Health Financial Systems	HAMILTON CEN	ITER, INC.		In Lie	u of Form CMS-2	2552-10
This report is required by law (42 USC 1395g; 42 CF payments made since the beginning of the cost repor					m FORM APPROVED OMB NO. 0938- EXPIRES 03-31	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO AND SETTLEMENT SUMMARY	ORT CERTIFICATI	ON Provider CC	F	eriod: rom 07/01/2019 o 06/30/2020		
PART I - COST REPORT STATUS					111/20/2020 //	
Provider 1. [X] Electronically prepared cost				Date: 11/25/2	2020 Time: 9	:17 am
use only 2. [] Manually prepared cost report 3. [0] If this is an amended report 4. [F] Medicare Utilization. Enter	enter the numb	er of times th "L" for low.	e provider res	ubmitted this	cost report	
use only (1) As Submitted 7. Contr (2) Settled without Audit 8. [N]	Received: actor No. Initial Report Final Report f	for this Prov or this Provide	11.Cor ider CCN 12.[(2 Date: htractor's Vend] f line 5, c number of tin	or Code: olumn 1 is 4: E mes reopened =	4 Inter 0-9.
PART II - CERTIFICATION						
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY O ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA	DER FEDERAL LAW DR INDIRECTLY O NY RESULT.	. FURTHERMORE F A KICKBACK O	, IF SERVICES R WERE OTHERWI	IDENTIFIED IN "	THIS REPORT WER	E
CERTIFICATION BY CHIEF FINANCIAL OFFICER OF	R ADMI NI STRATOR	OF PROVIDER(S)			
I HEREBY CERTIFY that I have read the above						
electronically filed or manually submitted						
Expenses prepared by HAMILTON CENTER, INC. ending 06/30/2020 and to the best of my kno						
complete and prepared from the books and re						
except as noted. I further certify that I health care services, and that the services laws and regulations.						
[X]I have read and agree with the above of	certification s	tatement. I ce	ertify that I i	ntend my elect	roni c	
signature on this certification state	ment to be the	legally bindin	ig equivalent o	of my original	si gnature.	
	(Si gn					
		Offi ce	er or Administ	rator of Provid	der(s)	
		CEO				
		Title				
				! + ! ! !		
		Date	when report i	s el ectroni cal l	ry srgned.)	
		bato				
				1		
Cost Center Description	Title V	Title Part A	XVIII Part B	ніт	Title XIX	
cost center bescription	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-523	3, 517			1.00
2.00 Subprovi der - IPF 3.00 Subprovi der - IRF	0	0	0		0	2.00 3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00

200.00Total0-5233,517032,787200.00The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless itdisplays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The timerequired to complete and review the information collection is estimated 673 hours per response, including the time to reviewinstructions, search existing resources, gather the data needed, and complete and review the information collection. If youhave any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS,7500 Securi ty Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRAReports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approvedunder the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questionsor concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

0

0

0 12.00

12.00 CMHC I

	AL AND HOSPITAL HEALTH CARE COMPLEX I						From 07/0 To 06/3)1/2019 30/2020		imo Dro	nare
							10 007.			2020 9:	
	1.00 Hospital and Hospital Health Care Co	mplex Addr	2.00		3.00			4.00			-
0	Street: 620 EIGHTH AVENUE		0 Box:								1
0	City: TERRE HAUTE		tate: IN	Zip Cod			nty: VIGO				2
		Compo	nent Name	CCN	CBS				ent Syst		
				Number	Numbe	er Type	Certifie		<u>F, O, or</u> XVIII	· ·	-
			1.00	2.00	3.00	0 4.00	5.00	6.00			1
	Hospital and Hospital-Based Componen			2.00	1 0.00	0 1.00	0.00	0.00	0 1 7.00	1 0.00	
0	Hospi tal		CENTER, INC.	154009	4546	0 4	11/15/19	73 N	Р	0	3
C	Subprovider - IPF										4
C	Subprovider - IRF										5
))	Subprovider - (Other) Swing Beds - SNF										6
0	Swing Beds - NF										8
0	Hospital-Based SNF										9
00	Hospital-Based NF										10
0C	Hospital-Based OLTC										11
00	Hospital-Based HHA										12
	Separatel y Certi fi ed ASC Hospi tal -Based Hospi ce										13
00 00	Hospital-Based Health Clinic - RHC										15
	Hospital -Based Health Clinic - FQHC										16
00	Hospital-Based (CMHC) I										17
00	Renal Dialysis										18
00	Other									<u> </u>	19
							Fro		Tc 2.		1
00	Cost Reporting Period (mm/dd/yyyy)							/2019	06/30		20
	Type of Control (see instructions)							2			21
					L						4
						1.00	2.	00	3.	00	
00	Inpatient PPS Information Does this facility qualify and is it	currently	receiving p	avments fo	r	N		۱.			22
00	disproportionate share hospital adju										
	§412.106? In column 1, enter "Y" fo	r yes or "	N" for no. I	s this							
	facility subject to 42 CFR Section §	• •		mendment							
01	hospital?) In column 2, enter "Y" for			nto for th		N					1 22
01	Did this hospital receive interim un cost reporting period? Enter in colu					Ν	1	1			22
	the portion of the cost reporting pe		2								
	Enter in column 2, "Y" for yes or "N										
	reporting period occurring on or afte										
02	Is this a newly merged hospital that					N		J			22
	payments to be determined at cost re Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob										
	or "N" for no, for the portion of the										
	October 1.										
03	Did this hospital receive a geograph					Ν		A .	N	1	22
	rural as a result of the OMB standard adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reporting										
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or afte										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41: yes or "N" for no.	2.105)? En	iter in colum	п 3, т г	or						
00	Which method is used to determine Me	dicaid day	vs on lines 2	4 and/or 2	5		3 1	J			23
	below? In column 1, enter 1 if date (
	if date of discharge. Is the method				cost						
	reporting period different from the										
	reporting period? In column 2, ente		Jes or N T		tate	Out-of	Out-of	Medi ca	aid 🛛 🗠	ther	
			Medio		caid	State	State	HMO da		di cai d	
			pai d		ible	Medi cai d	Medi cai d			days	
				· ·		paid days	eligible				
					ys	2.00	unpai d	F 61		(00	
0	If this provider is an IPPS hospital	optor th	1.0	0 2.	00	3.00	4.00	5.00	0	5.00 C	24
50	in-state Medicaid paid days in colum					0	0			Ľ	′ ²⁴
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu										

	Financial Systems HAMIL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC	CN: 15-4009	Peri		1 (2010		neet S-2	2
					To	n 0770 0673			ime Pre 2020 9:	
		In-State	In-State	Out-of	Out		Medi ca		Other	
		Medicaid paid days	Medicaid eligible	State Medicaid	Sta Medio		HMO da	<i>y</i>	di cai d days	
			unpai d	paid days	eligi	ible				
		1.00	days	0.00	unpa		- 00		(00	4
. 00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4. (00	5.00	0	6.00	25.
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.									
					Ur	<u>ban/R</u> 1. 0			f Geogr 00	-
. 00	Enter your standard geographic classification (not w		at the be	ginning of	the	1. 0	1	2.	00	26.
. 00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w		at the on	d of the co	c+		1			27.
. 00	reporting period. Enter in column 1, "1" for urban o				st		'			27.
	enter the effective date of the geographic reclassif	ication in	column 2.							
. 00	If this is a sole community hospital (SCH), enter th effect in the cost reporting period.	e number of	periods S	CH status i	n		0			35
	perfect in the cost reporting perfect.					Begi nr	ni ng:	End	i ng:	
00				04 6		1. (00	2.	00	
00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 TOP NUM	iber					36
. 00	If this is a Medicare dependent hospital (MDH), ente		er of perio	ds MDH stat	us		0			37
. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t	bo MDU tran	citional n	avmont in						37
. 01	accordance with FY 2016 OPPS final rule? Enter "Y" f									57
. 00	instructions) If line 37 is 1, enter the beginning and ending date	s of MDH st	atus. If I	ine 37 is			·			38
	greater than 1, subscript this line for the number o									
	enter subsequent dates.					Y/	N	V	/N	
						1.0			00	
. 00	Does this facility qualify for the inpatient hospita					Ν		l	N	39
	hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet				Imn					
	accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i				ves					
. 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio	n adjustmar	t2 Entor "	V" for ves	or	N			N	40
. 00	"N" for no in column 1, for discharges prior to Octo					IN IN			IN .	40
	no in column 2, for discharges on or after October 1	. (see inst	ructions)	-					VIV	
							V 1.00	2.00		-
	Prospective Payment System (PPS)-Capital							12100	10100	
. 00	Does this facility qualify and receive Capital payme	nt for disp	proporti ona	te share in	accor	rdance	N	N	N	45
o -	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc	eption for	extraordi n	ary circums	tances	S	N	N	N	46
. 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks									
. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS			5 V00 05 "N	l" for	no	N	N	N	47
		canital? F	nter "V fo			110.	N	N	N	48
. 00	Is the facility electing full federal capital paymen				no.				1]_,
. 00 . 00	Teaching Hospitals	t? Enter "	Y" for yes	or "N" for			1	1		56
. 00 . 00	Teaching Hospitals Is this a hospital involved in training residents in	t? Enter " approved (Y" for yes	or "N" for s? Enter "Y	" for	yes o R). MA	r N			
. 00 . 00 . 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for	t? Enter " approved (impacted by no in colu	Y" for yes ME program CR 11642 Mm 2.	or "N" for s? Enter "Y (or subsequ	(" for Went CF	R), MA	r N			
. 00 . 00 . 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting	t? Enter " approved C impacted by no in colu period duri	Y" for yes ME program CR 11642 mn 2. ng which r	<u>or "N" for</u> s? Enter "Y (or subsequ esidents in	(" for lent CF	R), MA oved				
. 00 . 00 . 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for	t? Enter " approved C impacted by no in colu period duri r yes or "N	Y" for yes ME program CR 11642 mn 2. ng which r " for no i	or "N" for s? Enter "Y (or subsequ esidents in n column 1.	(" for lent CF appro lf co	R), MA oved olumn	1			
00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	t? Enter " approved C impacted by no in cold period duri r yes or "N th of this Y", complet	Y" for yes ME program CR 11642 mn 2. ng which r " for no i cost repor e Workshee	or "N" for s? Enter "Y (or subsequ esidents in n column 1. ting period	(" for lent CF appro If co l? Ent	R), MA oved olumn ter "Y	1			
00 00 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	t? Enter " approved (impacted by no in colu period duri r yes or "N th of this Y", complet I, if appli	Y" for yes ME program CR 11642 mn 2. ng which r " for no i cost repor e Workshee cable.	or "N" for s? Enter "Y (or subsequ esidents in n column 1. ting period t E-4. If c	(" for lent CF appro If co l? Ent column	R), MA oved olumn ter "Y 2 is	1			57
. 00 . 00 . 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	t? Enter " approved (impacted by no in colu period duri r yes or "N th of this Y", complet I, if appli bursement f	Y" for yes ME program CR 11642 mm 2. ng which r " for no i cost repor e Workshee cable. Tor physici	or "N" for s? Enter "Y (or subsequ esidents in n column 1. ting period t E-4. If c	(" for lent CF appro If co l? Ent column	R), MA oved olumn ter "Y 2 is	1			57
. 00 . 00 . 00 . 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim	t? Enter " approved C impacted by no in colu- period duri r yes or "N th of this Y", complet l, if appli bursement f complete V	Y" for yes ME program or CR 11642 mm 2. ng which r " for no i cost repor re Workshee cable. for physici /kst. D-5.	or "N" for s? Enter "Y (or subsequ esidents in n column 1. ting period t E-4. If c ans' servic , Pt. I.	" for lent CF lf cc lf cc l? Ent column ces as	R), MA oved olumn ter "Y 2 is	1 " N			57 58 59
. 00 . 00 . 00 . 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	t? Enter " approved C impacted by no in colu- period duri r yes or "N th of this Y", complet l, if appli bursement f complete V	Y" for yes ME program or CR 11642 mm 2. ng which r " for no i cost repor re Workshee cable. for physici /kst. D-5.	or "N" for s? Enter "Y (or subsequ esidents in n column 1. ting period t E-4. If c ans' servic , Pt. I. NAHE 413.8	" for lent CF lf cc lf cc l? Ent column ces as	R), MA oved olumn ter "Y 2 is Worksh	1 " Neet A		hrough	57 58 59
. 00 . 00 . 00 . 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	t? Enter " approved C impacted by no in colu- period duri r yes or "N th of this Y", complet l, if appli bursement f complete V	Y" for yes ME program or CR 11642 mm 2. ng which r " for no i cost repor re Workshee cable. for physici /kst. D-5.	or "N" for s? Enter "Y (or subsequ esidents in n column 1. ting period t E-4. If c ans' servic , Pt. I.	" for lent CF lf cc lf cc l? Ent column ces as	R), MA oved olumn ter "Y 2 is	1 " Neet A	Qualif Crit	ication erion	57 58 59
. 00 . 00 . 00 . 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	t? Enter " approved C impacted by no in colu- period duri r yes or "N th of this Y", complet l, if appli bursement f complete V	Y" for yes ME program or CR 11642 mm 2. ng which r " for no i cost repor re Workshee cable. for physici /kst. D-5.	or "N" for s? Enter "Y (or subsequ esidents in n column 1. ting period t E-4. If c ans' servic , Pt. I. NAHE 413.8 Y/N	" for lent CF lf cc lf cc l? Ent column ces as	RĴ, MA oved olumn ter "Y 2 is Vorksh Line	1 " Neet A a #	Qualif Crit Cc	ication erion ode	57 58 59
7.00 3.00 5.00 7.00 3.00 9.00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye	t? Enter " approved C impacted by no in colu- period duri r yes or "N th of this Y", complet l, if appli bursement f complete V s, complete	Y" for yes ME program o CR 11642 mm 2. ng which r " for no i cost repor ce Workshee cable. Tor physici /kst. D-5. e Wkst. D-2	or "N" for s? Enter "Y (or subsequ esidents in n column 1. ting period t E-4. If c ans' servic , Pt. I. NAHE 413.8 Y/N 1.00	" for lent CF lf cc lf cc l? Ent column ces as	R), MA oved olumn ter "Y 2 is Worksh	1 " Neet A a #	Qualif Crit Cc	ication erion	57
7.00 3.00 5.00 7.00 3.00 9.00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413	t? Enter " approved (impacted by no in colu- period duri r yes or "N th of this Y", complet I, if appli bursement f complete V s, complete (NAHE) cos .85? (see	Y" for yes ME program or CR 11642 mm 2. ng which r " for no i cost repor e Workshee cable. "or physici Kst. D-5. e Wkst. D-2	or "N" for s? Enter "Y (or subsequ esidents in n column 1. ting period t E-4. If c ans' servic , Pt. I. NAHE 413.8 Y/N	" for lent CF lf cc lf cc l? Ent column ces as	RĴ, MA oved olumn ter "Y 2 is Vorksh Line	1 " Neet A a #	Qualif Crit Cc	ication erion ode	57 58 59
. 00 . 00 . 00 . 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, \$2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing and allied health education	t? Enter " approved () impacted by no in colu- period duri r yes or "N th of this Y", complet I, if appli bursement f complete V s, complete (NAHE) cos .85? (see lumn 1. If	Y" for yes ME program (CR 11642 mn 2. ng which r " for no i cost repor e Workshee cable. for physici /kst. D-5. (kst. D-2) (kst. D-2) (ts for	or "N" for s? Enter "Y (or subsequ esidents in n column 1. ting period t E-4. If c ans' servic , Pt. I. NAHE 413.8 Y/N 1.00	" for lent CF lf cc lf cc l? Ent column ces as	RĴ, MA oved olumn ter "Y 2 is Vorksh Line	1 " Neet A a #	Qualif Crit Cc	ication erion ode	57 58 59

SPI TAL	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider C		eriod: rom 07/01/2019	Worksheet S-2	2
				To		Part I Date/Time Pre 11/25/2020 9:	
		Y/N	IME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	d your hospital receive FTE slots under ACA ction 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.
	lumn 1. (see instructions)						
	ter the average number of unweighted primary care						61
	Es from the hospital's 3 most recent cost reports ding and submitted before March 23, 2010. (see						
	structions)						
	ter the current year total unweighted primary care E count (excluding OB/GYN, general surgery FTEs,						61
	d primary care FTEs added under section 5503 of						
ACA	A). (see instructions)						
	ter the base line FTE count for primary care d/or general surgery residents, which is used for						61
	termining compliance with the 75% test. (see						
	structions)						
	ter the number of unweighted primary care/or rgery allopathic and/or osteopathic FTEs in the						61
cui	rrent cost reporting period. (see instructions).						
	ter the difference between the baseline primary d/or general surgery FTEs and the current year's						61
	imary care and/or general surgery FTE counts (line						
	.04 minus line 61.03). (see instructions)						
	ter the amount of ACA §5503 award that is being ed for cap relief and/or FTEs that are nonprimary						61
	re or general surgery. (see instructions)						
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME	
						FTE Count	
10 OF	the FTFe in line (1 OF energify each new program		1.00	2.00	3.00	4.00	1 (1
	the FTEs in line 61.05, specify each new program ecialty, if any, and the number of FTE residents				0.00	0.00	01
foi	r each new program. (see instructions) Enter in						
	lumn 1, the program name. Enter in column 2, the ogram code. Enter in column 3, the IME FTE						
	weighted count. Enter in column 4, the direct GME						
	E unweighted count.				0.00	0.00	11
	the FTEs in line 61.05, specify each expanded ogram specialty, if any, and the number of FTE				0.00	0.00	01
res	sidents for each expanded program. (see						
	structions) Enter in column 1, the program name. ter in column 2, the program code. Enter in column						
	the IME FTE unweighted count. Enter in column 4,						
the	e direct GME FTE unweighted count.						
						1.00	
	A Provisions Affecting the Health Resources and Se ter the number of FTE residents that your hospital				iod for which	0.00	42
	ur hospital received HRSA PCRE funding (see instruc			reporting per		0.00	
	ter the number of FTE residents that rotated from a				your hospital	0.00	62
	ring in this cost reporting period of HRSA THC prog aching Hospitals that Claim Residents in Nonprovide			ms)			
00 Has	s your facility trained residents in nonprovider se	ettings	during this o			Ν	63
·· Y	" for yes or "N" for no in column 1. If yes, comple	ete IIn	es 64 through	Unweighted	Unweighted	Ratio (col.	
				FTEs	FTEs in	1/ (col . 1 +	
				Nonprovi der	Hospi tal	col. 2))	
				Si te 1.00	2.00	3.00	1
	ction 5504 of the ACA Base Year FTE Residents in No	•	0				
00 Ent	r <u>iod that begins on or after July 1, 2009 and befo</u> ter in column 1, if line 63 is yes, or your facilit	re June	e 30, 2010. ned residents	0.00	0.00	0. 000000	61
	the base year period, the number of unweighted nor			0.00	0.00	0.00000	04
res	sident FTEs attributable to rotations occurring in	all no	nprovi der				
se	ttings. Enter in column 2 the number of unweighted	•	2				
ree	sident FTEs that trained in your hospital. Enter ir	n colum	n 3 the ratio				

	EX IDENTIFICATION D	ATA Provider C		eriod:	u of Form CMS- Worksheet S-	2
			Fr To	rom 07/01/2019 06/30/2020	Date/Time Pr	epare
	Descent	Dura Cala			11/25/2020 9	17 a
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
			Nonprovi der	Hospi tal	col. 4))	
			Si te			
00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.00000	0 4 5
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Site	•		
Section 5504 of the ACA Current Y	loor FTE Docidents :	n Nonnrovidar Cattin	1.00	2.00	3.00	
beginning on or after July 1, 201		n wonprovider Settin	gsEffective i	or cost report	ing perious	
00 Enter in column 1 the number of u	inweighted non-prima		0.00	0.00	0. 00000	66.
00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	nweighted non-prima ccurring in all nonp nweighted non-prima nl. Enter in column	provider settings. ary care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider	0.00 Unweighted FTEs in Hospital	0.00000 Ratio(col. 3/(col.3+ col.4))	
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima curring in all nonp unweighted non-prima ul. Enter in column column 2)). (see in Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program	nweighted non-prima ccurring in all nonp nweighted non-prima nl. Enter in column column 2)). (see in	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima curring in all nonp unweighted non-prima ul. Enter in column column 2)). (see in Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
 FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima curring in all nonp unweighted non-prima ul. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u>	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.00000	0 67.
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	unweighted non-prima curring in all nonp unweighted non-prima il. Enter in column column 2)). (see in Program Name 1.00	Provi der settings. Ary care resident 3 the ratio of Instructions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.00000	0 67.
 FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 	unweighted non-prima curring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see in</u> <u>Program Name</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	(IPF), or does it con approved GME teach (2004? Enter "Y" for c)(D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subj ing program in yes or "N" for is in a new teacl yes or "N" for i	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? Y the most no. (see hi ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.00000	0 67.
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + (column 1 divided by (column 1 +)) OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF OO Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. OO If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412. 424(d) (1) (iii) (c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see in Program Name 1.00 1.00 25 75 75 76 76 75 75 76 75 75 75 75 75 75 75 75 75 75 75 75 75	TPF), or does it constitute to the constitution of the constitutio	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subj ing program in yes or "N" for in s in a new teach yes or "N" for in s cost reporting	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? Y the most no. (see hi ng no.	Rati o (col . 3/ (col . 3 + col . 4)) 5.00 0.00000 0.00000 0.00000 0.00000 0.00000	0 67. - - - - - - - - - 70.

DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider		Period: From 07/01/2019 To 06/30/2020		epared:
5.00 If line 75 is yes: Column 1: Did the facility have an approved GME teac recent cost reporting period ending on or before November 15, 2004? Ent no. Column 2: Did this facility train residents in a new teaching progr CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: indicate which program year began during this cost reporting period. (s	er "Y" for yes am in accordand If column 2 is	or "N" for ce with 42 Y,	0 2.00 3.00 0	76.00
Long Term Care Hospital PPS			1.00	_
 Long Term Care Hospital TTS 00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" fo 1.00 Is this a LTCH co-located within another hospital for part or all of th "Y" for yes and "N" for no. TEFRA Providers 		ng period? Enter	N N	80.00 81.00
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? En 5.00 Did this facility establish a new Other subprovider (excluded unit) und §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	85.00 86.00
7.00 Is this hospital an extended neoplastic disease care hospital classifie 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	d under sectior		N	87.00
		V 1.00	XI X 2.00	-
Title V and XIX Services		1.00	2.00	
0.00 Does this facility have title V and/or XIX inpatient hospital services? yes or "N" for no in the applicable column.		N	Y	90.00
I. 00 Is this hospital reimbursed for title V and/or XIX through the cost rep full or in part? Enter "Y" for yes or "N" for no in the applicable colu 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certific	mn.	N	Y N	91.00
instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does this facility operate an ICF/IID facility for purposes of title V		N	N	93.00
"Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for	no in the	N	N	94.00
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applicable col 5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for applicable column.		0. 00 N	0. 00 N	95.00 96.00
7.00 If line 96 is "Y", enter the reduction percentage in the applicable col 3.00 Does title V or XIX follow Medicare (title XVIII) for the interns and r stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "	esidents post	0. 00 Y	0. 00 Y	97.00 98.00
 column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and title XIX. 			Y	98.01
3.02 Does title V or XIX follow Medicare (title XVIII) for the calculation o bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for n		Y	Y	98. 02
for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a critical access reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" fo for title V, and in column 2 for title XVI			N	98.03
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed outpatient services cost? Enter "Y" for yes or "N" for no in column 1 f in column 2 for title XIX.		N	N	98.04
3. 05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX.			Y	98.05
3. 06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for titl column 2 for title XIX. Rural Providers		Y	Y	98.06
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-inclusive m for outpatient services? (see instructions)	ethod of paymer	N		105.00 106.00
101 outpatient services? (see instructions) 17.00 Column 1: If line 105 is Y, is this facility eligible for cost reimburs training programs? Enter "Y" for yes or "N" for no in column 1. (see i Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I approved medical education program in the CAH's excluded IPF and/or IR Enter "Y" for yes or "N" for no in column 2. (see instructions)	nstructions) &Rs in an			107.00
N8.00 Is this a rural hospital qualifying for an exception to the CRNA fee sc CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	hedul e? See 42	2 N		108.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod:	Worksheet S-	-2
		Fr To	rom 07/01/2019 0 06/30/2020		repare
	Physi cal	Occupati onal	Speech	Respiratory	
	1.00	2.00	3.00	4.00	
19.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.
				1.00	-
0.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Won applicable.	"Y" for yes o	r "N" for no. I	f yes,	N	110.
			1.00	2.00	-
1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this constrained in the sequence of the FCHIP demonstration for this constrained integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for a for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the n column 2.	N		111.
		1.00	2.00	3.00	_
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	period? s "Y", enter he	N			112.
Miscellaneous Cost Reporting Information .00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			0115
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes				
.00 Is this facility classified as a referral center? Enter "Y"	for yes or	Ν			116
"N" for no. 2001s this facility legally-required to carry malpractice insu	rance? Enter	Y			117.
"Y" for yes or "N" for no. 8.00 Is the malpractice insurance a claims-made or occurrence pol		2			118.
if the policy is claim-made. Enter 2 if the policy is occur	rence.	Premi ums	Losses	Insurance	
		1.00	2.00	3.00	-
.01 List amounts of malpractice premiums and paid losses:		97, 670		0	0118
			1.00	2.00	_
.02 Are malpractice premiums and paid losses reported in a cost	center other	than the	N 1.00	2.00	118
Administrative and General? If yes, submit supporting scheo and amounts contained therein. .00 DO NOT USE THIS LINE	dule listing (cost centers			119
SOLO NOT OUL THIS LINE			I	N	120
	n column 1, " ualifies for	Y" for yes or the Outpatient	N		
.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1,'" ualifies for nts? (see ins	Y" for yes or the Outpatient tructions)	N		121
 .00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Point of the Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. .00 Does the cost report contain heal thcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. 	n column 1, "" ualifies for nts? (see ins antable devic fined in §190	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the			121
 .00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. .00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 	n column 1, "" ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	Ν		
 .00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. .00 Does the cost report contain healthcare related taxes as det Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. .00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 	n column 1, "" ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	N		122
 .00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost implationts? Enter "Y" for yes or "N" for no. .00 Does the cost report contain healthcare related taxes as det Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information .00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. .00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 	n column 1, "" ualifies for nts? (see ins antable device fined in §190 1 is "Y", ent or yes and "N nter the cert 2.	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date	N		122 125 126
 .00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. .00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information .00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. .00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 	n column 1, "" ualifies for nts? (see ins antable device fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2.	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	N		122 125 126 127
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments. 0.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 0.00 Does the cost report contain healthcare related taxes as det Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. 0.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 0.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 	n column 1, "" ualifies for nts? (see ins antable device fined in §190 1 is "Y", ent or yes and "N nter the certi 2. ter the certi 2. ter the certi 2.	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date fication date	N N N		122 125 126 127 128
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implationation for the worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified heart transplant center, entification date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entification date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entification date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entification date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entification date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entification date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, entified liver transplant center, entified	n column 1, " ualifies for nts? (see ins antable device fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the cert 2. ter the cert 2. er the cert	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date fication date ication date in	N N N		122
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 0.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 0.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 0.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 0.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.00 If this is	n column 1, "" ualifies for nts? (see ins antable device fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the cert 2. er the cert 1 enter the cert function the cert 1 enter the cert lumn 2.	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date fication date ication date in rtification	N N N		122 125 126 127 128 129

USPITAL AND HUSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	CENTER, INC. Provider CC	CN: 15-4009	Period: From 07/01/2019 To 06/30/2020		-2 repared:
				1.00	2.00	-
32.00 If this is a Medicare certified i			ication date			132.00
in column 1 and termination date,	if applicable, in colum	ın 2.				100.00
33.00 Removed and reserved 34.00 If this is an organ procurement of	rappization (OPO) optor	the ODO number	in column 1			133.00 134.00
and termination date, if applicat		the opo number				134.00
All Providers						
40.00 Are there any related organization				N		140.00
chapter 10? Enter "Y" for yes or				5		
are claimed, enter in column 2 th		<u>er. (see instruc</u> 2.00		3.00		-
If this facility is part of a cha			ugh 143 the		s of the home	
office and enter the home office						
41.00Name:	Contractor's Name:		Contracto	or's Number:		141.00
42.00 Street:	PO Box:		7. 0. 1			142.00
43. 00 Ci ty:	State:		Zip Code:	:		143.00
					1.00	-
44.00 Are provider based physicians' co	osts included in Workshee	et A?			Y	144.00
				1.00	2.00	4.4= 0
45.00 If costs for renal services are a inpatient services only? Enter "\						145.00
no, does the dialysis facility in						
period? Enter "Y" for yes or "N			r opor tring			
46.00 Has the cost allocation methodol of				N		146.00
Enter "Y" for yes or "N" for no i		o. 15-2, chapter	40, §4020) I1	F		
yes, enter the approval date (mm/	/dd/yyyy) in column 2.					_
					1.00	_
					1 00	
47.00 Was there a change in the statist	tical basis? Enter "Y" fo	or yes or "N" for	no.		1.00 N	147.00
48.00 Was there a change in the order of	of allocation? Enter "Y"	for yes or "N" f	or no.		N N	148.00
	of allocation? Enter "Y"	for yes or "N" f <u>PEnter "Y" for y</u>	or no. es or "N" for		N N N	148.00
48.00 Was there a change in the order of	of allocation? Enter "Y"	for yes or "N" f PEnter "Y" for y Part A	or no. es or "N" for Part B	Title V	N N Title XIX	148.00
48.00Was there a change in the order of 49.00Was there a change to the simplif	of allocation? Enter "Y" fied cost finding method?	for yes or "N" f P Enter "Y" for y Part A 1.00	or no. es or "N" for Part B 2.00	Title V 3.00	N N Title XIX 4.00	148.00
48.00 Was there a change in the order of	of allocation? Enter "Y" fied cost finding method? vider that qualifies for	for yes or "N" f P Enter "Y" for y Part A 1.00 an exemption fro	or no. es or "N" for Part B 2.00 m the applic	Title V 3.00 ation of the lo	N N Title XIX 4.00 Wer of costs	148.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a pro- or charges? Enter "Y" for yes or 55.00 Hospital	of allocation? Enter "Y" fied cost finding method? vider that qualifies for	for yes or "N" f <u>Penter "Y" for y</u> <u>Part A</u> <u>1.00</u> an exemption fro <u>Donent for Part A</u> <u>N</u>	or no. es or "N" for Part B 2.00 om the applic. and Part B. N	Title V 3.00 ation of the low (See 42 CFR §4 N	N N Title XIX 4.00 wer of costs 13.13) N	148.00 149.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a pro- or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF	of allocation? Enter "Y" fied cost finding method? vider that qualifies for	for yes or "N" f P Enter "Y" for y Part A 1.00 an exemption from N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N	Title V 3.00 ation of the loo (See 42 CFR §4 N N	N N Title XIX 4.00 wer of costs 13.13) N N	148.00 149.00 155.00 155.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a provor or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF	of allocation? Enter "Y" fied cost finding method? vider that qualifies for	for yes or "N" f <u>Penter "Y" for y</u> <u>Part A</u> <u>1.00</u> an exemption fro <u>Donent for Part A</u> <u>N</u>	or no. es or "N" for Part B 2.00 om the applic. and Part B. N	Title V 3.00 ation of the low (See 42 CFR §4 N	N N Title XIX 4.00 wer of costs 13.13) N	148.00 149.00 155.00 156.00 157.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER	of allocation? Enter "Y" fied cost finding method? vider that qualifies for	for yes or "N" f P Enter "Y" for y Part A 1.00 an exemption from ponent for Part A N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N	Title V 3.00 ation of the loo (See 42 CFR §4 N N N N	N N Title XIX 4.00 wer of costs 13.13) N N N	148.00 149.00 155.00 156.00 157.00 158.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF	of allocation? Enter "Y" fied cost finding method? vider that qualifies for	for yes or "N" f P Enter "Y" for y Part A 1.00 an exemption from N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N	Title V 3.00 ation of the loo (See 42 CFR §4 N N	N N Title XIX 4.00 wer of costs 13.13) N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER	of allocation? Enter "Y" fied cost finding method? vider that qualifies for	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N	N N Title XIX 4.00 wer of costs 13.13) N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY	of allocation? Enter "Y" fied cost finding method? vider that qualifies for	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC	of allocation? Enter "Y" fied cost finding method? vider that qualifies for	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N	N N Title XIX 4.00 wer of costs 13.13) N N N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov- or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from ponent for Part A N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N N	N N N Title XIX 4.00 Wer of costs 13.13) N N N N N N N N 1.00	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov- or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from ponent for Part A N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov- or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N State Zi	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N FTE/Campus	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov- or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has	for yes or "N" f <u>Penter "Y" for y</u> <u>Part A</u> <u>1.00</u> an exemption from <u>N</u> <u>N</u> <u>N</u> <u>N</u> <u>N</u> <u>N</u> <u>N</u> <u>N</u>	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N State Zi	Title V 3.00 ation of the lo (See 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N S T.00	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 161.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov- or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N State Zi	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N S T.00	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 165.00
 48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a provor or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N State Zi	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N S T.00	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 161.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a provor or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N State Zi	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N S T.00	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 165.00
 48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N State Zi	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N S T.00	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 165.00
<pre>48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,</pre>	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N State Zi	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N S T.00	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 165.00
<pre>48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 SNF 50.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in</pre>	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N State Zi	Title V 3.00 ation of the lov (See 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 161.00
 48.00 Was there a change in the order of 49.00 Was there a change to the simplified or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has 0	for yes or "N" f 2 Enter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N N N N N	Title V 3.00 ation of the low (See 42 CFR §4 N <td>N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N S T.00</td> <td>148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 161.00</td>	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N S T.00	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 161.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a prov- or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has Name 0 1T) incentive in the Amer	for yes or "N" f 2 Enter "Y" for y Part A 1.00 an exemption from onent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N N N N N	Title V 3.00 ation of the low (See 42 CFR §4 N <td>N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N</td> <td>148.00 149.00 155.00 156.00 157.00 159.00 160.00 161.00 165.00 165.00 165.00</td>	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N	148.00 149.00 155.00 156.00 157.00 159.00 160.00 161.00 165.00 165.00 165.00
 48.00 Was there a change in the order of 49.00 Was there a change to the simplified or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	of allocation? Enter "Y" Fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has Name 0 1) incentive in the Amerer arr under §1886(n)? Enter	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N N N N N	Title V 3.00 ation of the loo (See 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N	147.00 148.00 149.00 149.00 155.00 156.00 157.00 158.00 159.00 161.00 161.00 165.00 161.00 165.00
 48.00 Was there a change in the order of 49.00 Was there a change to the simplified or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line for the reasonable cost incurred for the fo	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has Name 0 1T) incentive in the Amer er under §1886(n)? Enter 105 is "Y") and is a mear HIT assets (see instruct	for yes or "N" f Penter "Y" for y Part A 1.00 an exemption from conent for Part A N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N N N N N	Title V 3.00 ation of the loo (See 42 CFR §4 N N N N N P Code CBSA 3.00 4.00 Ation of the loo N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N	148.00 149.00 155.00 155.00 157.00 158.00 159.00 161.00 165.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplif Does this facility contain a provor or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line for the second	of allocation? Enter "Y" fied cost finding method? vider that qualifies for "N" for no for each comp campus hospital that has Name 0 1) incentive in the Amer er under §1886(n)? Enter 105 is "Y") and is a mear HIT assets (see instruct not a meaningful user, c	for yes or "N" f Part A Part A 1.00 an exemption from N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the applic. and Part B. N N N N N N N N N N N N N	Title V 3.00 ation of the loo (See 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N	148.00 149.00 155.00 155.00 157.00 157.00 159.00 160.00 161.00 165.00

Health Financial Systems	HAMI LTON CENT	ER, INC.	In Lieu of Form CMS-2			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	ENTIFICATION DATA		Period:	Worksheet S-2		
			From 07/01/2019		and the set	
			To 06/30/2020	Date/Time Pre		
				11/25/2020 9:	<u>17 am</u>	
			Begi nni ng	Endi ng		
			1.00	2.00		
170.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)			170.00			
			1.00	2.00	1	
171.00 If line 167 is "Y", does this provider	have any days for ind	ividuals enrolled in	N	C	171.00	
section 1876 Medicare cost plans repor	ted on Wkst. S-3, Pt.	I, line 2, col. 6? Enter				
"Y" for yes and "N" for no in column 1.	lf column 1 is ves.	enter the number of sectio	n			
1876 Medicare days in column 2. (see in						
	13 (1 00 (1 0113)			1	1	

	Financial Systems HAMILTON CENT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-4009	Peri od:	u of Form CMS- Worksheet S-2	
00111				From 07/01/2019 To 06/30/2020	Part II	epare
				Y/N	Date	
		fam all NO a		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	TOT ALL NO TO	esponses. En	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	bogi ppi pg_of	the cost	N		1 1.
. 00	reporting period? If yes, enter the date of the change in co					'.
			Y/N	Date	V/I	
00	Use the manifold termineted month direction in the Medicense D		1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members or of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi	ified Public	N	A	12/31/2020	4
00	Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled,	N	A	12/31/2020	4
00	Are the cost report total expenses and total revenues differ		N			5
	those on the filed financial statements? If yes, submit reco	onciliation.		Y/N	Legal Oper.	
				1.00	2.00	-
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is t	he provider i	is N		6
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved a		d during the	N N		7
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved of	araduate medi	cal education	n N		9
0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	S.		N		10
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	Ν		11
					Y/N	
	Pad Dahta				1.00	
2.00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection provider's bad debt collection provider.	, see instruc olicy change	tions. during this (cost reporting	N N	12 13
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement	nts waived? I	fyes, see in	nstructions.	Ν	14
5.00	Did total beds available change from the prior cost reporti	<u>v</u> .			N t B	15
		Y/N	t A Date	Y/N	тв Date	
		1.00	2.00	3.00	4.00	
-	PS&R Data		00 (1 1 (00 00		00/14/0000	
b. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	Y	09/14/2020	Y Y	09/14/2020	16
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions)	Ν		N		17
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19

SPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 15-4009	Period: From 07/01/2019 To 06/30/2020		repared	
	Desc	cription	Y/N	Y/N		
		0	1.00	3.00		
00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.	
	Y/N	Date	Y/N	Date	_	
	1.00	2.00	3.00	4.00	0.1	
00 Was the cost report prepared only using the provider's records? If yes, see instructions.	S N		N		21.	
				1.00		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY	(EXCEPT CHILDRENS	6 HOSPITALS)				
Capital Related Cost 00 Have assets been relifed for Medicare purposes? If yes		26			22.	
.00 Have changes occurred in the Medicare depreciation exp			iring the cost		22.	
reporting period? If yes, see instructions.	ense due to appra		aring the cost		23.	
.00 Were new leases and/or amendments to existing leases e If yes, see instructions	ntered into durir	ng this cost i	reporting period?		24.	
.00 Have there been new capitalized leases entered into du	iring the cost rep	porting period	d?lfyes, see		25.	
instructions. .00 Were assets subject to Sec. 2314 of DEFRA acquired duri	ng the cost repor	cting period?	lfves see		26.	
instructions.	ing the cost repor	ang partou?	300, 300			
.00 Has the provider's capitalization policy changed durin copy.	g the cost report	ting period?	fyes, submit		27.	
Interest Expense00Were new Loans, mortgage agreements or letters of cred	lit entered into a	during the cos	st reporting		28.	
period? If yes, see instructions.Did the provider have a funded depreciation account an		(Debt Service	Reserve Fund)		29.	
treated as a funded depreciation account? If yes, see 00 Has existing debt been replaced prior to its scheduled		ew debt? If ye	es, see		30.	
instructions.Has debt been recalled before scheduled maturity witho instructions.	out issuance of ne	ew debt? If ye	es, see		31.	
Purchased Services 00 Have changes or new agreements occurred in patient car		abod through	antractual		32.	
arrangements with suppliers of services? If yes, see i	nstructions.	-				
00 If line 32 is yes, were the requirements of Sec. 2135. no, see instructions.	2 applied pertair	ning to compe ⁻	titive bidding? If		33.	
Provi der-Based Physi ci ans						
.00 Are services furnished at the provider facility under If yes, see instructions.	an arrangement wi	th provider-	based physicians?		34.	
 b) 10 10 10 10 10 10 10 10 10 10 10 10 10		ments with the	e provi der-based		35.	
			Y/N	Date		
llama Offica Casta			1.00	2.00		
Home Office Costs 00 Were home office costs claimed on the cost report?					36.	
00 If line 36 is yes, has a home office cost statement be If yes, see instructions.	en prepared by th	ne home office	9?		37.	
00 If line 36 is yes, was the fiscal year end of the hom the provider? If yes, enter in column 2 the fiscal yea			of		38.	
00 If line 36 is yes, did the provider render services to see instructions.			es,		39.	
00 If line 36 is yes, did the provider render services to instructions.	the home office?	? If yes, see	e		40.	
		1.00	2	00		
Cost Report Preparer Contact Information			2.			
00 Enter the first name, last name and the title/position			SEVERS		41.	
held by the cost report preparer in columns 1, 2, and			1			
	BLUE & CO LL	С			42.	

Health Financial S	Systems	HAMI LTON CE	NTER, INC.		In Lie	u of Form CMS-:	2552-10
HOSPI TAL AND HOSP	TAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-4009	Period:	Worksheet S-2	2
					From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 9:	pared: 17 am
				3.00			
Cost Report	Preparer Contact Information						
41.00 Enter the f	irst name, last name and the	ti tl e/posi ti on	MANAGER				41.00
held by the	e cost report preparer in colu	mns 1, 2, and 3,					
respecti vel	у.						
42.00 Enter the e	mployer/company name of the c	ost report					42.00
preparer.							
43.00 Enter the t	elephone number and email add	ress of the cost					43.00
report prep	arer in columns 1 and 2, resp	ecti vel y.					

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HAMILTON CEN	Provider C	N. 15-4000	Period:	u of Form CMS-2 Worksheet S-3	
HUSPI I	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-4009	From 07/01/2019	Part I	
					To 06/30/2020	Date/Time Pre	
						11/25/2020 9:	17 am
						I/P Days / O/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	component	Line Number	NO. OF DEUS	Avai I abl e	OAT HOURS	intro v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	16			0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		16	5, 85	56 0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		17	E 01		0	13.00
14.00 15.00	Total (see instructions)		16	5, 85	56 0.00	0	14.00 15.00
15.00	CAH visits SUBPROVIDER - IPF					0	16.00
17.00	SUBPROVIDER - IRF						17.00
17.00	SUBPROVI DER						17.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	25.00
26.00	RURAL HEALTH CLINIC					-	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		16				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HAMILTON CENT AL DATA	Provider CC	CN: 15-4009	Period: From 07/01/2019		1
					To 06/30/2020	Date/Time Pre 11/25/2020 9:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		(00	7.00	Patients	& Residents	Payrol I	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	<u>6.00</u> 1,119	7.00	8.00 5,5	9.00	10.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	1, 11,	010	0,0			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	0	505				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF	1 110	0 840	E E .	0		6.00
	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 119	840	5, 51			7.00
8.00							8.00
9.00 10.00	CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T						9.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1, 119	840	5, 51	0.00	487.00	•
15.00	CAH visits	0	0		0		15.OC
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00 24.10	HOSPICE				0		24.00
24.10	HOSPICE (non-distinct part) CMHC - CMHC	0	0		0 0.00	0.00	•
26.00	RURAL HEALTH CLINIC	0	0		0.00	0.00	25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
27.00	Total (sum of lines 14-26)	0	0		0.00		
28.00	Observation Bed Days		0		0		28.00
29.00	Ambul ance Trips	0					29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	0		0		32.00
32.01	Total ancillary labor & delivery room				0		32.01
	outpatient days (see instructions)	_					0.0
33.00	LTCH non-covered days	0					33.00 33.01
33.01	LTCH site neutral days and discharges	0	I				I

	_Financial Systems "AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HAMILTON CENT AL DATA	Provider C	CN: 15-4009	In Lie Period:	Worksheet S-3	
					From 07/01/2019 To 06/30/2020		
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider		0		0 68 0 0	798	1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 24.10	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	0.00	0	1	55 135	798	15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 24.10
24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0.00 0.00 0.00					24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

RECLASSI FI CATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-4009 Period: Provider CCN: 15-4009 Period: Provider CCN: 15-4009 Period: Provider CCN: 15-4009 Period: Provider CN: 15-4009 Worksheet A Cost Center Description Salaries Other Total (col. 1 + col. 2) Reclassified ions (See Reclassified rol 3000 Trial Balance (col. 3 + - col. 4) 1.00 2.00 3.00 4.00 5.00 Reclassified rol 3.00 Reclassified rol 3.00 1.00 2.00 8.00 2.078,465 1.00 0.00 000000 OTHER CAP REL COSTS 6.137,078 8.607,222 7.0 1.245,774 0 8.9,330 0 8.9,330 8.9,330 7.00 1.245,774 0 1.00 1.80,	Health Financial Systems	HAMILTON CENT	ER, INC.		In Lieu	u of Form CMS-2	2552-10
Cost Center Description Sal aries Other Total (col. 1 + col. 2) Reclassified risk (see A-6) Reclassified rol 3.00 Reclassified rol 4.00 00100 (CAP REL COSTS-BLDG & FIXT 0.00 00100 (EMP LOYE BENFEITS DEPARTMENT 0.00 00300 OTHER CAP REL COSTS 0.00 00300 OTHER CAP REL COSTS 0.00 0000 (EMP LOYE BENFEITS DEPARTMENT 0.00 00000 (EMP LOYE BENFEITS DEPARTMENT 0.00 0000 OPERATION OF PLANT 0.00 00900 HUUSEKEPI NG 0.00 00900 HUUSEKEPI NG 0.00 00900 HUUSEKEPI NG 0.00 0000 OPERATION OF LANT 0.00 0000 OPERATION OF LANT 0.00 0000 OPERATION OF DLANT 0.00 0.	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CO			Worksheet A	
Cost Center Description Sal aries Other Total (col. 2) Reclass fied assified ions (See A-6) Icol assified trial Bal ance (col. 3 + - col. 4) 1.00 2.00 3.00 4.00 5.00 00100 (CAP REL COSTS CENTERS 0 0 2.078, 465 2.078, 465 2.078, 465 1.00 0.00 0000 Other CAP REL COSTS 661, 274 584, 500 1.245, 774 0 1.265, 774 4.00 0.00 0000 Other CAP REL COSTS 6, 137, 078 -8, 607, 222 -2, 470, 144 12, 770, 600 10.300, 456, 50.00 0.00 0000 ODM HUSESEREPT NG 176, 750 92, 499 269, 249 0 269, 249, 90.00 14.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 16.00 16.00 15.00 01500 PHARMACY 0 0 0 0 0 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 0 <						Data /Tima Dra	norod.
Cost Center Description Sal aries Other Total (col. 1) + col. 2) Reclassified risk Balance (col. 3) +- col. 4) 1.00 2.00 3.00 4.00 5.00 00100 (CAP REL COSTS-BLDG & FIXT 0.00 0 0 2,078,465 2,078,465 1.00 0.00 00300 OTHER CAP REL COSTS- 0 0 0 0 2,078,465 1.00 5.00 00300 OTHER CAP REL COSTS 0 0 0 0 3.00 6 0.00 0,000 (MOD CMPLOYER BENKPI TS DEPARTMENT 6.137,078 6.607,222 -2,470,144 12,770,600 10,300,456 5.00 7.00 0.00 (ODO HOUSEKEPI NG 0.00 (ODO HOUSEKEPI NG 176,750 92,499 269,249 0 269,249,90.00 14.00 16.00 0.00 (ODO HOUSEKEPI NG 176,750 92,499 0 240,00 0 0 0 0 0 0 18.00 18.00 16.00 0.00 (ODO MEDI CAL RECORDS & LIBRARY 196,740 228,163 424,903 0 424,903 16.00 0 0 0					0 06/30/2020		
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat		
Image: Constraint of the second sec							
GENERAL SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 00100 CAP REL COSTS-BLDG & FIXT 0				,	A-6)	(col. 3 +-	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 0							
1.00 00100 CAP REL COSTS-BLDG & FIXT 0 0 2.078,465 2.078,465 2.078,465 1.00 3.00 00300 OTHER CAP REL COSTS 0 <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>		1.00	2.00	3.00	4.00	5.00	
3.00 00300 OTHER CAP REL COSTS 0 1 , 245, 774 0 1 , 245, 774 0 10, 300, 456 5.00 7.00 00700 0 0 0 0 889, 330 7.00 889, 330 7.00 9.00 0 0 0 0 0 0 14.00 0 0 0 0 0 14.00 15.00 0 0 0 0 0 0 0 16.00 15.00 0 0 0 0 0 0 16.00 16.00 0 0 0 0 0 0 0 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 23.00 0 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 661,274 584,500 1,245,774 0 1,245,774 4.00 5. 00 00500 ADMI NI STRATI VE & GENERAL 6,137,078 -8,607,222 -2,470,144 12,770,600 10,300,456 5.00 9. 00 00900 HOUSEKEEPI NG 176,750 92,499 269,249 0 269,249 9.00 14. 00 01400 CENTRAL SERVI CES & SUPPLY 0 0 0 0 14.00 15.00 01500 PHARMACY 0 0 0 0 16.00 16.00 01600 MEDI CAL RECORDS & LI BRARY 196,740 228,163 424,903 0 424,903 16.00 18.00 01850 OTHER GENERAL SERVI CE (SPECI FY) 0 0 0 0 0 23.00 23.00 03000 ADULTS & PEDI ATRICS 1,479,205 4,277,890 5,757,095 -1,886,397 3,870,698 30.00 40.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td></td> <td>0</td> <td>(</td> <td>2, 078, 465</td> <td>2, 078, 465</td> <td></td>			0	(2, 078, 465	2, 078, 465	
5.00 00500 ADMI NI STRATI VE & GENERAL 6, 137, 078 -8, 607, 222 -2, 470, 144 12, 770, 600 10, 300, 456 5.00 7.00 00700 OPERATI ON OF PLANT 581, 754 307, 576 889, 330 0 889, 330 7.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 <			0	(0 0	0	3.00
7.00 00700 OPERATION OF PLANT 581,754 307,576 889,330 0 889,330 7.00 9.00 00900 HUJSEKEEPING 176,750 92,499 269,249 0 269,249 9.00 14.00 ONTORAL SERVICES & SUPPLY 0 0 0 0 0 0 0 0 0 14.00 15.00 01500 PHARMACY 0 0 0 0 0 0 15.00 16.00 01600 MEDI CAL_RECORDS & LIBRARY 196,740 228,163 424,903 0 424,903 16.00 18.00 01500 PHARMED ED PRGM-(SPECIFY) 0 0 0 0 23.00 0.0300 ADULTS & PEDIATRICS 1,479,205 4,277,890 5,757,095 -1,886,397 3,870,698 30.00 400 05400 RADI LLARY SERVICE COST CENTERS		661, 274	584, 500			1, 245, 774	4.00
9.00 00900 HOUSEKEEPING 176,750 92,499 269,249 0 269,249 9.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 14.00 15.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 14.00 15.00 01600 MEDICAL RECORDS & LIBRARY 196,740 228,163 424,903 0 424,903 16.00 18.00 01850 01480 GENERAL SERVICE (SPECIFY) 0 0 0 0 0 18.00 0.0300 PARAMED ED PRGM-(SPECI FY) 0 0 0 0 0 23.00 INPATI ENT ROUTINE SERVICE COST CENTERS 1,479,205 4,277,890 5,757,095 -1,886,397 3,870,698 30.00 60.00 06000 LABORATORY 0 0 0 0 60,434 0 60,434 60,0434 60,0434 60,0434 60,0434 60,0434 60,0434 60,0434 60,0434 60,0434 60,0434 60,0434 60,0434 60,0434 <td< td=""><td></td><td>6, 137, 078</td><td>-8, 607, 222</td><td>-2, 470, 144</td><td>12, 770, 600</td><td>10, 300, 456</td><td>5.00</td></td<>		6, 137, 078	-8, 607, 222	-2, 470, 144	12, 770, 600	10, 300, 456	5.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 0 0 0 0 0 0 14.00 15.00 01500 PHARMACY 0 0 0 0 0 0 0 0 0 0 15.00 16.00 01500 PHARMACY 196,740 228,163 424,903 0 424,903 16.00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 0 0 0 0 18.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 0 0 0 23.00 30.00 03000 ADULTS & PEDI ATRICS 1,479,205 4,277,890 5,757,095 -1,886,397 3,870,698 30.00 54.00 05400 RADI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 64.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		581, 754	307, 576	889, 330	0 0	889, 330	
15.00 01500 PHARMACY 0 0 0 0 0 15.00 16.00 01600 MEDI CAL RECORDS & LI BRARY 196, 740 228, 163 424, 903 0 424, 903 16.00 18.00 02300 PARAMED ED PROM-(SPECI FY) 0 0 0 0 0 23.00 02300 PARAMED ED PROM-(SPECI FY) 0 0 0 0 0 23.00 03000 ADULTS & PEDI ATRI CS 1,479,205 4,277,890 5,757,095 -1,886,397 3,870,698 30.00 60.00 06000 LABORATORY 0		176, 750	92, 499	269, 249	0	269, 249	9.00
16.00 01600 MEDI CAL RECORDS & LI BRARY 196,740 228,163 424,903 0 424,903 16.00 18.00 01850 0THER GENERAL SERVICE (SPECIFY) 0		0	0	(0 0	0	
18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 0 0 0 0 23.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 0 0 23.00 INPATI ENT ROUTINE SERVICE COST CENTERS 1.479,205 4.277,890 5.757,095 -1,886,397 3.870,698 30.00 ANCILLARY SERVICE COST CENTERS 1.479,205 4.277,890 5.757,095 -1,886,397 3.870,698 30.00 60.00 05400 RADIOLOGY - DI AGNOSTI C 0 0 0 0 54.00 60.00 06000 LABORATORY 0 60,434 60,434 0 60,434 60.00 69.00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 149,337 149,337 149,337 73.00 73.00 DUTPATIENT SERVICE COST CENTERS 0 0 0 0 90.00 90.00 <		0	0	(0 0	0	15.00
23.00 02300 PARAMED ED PRGM-(SPECIFY) 0		196, 740	228, 163	424, 903	3 0	424, 903	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1,479,205 4,277,890 5,757,095 -1,886,397 3,870,698 30.00 30.00 ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 0 0 0 0 54.00 06000 LABORATORY 0		0	0	(0	-	
30. 00 03000 ADULTS & PEDIATRICS 1,479,205 4,277,890 5,757,095 -1,886,397 3,870,698 30. 00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 54. 00 54. 00 06000 LABORATORY 0 0 0 0 54. 00 60. 00 06000 LABORATORY 0 60,434 60,434 0 60,434 60,00 69. 00 06090 ELECTROCARDI OLOGY 0 0 0 0 69. 00 70. 00 60. 00 69. 00 70. 00 0 0 0 69. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 71. 00 70. 00 71. 00 70. 00 72. 00 73. 00 73. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 749, 337 749, 337 73. 00 749, 337 73. 00 73. 00 90. 00 99. 00 99. 00 99. 00 99. 00 99. 00 <		0	0	(0	0	23.00
ANCI LLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 <td></td> <td>· · · · · · · · · · · · · · · · · · ·</td> <td></td> <td></td> <td>1</td> <td></td> <td></td>		· · · · · · · · · · · · · · · · · · ·			1		
54.00 05400 RADI OLOGY - DI AGNOSTI C 0		1, 479, 205	4, 277, 890	5, 757, 095	-1, 886, 397	3, 870, 698	30.00
60.00 06000 LABORATORY 0 60,434 60,434 0 60,434 60,434 60,00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 149,337 149,337 0 149,337 73.00 0UTPATI ENT SERVICE COST CENTERS 0 10,131,007 13,557,029 23,688,036 -18,681,922 5,006,114 90.00 90.00 09500 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 90.00 99.00 09900 CMHC 0 0 0 0 99.00 99.00 SPECI AL PURPOSE COST CENTERS 0 0 0 0 0 99.00		r			1		
69.00 06900 ELECTROCARDI OLOGY 0		0	0		-	-	
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 149,337 149,337 0 149,337 73.00 OUTPATIENT SERVICE COST CENTERS 0 149,337 149,337 0 149,337 73.00 90.00 09000 CLINIC 0 10,131,007 13,557,029 23,688,036 -18,681,922 5,006,114 90.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 0 0 0 0 99.00		0	60, 434	60, 434	0	60, 434	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 149, 337 149, 337 0 149, 337 73.00 001PATI ENT SERVI CE COST CENTERS 0 10, 131, 007 13, 557, 029 23, 688, 036 -18, 681, 922 5, 006, 114 90.00 90.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98.00 99.00 0 0 0 0 99.00 99.00 99.00 99.00 0 0 0 0 99.00 0 99.00 99.00 99.00 99.00 0 0 0 0 99.00		0	0	(0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 73.00 72.00 73.00 72.00 73.00 149,337 149,337 0 149,337 73.00		0	0	(0	0	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 149, 337 149, 337 0 149, 337 73. 00 0UTPATI ENT SERVICE COST CENTERS 0 10, 131, 007 13, 557, 029 23, 688, 036 -18, 681, 922 5, 006, 114 90. 00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 990.00 0 98. 00 99.00 99.00 0 0 0 99.00 99.00 0 99.00 99.00 99.00 0 0 0 99.00 99.00 0 99.00 0 0 0 99.00 0 99.00 0 99.00 0 99.00 0 99.00 0 99.00 0 0 0 0 99.00 0 99.00 0 0 0 0 99.00 99.00 99.00 99.00 99.00 99.00 0 0 0 0 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 0 0 0 0 0 99.0		0	0	(0	0	
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC 10, 131, 007 13, 557, 029 23, 688, 036 -18, 681, 922 5, 006, 114 90. 00 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 0 99. 00 SPECI AL PURPOSE COST CENTERS 0 0 0 0 99. 00		0	0	0	0 0	-	
90. 00 09000 CLINIC 10, 131, 007 13, 557, 029 23, 688, 036 -18, 681, 922 5, 006, 114 90. 00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 98. 00 99.00 09000 CMHC 0 0 0 99. 00 99.00 99.00 0 0 0 0 99. 00 99.00 99.00 0 0 0 0 99.00 99.00 99.00 0 0 0 0 99.00 99.00 99.00 0 0 0 0 99.00		0	149, 337	149, 337	0	149, 337	73.00
OTHER REI MBURSABLE COST CENTERS 98.00 998.00 0 0 0 0 98.00 98.00 99.00 0 0 0 0 0 98.00 99.00 99.00 0 0 0 0 0 99.00							
98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 98.00 98.00 99.00 0 0 0 0 0 0 0 99.00		10, 131, 007	13, 557, 029	23, 688, 036	-18, 681, 922	5, 006, 114	90.00
99.00 09900 CMHC 0 0 0 0 99.00 SPECIAL PURPOSE COST CENTERS							
SPECIAL PURPOSE COST CENTERS						-	
		0	0	(0	0	99.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 19, 363, 808 10, 650, 206 30, 014, 014 -5, 719, 254 24, 294, 760 118.00					1		
		19, 363, 808	10, 650, 206	30, 014, 014	-5, 719, 254	24, 294, 760	118.00
NONREI MBURSABLE COST CENTERS							
194. 00 07950 OTHER NONRELMB COST CENTER 6, 947, 297 8, 932, 616 15, 879, 913 5, 719, 254 21, 599, 167 194. 00							
200.00 TOTAL (SUM OF LINES 118 through 199) 26,311,105 19,582,822 45,893,927 0 45,893,927 200.00	200.00 101AL (SUM OF LINES 118 through 199)	26, 311, 105	19, 582, 822	45, 893, 927	' O	45, 893, 927	200.00

Health Financial Systems	HAMI LTON CEN	HAMILTON CENTER, INC.			In Lieu of Form CMS-2552-10		
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANG		Provider C	CN: 15-4009	Period: From 07/01/2019 To 06/30/2020	Worksheet A Date/Time Prepared: 11/25/2020 9:17 am		
Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation					
	6.00	7.00					
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT	-37, 423	2, 041, 042			1.00		
3.00 00300 OTHER CAP REL COSTS	0	0			3.00		
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-19	1, 245, 755			4.00		
5. 00 00500 ADMINI STRATI VE & GENERAL	-2, 637, 370	7, 663, 086			5.00		
7.00 00700 OPERATION OF PLANT	-145	889, 185			7.00		
9.00 00900 HOUSEKEEPI NG	0	269, 249			9.00		
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0			14.00		
15.00 01500 PHARMACY	0	0			15.00		
16.00 01600 MEDICAL RECORDS & LIBRARY	-20, 884	404,019			16.00		
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0			18.00		
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0			23.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	-1, 363, 853	2, 506, 845			30.00		
ANCI LLARY SERVI CE COST CENTERS	, ,	,					
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0			54.00		
60. 00 06000 LABORATORY	0	60, 434			60.00		
69. 00 06900 ELECTROCARDI OLOGY	0	0			69.00		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			70.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	s o	0			71.00		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0			72.00		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	149, 337			73.00		
OUTPATIENT SERVICE COST CENTERS		117,007			, 0. 00		
90. 00 09000 CLINIC	-98, 602	4, 907, 512			90.00		
OTHER REIMBURSABLE COST CENTERS	70,002	1, 707, 012			/0.00		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			98.00		
99. 00 09900 CMHC	0	0			99.00		
SPECIAL PURPOSE COST CENTERS	0	0			77.00		
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) -4, 158, 296	20, 136, 464			118.00		
NONREI MBURSABLE COST CENTERS		20, 100, 404			110.00		
194. 00/07950 OTHER NONRELMB COST CENTER	0	21, 599, 167			194.00		
200.00 TOTAL (SUM OF LINES 118 through 199		41, 735, 631			200.00		
	-4, 150, 290	41,755,051	l		1200.00		

Heal th	Financial Systems		HAMILTON CEN	TER, INC.		In Lieu	J of Form CMS-2552-1	10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-4009	Peri od:	Worksheet A-6	_
						From 07/01/2019 To 06/30/2020	Date/Time Prepared	ŀ
					1		11/25/2020 9:17 am	1
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - DEPRECIATION EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 935, 123			1.0)0
2.00		0.00	0	0			2.0)0
3.00		0.00	0	0			3.0)0
	TOTALS		0	1, 935, 123				
	B - OVERHEAD ALLOCATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11, 824, 608			1.0)0
2.00		0.00	0	0			2.0)0
3.00		0.00	0	0			3.0)0
	TOTALS			11, 824, 608				
	C - PSYCHIATRY ALLOCATION	· · · · ·						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 362, 541			1.0	00
2.00		0.00	0	0			2.0	00
3.00		0.00	0	0			3.0	00
	TOTALS			2, 362, 541				
	D – MRO EXPENSE							
1.00	OTHER NONREIMB COST CENTER	194.00	4, 676, 997	5, 360, 007			1.0	00
	TOTALS		4, 676, 997	5, 360, 007	1			
	E - INSURANCE RECLASS							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	143, 342			1.0	00
	TOTALS			143, 342				
500.00	Grand Total: Increases		4, 676, 997	21, 625, 621	1		500. C	00
	,	· · ·					1	

Heal th	Financial Systems		HAMILTON CENT	ER, INC.		In Lieu	u of Form CMS-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 15-4009	Peri od:	Worksheet A-6
						From 07/01/2019 To 06/30/2020	Date/Time Prepared: 11/25/2020 9:17 am
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	· .	
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 273, 207	r	9	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	48, 749		0	2.00
3.00		90.00	0	61 <u>3, 1</u> 67	·	0	3.00
	TOTALS		0	1, 935, 123			
	B - OVERHEAD ALLOCATION						
1.00	ADULTS & PEDIATRICS	30.00	0	1, 682, 665))	0	1.00
2.00	CLINIC	90.00	0	6, 411, 521		0	2.00
3.00	OTHER NONREIMB COST CENTER	194.00	0	3, 730, 422		0	3.00
	TOTALS		0	11, 824, 608	8		
	C - PSYCHIATRY ALLOCATION						
1.00	ADULTS & PEDIATRICS	30.00	0	154, 983	6	0	1.00
2.00	CLINIC	90.00	0	1, 620, 230)	0	2.00
3.00	OTHER NONREIMB COST CENTER	194.00	0	587, 328	8	0	3.00
	TOTALS		0	2, 362, 541			
	D – MRO EXPENSE						
1.00		90.00	4, 676, 997	5, 360, 007	r	0	1.00
	TOTALS		4, 676, 997	5, 360, 007	r		
	E - INSURANCE RECLASS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	143, 342		9	1.00
	TOTALS		o	143, 342			
500.00	Grand Total: Decreases		4, 676, 997	21, 625, 621			500.00

Health Financial Systems	HAMILTON CENTER, INC.			In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-4009	Period: From 07/01/2019 To 06/30/2020			
			Acqui si ti ons			1172372020 9.	
	Begi nni ng	Purchases	Donati on		Total	Disposals and	
	Bal ances	i ui ondooo	bonation		rotai	Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00 Land	2, 944, 892	165, 371		0	165, 371	0	1.00
2.00 Land Improvements	0	0		0	0	0	2.00
3.00 Buildings and Fixtures	22, 504, 542	823, 230		0	823, 230	0	3.00
4.00 Building Improvements	53, 856	513, 793		0	513, 793	0	4.00
5.00 Fixed Equipment	6, 248, 107	343, 000		0	343, 000	0	5.00
6.00 Movable Equipment	2, 681, 704	320, 467		0	320, 467	0	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	34, 433, 101	2, 165, 861	1	0	2, 165, 861	0	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	34, 433, 101	2, 165, 861		0	2, 165, 861	0	10.00
	Endi ng	Fully					
	Bal ance	Depreciated					
		Assets					
	6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00 Land	3, 110, 263	0					1.00
2.00 Land Improvements	0	0					2.00
3.00 Buildings and Fixtures	23, 327, 772	0					3.00
4.00 Building Improvements	567, 649	0					4.00
5.00 Fixed Equipment	6, 591, 107	0					5.00
6.00 Movable Equipment	3, 002, 171	0					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	36, 598, 962	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	36, 598, 962	0					10.00

Health Financial Systems	HAMILTON CEN	NTER, INC.		In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-4009		Period: From 07/01/2019	Worksheet A-7	
					Date/Time Pre 11/25/2020 9:	epared: 17 am
		SL	IMMARY OF CAP	I TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see instructions)	instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	<u>WN 2, LINES 1 a</u>	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
3.00 Total (sum of lines 1-2)	0	0		0 0	0	3.00
	SUMMARY O	F CAPI TAL				
Cost Center Description	Other	Total (1)	1			
	Capital - Relat	(sum of cols.				
	ed Costs (see	9 through 14)				
	instructions)	_				
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00 CAP REL COSTS-BLDG & FIXT	0	0				1.00
3.00 Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	HAMILTON CEN	NTER, INC.		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2019 To 06/30/2020		pared:
	COMF	PUTATION OF RA	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 -	Ratio (see instructions)	Insurance	
	1.00	2.00	<u>col.2)</u> 3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2100	0100		0100	
1.00 CAP REL COSTS-BLDG & FIXT	36, 598, 962	0	36, 598, 96	2 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	36, 598, 962		36, 598, 96	2 1.000000	0	3.00
	ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	f Depreciation	Lease	
		Capital-Relat				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	-	0		0 0.041.040	0	1 00
1.00 CAP REL COSTS-BLDG & FIXT 3.00 Total (sum of lines 1-2)	0			0 2, 041, 042 0 2, 041, 042		1.00
3.00 Total (sum of lines 1-2)	0	•	I IMMARY OF CAPI		0	3.00
		30	JWWART UP CAPT	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions	Capital - Relat		
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 0	2, 041, 042	1.00
3.00 Total (sum of lines 1-2)	0	0		0 0	2, 041, 042	3.00

Health Financial Systems		HAMI LTON CE	NTER, INC.	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			F	Period: From 07/01/2019 Fo 06/30/2020	Worksheet A-8 Date/Time Pre 11/25/2020 9:	pared:
			Expense Classification on To/From Which the Amount is			
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)	2.00	3.00	4.00	Ref. 5.00	
1.00 Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		o	*** Cost Center Deleted ***	2.00	0	2.00
COSTS-MVBLE EQUIP (chapter 2)					0	3.00
(chapter 2)		0		0.00	-	
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by	В	-37,423	CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
suppliers (chapter 8) 7.00 Telephone services (pay		0		0.00	0	7.00
stations excluded) (chapter 21)						
8.00 Television and radio service		0		0.00	0	8.00
(chapter 21) 9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provi der-based physi ci an adjustment	A-8-2	-2, 041, 195			0	10.00
11.00 Sale of scrap, waste, etc.		0		0.00	0	11.00
(chapter 23) 12.00 Related organization	A-8-1	0			0	12.00
transactions (chapter 10) 13.00 Laundry and Linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guest		0		0.00	0	14.00
15.00 Rental of quarters to employe and others	e	0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than		0		0.00	0	16.00
patients				0.00		17 00
17.00 Sale of drugs to other than patients		0		0.00		17.00
18.00 Sale of medical records and abstracts	В	-20, 884	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees,	В	-466	ADMI NI STRATI VE & GENERAL	5.00	0	19.00
books, etc.)						
20.00 Vending machines 21.00 Income from imposition of		0		0.00	0	20.00 21.00
interest, finance or penalty charges (chapter 21)						
22.00 Interest expense on Medicare		0		0.00	0	22.00
overpayments and borrowings t repay Medicare overpayments	0					
23.00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
limitation (chapter 14)			*** 0+ 0+ 0-!-+! ***	((00		24.00
24.00 Adjustment for physical therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
limitation (chapter 14) 25.00 Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
physicians' compensation						
(chapter 21) 26.00 Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist		∩	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see		_ ^	ADULTS & PEDIATRICS	30.00		30. 99
i nstructi ons)				30.00		50.77

Heal th	Fi nanci al	Systems					
AD ILISTMENTS TO EXPENSES							

Heal th	Financial Systems		HAMI LTON CE	NTER, INC.	In Lieu of Form CMS-2552-10		
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 07/01/2019		
					To 06/30/2020		
					10/	11/25/2020 9:	17 am
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Costos Description	Deel a (Cede	A	Cast Castas	1.1.000 //	W/L = + A 7	
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	2.00	2.00	4.00	Ref.	
21 00	Adi watarant fan anarah	1.00	2.00		4.00	5.00	21.00
31.00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
	pathology costs in excess of						
00.00	limitation (chapter 14)		0		0.00		00.00
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest		1 057		F 00	0	
33.00	ADVERTI SI NG	A		ADMI NI STRATI VE & GENERAL	5.00	0	00.00
33.01	PUBLIC RELATIONS	A		EMPLOYEE BENEFITS DEPARTMEN		0	
33.02	PUBLIC RELATIONS	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.03	PUBLIC RELATIONS	A		ADULTS & PEDIATRICS	30.00	0	
33.04	PUBLIC RELATIONS	A		CLINIC	90.00	0	00.01
33.05	REPRESENTATI VE PAYEE FEES	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.06	WABASH VALLEY HEALTH CENTER	В	-38, 616	ADMINISTRATIVE & GENERAL	5.00	0	33.06
	INCOME						
33.07	MISC INCOME	В		ADMINISTRATIVE & GENERAL	5.00	0	
33.08	BOARD OF DIRECTOR FEES	В		ADMINISTRATIVE & GENERAL	5.00	0	00.00
33.09	ADVERTI SI NG	A		CLINIC	90.00	0	
33.10	REPRESENTATI VE PAYEE FEES	В		ADMINISTRATIVE & GENERAL	5.00	0	00110
33.11	MISC INCOME	В		CLINIC	90.00	0	
33.12	WABASH VALLEY HEALTH CENTER	В	-78, 503	CLINIC	90.00	0	33.12
	I NCOME						
33.13	WABASH VALLEY HEALTH CENTER	В	0	ADMINISTRATIVE & GENERAL	5.00	0	33.13
	EAP						
33.14	MARKETING	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.15	XIX HOSPITAL ASSESSMENT FEE	A	-1, 316, 904	ADULTS & PEDIATRICS	30.00	0	33.15
	A/C 9312						
33.16	DONATION EXPENSE	A		EMPLOYEE BENEFITS DEPARTMEN		0	00110
33.17	DONATION EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 18	DONATION EXPENSE	A		OPERATION OF PLANT	7.00	0	00110
33.19	DONATION EXPENSE	A		ADULTS & PEDIATRICS	30.00	0	
33.20	В	A		CLINIC	90.00	0	
33.21	SCHOOL BASED SERVICES	В	-13, 091		90.00	0	
33. 22	SCHOOL SERVICES C&A AND GREENE	В	-800	CLINIC	90.00	0	33.22
	COUNT						
50.00	TOTAL (sum of lines 1 thru 49)		-4, 158, 296				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

 column 6, line 200.)

 (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

	Financial Syste		HAMI LTON CE				eu of Form CMS-	
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Peri od:	Worksheet A-8	3-2
						From 07/01/2019 To 06/30/2020		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	847, 170			0 ס	-	
2.00		ADMI NI STRATI VE & GENERAL	1, 148, 839			0 0	-	
3.00		ADULTS & PEDIATRICS	45, 186	45, 186		0 0	0	3.00
4.00	0.00		0	0		0 0	0	4.00
5.00	0.00		0	0	(0 ס	0	5.00
6.00	0.00		0	0		0 ס	0	6.00
7.00	0.00		0	0	(0 ס	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			2, 041, 195	2, 041, 195	(C	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships 8	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	0			0 ס	0	1.00
2.00		ADMINISTRATIVE & GENERAL	0			0 0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	(0 0	0	3.00
4.00	0.00		0	0	(0 0	0	4.00
5.00	0.00		0	0	(0 0	0	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(o l	0	7.00
8.00	0.00		0	0	(o l	0	8.00
9.00	0,00		0	0	(0 0	0	9.00
10.00	0.00		0	0			0	
200.00			0	0			0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMI NI STRATI VE & GENERAL	0	0	(0 847, 170		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	(1, 148, 839		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	(45, 186		3.00
4.00	0.00		0	0	(0 0		4.00
5.00	0.00		0	0	(o o		5.00
6.00	0.00		0	0	(0 0		6.00
7.00	0.00		0					7.00
8.00	0.00		0					8.00
9.00	0.00		0					9.00
10.00	0.00		0					10.00
200.00			0	-		2,041,195		200.00
_00.00	I	1		0	1	2, 3 , 1 / 0	1	

Heal th	n Financial Systems	HAMILTON CEN	NTER, INC.		In Lie	u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 07/01/2019 To 06/30/2020	Worksheet B Part I Date/Time Pre 11/25/2020 9:	epared: 17 am
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL <u>RELATED COSTS</u> BLDG & FI XT	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	
		0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 041, 042 1, 245, 755	41, 789	1, 287, 54			1.00 4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	7, 663, 086 889, 185	228, 068	29, 20	1, 146, 455	305, 526	7.00
9.00 14.00	00900 HOUSEKEEPI NG 01400 CENTRAL SERVI CES & SUPPLY	269, 249 0	0	8, 87	2 278, 121 0 0	74, 118 0	14.00
15.00	01500 PHARMACY	0	0		0 0	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	404, 019		9, 87			1
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0			0 0	0	
23.00		0	0		0 0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 506, 845	516, 136	74, 25	3, 097, 233	825, 400	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	2, 500, 845	510, 130	/4, 25	3,097,233	825, 400	30.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	60, 434	-		0 60, 470		
69.00	06900 ELECTROCARDI OLOGY	00, 434	0		0 00,470	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00		0	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00		149, 337	36		0 149, 373	39, 807	73.00
	OUTPATIENT SERVICE COST CENTERS				-1		
90.00		4, 907, 512	368, 288	273, 77	5 5, 549, 575	1, 478, 940	90.00
	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99.00	09900 CMHC	0	0		0 0	0	99.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	20, 136, 464	2, 041, 042	704, 04	0 19, 552, 960	2, 870, 418	118.00
	NONREI MBURSABLE COST CENTERS						
	07950 OTHER NONREIMB COST CENTER	21, 599, 167	0	583, 50	22, 182, 671	5, 911, 580	1
200.00					0		200.00
201.00			0		0 0		201.00
202.00) TOTAL (sum lines 118 through 201)	41, 735, 631	2, 041, 042	1, 287, 54	4 41, 735, 631	8, 781, 998	202.00

Heal th	n Financial Systems	HAMI LTON CEI	NTER, INC.		In Lie	u of Form CMS-:	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-4009	Period:	Worksheet B	
					From 07/01/2019 To 06/30/2020	Part I	narad
					To 06/30/2020	Date/Time Pre 11/25/2020 9:	17 am
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	CENTRAL	PHARMACY	MEDICAL	
	•	PLANT		SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		7.00	9.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	1, 451, 981					7.00
9.00	00900 HOUSEKEEPI NG	0	352, 239				9.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0		14.00
15.00	01500 PHARMACY	0	0		0 0		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	114, 666	27, 817		0 0	762, 730	16.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		0 0	0	18.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	780, 372	189, 313		0 0	259, 111	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	55	13		0 0	2, 747	60.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	55	13		0 0	6, 787	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	556, 833	135, 083		0 0	494, 085	90.00
	OTHER REIMBURSABLE COST CENTERS						
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99.00	09900 CMHC	0	0		0 0	0	99.00
	SPECIAL PURPOSE COST CENTERS						
118.00		1, 451, 981	352, 239		0 0	762, 730	118.00
	NONREI MBURSABLE COST CENTERS			-			
194.00	007950 OTHER NONREIMB COST CENTER	0	0		0 0	0	194.00
200.00							200.00
201.0		0	0		0 0		201.00
202.0) TOTAL (sum lines 118 through 201)	1, 451, 981	352, 239		0 0	762, 730	202.00

Health Financial Systems	HAMILTON CEN	TER, INC.		In Lie	u of Form CMS-3	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	11	Provider CC	N: 15-4009	Period: From 07/01/2019 To 06/30/2020	Worksheet B Part I Date/Time Pre 11/25/2020 9:	pared: 17 am
	OTHER GENERAL SERVI CE					
Cost Center Description	(SPECI FY)	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	18.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS	i					
1.0000100CAPRELCOSTS-BLDG& FIXT4.0000400EMPLOYEEBENEFITSDEPARTMENT5.0000500ADMINISTRATIVE& GENERAL7.0000700OPERATIONOFPLANT						1.00 4.00 5.00 7.00
9. 00 00900 HOUSEKEEPI NG						9.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						9.00
15. 00 01500 PHARMACY						14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY						16.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0					18.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	о				23.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	UU				23.00
30. 00 03000 ADULTS & PEDIATRICS	0	0	5, 151, 42	29 0	5, 151, 429	30.00
ANCI LLARY SERVICE COST CENTERS			0,101,1		0/101/12/	00100
54.00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0	79, 40		79, 400	60.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	,	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	196, 03	35 0	196, 035	73.00
OUTPATIENT SERVICE COST CENTERS	· · ·					1
90. 00 09000 CLINIC	0	0	8, 214, 5	16 0	8, 214, 516	90.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	13, 641, 38	30 0	13, 641, 380	118.00
NONREI MBURSABLE COST CENTERS						
194.0007950 OTHER NONREIMB COST CENTER	0	0	28, 094, 25		28, 094, 251	
200.00 Cross Foot Adjustments		0		0 0		200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	O	41, 735, 63	31 0	41, 735, 631	202.00

Heal th	Financial Systems	HAMILTON CEN	ITER, INC.		In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CC	N: 15-4009	Period: From 07/01/2019 To 06/30/2020		
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI V E & GENERAL	
		0	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	41, 789	41, 78	39 41, 789		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	810, 849	810, 84	19 9, 997	820, 846	5.00
7.00	00700 OPERATION OF PLANT	0	228, 068	228, 06	58 948	28, 557	7.00
9.00	00900 HOUSEKEEPI NG	0	0		0 288	6, 928	9.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	14.00
15.00	01500 PHARMACY	0	0		0 0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	75, 840	75, 84	40 320	12, 199	16.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		0 0	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				- <u>-</u>		
30.00	03000 ADULTS & PEDIATRICS	0	516, 136	516, 13	36 2, 410	77, 149	30.00
	ANCI LLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	0	36	3	36 0	1, 506	60.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	36	3	36 0	3, 721	
	OUTPATIENT SERVICE COST CENTERS	-				•, · = ·	
90.00	09000 CLINIC	0	368, 288	368, 28	8, 885	138, 234	90.00
	OTHER REIMBURSABLE COST CENTERS	-					
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
	09900 CMHC	0	0		0 0	0	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	SPECIAL PURPOSE COST CENTERS				0		/// 00
118.00		0	2,041,042	2,041,04	22, 848	268, 294	118 00
110.00	NONREIMBURSABLE COST CENTERS		2,041,042	2, 041, 04	22,040	200, 274	1 10.00
194 00	07950 OTHER NONREI MB COST CENTER	0	0		0 18, 941	552, 552	194 00
200.00		0	0		0 10, 941	552, 552	200.00
200.00	5		_		0 0	_	200.00
201.00		0	2,041,042	2,041,04	0		
202.00	I TOTAL (Sum TIMES TTO LITUUGA 201)		2,041,042	2,041,02	+2 41, 789	020, 840	202.00

Heal th	n Financial Systems	HAMI LTON CEN	NTER, INC.		In Lieu of Form CMS-2552-10		
ALLOC	ATION OF CAPITAL RELATED COSTS				Period: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 9:	
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	CENTRAL	PHARMACY	MEDI CAL	
		PLANT		SERVICES & SUPPLY		RECORDS & LI BRARY	
		7.00	9,00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	7.00	7.00	14.00	13.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	257, 573					7.00
9.00	00900 HOUSEKEEPI NG	0	7, 216				9.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0		14.00
15.00	01500 PHARMACY	0	0		0 0		15.00
16.00		20, 341	570		0 0	109, 270	
18.00		0	0		0 0	0	
23.00		0	0		0 0	-	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS		-	1	-1 -		
30.00		138, 433	3, 879		0 0	37, 121	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	10	0		0 0	393	60.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10	0		0 0	972	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	98, 779	2, 767		0 0	70, 784	90.00
	OTHER REIMBURSABLE COST CENTERS						
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99.00	09900 CMHC	0	0		0 0	0	99.00
	SPECIAL PURPOSE COST CENTERS			-			
118.0		257, 573	7, 216		0 0	109, 270	118.00
	NONREI MBURSABLE COST CENTERS	1	-				
	0079500THER NONREIMB COST CENTER	0	0		0 0		194.00
200.0							200.00
201.0		0	0		0 0		201.00
202.0	0 TOTAL (sum lines 118 through 201)	257, 573	7, 216		0 0	109, 270	202.00

Health Financia		HAMILTON CEN	ITER, INC.		In Lie	u of Form CMS-	2552-10
ALLOCATION OF	CAPITAL RELATED COSTS		Provider C	CN: 15-4009	Period: From 07/01/2019 To 06/30/2020		epared: 17 am
Co	ost Center Description	OTHER GENERAL SERVI CE (SPECI FY)	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		18.00	23.00	24.00	25.00	26.00	
	SERVICE COST CENTERS	i					
4.00 00400 EM 5.00 00500 AD 7.00 00700 OP	AP REL COSTS-BLDG & FIXT MPLOYEE BENEFITS DEPARTMENT DMINISTRATIVE & GENERAL PERATION OF PLANT						1.00 4.00 5.00 7.00
	DUSEKEEPI NG						9.00
14.00 01400 CE	ENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PH							15.00
16.00 01600 ME	DICAL RECORDS & LIBRARY						16.00
18.00 01850 OT	THER GENERAL SERVICE (SPECIFY)	0					18.00
23.00 02300 PA	ARAMED ED PRGM-(SPECIFY)	0	0)			23.00
I NPATI EN	NT ROUTINE SERVICE COST CENTERS	· · · · · ·		•			1
30.00 03000 AD	DULTS & PEDIATRICS	0		775, 1	28 0	775, 128	30.00
ANCI LLAF	RY SERVICE COST CENTERS						1
	ADIOLOGY – DIAGNOSTIC	0			0 0	0	54.00
	ABORATORY	0		1,9	45 0	1, 945	60.00
	ECTROCARDI OLOGY	0		.,.	0 0	0	
	ECTROENCEPHALOGRAPHY	0			0 0	0	
	EDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
	IPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
	RUGS CHARGED TO PATIENTS	0		4,7		4, 739	
	ENT SERVICE COST CENTERS	0		<u> </u>	57	4,737	/ 5.00
90.00 09000 CL		0		687.7	37 0	687, 737	90.00
	EIMBURSABLE COST CENTERS	0		007,7	57 0	007,737	90.00
	THER REIMBURSABLE COST CENTERS	0		1	0 0	0	98.00
99.00 09900 CM		0			0 0	0	
	PURPOSE COST CENTERS	U			0 0	0	99.00
		0		1 4/0 5	40 0	1 4/0 540	1110 00
	JBTOTALS (SUM OF LINES 1 through 117)	U	0	1, 469, 5	49 0	1, 469, 549	118.00
	BURSABLE COST CENTERS			574.4	00	574 400	101 00
	THER NONREIMB COST CENTER	0	~	571, 4		571, 493	
	oss Foot Adjustments		0		0 0		200.00
	egative Cost Centers	0	0		0 0	-	201.00
202.00 T0)TAL (sum lines 118 through 201)	0	0	2,041,0	42 0	2, 041, 042	1202. UU

COST ALLOCATION - STATISTICAL BASIS Provider COX: 15.4009 Period: From 07/01/2011 To 06/30/2020 Worksheet B-1 Bit/25/2020 9: 17 am 11/25/2020 9: 17 am 1		Financial Systems	HAMILTON CEN			In Lie	u of Form CMS-2	
Cost Center Description CAPITAL RELATED COSTS (SUARE FEET) FMPLOYEE FEMELTS DEPARTMENT Reconciliatio n AMMINISTRATIV E & GENERAL (ACCUM COST) OPERATION OF PLAYT OPERATION (SUARE FEET) EENERAL SERVICE COST CENTERS 1.00 4.00 5.4 5.00 7.00 1.00 00100 (CAP REL COSTS FLIDE & FIXT (GROSS) 1.00 4.00 5.4 5.00 7.00 1.00 00100 (CAP REL COSTS FLIDE & FIXT (SUARE FEET) 5.924 5.87,77,078 -8,781,998 32,953,633 5.00 7.00 5.00 00000 (CAP REL COSTS FLIDE & SUPPLY (CORD FRATION OF PLAYT (SUARE FEET) 0 1.40,0 5.8,77,078 -8,781,998 32,953,633 5.00 7.00 5.00 00000 (CAPR FLIC LOSTS FLIDE & SUPPLY (CORD FRATION OF PLAYT (SUARE SERVICE COST CENTERS 0 1.40,0 1.40,0 1.40,0 6.00 01600 (MEDI CAL, RECORDS & LIBRAY (CORD FRE CENTRAL SERVICE COST CENTERS 0 0 0 0 0 0 0 18,00 7.00 00000 (AULES A LIBRAY 1.479,205 0 3.097,233 14,142 3.00,0 14,00 0 0	COST AL	LOCATION - STATISTICAL BASIS		Provider C	CN: 15-4009 P		Worksheet B-1	
Cost Center Description CAPITAL RELATED COSTS BLDG & FIXT SUBAR F2ET) HD/VEE BEAU (SUBAR F2ET) Reconciliatio n ADM NISTRATIV E & GENERAL SERVICE OPFANTION (SUBAR SALARIES) 1.00 5.00 7.00 4.00 5.00 7.00 1.00 4.00 5.00 7.00 4.00 5.00 7.00 1.00 4.00 00400 EMPLOYEE BENETIS DEPARTMENT 1.145 25.649.831 1.00 4.00 1.00 00100 CAP REL COSTS BLDG & FIXT 1.145 25.649.831 - 1.00 4.00 1.00 00100 CAP REL COSTS SUPPARTMENT 1.145 25.649.831 - 1.00 - 4.00 1.00 001000 DEPRATION 0F PLANT 6.244 531.754 0 1.146.455 26.313 7.00 1.00 001000 CONTRAL SERVICE COST & SUPPLY 0 176.70 0 489.735 2.073 16.00 16.00 1.00 00000 CONTRAL SERVICE COST CENTERS 14.142 1.479.205 0 3.097.233 14.142 30.00 1.00 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>Data/Tima Dra</td><td>narod</td></t<>							Data/Tima Dra	narod
Cost Center Description CCAPT TAL RELATED COSTS BLDG & FLATT (SQUARE FEET) EMPLOYEE BENEFIET Reconciliation PLATT DepARTMENT (GRUSS) ADMINISTRATIV EXCLUE COST (SQUARE FEET) OPERATION OF PLATT DepARTMENT (GRUSS) 00100 CAP REL COST CENTERS 1.00 4.00 5.00 7.00 1.00 4.00 5.00 7.00 4.00 0.00 OOF CAP REL COST SENDS & FLAT 55.924 25.649,831 -8.781,998 32.953.633 1.00 0.00 OOF DEPARTINON OF PLATT 6.249 51.764 0.027,800 0.0114.00 4.00 0.00 OOF OOR DEFAITION OF PLATT 6.249 513.708 -8.781,998 32.953.633 7.00 5.00 0.00 OFFOO DEFAITION OF EVANT 0.2781 0.00 0.00 0.0144.00 1.00 1.00 OFFOO DEFAITION OF EVANT 0.2775 0.00 0.00 0.00 1.40.01460.00 1.00 1.00 OFFOO DEFAITION OF EVANT 0.2775 0.00 1.00.01 1.00.01 1.00.01 1.00.01 1.00.01 1.00.01 1.00.01 1.00.01 1.00.01 1.00.01 1.00.01 1.00.01 1.00.01					1	0 00/30/2020		
Cost Center Description RELATE DOSTS BLG & FINT (SQUARE FEET) SUARE FEET) EMPLOYEE BENERFITS DEPARTMENT (SQUARE FEET) Reconciliatio n ADMINISTRATIV Ex 6.000000 OPERATION OF PLNAT (SQUARE FEET) 1:00 0.00000 Contraction 1:00 4:00 54 5:00 7:00 1:00 0.00000 Contraction 59,42 5:00 7:00 4:00 5:00 7:00 0:00 000000 Contraction 5:00 7:00 4:00 5:00 7:00 4:00 0:00 00000 Contraction 5:00 7:00 4:00 5:00 7:00 4:00 5:00 7:00 4:00			CAPI TAL				1172072020 7.	
Cost Center Description BLDG & FIXT (SOUARE FEET) END (VEE BENEFITS) Reconcilitation (ADM IN STRATIV (CACUM. COST) OPERATION OF PLANT (SOUARE FEET) 0 0 0 0 5.00 7.00 1.00 4.00 5.4 5.00 7.00 1.00 00100 (CAP REL COST CENTERS 1.145 25.649,831 - 1.00 4.00 5.0 5.00 7.00 0.00 (CAP REL COST CENTERS 0.176,750 0.22,953,633 2.6,313 7.00 9.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
END SQUARE FEET) DEPARTMENT (CROSS SALARIES) n E & CENERAL (ACCUM. COST) (SOURARE FEET) 1.00 4.00 5.0 7.00 1.00 4.00 5.0 7.00 00100 CAP REL COST-ELICE & FIXT 55.924 5.00 7.00 0.00 00500 ADMINISTRATIVE & GENERAL 0.000000 OPENATION OF PLANT 6.249 581.754 -8.781,998 32,953.633 5.00 7.00 7.00 07000 OPENATION OF PLANT 6.249 581.754 -0 1.146.455 26.013 7.00 9.00 09900 HOUSEKEEPINS DEPARTMENT 0.146.455 26.713 7.00 0.00 1.146.455 26.718 5.00 7.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 1.160.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		Cost Center Description		EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
DEPARTMENT (CROSS SALARIES) CACCUM. COST) (SOUARE FEET) CSOUARE FEET) (SOUARE FEET) 0 0.000 CAP REL COSTS-BLIDG & FIXT 1.00 4.00 5A 5.00 7.00 4.00 0.000 CAP REL COSTS-BLIDG & FIXT 1.145 25.649,831 1.00 4.00 4.00 0.0000 CAP REL COSTS-BLIDG & FIXT 1.145 25.649,831 4.00 7.00 0.0000 CMMIN ISTRATIVE & GENRAL 22.217 6.137,767 -8,781,998 32.953,633 5.00 7.00 0.0000 CMPEARILON OF PLANT 6.249 581,754 0 1.146,455 26,313 7.00 9.00 0.0100 CMPEARILON OF PLANT 6.249 581,754 0 0 0 16.00 10.00 CAP MARINCE NE SUPPLY 0 0 0 0 0 16.00								
SALAR ES) SALAR ES) SALAR ES) SALAR ES) 1.00 4.00 5A 5.00 7.00 1.00 00000 CAP REL COST CENTERS 7.00 1.00 1.00 4.00 00000 CAP REL COST SHUG & FLYT 1.145 25.649,831 1.00 4.00 0.00 00000 OPERATION OF PLANT 6.249 581,754 0 1.146,455 22.313 7.00 0.00 00000 OPERATION OF PLANT 6.249 581,754 0 1.146,455 22.313 7.00 15.00 01300 CENTRAL SERVICE SE SUPPLY 0 0 0 0 0 0 0 14.00 14.00 0			· í	DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
CENERAL SERVICE COST CENTERS 1.00 4.00 5A 5.00 7.00 1.00 OOTOO (AP REL COSTS -BLIG & FIXT 55.924				(GROSS		l` í		
CENERAL SERVICE COST CENTRES 1.00 1.00 00100 CAP REL COST SELDG & FLXT 55,924 4.00 00000 CAP REL COST SELDG & FLXT 1.145 5.00 00500 CAP REL COST SELDG & FLXT 1.146,455 5.00 00000 OPERATION OF PLANT 6.249 7.00 00000 OPERATION OF PLANT 6.249 7.00 00000 OPERATION OF PLANT 6.249 7.00 0 0 7.00 01400 CENTRAL SERVICE & SUPLY 0 7.00 01400 CENTRAL SERVICE (SPCI FY) 0 7.00 0 0 0 7.00 00000 OPERATION OF PLANACY 0 0 7.00 0 0 0 0 7.00 01400 CENTRAL SERVICE CORDS CENTERS 0 0 0 7.00 01400 CHEN CONTREAL SERVICE COST CENTERS 0 0 0 0 7.00 0 0 0 0 0 0 0 7.00 0 0 0 0 0 0 0 <td></td> <td></td> <td></td> <td>SALARI ES)</td> <td></td> <td></td> <td></td> <td></td>				SALARI ES)				
1.00 00100 (AP REL COSTS-BLOG & FLXT 55,924 1.00 0.00 000500 (APUCYEE ENFITS DEPARTMENT 1.145 25,649,831 0.00 0.00 000500 (APUCYEE ENFITS DEPARTMENT 22,217 6,137,078 -8,781,998 32,953,633 5.00 0.00 000900 (HOUSEKEEPI NG 6,249 581,754 0 1.146,455 26,313 0 9.00 0.00 000900 (HOUSEKEEPI NG 0 0 0 0 0 0 14.00 16.00 D15000 (HERICAL SERVICES & SUPPLY 0<			1.00	4.00	5A	5.00	7.00	
4. 00 00400 [EMPLOYEE BENFFITS DEPARTMENT] 1, 145 25, 649, 831 4. 00 0.00 00700 (PERATION OF PLANT 6, 249 6, 137, 078 -8, 781, 998 32, 953, 633 7, 00 0.00 000700 (PERATION OF PLANT 6, 249 6, 137, 078 -8, 781, 998 32, 953, 633 7, 00 0.00 001400 (ENTRAL SERVICES & SUPPLY 0 176, 750 0 278, 121 0 14, 00 0		GENERAL SERVICE COST CENTERS						
5. 00 00500 ADMINISTRATIVE & GENERAL 22, 217 6, 137, 08 -8, 781, 998 32, 953, 633 5. 00 7.00 00700 OPERATION OF PLANT 6, 249 581, 754 0 1, 146, 455 26, 313 7. 00 14.00 10400 CENTRAL SERVICES & SUPPLY 0 0 0 0 1, 146, 455 26, 313 7. 00 14.00 10400 CENTRAL SERVICE (S & SUPPLY 0 0 0 0 0 14. 00 16.00 10500 PHARMACY 0 0 0 0 0 0 0 15. 00 18.00 01850 OTHER GENERAL SERVICE (SPECI FY) 0 0 0 0 0 18. 00 0.00 02300 PARAMED ED PROM.(SPECI FY) 0 </td <td>1.00</td> <td>00100 CAP REL COSTS-BLDG & FIXT</td> <td>55, 924</td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td>	1.00	00100 CAP REL COSTS-BLDG & FIXT	55, 924					1.00
7. 00 00700 (PPERATION OF PLANT 6, 249 581,754 0 1,146,455 26,313 7. 00 9.00 00900 (HUSEKEEPING 0 170,750 0 278,121 0 9.00 14.00 OttA00 (CRTRAL SERVICES & SUPPLY 0 <	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 145	25, 649, 831				4.00
9. 00 00000 HOUSEKEEPING 0 176,750 0 278,121 0 9.00 14. 00 1000 CENTRAL SERVICES & SUPPLY 0	5.00	00500 ADMI NI STRATI VE & GENERAL	22, 217	6, 137, 078	-8, 781, 998	32, 953, 633		5.00
14.00 0 01400 CENTRAL_SERVICES & SUPPLY 0	7.00	00700 OPERATION OF PLANT	6, 249	581, 754	0	1, 146, 455	26, 313	7.00
15 00 01500 PHARMACY 0 0 0 0 0 0 15.00 0 000 15.00 14.00	9.00	00900 HOUSEKEEPI NG	0	176, 750	c c	278, 121	0	9.00
16 00 01600 MEDICAL RECORDS & LIBRARY 2,078 196,740 0 489,735 2,078 16.00 18 00 01800 01800 0 0 0 0 0 0 0 23.00 18 00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 0 0 0 0 0 23.00 10 0500 AMCILLARY SERVICE COST CENTERS 14,142 1,479,205 0 3,097,233 14,142 30.00 ANCILLARY SERVICE COST CENTERS	14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	c	0	0	14.00
18:00 018:00 018:00 0	15.00	01500 PHARMACY	0	0	c c	0	0	15.00
18:00 018:00 018:00 0	16.00	01600 MEDICAL RECORDS & LIBRARY	2,078	196, 740	l a	489, 735	2,078	16.00
23.00 023.00 023.00 0								1
INPATIENT ROUTINE SERVICE COST CENTERS 30:00 00000 ADULTS & PEDIATRICS 14,142 1,479,205 0 3,097,233 14,142 30:00 00000 ADULTS & PEDIATRICS 0 <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td>				0		0		
30.00 03000 ADULTS & PEDIATRICS 14,142 1,479,205 0 3,097,233 14,142 30.00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 54.00 54.00 05400 RADIOLOGY - DIARNOSTIC 0 0 0 0 0 0 60.00 60.00 0000 LECETROCARDIOLOGY 1 0 0 0 60.00 60.00 70.00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 72.00 7								20100
ANCILLARY SERVICE COST CENTERS Image: Control of the con			14, 142	1, 479, 205	0	3, 097, 233	14, 142	30.00
54.00 05400 RADI OLOGY - DI AGNOSTI C 0				.,,	-			
60.00 06000 LABORATORY 1 0 0 60.00 60.01 60.00 70.00<			0	0	C) 0	0	54.00
69.00 06900 ELECTROCARDIOLOGY 0 <td></td> <td></td> <td>1</td> <td>0</td> <td></td> <td>60, 470</td> <td>1</td> <td>60.00</td>			1	0		60, 470	1	60.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 <th< td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td></td><td>0</td><td></td></th<>			0	0	0		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 73.00 73.00 073.00 0 0 0 149,373 1 00 0 0 0 0 0 0 0 90.00 00 0 0 0 0 0 0 90.00 00 0 0 0 0 0 0 90.00 00 0 0 0 0 0 90.00 98.00 99.00 0 0 0 0 0 90.00 99.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 55.924 14.025.537 -8.781,998 10,770,962 26.313 118.00 NORREI MBURSABLE COST CENTER 0 11,624,294 0 22.182,671 0 20.00 20.00 20.00 20.00 20.00 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>-</td><td></td></td<>			0	0		0	-	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 149, 373 1 73.00 DRUGS CHARGED TO PATIENTS 1 0 0 149, 373 1 73.00 90.00 DOPOD CLINIC 10,091 5,454,010 0 5,549,575 10,091 90.00 90.00 OPODO CLINIC 10,091 5,454,010 0 5,549,575 10,091 90.00 90.00 OPODO CLINIC 0 0 0 0 0 90.00 90.00 OPODO CHAR REIMBURSABLE COST CENTERS 0 0 0 0 98.00 99.00 OPODO CHAC 0 0 0 0 0 98.00 99.00 OPODO CHAC 0 0 0 0 0 98.00 99.00 OPODO CHAC 0 0 0 0 0 99.00 90.00 SUBTOTALS SUBTOTALS SUBTOTALS SUBTOTALS SUBTOTALS SUBTOTALS 118.00 118.00 Cross Foot Adjustments 0 11, 624, 294 0 22			0	0		0	0	
73.00 DRUGS CHARGED TO PATIENTS 1 0 0 149,373 1 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 5,549,575 10,091 90.00 00000 CLINIC 0 5,454,010 0 5,549,575 10,091 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 90.00 99.00 CMUC 0 0 0 0 0 90.00 99.00 O9900 (CMHC 0 0 0 0 0 90.00 99.00 CMUC 0 0 0 0 0 90.00 SPECIAL PURPOSE COST CENTERS 11,624,294 0 22,182,671 0 194.00 100 O7950 OTHER NONREI MB COST CENTER 0 11,624,294 0 22,182,671 0 194.00 202.00 Cost to be allocated (per Wkst. B, Part I) 36.496710 0.050197 0.266496 55.181127 203.00 203.00 Unit cost multiplier (Wkst. B, Part I) 36.496710 0.001629 0.024909 9.788812			0	0		0		
OUTPATI ENT SERVICE COST CENTERS Image: Cost of the cost centers Image: Cost centers			1	0	-	-	-	
90.00 OPODOC CLINIC 10,091 5,454,010 0 5,549,575 10,091 90.00 07HER REIMBURSABLE COST CENTERS 0 0 0 0 0 98.00 98.00 99.00 00 0 0 0 0 0 0 99.00 00 0 0 0 0 0 99.00 00 99.00 00 0 0 0 0 0 99.00 00 0 0 0 0 99.00 00 99.00 99.00 00 0 0 0 0 99.00 00 99.00 00 99.00 00 99.00 00 99.00			•1		, <u> </u>	117,070	· ·	1 1 0 1 0 0
OTHER REI MBURSABLE COST CENTERS O <tho<< td=""><td></td><td></td><td>10, 091</td><td>5, 454, 010</td><td>0</td><td>5, 549, 575</td><td>10, 091</td><td>90.00</td></tho<<>			10, 091	5, 454, 010	0	5, 549, 575	10, 091	90.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 <td></td> <td></td> <td></td> <td>-,</td> <td>-</td> <td></td> <td></td> <td></td>				-,	-			
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 55,924 14,025,537 -8,781,998 10,770,962 26,313 118.00 NONREL MBURSABLE COST CENTERS 194.00 07500 OTHER NONREIMB COST CENTER 0 11,624,294 0 11,624,294 0 194.00 200.00 Cross Foot Adjustments 201.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 36.496710 0.050197 0.266496 55.181127 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 36.496710 0.001629 0.024909 9.788812 205.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.001629 0.024909<			0	0	C) 0	0	98.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 55,924 14,025,537 -8,781,998 10,770,962 26,313 118.00 NONREI MBURSABLE COST CENTERS 0 011,624,294 0 22,182,671 0 194.00 200.00 Cross Foot Adj ustments 0 11,624,294 0 22,182,671 0 194.00 201.00 Negati ve Cost Centers 200.00 200.00 200.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 36.496710 0.050197 0.266496 55.181127 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 36.496710 0.001629 0.024909 9.788812 205.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.001629 0.024909 9.788812 205.00 11) 206.00 NAHE adj ustment amount to be allocated (per Wkst. D, 206.00 206.00 206.00 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.001629 0.024909 9.788812 205.00 206.00	99.00	09900 CMHC	0	0	c c	0	0	99.00
NORE I MBURSABLE COST CENTERS 194.00 07950 OTHER NONREI MB COST CENTER 0 11, 624, 294 0 22, 182, 671 0 194.00 200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 200.00 201.00 200.00 201.00 202.00 203.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 206.00 206.00 206.00 206		SPECIAL PURPOSE COST CENTERS						
194.00 07950 OTHER NONREIMB COST CENTER 0 11,624,294 0 22,182,671 0 194.00 200.00 Cross Foot Adjustments 0 11,624,294 0 22,182,671 0 200.00 201.00 Negative Cost Centers 200.00 201.00 202.00 201.00 202.00 201.00 203.00 205.00 0.050197 0.266496 55.181127 203.00 203.00 204.00 205.00 205.00 205.00 205.00 205.00 205.00 206.00 206.00 206.00 206.00 <t< td=""><td>118.00</td><td>SUBTOTALS (SUM OF LINES 1 through 117)</td><td>55, 924</td><td>14,025,537</td><td>-8, 781, 998</td><td>10, 770, 962</td><td>26, 313</td><td>118.00</td></t<>	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	55, 924	14,025,537	-8, 781, 998	10, 770, 962	26, 313	118.00
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 200.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 2,041,042 1,287,544 8,781,998 1,451,981 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 36.496710 0.050197 0.266496 55.181127 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 36.496710 0.001629 0.266496 55.181127 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 36.496710 0.001629 0.024909 9.788812 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 0.001629 0.024909 9.788812 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.001629 0.024909 207.00	Ī	NONREI MBURSABLE COST CENTERS						
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 2,041,042 1,287,544 8,781,998 1,451,981 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 36.496710 0.050197 0.266496 55.181127 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 36.496710 0.001629 0.266496 55.181127 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.001629 0.024909 9.788812 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 0.001629 0.024909 9.788812 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.001629 0.001629 207.00	194.00	07950 OTHER NONREIMB COST CENTER	0	11, 624, 294	0	22, 182, 671	0	194.00
202.00 Cost to be allocated (per Wkst. B, Part I) 2,041,042 1,287,544 8,781,998 1,451,981 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 36.496710 0.050197 0.266496 55.181127 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 36.496710 0.001629 0.266496 55.181127 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.001629 0.024909 9.788812 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B, 2) 0.001629 0.024909 9.788812 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.001629 0.001629 207.00	200.00	Cross Foot Adjustments						200.00
203.00 Unit cost multiplier (Wkst. B, Part I) 36.496710 0.050197 0.266496 55.181127 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 36.496710 0.050197 0.266496 55.181127 203.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.001629 0.024909 9.788812 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.001629 0.024909 9.788812 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.001629 0.024909 207.00	201.00	Negative Cost Centers						201.00
203.00 Unit cost multiplier (Wkst. B, Part I) 36.496710 0.050197 0.266496 55.181127 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 36.496710 0.050197 820,846 257,573 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.001629 0.024909 9.788812 205.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.001629 0.024909 9.788812 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.001629 0.024909 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.001629 0.024909 207.00	202.00	Cost to be allocated (per Wkst. B,	2,041,042	1, 287, 544		8, 781, 998	1, 451, 981	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) 41,789 820,846 257,573 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.001629 0.024909 9.788812 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00		Part I)						
Part II) Unit cost multiplier (Wkst. B, Part I) 0.001629 0.024909 9.788812 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.001629 206.00 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0 207.00 207.00	203.00	Unit cost multiplier (Wkst. B, Part I)	36. 496710	0. 050197		0. 266496	55. 181127	203.00
Part II) Unit cost multiplier (Wkst. B, Part I) 0.001629 0.024909 9.788812 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.001629 206.00 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0 207.00 207.00	204.00	Cost to be allocated (per Wkst. B,		41, 789		820, 846	257, 573	204.00
206.00II)206.00206.00207.00NAHE unit cost multiplier (Wkst. D,207.00								
206.00II)206.00206.00207.00NAHE unit cost multiplier (Wkst. D,207.00	205.00	Unit cost multiplier (Wkst. B, Part		0. 001629		0. 024909	9. 788812	205.00
(per Wkst. B-2)207.00NAHE unit cost multiplier (Wkst. D,207.00								
207.00 NAHE unit cost multiplier (Wkst. D, 207.00	206.00							206.00
Parts III and IV)	207.00							207.00
		Parts III and IV)			I			

Health Financial Systems	HAMILTON CEN			In Lie	u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-4009	Period:	Worksheet B-1	l
				From 07/01/2019 To 06/30/2020		enared.
				10 00/ 30/ 2020	11/25/2020 9:	
					OTHER GENERAL	
					SERVI CE	
Cost Center Description	HOUSEKEEPI NG	CENTRAL	PHARMACY	MEDI CAL	(SPECI FY)	
	(SQUARE FEET)	SERVICES &	(COSTED	RECORDS &	(TIME SPENT)	
		SUPPLY	REQUIS.)	LI BRARY		
		(COSTED		(GROSS		
	0.00	REQUIS.)	15.00	CHARGES)	10.00	
GENERAL SERVICE COST CENTERS	9.00	14.00	15.00	16.00	18.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT			1			1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7.00
9. 00 00900 HOUSEKEEPI NG	26, 313					9.00
14.00 01400 CENTRAL SERVICES & SUPPLY	20,010	0				14.00
15. 00 01500 PHARMACY	o	0		0		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2,078	0		0 18, 762, 338		16.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		0 0	c c	18.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·					1
30. 00 03000 ADULTS & PEDIATRICS	14, 142	0		0 6, 373, 879	0	30.00
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY – DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	1	0		0 67, 564	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	1	0		0 166, 957	0	73.00
OUTPATI ENT SERVI CE COST CENTERS	10.001			0 10 150 000		
90.00 09000 CLINIC	10, 091	0		0 12, 153, 938	0	90.00
0THER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE COST CENTERS		0		0 0	0	98.00
98. 00 09850 0THER REIMBURSABLE COST CENTERS 99. 00 09900 CMHC	0	0		0 0		
SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	99.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	26, 313	0		0 18, 762, 338	0	118.00
NONREI MBURSABLE COST CENTERS	20,010	0	1	0 10, 702, 000	<u> </u>	110.00
194. 00 07950 OTHER NONREI MB COST CENTER	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments		-		-		200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	352, 239	0		0 762,730	0	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	13. 386501	0. 000000	0. 0000	00 0. 040652	0. 000000	203.00
204.00 Cost to be allocated (per Wkst. B,	7, 216	0		0 109, 270	0	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 274237	0. 000000	0.0000	00 0. 005824	0.00000	205.00
)						
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						007.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)	I I		I	ļ	I	1

Heal th	Financial Systems	HAMILTON CENT	ER, INC.	In Lieu of Form CMS	-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CCN: 15-4009	Period: Worksheet B-	-1
				From 07/01/2019	
				To 06/30/2020 Date/Time Pr 11/25/2020 9	
	Cost Center Description	PARAMED ED		11/23/2020 9	
	cost center bescription	PRGM			
		(ASSI GNED			
		TIME)			
		23.00			
	GENERAL SERVICE COST CENTERS	23.00			_
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
	00500 ADMINI STRATI VE & GENERAL				
5.00					5.00
7.00	00700 OPERATION OF PLANT				7.00
9.00	00900 HOUSEKEEPI NG				9.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
	01600 MEDI CAL RECORDS & LI BRARY				16.00
	01850 OTHER GENERAL SERVICE (SPECIFY)				18.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0			30.00
	ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADI OLOGY - DI AGNOSTI C	0			54.00
60.00	06000 LABORATORY	0			60.00
69.00	06900 ELECTROCARDI OLOGY	О			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	o			70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.00
	07300 DRUGS CHARGED TO PATIENTS	0			73.00
	OUTPATIENT SERVICE COST CENTERS	-1			
90.00	09000 CLINIC	0			90.00
701.00	OTHER REIMBURSABLE COST CENTERS				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0			98.00
	09900 CMHC	Ő			99.00
77.00	SPECIAL PURPOSE COST CENTERS	0			//.00
118.00		0			118.00
110.00	NONREIMBURSABLE COST CENTERS	0			118.00
104 00	07950 OTHER NONREIMB COST CENTERS	0			194.00
200.00		0			200.00
	5				
201.00		0			201.00
202.00		0			202.00
	Part I)				
203.00		0. 000000			203.00
204.00		0			204.00
	Part II)				
205.00		0. 000000			205.00
	11)				
206.00		0			206.00
	(per Wkst. B-2)				
207.00		0. 000000			207.00
	Parts III and IV)				

Health Financial Systems	HAMILTON CEN	NTER, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2019	Worksheet C Part I	
				To 06/30/2020		pared: 17 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 151, 429		5, 151, 42	9 0	5, 151, 429	30.00
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY - DI AGNOSTI C	0			0 0	0	54.00
60. 00 06000 LABORATORY	79, 400		79,40	0 0	79, 400	
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	196, 035		196, 03	5 0	196, 035	73.00
OUTPATIENT SERVICE COST CENTERS			1	-		
90. 00 09000 CLINIC	8, 214, 516		8, 214, 51	6 0	8, 214, 516	90.00
OTHER REIMBURSABLE COST CENTERS	1		1	- I		
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	70.00
99. 00 09900 CMHC	0			0	0	99.00
200.00 Subtotal (see instructions)	13, 641, 380	0	13, 641, 38	0 0	13, 641, 380	
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	13, 641, 380	0	13, 641, 38	0	13, 641, 380	202.00

Health Financial Systems		HAMILTON CENTER, INC.			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-4009		Period: From 07/01/2019	Worksheet C Part I	
					To 06/30/2020		pared:
					11/25/2020		17 am
			Title XVIII		Hospi tal	PPS	
		Charges			_		
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	TIENT ROUTINE SERVICE COST CENTERS						
	0 ADULTS & PEDIATRICS	6, 373, 879		6, 373, 87	9		30.00
	LLARY SERVICE COST CENTERS	TT		L			
	0 RADI OLOGY – DI AGNOSTI C	0	0		0 0. 000000		
	0 LABORATORY	67, 564	0	67,56			
	0 ELECTROCARDI OLOGY	0	0		0 0. 000000		
	0 ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000		
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0. 000000	0. 000000	71.00
	O IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	166, 957	0	166, 95	7 1. 174165	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 0900		0	12, 153, 938	12, 153, 93	8 0. 675873	0. 000000	90.00
OTHER REIMBURSABLE COST CENTERS							
98.00 0985	O OTHER REIMBURSABLE COST CENTERS	0	0		0 0.000000	0. 000000	98.00
99.00 0990	O CMHC	0	0		0		99.00
200.00	Subtotal (see instructions)	6, 608, 400	12, 153, 938	18, 762, 33	8		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	6, 608, 400	12, 153, 938	18, 762, 33	8		202.00
							-

Health Financial Systems	HAMILTON CENT	FER, INC.	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4009	Period: From 07/01/2019	Worksheet C Part I	
			To 06/30/2020		pared:
			10 00/00/2020	11/25/2020 9:	17 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVICE COST CENTERS					
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000				54.00
60. 00 06000 LABORATORY	1. 175182				60.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 174165				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 675873				90.00
OTHER REIMBURSABLE COST CENTERS					
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.00
99. 00 09900 CMHC					99.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Fina	ancial Systems	HAMILTON CEN	NTER, INC.		In Lie	u of Form CMS-	2552-10
COMPUTATIO	N OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2019 To 06/30/2020		pared: 17 am
			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	ATIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	DO ADULTS & PEDIATRICS	5, 151, 429		5, 151, 42	9 0	5, 151, 429	30.00
ANCI	LLARY SERVICE COST CENTERS			-			
54.00 0540	DO RADIOLOGY – DIAGNOSTIC	0			0 0	0	01100
60.00 0600	DO LABORATORY	79, 400		79, 40	0 0	79, 400	60.00
	DO ELECTROCARDI OLOGY	0			0 0	0	
	DO ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	1 / 00
	DOIMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
	DO DRUGS CHARGED TO PATIENTS	196, 035		196, 03	5 0	196, 035	73.00
	PATIENT SERVICE COST CENTERS						
90.00 0900		8, 214, 516		8, 214, 51	6 0	8, 214, 516	90.00
	ER REIMBURSABLE COST CENTERS	1		1			-
	50 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	10100
99.00 0990		0			0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
200.00	Subtotal (see instructions)	13, 641, 380	0	13, 641, 38	0 0		
201.00	Less Observation Beds	0			0		201.00
202.00	Total (see instructions)	13, 641, 380	0	13, 641, 38	0 0	13, 641, 380	202.00

Health Financial Systems	HAMILTON CEN	ITER, INC.		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2019 To 06/30/2020		
		Ti tl	e XIX	Hospi tal	Cost	
	Charges					
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1 1			- T		
30. 00 03000 ADULTS & PEDIATRICS	6, 373, 879		6, 373, 87	9		30.00
ANCI LLARY SERVICE COST CENTERS	1 1			- 1		
54.00 05400 RADI OLOGY – DI AGNOSTI C	0	0		0 0. 000000	0. 000000	54.00
60. 00 06000 LABORATORY	67, 564	0	67, 56	4 1. 175182	0.00000	60.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0. 000000	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0. 000000	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0. 000000	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	166, 957	0	166, 95	7 1. 174165	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	12, 153, 938	12, 153, 93	8 0. 675873	0.00000	90.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0. 000000	0. 000000	98.00
99.00 09900 CMHC	0	0		0		99.00
200.00 Subtotal (see instructions)	6, 608, 400	12, 153, 938	18, 762, 33	8		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	6, 608, 400	12, 153, 938	18, 762, 33	8		202.00

Health Financial Systems	HAMILTON CEN	TER, INC.	In Lieu of Form CMS-2552		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4009	Period: From 07/01/2019 To 06/30/2020		
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	·				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					
54.00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
OTHER REIMBURSABLE COST CENTERS					
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.00
99. 00 09900 CMHC					99.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	HAMILTON CEN	NTER, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2019		
				To 06/30/2020	Date/Time Pre 11/25/2020 9:	pared: 17 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	775, 128	0	775, 12	8 5, 511	140.65	30.00
200.00 Total (lines 30 through 199)	775, 128		775, 12	8 5, 511		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 119	157, 387				30.00
200.00 Total (lines 30 through 199)	1, 119	157, 387				200.00

Health Financial Systems	HAMI LTON CEI	NTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-4009	Period: From 07/01/2019 To 06/30/2020		pared: 17 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cos to Charges (col. 1 ÷ col. 2)	t Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		•	•			
54.00 05400 RADI OLOGY – DI AGNOSTI C	0	0	0.00000		0	54.00
60. 00 06000 LABORATORY	1, 945	67, 564	0. 02878	8 11, 628	335	60.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 739	166, 957	0. 02838	5 26, 025	739	73.00
OUTPATIENT SERVICE COST CENTERS		-		-		
90. 00 09000 CLINIC	687, 737	12, 153, 938	0. 05658	6 0	0	90.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 00000		0	
200.00 Total (lines 50 through 199)	694, 421	12, 388, 459		37, 653	1, 074	200.00

Health Financial Systems	HAMI LTON CEN	NTER, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 07/01/2019		
				To 06/30/2020	Date/Time Pre 11/25/2020 9:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursing		Allied Health	All Other	
oost oontor boson ptron	School	School	Post-Stepdowr		Medi cal	
	Post-Stepdown	0011001	Adjustments	1 0051	Education	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	C	30.00
200.00 Total (lines 30 through 199)	0	0		0 0	(c	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien ⁻	t Per Diem	Inpati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	-	col. 6)		
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	5, 51			30.00
200.00 Total (lines 30 through 199)		0	5, 51	1	1, 119	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						200.00
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	HAMILTON CEI	NTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-4009	Period: From 07/01/2019	Worksheet D Part IV	
				To 06/30/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments		-		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS			_			
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
OTHER REIMBURSABLE COST CENTERS			•			
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems	HAMILTON CEN	NTER, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2019		
				To 06/30/2020	Date/Time Pre 11/25/2020 9:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
		Í Í	and 4)	· · · · · · · · · · · · · · · · · · ·	(see	
			· ·		instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0. 000000	54.00
60. 00 06000 LABORATORY	0	0		0 67, 564	0. 000000	60.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 166, 957	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 12, 153, 938	0.000000	90.00
OTHER REIMBURSABLE COST CENTERS	1		1	-		
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0. 000000	
200.00 Total (lines 50 through 199)	0	0		0 12, 388, 459		200.00

Health Financial Systems	HAMILTON CENT	ER, INC.		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-4009	Period: From 07/01/2019	Worksheet D Part IV		
				To 06/30/2020		pared: 17 am	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent		
	Ratio of Cost	Program	Program	Program	Program		
	to Charges	Charges	Pass-Through	n Charges	Pass-Through		
	(col. 6 ÷		Costs (col.	8	Costs (col. 9		
	col. 7)		x col. 10)		x col. 12)		
	9.00	10.00	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS							
54.00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	0		0 0	0	54.00	
60. 00 06000 LABORATORY	0. 000000	11, 628		0 0	0	60.00	
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	1	0 0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	26, 025		0 0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0.000000	0		0 640, 770	0	90.00	
OTHER REIMBURSABLE COST CENTERS	· · ·					1	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0		0 0	0	98.00	
200.00 Total (lines 50 through 199)		37, 653		0 640, 770	0	200.00	
				1	•	•	

Health Financial Systems	HAMI LTON CEN	NTER, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 9:	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Reimbursed	(see inst.)	
		Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000			0 0	0	
60. 00 06000 LABORATORY	1. 175182			0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	07.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 174165	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 675873	640, 770		0 0	433, 079	90.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00
200.00 Subtotal (see instructions)		640, 770		0 0	433, 079	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		640, 770		0 0	433, 079	202.00

Heal th	Financial Systems	HAMI LTON CE	NTER, INC.		In Lieu of Form CMS-2552-10		
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-4009	Period: From 07/01/2019	Worksheet D Part V	
					To 06/30/2020		ed: am
			Title	e XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.)	(see inst.)	_			
		6.00	7.00				
	ANCI LLARY SERVICE COST CENTERS						~~
	05400 RADI OLOGY - DI AGNOSTI C	0				54.	
	06000 LABORATORY	0				60.	
		0				69.	
	07000 ELECTROENCEPHALOGRAPHY	0				70.	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0				71.	
		0				72.	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0				/3.	00
90.00	09000 CLINIC	0	C			90.	00
	OTHER REIMBURSABLE COST CENTERS	0		/		90.	00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0			98.	00
200.00		0				200.	
200.00		0				200.	
2011.00	Only Charges					201.	00
202.00		o	C			202.	. 00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-4009	Period: From 07/01/2019	Worksheet D-1	
			To 06/30/2020	Date/Time Pre 11/25/2020 9:	par 17
	Cost Center Description	Title XVIII	Hospi tal	PPS 1.00	
	PART I - ALL PROVIDER COMPONENTS		I	1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s. excluding newborn)		5, 511	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	bed and newborn days)	rivate room days,	5, 511 0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	od davs)	-	5, 511	
00	Total swing-bed SNF type inpatient days (including private ro reporting period		er 31 of the cost	0	ĺ
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through Decembe	r 31 of the cost	0	
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	0	0 0	1, 119	Ģ
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc	tions)		0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)		0	11
	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period			0	12
	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this li	ne)	0	
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 0	14 15
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	10
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 c	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of	the cost	0.00	20
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	5, 151, 429 0	21 22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporti	ng period (line 6	0	2:
. 00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	r 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 5, 151, 429	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed c	harges)	0	28
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
	Average semi-private room per diem charge (line 2) + line 3)			0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	, ,		0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	ifferential (line	5, 151, 429	37
	PROT I - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see			934.75	3
	Program general inpatient routine service cost (line 9 x line	-		1, 045, 985	
	Medically necessary private room cost applicable to the Progr			0	40
). 00					

	Financial Systems	HAMI LTON CE				u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider (1	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Pre	
						11/25/2020 9:	
	Cost Center Description	Total	Total	Average Per	Hospital Program Days	PPS Program Cost	
		Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col . 2)	4.00	<u>col. 4)</u>	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
43.00	I NTENSI VE CARE UNI T						43.00
44.00	CORONARY CARE UNIT						44.00
45.00 46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description	-	•	•			
48.00	Program inpatient ancillary service cost (Wk		2 Line 200)			1.00	3 48. OC
	Total Program inpatient costs (sum of lines			ons)		44, 223 1, 090, 208	
	PASS THROUGH COST ADJUSTMENTS	in through 10)	(000 111011 4011	0110)		1,0,0,200	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sun	n of Parts I and	157, 387	50.00
51.00	<pre>III) Pass through costs applicable to Program inp</pre>	ationt ancilla	ny conviors (f	From What D	um of Dorte II	1 07/	51.00
51.00	and IV)		Ty services (1	TOIN WEST. D, S		1, 074	1 51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				158, 461	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	iysician anesth	netist, and	931, 747	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00	Program di scharges					C	54.00
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					C	
57.00 58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and t	arget amount (IIne 56 minus	line 53)	C	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the		
	market basket		Ū I	•			
60.00	Lesser of lines 53/54 or 55 from prior year				the emount by	0. OC C	
61.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					Ĺ	01.00
	amount (line 56), otherwise enter zero (see				<u>-</u> <u>-</u>		
62.00	Relief payment (see instructions)					C	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Instr	uctions)			C	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost reporti	ng period (See	C	64.00
	instructions)(title XVIII only)					_	
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decem	ber 31 of the	cost reporting	period (See	C	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	C	66. 00
	CAH (see instructions)						
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs throug	h December 31	of the cost re	eporting period	C	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after	December 31 of	the cost repo	ortina period	C	68.00
	(line 13 x line 20)				512		
69.00	Total title V or XIX swing-bed NF inpatient					C	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c	2		• •			71.00
72.00	Program routine service cost (line 9 x line		<i>.</i>				72.00
73.00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.00
74.00 75.00	Capital -related cost allocated to inpatient	•		,	Part II, column		74.00
	26, line 45)		(
76.00	Per diem capital -related costs (line 75 ÷ li						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.00
79.00	Aggregate charges to beneficiaries for exces		provi der recor	ds)			79.00
80.00	Total Program routine service costs for comp	arison to the			nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi		1)				81.00
82.00 83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00
84.00	Program inpatient ancillary services (see in						84.00
85.00	Utilization review - physician compensation	(see instructi					85.00
86.00	Total Program inpatient operating costs (sum						86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PAS: Total observation bed days (see instructions					C	87.00
88.00	Adjusted general inpatient routine cost per		÷line 2)				88.00
00.00		e instructions					89.00

Health Financial Systems	HAMILTON CEN	ITER, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020		pared: 17 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	775, 128	5, 151, 429	0. 15046	9 0	0	90.00
91.00 Nursing School cost	0	5, 151, 429	0.0000	0 0	0	91.00
92.00 Allied health cost	0	5, 151, 429	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 151, 429	0.00000	0 0	0	93.00

	Financial Systems HAMILTON CENTER, INC. In Li ATION OF INPATIENT OPERATING COST Provider CCN: 15-4009 Period: From 07/01/201 To 06/30/202		pare
	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
	Inpatient days (including private room days and swing-bed days, excluding newborn)	5, 511	1.
	Inpatient days (including private room days, excluding swing-bed and newborn days)	5, 511	2.
. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days do not complete this line.	s, 0	3.
. 00	Semi-private room days (excluding swing-bed and observation bed days)	5, 511	4.
. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cos	t O	5.
. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	4
. 00	reporting period (if calendar year, enter 0 on this line)	0	6.
. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.
00	reporting period	0	8.
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	ο.
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	840	9.
0.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.
0.00	through December 31 of the cost reporting period (see instructions)	0	10.
1.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	. 0	11.
2 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.
2.00	through December 31 of the cost reporting period	0	12.
3.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.
1 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14
	Total nursery days (title V or XIX only)	0	14
	Nursery days (title V or XIX only)	0	16
7 00 7	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17
7.00	reporting period	0.00	17.
8.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18
9 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	10
7.00	reporting period	0.00	
0.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20
1.00	reporting period Total general inpatient routine service cost (see instructions)	5, 151, 429	21
2.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (lir		22
2 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line	6 0	23
3.00	x line 18)	8 0	23
4.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24
5 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25
5.00	x line 20)		25
	Total swing-bed cost (see instructions)	0	26
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	5, 151, 429	27
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28
	Private room charges (excluding swing-bed charges)	0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	30 31
	Average private room per diem charge (line 29 ÷ line 3)	0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33
	Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0.00	
	Private room cost differential adjustment (line 3 x line 35)	0.00	36
	General inpatient routine service cost net of swing-bed cost and private room cost differential (lir	ie 5, 151, 429	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PART IT - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
8.00	Adjusted general inpatient routine service cost per diem (see instructions)	934. 75	
	Program general inpatient routine service cost (line 9 x line 38) Medically pecessary private room cost applicable to the Program (line 14 x line 35)	785, 190	39 40
U. UU	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 785, 190	

	Financial Systems	HAMILTON CEN				u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider (Period: From 07/01/2019 To 06/30/2020	Worksheet D- Date/Time Pre 11/25/2020 9:	epared:
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Total I npati ent	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		<u>Cost</u> 1.00	<u>Days</u> 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	
42.00							42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1			43.00
44.00	CORONARY CARE UNI T						44.00
							45.00
46.00 47.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						46.00
	Cost Center Description			1			
48.00	Program inpatient ancillary service cost (Wk	st D-3 col 3	3 Line 200)			1.00	48.00
	Total Program inpatient costs (sum of lines			ons)		785, 190	
50.00	PASS THROUGH COST ADJUSTMENTS				C Data L		50.00
50.00	Pass through costs applicable to Program inp	atient routine	services (Tro	OM WKST. D, SU	n of Parts I and	C	50.00
51.00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	C	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				C	52.00
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		elated, non-ph	ysician anest	netist, and	C	53.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges						54.00
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					C	
57.00 58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (line 56 minus	line 53)	C	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the		
60.00	market basket Lesser of lines 53/54 or 55 from prior year		0			0.00	
61.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that	s 55, 59 or 60	enter the les	ser of 50% of	the amount by f the target	C	1
(0.00	amount (line 56), otherwise enter zero (see				Ũ		
62.00 63.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			C	
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST	*	•	a agat rapart	ng posied (See	C	
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	is through Dece		le cost report	ng period (see	Ĺ	64.00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reportin	g period (See	C	65.00
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	l only). For	C	66.00
67.00		e costs through	n December 31	of the cost r	eporting period	C	67.00
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost rep	orting period	C	68.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					C	69.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	utine service	cost (line 37)		70.00
71.00 72.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71.00
73.00	Medically necessary private room cost applic		n (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73	3)			74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)		e costs (from	Worksheet B,	Part II, column		75.00
76.00 77.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.00
78.00	Inpatient routine service cost (line 74 minu	s line 77)					78.00
79.00	Aggregate charges to beneficiaries for exces						79.00
80.00 81.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		JUST TIMITATIC	m (ine /8 mi	ius i i ne 79)		80.00
82.00	Inpatient routine service cost limitation (I		1)				82.00
83.00	Reasonable inpatient routine service costs (ıs)				83.00
84.00 85.00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84.00 85.00
	Total Program inpatient operating costs (sum	of lines 83 th					86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PAS						07.00
87.00 88.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		⊦line 2)			0. 00) 87.00) 88.00
	Observation bed cost (line 87 x line 88) (se	•	,				89.00

Health Financial Systems	HAMILTON CEN	ITER, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Peri od:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020		pared: 17 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	775, 128	5, 151, 429	0. 15046	09 0	0	90.00
91.00 Nursing School cost	0	5, 151, 429	0.0000	0 0	0	91.00
92.00 Allied health cost	0	5, 151, 429	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 151, 429	0.0000	0 0	0	93.00

Health Financial Systems HAM	ILTON CENTER, INC.		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period:	Worksheet D-3	
			From 07/01/2019 To 06/30/2020		pared: 17 am
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	<u>col.2)</u> 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			1, 342, 800		30.00
ANCI LLARY SERVICE COST CENTERS		I	1, 342, 000		30.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0.00000	0 0	0	54.00
60. 00 06000 LABORATORY		1. 17518		13, 665	
69.00 06900 ELECTROCARDI OLOGY		0.00000		0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0.00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000	0 C	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		1. 17416	5 26, 025	30, 558	73.00
OUTPATIENT SERVICE COST CENTERS		1	-		
90. 00 09000 CLINIC		0. 67587	3 0	0	90.00
OTHER REIMBURSABLE COST CENTERS		1		I	
98.00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	
200.00 Total (sum of lines 50 through 94 and 96 thro			37, 653		
201.00 Less PBP Clinic Laboratory Services-Program (only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	37, 653		202.00

Health Financial Systems	HAMILTON CENTER, INC.		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 07/01/2019 To 06/30/2020		narod
			10 00/ 30/ 2020	11/25/2020 9:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			966, 375		30.00
ANCI LLARY SERVI CE COST CENTERS					
54.00 05400 RADI OLOGY - DI AGNOSTI C		0.00000		0	54.00
60. 00 06000 LABORATORY		1. 17518		0	60.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.00000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1. 17416	5 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		1	-		
90. 00 09000 CLINIC		0. 67587	3 0	0	90.00
OTHER REIMBURSABLE COST CENTERS					
98.00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000	0 0		98.00
200.00 Total (sum of lines 50 through 94 and 96			0		200.00
201.00 Less PBP Clinic Laboratory Services-Prog	gram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			0		202.00

	Financial Systems HAMILTON CENTER, IN ATION OF REIMBURSEMENT SETTLEMENT Prov	NC. vider CCN: 15-4009	Period: From 07/01/2019		
			To 06/30/2020	11/25/2020 9:	
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions	s)		433, 079	2.00
3.00	OPPS payments			592, 111	
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
4.01 5.00	Enter the hospital specific payment to cost ratio (see instruction	ns)		0.000	
6.00	Line 2 times line 5	,		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, o	col. 13. line 200		0	
10.00	Organ acqui si ti ons	·····		0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line (69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for payme	ent for services on	a charge basi s	0	15.00
16.00	Amounts that would have been realized from patients liable for pay	yment for services	on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0.000000	18.00
19.00	Excess of customary charges over reasonable cost (complete only it	fline 18 exceeds l	ine 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only it	fline 11 exceeds l	ine 18) (see	0	20.00
20.00	instructions)	I THE TT EXCEEds T	The 10) (See	0	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructi	ions)		0	22.00 23.00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	10113)		592, 111	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24	(for CAN soo inst	ructions)	0 152, 657	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			439, 454	
	instructions)				
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, line 5 ESRD direct medical education costs (from Wkst. E-4, line 36)	50)		0	28.00 29.00
30.00	Subtotal (sum of lines 27 through 29)			439, 454	
	Primary payer payments			0	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			439, 454	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			6,077	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructi	ions)		3, 950 0	35.00 36.00
	Subtotal (see instructions)			443, 404	
38.00	MSP-LCC reconciliation amount from PS&R			0	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replaced of	devices (see instru	ctions)	0	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 443, 404	39.99 40.00
40.00	Sequestration adjustment (see instructions)			7, 405	
40. 02	Demonstration payment adjustment amount after sequestration			0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs Interim payments			122 102	40.03 41.00
41.00 41.01	Interim payments			432, 482	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only)			0 517	42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			3, 517	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance v §115.2	with CMS Pub. 15-2,	chapter 1,	0	
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
00			I	0	, ,

	n Financial Systems HAMILTON CEN SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der C	CN: 15-4009	Period: From 07/01/2019	eu of Form CMS-2 Worksheet E-1 Part I	
				To 06/30/2020		pared: 17 am
		Title	XVIII	Hospi tal	PPS	TT Cam
		I npati en	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		765, 8	43 0	432, 482 0	1.00 2.00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	
3.03 3.04				0	0	3.03 3.04
3.05				0	0	3.05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.50
3.50	ADJUSTWIENTS TO PROGRAW			0	0	
3. 52				0	0	3.5
3.53 3.54				0	0	3.5
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
	3. 50-3. 98)			10	100 100	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		765, 8	43	432, 482	4.00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVIDER			0	0	5.0'
5.02				0	0	
5.03	Provider to Program			0	0	5.03
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.52 5.99
6.00	5.50-5.98) Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		-	0	3, 517	6.0
6.02 7.00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		5 765, 3	23 20	0 435, 999	6.0 7.0
				Contractor	NPR Date	
		()	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
8.00	Name of Contractor			1.00	2.00	8.00

CALCUI	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4009	Period: From 07/01/2019	Worksheet E-3	
			To 06/30/2020	Part II Date/Time Pre 11/25/2020 9:	
		Title XVIII	Hospi tal	PPS	
			-	1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and	d medical education payments)	927, 610	
2.00	Net IPF PPS Outlier Payments			0	
3.00	Net IPF PPS ECT Payments Unweighted intern and resident FTE count in the most rece	ant aget report filed on er	hoforo Novembor	0	
4.00	15, 2004. (see instructions)	ent cost report fired on or	berore woveniber	0.00	4.0
4.01	Cap increases for the unweighted intern and resident FTE	count for residents that we	re displaced by	0.00	4.0
	program or hospital closure, that would not be counted wi				
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)				
5.00	New Teaching program adjustment. (see instructions)			0.00	5.0
5.00	Current year's unweighted FTE count of I&R excluding FTEs	s in the new program growth	period of a "new	0.00	6.0
7 00	teaching program" (see instuctions)			0.00	7.0
7.00	Current year's unweighted I&R FTE count for residents with teaching program" (see instuctions)	thin the new program growth	period of a new	0.00	7.0
3. 00	Intern and resident count for IPF PPS medical education a	adiustment (see instructions)	0.00	8.0
9.00	Average Daily Census (see instructions)		,	15.057377	
0.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	d to the power of .5150 -1}.		0.000000	
1.00	Teaching Adjustment (line 1 multiplied by line 10).			0	11.0
2.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and			927, 610	12.0
3.00	5 15 1	ruction)		0	
4.00	Organ acquisition (DO NOT USE THIS LINE)				14.0
5.00		instructions)		0	
6.00 7.00				927, 610 0	
8.00				927, 610	
9.00	Deducti bl es			143, 660	
0.00				783, 950	
1. 00	Coinsurance			5, 632	21.0
	Subtotal (line 20 minus line 21)			778, 318	
3.00		services) (see instructions)		0	
4.00	, , , , , , , , , , , , , , , , , , ,			0	
5.00 6.00	5 .	Instructions)		0	
7.00		ops)		778, 318 0	
8.00	Other pass through costs (see instructions)	013)		0	
9.00				0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
0.50	Pioneer ACO demonstration payment adjustment (see instruc	ctions)		0	30.5
0. 99	Demonstration payment adjustment amount before sequestrat	tion		0	
1.00				778, 318	
1.01	Sequestration adjustment (see instructions)			12, 998	
1.02		on		745 042	
2.00	Interim payments			765, 843 0	
4.00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01,	31.02. 32 and 33)		-523	
35.00	Protested amounts (nonallowable cost report items) in acc		chapter 1,	0	
	§115.2 TO BE COMPLETED BY CONTRACTOR				
50.00		e 2		0	50.0
51.00				0	
52.00	The rate used to calculate the Time Value of Money	-			52.0
- 2 00	Time Value of Money (see instructions)			0	53.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4009	Peri od:	Worksheet E-3	
			From 07/01/2019 To 06/30/2020	Part VII	pare
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR	XIX SERVICES		-
. 00	COMPUTATION OF NET COST OF COVERED SERVICES		785, 190		1 1.
. 00	Medical and other services		763, 190	0	
. 00	Organ acquisition (certified transplant centers only)		0	0	3.
00	Subtotal (sum of lines 1, 2 and 3)		785, 190	0	
00	Inpatient primary payer payments		0	-	5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		785, 190	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
00	Routi ne servi ce charges		966, 375	0	8
00). 00	Ancillary service charges Organ acquisition charges, net of revenue		0	0	9 10
I. 00	Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		966, 375	0	
	CUSTOMARY CHARGES		700, 070		1 12
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
	basi s	5			
l. 00	Amounts that would have been realized from patients liable for	payment for services	on 0	0	14
	a charge basis had such payment been made in accordance with 4	l2 CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.000000	
5.00	Total customary charges (see instructions)		966, 375	0	16
7.00	Excess of customary charges over reasonable cost (complete onl line 4) (see instructions)	y IT line 16 exceeds	181, 185	0	17
3. 00	Excess of reasonable cost over customary charges (complete onl	vifling 1 exceeds li	no 0	0	18
5.00	16) (see instructions)	y II IIIe 4 exceeds II	0	0	
9.00	Interns and Residents (see instructions)		0	0	19
0. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line 1	6)	785, 190	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS prov	i ders.		
	Other than outlier payments		0	0	
3.00	Outlier payments		0	0	
1.00	Program capital payments		0		24
5.00	Capital exception payments (see instructions)		0	0	25
5.00 7.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	26
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	28
9.00	Titles V or XIX (sum of lines 21 and 27)		785, 190	0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		700,170	0	1 - 1
0. 00	Excess of reasonable cost (from line 18)		0	0	30
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		785, 190	0	31
2.00	Deducti bl es		0	0	
8.00	Coinsurance		0	0	
1.00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
5.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	785, 190	0	
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
3.00	Subtotal (line 36 ± line 37)		785, 190	0	38
9.00).00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0 785, 190	0	
1.00	Interim payments		752, 403	0	40
2.00	Balance due provider/program (line 40 minus line 41)		32, 787	0	
3.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2.	0	0	43
-	chapter 1, §115.2	/		-	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		riod: om 07/01/2019 06/30/2020	Worksheet G Date/Time Pre 11/25/2020 9:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	10, 646, 478	0	0	0	1.00
2.00	Temporary investments	13, 227, 878		0	0	2.00
3.00 4.00	Notes receivable Accounts receivable	0 1, 637, 719	0	0	0	3.00
4.00 5.00	Other receivable	2, 663, 319		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00 9.00	Prepaid expenses Other current assets	582, 291	0	0	0	8.00 9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28, 757, 685	0	0	0	
	FIXED ASSETS					
	Land Land improvements	11, 433, 477	0	0	0	12.00 13.00
	Accumulated depreciation	0	0	0	0	14.00
	Bui I di ngs	0	0	0	0	
	Accumulated depreciation	0	0	0	0	16.00
	Leasehold improvements Accumulated depreciation	0	0	0	0	17.00 18.00
	Fixed equipment	0	0	0	0	19.00
	Accumulated depreciation	0	0	0	0	20.00
	Automobiles and trucks	0	0	0	0	21.00
	Accumulated depreciation	0	0	0	0	22.00 23.00
	Major movable equipment Accumulated depreciation	0	0	0	0	
	Mi nor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
	HIT designated Assets	3, 408, 973	0	0	0	27.00
	Accumulated depreciation Minor equipment-nondepreciable	0	0	0	0	28.00 29.00
	Total fixed assets (sum of lines 12-29)	14, 842, 450	-	0	0	30.00
	OTHER ASSETS					
	Investments	1, 347, 380		0	0	
32.00 33.00	Deposits on Leases Due from owners/officers	1, 340, 748	0	0	0	32.00 33.00
	Other assets	1, 340, 740	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2, 688, 128		0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	46, 288, 263	0	0	0	36.00
37.00	Accounts payable	1, 224, 131	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4, 270, 502	0	0	0	38.00
39.00 40.00	Payroll taxes payable Notes and Loans payable (short term)	0	0	0	0	
	Deferred income	48, 795	0	0	0	
	Accel erated payments	0				42.00
	Due to other funds	0	0	0	0	
	Other current liabilities	1, 896, 877		0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	7, 440, 305	0	0	0	45.00
46.00	Mortgage payable	500, 000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	
	Unsecured Loans	0	0	0	0	
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	0 500, 000	0	0	0	49.00 50.00
	Total liabilities (sum of lines 45 and 50)	7, 940, 305		0	0	51.00
	CAPI TAL ACCOUNTS					
	General fund balance	38, 347, 958				52.00
53.00 54.00	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53.00 54.00
55.00	Donor created - endowment fund balance - restricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	38, 347, 958	0	0	0	59.00
				0	0	

Heal th	Financial Systems	HAMILTON CENT	ER, INC.		In Lie	eu of Form CMS-	2552-10
STATE	STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-4009	Period: From 07/01/2019 To 06/30/2020		epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4,00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 19.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	30 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 40, 943, 750 -2, 595, 822 38, 347, 928 30 38, 347, 958 0 38, 347, 958	3.00)	5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
		Endowment Fund	PI ant	Fund	_		
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-4009	Peri od:		Worksheet G-2	2552-10 !
					7/01/2019 5/30/2020	Parts I & II Date/Time Pre 11/25/2020 9:	
	Cost Center Description		I npati ent	Out	oatient	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
1 00	General Inpatient Routine Services		(070 0	70		(070 070	1 1 00
1.00			6, 373, 8	/9		6, 373, 879	
2.00 3.00	SUBPROVI DER – I PF SUBPROVI DER – I RF						2.00
4.00	SUBPROVIDER - TRF						4.00
5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			J. J		Ū	7.00
8.00	NURSI NG FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		6, 373, 8	79		6, 373, 879	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	I NTENSI VE CARE UNI T						11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00							14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	6.11		~			15.00
16.00	Total intensive care type inpatient hospital services (sum	of lines		0		0	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and	14)	6, 373, 8	70		6, 373, 879	17.00
18.00	Ancillary services	10)	234, 52		0	234, 521	
19.00	Outpatient services		234, 32		2, 153, 938	12, 153, 938	
	RURAL HEALTH CLINIC			0	2, 133, 730	12, 133, 730	•
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	•
	HOME HEALTH AGENCY			-	-	-	22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС				0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	PROFESSIONAL FEES		364, 29		556, 875	921, 171	
27.01	PHYSI CI ANS' PRI VATE OFFI CES			0	0	0	
27.02					3, 884, 909	13, 884, 909	
27.03	CSP			0	0	10 504 000	
27.04	MRO	2 to Wkot	6 072 60		2, 594, 928	12, 594, 928	
28.00	Total patient revenues (sum of lines 17-27)(transfer column G-3, line 1)	S LU WKSL.	6, 972, 69	90 3	9, 190, 650	46, 163, 346	28.00
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)			4	5, 893, 927		29.00
30.00	ADD (SPECI FY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECIFY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00 42.00	Total deductions (sum of lines 37-41)			0	0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		1	5, 893, 927		42.00
	protein operating expenses (sum of Trines 27 and 50 millios Trine			4	5,075,721		1 -2.00

Heal th	Financial Systems	HAMILTON CENTER, INC.	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-4009	Peri od:	Worksheet G-3	
			From 07/01/2019 To 06/30/2020	Date/Time Pre	pared:
				11/25/2020 9:	17 am
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I	. column 3. line 28)		46, 163, 346	1.00
2.00	Less contractual allowances and discounts on p	· · · · · · · · · · · · · · · · · · ·		20, 421, 090	2.00
3.00	Net patient revenues (line 1 minus line 2)			25, 742, 256	3.00
4.00	Less total operating expenses (from Wkst. G-2,	Part II, line 43)		45, 893, 927	4.00
5.00	Net income from service to patients (line 3 mi			-20, 151, 671	5.00
	OTHER INCOME			., . , .	
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneou	us communication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guest	ts		0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supp	olies to other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patie	ents		0	17.00
18.00	Revenue from sale of medical records and abstr	racts		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, et	tc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and	d canteen		0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	INTEREST INCOME			0	24.00
24.01	GRANTS			11, 733, 641	
24.02	COUNTY TAX LEVY			1, 326, 420	24.02
24.03	CONTRI BUTI ONS			362, 423	24.03
	NET UNREALIZED ON INVESTMENT			-1, 476, 764	
	INTEREST INCOME WITH DONOR RESTR.			0	24.05
	CONTRIBUTIONS WITH DONOR RESTR.			207, 171	
	NET REALIZED GAIN ON INVEST			0	24.07
	NET UNREALIZED GAIN ON INVEST			124, 248	
	MENTAL HEALTH FUNDS RECOVERY			4, 764, 997	
	GAIN ON SALE ON DISPOSITION OF ASSET			4, 196	
	NET ASSETS RELEASED FROM DONOR RESTR			0	
	OTHER INCOME			509, 517	
	COVI D-19 PHE Funding			0	24.50
	Total other income (sum of lines 6-24)			17, 555, 849	
	Total (line 5 plus line 25)			-2, 595, 822	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subso			0	28.00
29.00	Net income (or loss) for the period (line 26 m	minus line 28)		-2, 595, 822	29.00