$ 16,315	$ 9,190
37	7300 DRUGS CHARGED TO PATIENTS		0.263978	56,886	67,918					8,532	7,250	$ 65,418	$ 75,168
38	7400 RENAL DIALYSIS		0.202174	-	-					-	-	$ -	$ -
39	9000 CLINIC		0.426418	160	14,280					-	788	$ 160	$ 15,068
40	9100 EMERGENCY		0.179910	24,899	288,982					5,080	46,842	$ 29,979	$ 335,824
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) 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 (10/01/2020-09/30/2021) 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			-									$ -	$ -
				$ 377,049	$ 865,879	$ -	$ -	$ -	$ -	$ 130,182	$ 155,118		

Totals / Payments

		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	
128	**Total Charges (includes organ acquisition from Section K)**	$ 568,857	$ 865,879	$ -	$ -	$ -	$ -	$ 147,397	$ 155,118	$ 716,254	$ 1,020,997
129	Total Charges per PS&R or Exhibit Detail	$ 568,857	$ 865,879	$ -	$ -	$ -	$ -	$ 147,397	$ 155,118		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 168,250	$ 134,889	$ -	$ -	$ -	$ -	$ 36,538	$ 17,504	$ 204,788	$ 152,393
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 79,551	$ 34,021					$ -	$ 256	$ 79,551	$ 34,277
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)	$ -	$ -					$ -	$ 28,014	$ -	$ 28,014
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -					$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 79,551	$ 34,021	$ -	$ -						
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)							$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 11,188	$ 3,421	$ 11,188	$ 3,421
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)**	$ 88,699	$ 100,868	$ -	$ -	$ -	$ -	$ 25,350	$ (14,187)	$ 114,049	$ 86,681
144	**Calculated Payments as a Percentage of Cost**	47%	25%	0%	0%	0%	0%	31%	181%	44%	43%

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 (10/01/2020-09/30/2021) 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 (10/01/2020-09/30/2021) 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 (10/01/2020-09/30/2021) 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)*		$ 3,366,128		
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 ---------->)		$ 3,366,128		
	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		$ 3,366,128
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	331,125,562
19	Uninsured Hospital	**Charges Sec. G**	125,588,574
20	Total Hospital	**Charges Sec. G**	1,256,218,484
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		26.36%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.00%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 887,275
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 336,524
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 1,223,799**

** 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.*