DSH Version 8.11 2/10/2023

D. General Cost Report Year Information 10/1/2021 - 9/30/2022

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		
	10/1/2021 through 9/30/2022		
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:	3/1/2023		

	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	

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: (10/01/2021 - 09/30/2022)

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)	$ 307,417	$ 955,609	$1,263,026
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,207,966	$ 7,592,903	$8,800,869
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)	$1,515,383	$8,548,512	$10,063,895
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	20.29%	11.18%	12.55%

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 (10/01/2021 - 09/30/2022)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	45,928 (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	-
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	35,650,164
8.	Outpatient Hospital Charity Care Charges	61,523,392
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 97,173,556

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	$143,023,271.00			$ 109,827,263	$ -	$ -	$ 33,196,008
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	$430,364,385.00	$715,905,634.00		$ 330,475,888	$ 549,742,401	$ -	$ 266,051,730
20.	Outpatient Services		$140,411,592.00			$ 107,821,760	$ -	$ 32,589,832
21.	Home Health Agency			$4,426,476.00			$ 3,399,081	
22.	Ambulance	-	-	$ -	-	-	$ -	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$2,982,057.00			$ 2,289,915	
26.	Other	$29,239,258.00	$21,548,220.00	$0.00	$ 22,452,763	$ 16,546,832	$ -	$ 11,787,883
27.	Total	$ 602,626,914	$ 877,865,446	$ 7,408,533	$ 462,755,915	$ 674,110,993	$ 5,688,997	$ 343,625,453
28.	Total Hospital and Non Hospital		Total from Above	$ 1,487,900,893		Total from Above	$ 1,142,555,904	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,487,900,893	Total Contractual Adj. (G-3 Line 2)	1,138,276,174
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)			+	4,279,730
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.	Adjusted Contractual Adjustments				1,142,555,904
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) 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	$ 36,165,779	$ 2,807,207	$ -	$0.00	$ 38,972,986	36,279	$96,801,338.00		$ 1,074.26
2	03100 INTENSIVE CARE UNIT	$ 13,344,598	$ 696,894	$ -		$ 14,041,492	5,492	$29,182,483.00		$ 2,556.72
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 5,808,389	$ -	$ -		$ 5,808,389	1,894	$9,333,807.00		$ 3,066.73
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	$ 4,770,119	$ -	$ -		$ 4,770,119	2,626	$11,120,546.00		$ 1,816.50
11	3201 PEDIATRIC INTENSIVE CARE UNIT	$ 3,049,273	$ 68,708	$ -		$ 3,117,981	3,118	$7,705,643.00		$ 999.99
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 63,138,158	$ 3,572,809	$ -	$ -	$ 66,710,967	49,409	$ 154,143,817		
19	Weighted Average									$ 1,350.18

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)	3,481	-	-	$ 3,739,499	$2,017,956.00	$8,470,867.00	$ 10,488,823	0.356522

Line #	Cost Center Description	*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	$12,225,733.00	$ 863,756	$ 43,932	$ 13,133,421	$42,963,340.00	$79,763,025.00	$ 122,726,365	0.107014
22	5100 RECOVERY ROOM	$1,659,814.00	$ -	$ -	$ 1,659,814	$4,310,075.00	$7,773,013.00	$ 12,083,088	0.137367
23	5200 DELIVERY ROOM & LABOR ROOM	$4,941,084.00	$ -	$ -	$ 4,941,084	$22,437,780.00	$1,135,970.00	$ 23,573,750	0.209601
24	5300 ANESTHESIOLOGY	$2,284,966.00	$ -	$ -	$ 2,284,966	$5,332,778.00	$11,702,249.00	$ 17,035,027	0.134133
25	5400 RADIOLOGY-DIAGNOSTIC	$22,149,129.00	$ 510,401	$ -	$ 22,659,530	$16,505,336.00	$114,788,926.00	$ 131,294,262	0.172586
26	5700 CT SCAN	$2,905,344.00	$ -	$ -	$ 2,905,344	$27,993,275.00	$70,443,085.00	$ 98,436,360	0.029515
27	5800 MRI	$1,957,843.00	$ -	$ -	$ 1,957,843	$5,223,817.00	$20,826,293.00	$ 26,050,110	0.075157
28	5900 CARDIAC CATHETERIZATION	$3,463,289.00	$ -	$ -	$ 3,463,289	$44,812,352.00	$49,699,139.00	$ 94,511,491	0.036644
29	6000 LABORATORY	$18,540,410.00	$ -	$ -	$ 18,540,410	$84,764,141.00	$120,127,226.00	$ 204,891,367	0.090489

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) 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	$7,076,826.00	$ 294,462	$ -	$ 7,371,288	$57,732,411.00	$26,340,054.00	$ 84,072,465	0.087678
31	6600	PHYSICAL THERAPY	$7,242,604.00	$ 39,262	$ -	$ 7,281,866	$8,106,580.00	$14,950,350.00	$ 23,056,930	0.315821
32	6900	ELECTROCARDIOLOGY	$1,296,904.00	$ 608,556	$ -	$ 1,905,460	$320,028.00	$7,333,292.00	$ 7,653,320	0.248972
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$22,681,106.00	$ -	$ -	$ 22,681,106	$27,128,557.00	$17,616,048.00	$ 44,744,605	0.506901
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$23,357,598.00	$ -	$ -	$ 23,357,598	$20,800,333.00	$25,688,019.00	$ 46,488,352	0.502440
35	7300	DRUGS CHARGED TO PATIENTS	$42,893,222.00	$ -	$ -	$ 42,893,222	$55,011,177.00	$144,256,128.00	$ 199,267,305	0.215255
36	7400	RENAL DIALYSIS	$989,433.00	$ 343,539	$ -	$ 1,332,972	$6,922,406.00	$3,462,817.00	$ 10,385,223	0.128353
37	9000	CLINIC	$5,051,437.00	$ -	$ -	$ 5,051,437	$0.00	$10,306,379.00	$ 10,306,379	0.490127
38	9100	EMERGENCY	$21,261,854.00	$ 451,509	$ -	$ 21,713,363	$20,745,648.00	$98,870,742.00	$ 119,616,390	0.181525
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 (10/01/2021-09/30/2022) 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**	$ 201,978,596	$ 3,111,485	$ 43,932		$ 205,134,013	$ 453,127,990	$ 833,553,622	$ 1,286,681,612	
127		**Weighted Average**									0.162335
128		**Sub Totals**	$ 265,116,754	$ 6,684,294	$ 43,932		$ 271,844,980	$ 607,271,807	$ 833,553,622	$ 1,440,825,429	
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**					$ 271,844,980				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					2.52%				

* 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 (10/01/2021-09/30/2022) 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	$ 1,074.26		2,990		2,024		2,614		2,023		2,692		9,651		37.74%
2	03100 INTENSIVE CARE UNIT	$ 2,556.72		772		126		389		183		928		1,470		44.43%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,066.73				92		385		345		223		822		55.23%
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 1,816.50		817		1,329				6		15		2,152		82.67%
11	3201 PEDIATRIC INTENSIVE CARE UNIT	$ 999.99		2		1,883				6		42		1,891		62.67%
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	4,581		5,454		3,388		2,563		3,900		15,986		40.46%
19	Total Days per PS&R or Exhibit Detail			4,581		5,454		3,388		2,563		3,900				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 10,918,230		$ 17,499,960		$ 10,795,642		$ 8,320,440		$ 14,136,487		$ 47,534,272		40.31%
21.01	Calculated Routine Charge Per Diem			$ 2,383.37		$ 3,208.65		$ 3,186.44		$ 3,246.37		$ 3,624.74		$ 2,973.49		
	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)		0.356522	255,141	765,478	34,807	283,427	292,338	410,982	103,937	586,096	109,009	829,005	$ 686,223	$ 2,045,983	35.24%
23	5000 OPERATING ROOM		0.107014	5,488,034	3,166,736	2,599,500	2,757,742	2,139,828	3,043,585	2,398,888	3,463,778	3,302,065	4,694,459	$ 12,626,250	$ 12,431,841	26.98%
24	5100 RECOVERY ROOM		0.137367	304,637	286,605	370,795	529,782	268,049	204,130	255,900	251,395	438,233	732,938	$ 1,199,381	$ 1,271,912	30.24%
25	5200 DELIVERY ROOM & LABOR ROOM		0.209601	1,760,764	2,559	7,092,322	171,751	478,899	54,320	658,525	47,317	765,407	97,908	$ 9,990,510	$ 275,947	47.33%
26	5300 ANESTHESIOLOGY		0.134133	417,000	371,897	445,110	466,774	242,507	369,231	289,732	443,861	539,357	698,294	$ 1,394,349	$ 1,651,763	25.23%
27	5400 RADIOLOGY-DIAGNOSTIC		0.172586	1,200,440	4,105,373	483,711	6,694,664	1,098,482	6,628,754	1,148,596	4,801,777	1,642,162	8,356,370	$ 3,931,229	$ 22,230,568	27.65%
28	5700 CT SCAN		0.029515	2,126,087	3,189,653	547,262	4,937,652	2,424,955	3,554,600	1,794,898	3,334,054	3,276,319	9,489,954	$ 6,893,202	$ 15,015,959	35.46%
29	5800 MRI		0.075157	292,219	940,443	101,787	1,065,312	304,401	1,225,362	246,473	1,189,502	704,916	1,049,563	$ 944,880	$ 4,420,619	27.39%
30	5900 CARDIAC CATHETERIZATION		0.036644	1,518,995	1,272,635	1,413,838	1,441,967	2,290,543	2,243,154	2,817,454	2,384,266	4,078,871	2,426,393	$ 8,040,830	$ 7,342,022	23.28%
31	6000 LABORATORY		0.090489	9,045,268	8,109,179	3,470,032	14,271,489	6,951,611	7,696,774	5,364,348	5,222,311	8,876,435	12,986,738	$ 24,831,259	$ 35,299,753	40.24%
32	6500 RESPIRATORY THERAPY		0.087678	3,366,604	270,309	1,803,193	1,649,718	4,636,919	1,596,097	4,502,434	1,765,927	4,880,379	2,881,265	$ 14,309,150	$ 5,282,051	32.73%
33	6600 PHYSICAL THERAPY		0.315821	813,039	218,860	155,814	1,299,987	638,739	369,627	428,493	491,121	714,725	288,875	$ 2,036,085	$ 2,379,595	23.60%
34	6900 ELECTROCARDIOLOGY		0.248972	1,621,194	612,857	1,762	412,868	28,815	461,349	16,351	356,192	28,904	340,323	$ 1,668,122	$ 1,843,266	50.80%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.506901	2,205,729	603,104	1,455,819	899,531	1,789,287	606,254	1,848,869	739,475	1,980,257	1,337,448	$ 7,299,704	$ 2,848,364	30.28%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.502440	873,290	515,096	134,121	199,069	1,100,742	941,827	1,213,499	1,336,612	929,529	687,535	$ 3,321,652	$ 2,992,604	17.06%
37	7300 DRUGS CHARGED TO PATIENTS		0.215255	5,321,109	10,062,487	2,550,833	7,030,621	3,900,317	9,526,815	3,235,874	2,944,502	5,772,940	6,695,777	$ 15,008,133	$ 29,564,425	28.73%
38	7400 RENAL DIALYSIS		0.128353	357,592	-	29	-	912,106	382,225	366,322	41,754	594,435	2,634,400	$ 1,636,049	$ 423,979	51.01%
39	9000 CLINIC		0.490127	36,643	22,034	2,414	405,990	379	579,837	293	445,941	220	373,467	$ 39,729	$ 1,453,802	18.15%
40	9100 EMERGENCY		0.181525	1,270,936	4,274,957	429,718	16,136,825	1,708,304	4,150,798	1,360,285	3,821,595	2,332,403	20,017,949	$ 4,769,243	$ 28,384,175	46.83%
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (10/01/2021-09/30/2022) 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			-											$ -	$ -
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120			-											$ -	$ -
121			-											$ -	$ -
122			-											$ -	$ -
123			-											$ -	$ -
124			-											$ -	$ -
125			-											$ -	$ -
126			-											$ -	$ -
127			-											$ -	$ -
				$ 38,274,721	$ 38,790,262	$ 23,092,867	$ 60,655,169	$ 31,207,221	$ 44,045,721	$ 28,051,171	$ 33,667,476	$ 40,966,566	$ 76,618,661		

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

Cost Report Year (10/01/2021-09/30/2022) 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)***	$ 49,192,951	$ 38,790,262	$ 40,592,827	$ 60,655,169	$ 42,002,863	$ 44,045,721	$ 36,371,611	$ 33,667,476	$ 55,103,053 (Agrees to Exhibit A)	$ 76,618,661 (Agrees to Exhibit A)	$ 168,160,252	$ 177,158,628	33.29%
129	Total Charges per PS&R or Exhibit Detail	$ 49,192,951	$ 38,790,262	$ 40,592,827	$ 60,655,169	$ 42,002,863	$ 44,045,721	$ 36,371,611	$ 33,667,476	$ 55,103,053	$ 76,618,661			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 12,935,462	$ 6,118,100	$ 11,077,943	$ 9,148,600	$ 9,825,751	$ 6,970,378	$ 8,151,923	$ 5,256,560	$ 11,962,757	$ 11,126,262	$ 41,991,079	$ 27,493,638	34.23%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 7,476,526	$ 4,796,943			$ 339,296	$ 527,214	$ 227,236	$ 362,004			$ 8,043,058	$ 5,686,161	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 7,670,516	$ 8,060,761							$ 7,670,516	$ 8,060,761	
134	Private Insurance (including primary and third party liability)					$ 26,020	$ 11,432	$ 401,254	$ 899,861			$ 427,274	$ 911,293	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 56,318	$ 7,133				$ 575					$ 56,318	$ 7,708	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 7,532,844	$ 4,804,076	$ 7,670,516	$ 8,060,761									
137	Medicaid Cost Settlement Payments (See Note B)		$ (152,998)									$ -	$ (152,998)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 5,864,692	$ 4,858,709					$ 5,864,692	$ 4,858,709	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 5,144,555	$ 2,889,408			$ 5,144,555	$ 2,889,408	
141	Medicare Cross-Over Bad Debt Payments					$ 347,796	$ 241,038			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 347,796	$ 241,038	
142	Other Medicare Cross-Over Payments (See Note D)					$ 687,713	$ 152,165					$ 687,713	$ 152,165	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 307,417	$ 955,609			
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)**	$ 5,402,618	$ 1,467,022	$ 3,407,427	$ 1,087,839	$ 2,560,234	$ 1,179,245	$ 2,378,878	$ 1,105,287	$ 11,655,340	$ 10,170,653	$ 13,749,157	$ 4,839,393	
146	**Calculated Payments as a Percentage of Cost**	58%	76%	69%	88%	74%	83%	71%	79%	3%	9%	67%	82%	
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)**					22,613								
148	**Percent of cross-over days to total Medicare days from the cost report**					15%								

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 (10/01/2021-09/30/2022) 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	$ 1,074.26		35								35	
2	03100 INTENSIVE CARE UNIT	$ 2,556.72		42								42	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,066.73		1								1	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,816.50		4								4	
11	3201 PEDIATRIC INTENSIVE CARE UNIT	$ 999.99		21								21	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	103		-		-		-		103	
19	Total Days per PS&R or Exhibit Detail			103		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 464,627								$ 464,627	
21.01	Calculated Routine Charge Per Diem			$ 4,510.94		$ -		$ -		$ -		$ 4,510.94	
	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)		0.356522	3,948	22,531							$ 3,948	$ 22,531
23	5000 OPERATING ROOM		0.107014	18,066	39,259							$ 18,066	$ 39,259
24	5100 RECOVERY ROOM		0.137367	3,916	7,525							$ 3,916	$ 7,525
25	5200 DELIVERY ROOM & LABOR ROOM		0.209601	26,253	1,712							$ 26,253	$ 1,712
26	5300 ANESTHESIOLOGY		0.134133	7,486	6,817							$ 7,486	$ 6,817
27	5400 RADIOLOGY-DIAGNOSTIC		0.172586	28,249	120,705							$ 28,249	$ 120,705
28	5700 CT SCAN		0.029515	62,092	165,512							$ 62,092	$ 165,512
29	5800 MRI		0.075157	10,016	6,060							$ 10,016	$ 6,060
30	5900 CARDIAC CATHETERIZATION		0.036644	79,845	29,679							$ 79,845	$ 29,679
31	6000 LABORATORY		0.090489	170,947	283,261							$ 170,947	$ 283,261
32	6500 RESPIRATORY THERAPY		0.087678	116,808	51,231							$ 116,808	$ 51,231
33	6600 PHYSICAL THERAPY		0.315821	21,020	618							$ 21,020	$ 618
34	6900 ELECTROCARDIOLOGY		0.248972	7,315	59							$ 7,315	$ 59
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.506901	61,186	22,925							$ 61,186	$ 22,925
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.502440	51	-							$ 51	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.215255	172,446	45,102							$ 172,446	$ 45,102
38	7400 RENAL DIALYSIS		0.128353	8,463	-							$ 8,463	$ -
39	9000 CLINIC		0.490127	2	2,997							$ 2	$ 2,997
40	9100 EMERGENCY		0.181525	58,049	449,449							$ 58,049	$ 449,449
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2021-09/30/2022) 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 (10/01/2021-09/30/2022) 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			-									$ -	$ -
				$ 856,158	$ 1,255,442	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ 1,320,785	$ 1,255,442	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,320,785	$ 1,255,442
129	Total Charges per PS&R or Exhibit Detail			$ 1,320,785	$ 1,255,442	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 311,041	$ 176,519	$ -	$ -	$ -	$ -	$ -	$ -	$ 311,041	$ 176,519
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 51,675	$ 61,500							$ 51,675	$ 61,500
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)				$ 3,471							$ -	$ 3,471
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 51,675	$ 64,971	$ -	$ -						
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)											$ -	$ -
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)**			$ 259,366	$ 111,548	$ -	$ -	$ -	$ -	$ -	$ -	$ 259,366	$ 111,548
144	**Calculated Payments as a Percentage of Cost**			17%	37%	0%	0%	0%	0%	0%	0%	17%	37%

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 (10/01/2021-09/30/2022) 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 (10/01/2021-09/30/2022) 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 (10/01/2021-09/30/2022) 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)*		$ 3,630,734		
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)		$ 3,630,734	5.01	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	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		$ 3,630,734		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	347,895,107
19	Uninsured Hospital	**Charges Sec. G**	131,721,714
20	Total Hospital	**Charges Sec. G**	1,440,825,429
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		24.15%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.14%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

** 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.*