		N CENTER,			u of Form CMS-255	52-10
	eport is required by law (42 USC 1395g; 42 CFR 413.20(b ts made since the beginning of the cost reporting perio				FORM APPROVED OMB NO. 0938-005 EXPIRES 03-31-20	
	AL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFI TTLEMENT SUMMARY	CATION Pr	ovider CCN: 15-4009	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepar 11/30/2022 8:52	
PART I	- COST REPORT STATUS					
Provi d				Date: 11/30/2	022 Time: 8:5	2 am
use on	 Iy 2. []Manually prepared cost report 3. [0]If this is an amended report enter the 4. [F]Medicare Utilization. Enter "F" for ful 	number of or "L" f	times the provider r `or low.	resubmitted this o	cost report	
Contra use on		port for t ort for thi	11.(his Provider CCN 12.		or Code: Jumn 1 is 4: Ent Nes reopened = 0-	
MI SREP ADMI NI S PROVI DI	I - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMIN RESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAIN STRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL ED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECT STRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	IED IN THIS LAW. FUR	COST REPORT MAY BE THERMORE, IF SERVICE	S IDENTIFIED IN T	HIS REPORT WERE	
	CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINIST	RATOR OF PR	ROVI DER(S)			
	I HEREBY CERTIFY that I have read the above certifical electronically filed or manually submitted cost report Statement of Revenue and Expenses prepared by HAMILTO beginning 07/01/2021 and ending 06/30/2022 and to the are true, correct, complete and prepared from the boo applicable instructions, except as noted. I further of regarding the provision of health care services, and provided in compliance with such laws and regulations	rt and subm DN CENTER, e best of m oks and rec certify that that the s	hitted cost report ar INC. (15–4009) for my knowledge and beli cords of the provider at I am familiar with	nd the Balance She the cost reporti ef, this report a in accordance wi the laws and reg	eet and ng period and statement th gulations	
	GIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C		
	1	2	SIG	NATURE STATEMENT		
1	Tracie Session	Y	I have read and agr statement. I certif signature on this c binding equivalent	y that I intend m ertification be t	y electronic he legally	1

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	0	0	0	-107,838	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
12.00	CMHCI	0		0		0	12.00
200.00	Total	0	0	0	0	-107.838	200.00

3

The 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 it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security 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 PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

2 Signatory Printed Name Tracie Session

CFO

(Dated when report is electronica

3 Signatory Title

4 Date

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENIIFICATION DATA	Provi d	er CCN	F	Period: From 07/01/2 To 06/30/2		Workshe Part I Date/Ti 11/30/2	me Pre	epare
	1.00	2.00		3.00		4	. 00			
	Hospital and Hospital Health Care Co									
00	Street: 620 EIGHTH AVENUE	PO Box:								1.
00	City: TERRE HAUTE	State: IN	Zip Code	e: 4780	04 County	y: VIGO				2.
		Component Name	CCN	CBSA	A Provider	Date	Payme	nt Syst	em (P,	
			Number	Numbe	er Type	Certi fi ed	Т,	0, or	N)	
						1	V	XVIII	XIX	1
		1.00	2.00	3.00	0 4.00	5.00	6.00	7.00	8.00	1
	Hospital and Hospital-Based Componer				- 1			1	1 0.00	
00	Hospi tal	HAMILTON CENTER, INC.	154009	4546	0 4	11/15/1973	N	Р	0	3.
00	Subprovider - IPF								-	4.
00	Subprovider - IRF									5.
00	Subprovider - (Other)									6.
										1
00	Swing Beds - SNF									7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF									9.
. 00	Hospital-Based NF									10.
. 00	Hospital-Based OLTC									11.
. 00	Hospital-Based HHA									12.
. 00	Separately Certified ASC									13.
. 00	Hospital-Based Hospice									14.
. 00	Hospital-Based Health Clinic - RHC									15.
00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17.
00	Renal Dialysis									18.
	Other									19.
	[L			I	From:		То		
						1.00		2. (1
00	Cost Reporting Period (mm/dd/yyyy)					07/01/20)21	06/30/		20.
	Type of Control (see instructions)					2		00,00,	LOLL	21.
00						2				21.
				-	1.00	2.00		3. (0	1
	Inpatient PPS Information				1.00	2.00		0.0		
. 00	Does this facility qualify and is it	currently receiving pa	wments for	-	N	N				22.
. 00	disproportionate share hospital adju				IN IN	IN IN				22.
	§412.106? In column 1, enter "Y" fo			`						
	facility subject to 42 CFR Section §									
			lenument							
01	hospital?) In column 2, enter "Y" fo		te for thi	c	Ν	N				22.
01	Did this hospital receive interim un cost reporting period? Enter in colu				IN	IN IN				22.
	1 51									
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N			cost						
	reporting period occurring on or aft									
02	Is this a newly merged hospital that				N	N				22.
	payments to be determined at cost re			וs)						
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob	er 1. Enter in column 2	2, "Y" for	yes						
	or "N" for no, for the portion of th	e cost reporting period	l on or aft	ter						
	October 1.									
	Did this hospital receive a geograph	ic reclassification fro	om urban to	o	N	N		N		22.
03	and an a manulation of the OND stands	ds for delineating stat	istical a	reas						
03	FULTAL AS A LESULE OF THE OWB STANDAR									
03				ן סר						
03	adopted by CMS in FY2015? Enter in c	olumn 1, "Y" for yes or	"N" for r							
03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir	olumn 1, "Y" for yes or g period prior to Octob	- "N" for r per 1. Ente							
03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for	olumn 1, "Y" for yes or g period prior to Octob no for the portion of t	"N" for r per 1. Ente the cost							
03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see ins1	"N" for r ber 1. Ente he cost ructions)	er						
03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	r "N" for r ber 1. Ente the cost tructions) 199 beds (a	er as						
03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	r "N" for r ber 1. Ente the cost tructions) 199 beds (a	er as						
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in column	"N" for r ber 1. Ente the cost cructions) 199 beds (a n 3, "Y" fo	er as or	Ν	Ν		Ň		22
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro	"N" for r per 1. Ente the cost ructions) 199 beds (a 1 3, "Y" fo pm urban to	er as or o	Ν	N		Ν		22.
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME	olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati	"N" for r per 1. Ente the cost ructions) 199 beds (a n 3, "Y" fo om urban to stical are	er as or o eas	Ν	N		Ν		22.
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o	"N" for r per 1. Ente the cost rructions) 199 beds (a n 3, "Y" fo om urban to stical are or "N" for	er as or ceas no	Ν	N		Ν		22.
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob	"N" for r per 1. Ente the cost tructions) 199 beds (a n 3, "Y" fo stical are or "N" for per 1. Ente	er as or ceas no	Ν	N		Ν		22.
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of 1	"N" for r per 1. Ente cructions) 199 beds (a n 3, "Y" fo murban to stical are per 1. Ente che cost	er as or ceas no	Ν	N		N		22.
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of 1 er October 1. (see inst	"N" for r per 1. Ente cructions) 199 beds (a m urban to stical arc pr "N" for ver 1. Ente che cost cructions)	er as or eas no er	Ν	N		Ν		22.
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4	"N" for r per 1. Ente cructions) 199 beds (2 om urban to stical arc or "N" for oper 1. Ente che cost cructions) 199 beds (2	er as or eas no er	Ν	N		Ν		22.
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4	"N" for r per 1. Ente cructions) 199 beds (2 om urban to stical arc or "N" for oper 1. Ente che cost cructions) 199 beds (2	er as or eas no er	Ν	Ν		Ν		22.
04	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum	"N" for r per 1. Ente the cost (199 beds (a n 3, "Y" for stical are or "N" for per 1. Ente the cost (199 beds (a n 3, "Y" f	er as or eas no er as for	Ν			Ν		
04	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum	"N" for r per 1. Ente the cost (199 beds (a n 3, "Y" for stical are or "N" for per 1. Ente the cost (199 beds (a n 3, "Y" f	er as or eas no er as for		N 3 N		Ν		22.
04	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum dicaid days on lines 24	"N" for r per 1. Ente cructions) 199 beds (a n 3, "Y" for stical arc stical arc stical arc tor "N" for per 1. Ente che cost rructions) 199 beds (a nn 3, "Y" 1	er as bor eas no er as for				Ν		
04	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum dicaid days on lines 24 of admission, 2 if cens	"N" for r per 1. Ente cructions) 199 beds (a n 3, "Y" for stical arc or "N" for or "N" for ser 1. Ente che cost cructions) 199 beds (a nn 3, "Y" 1 4 and/or 25 sus days, o	er as or eas no er as for 5 7 7				Ν		

	RE COMPLEX IDENTIFICATION D	ATA I	Provider CC	CN: 15-4009	Period:	1/2021	Works Part	heet S-2	2
				1		30/2022	Date/ 11/30	Time Pre 1/2022 8:	eparec 52 am
		In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medica HMO da		Other edi cai d	
		pai d days	el i gi bl e	Medi cai d	Medi cai d		ays w	days	
			unpai d	paid days	el i gi bl e				
		1.00	days 2.00	3.00	unpai d 4. 00	5.00		6.00	-
1.00 If this provider is an IF	PPS hospital, enter the	1.00	2.00				0	0.00 C	24.
in-state Medicaid paid da	ays in column 1, in-state						-		
Medicaid eligible unpaid									
out-of-state Medicaid pai	gible unpaid days in column	1							
4, Medicaid HMO paid and	eligible but unpaid days ir								
column 5, and other Medic		0	0	0	0		0		25
.00 If this provider is an IF Medicaid paid days in col		0	0	0	0		0		25.
Medicaid eligible unpaid	days in column 2,								
	ys in column 3, out-of-state	9							
5 1	days in column 4, Medicaid t unpaid days in column 5.								
		1		1	Urban/F			of Geogr .00	
	raphic classification (not w nter "1" for urban or "2" fo		at the be	gi nni ng of		1	2		26.
	raphic classification (not v		at the en	d of the co	st	1			27.
reporting period. Enter i	n column 1, "1" for urban o	or"2" for r	ural. If a						
.00 If this is a sole communi	of the geographic reclassif				n	C			35.
effect in the cost report			perrous s	UN STATUS I	11	C C	ĺ		35.
					Begi n			di ng:	_
.00 Enter applicable beginnir	a and ending dates of SCH s	status Subs	crint line	36 for num	1.	00	2	2. 00	36.
	one and enter subsequent dat		cript rine	30 101 1101					50.
.00 If this is a Medicare dep		er the numbe	er of perio	ds MDH stat	us	C			37.
is in effect in the cost 01 Is this hospital a former	reporting period. ^MDH that is eligible for 1	bo MDH tran	citional n	avmont in					37.
	OPPS final rule? Enter "Y" f								57.
instructions)									
3.00 fline 37 is 1, enter th	ne beginning and ending date	se of MDH et							
greater than 1 subscript	t this line for the number of	f neriode i	atus. It I	ine 37 is					38.
greater than 1, subscript enter subsequent dates.	t this line for the number of	of periods i	n excess o	f one and					38.
greater than 1, subscript	t this line for the number of	of periods i	n excess o	f one and	Y/			Y/N	38.
greater than 1, subscript enter subsequent dates.		of periods i	n excess o	f one and	1.	00		2. 00	_
greater than 1, subscript enter subsequent dates. .00 Does this facility qualif	t this line for the number of fy for the inpatient hospita vith 42 CFR §412.101(b)(2)(i	of periods i al payment a	n excess o	f one and	1. ume N	00			_
greater than 1, subscript enter subsequent dates. .00 Does this facility qualif hospitals in accordance v 1 "Y" for yes or "N" for	Fy for the inpatient hospita vith 42 CFR §412.101(b)(2)(i no. Does the facility meet	of periods i al payment a), (ii), or the mileage	n excess o djustment (iii)? En e requireme	f one and for low vol ter in colu nts in	ume M mn	00		2. 00	_
greater than 1, subscript enter subsequent dates.	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i	of periods i al payment a), (ii), or the mileage	n excess o djustment (iii)? En e requireme	f one and for low vol ter in colu nts in	ume M mn	00		2. 00	_
greater than 1, subscript enter subsequent dates.	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions)	of periods i al payment a), (ii), or the mileage ii)? Enter	n excess o djustment (iii)? En e requireme in column	f one and for low vol ter in colu nts in 2 "Y" for y	ume M mn res	00		2. 00	39.
greater than 1, subscript enter subsequent dates. .00 Does this facility qualif hospitals in accordance v 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr .00 Is this hospital subject "N" for no in column 1, f	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reductio for discharges prior to Octo	of periods i al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente	n excess o djustment (iii)? En e requireme in column ht? Enter " er "Y" for	f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes	ume 1. mn es or N	00		2. 00	39.
greater than 1, subscript enter subsequent dates. .00 Does this facility qualif hospitals in accordance v 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr .00 Is this hospital subject "N" for no in column 1, f	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i -uctions) to the HAC program reductio	of periods i al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente	n excess o djustment (iii)? En e requireme in column ht? Enter " er "Y" for	f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes	ume 1. mn es or N	00	2	N. 00	39.
greater than 1, subscript enter subsequent dates. 00 Does this facility qualif hospitals in accordance v 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr 00 Is this hospital subject "N" for no in column 1, f no in column 2, for disch	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reductio for discharges prior to Octo harges on or after October 1	of periods i al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente	n excess o djustment (iii)? En e requireme in column ht? Enter " er "Y" for	f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes	ume 1. mn es or N	00	2 XVI I	2. 00 N N	39.
greater than 1, subscript enter subsequent dates. .00 Does this facility qualif hospitals in accordance v 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr .00 Is this hospital subject "N" for no in column 1, f no in column 2, for disch Prospective Payment Syste	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital	of periods i al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente 1. (see inst	n excess o djustment (iii)? En requireme in column er "Y" for ructions)	f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes yes or "N"	1. mn es or N for	00 N N 1.00	XVI 1 0 2.00	N N 1 XIX 0 3.00	39. 40.
greater than 1, subscript enter subsequent dates. .00 Does this facility qualif hospitals in accordance v 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr .00 Is this hospital subject "N" for no in column 1, f no in column 2, for disch Prospective Payment Syste	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital fy and receive Capital payme	of periods i al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente 1. (see inst	n excess o djustment (iii)? En requireme in column er "Y" for ructions)	f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes yes or "N"	1. mn es or N for	00 N N 1.00	2 XVI I	2. 00 N N	38. 39. 40. 45.
greater than 1, subscript enter subsequent dates. .00 Does this facility qualif hospitals in accordance w 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr "N" for no in column 1, f no in column 2, for disch .00 Does this facility qualif with 42 CFR Section §412. .00 Is this facility eligible	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital fy and receive Capital payme 320? (see instructions) e for additional payment exc	of periods i al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente L. (see inst ent for disp ception for	n excess o djustment (iii)? En requireme in column t? Enter " ructions) proportiona extraordin	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums	1. ume N mn es or N for accordance tances	00 N N E N N	XVI 1 0 2.00	N N 1 XIX 0 3.00	39. 40. 45.
greater than 1, subscript enter subsequent dates. .00 Does this facility qualif hospitals in accordance w 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr 00 Is this hospital subject "N" for no in column 1, f no in column 2, for disch .00 Does this facility qualif with 42 CFR Section §412. .00 Is this facility eligible pursuant to 42 CFR §412.3	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital fy and receive Capital payme 320? (see instructions)	of periods i al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente L. (see inst ent for disp ception for	n excess o djustment (iii)? En requireme in column t? Enter " ructions) proportiona extraordin	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums	1. ume N mn es or N for accordance tances	00 N N E N N	2 XVII 0 2.00 N	N N I XIX 0 3.00	39. 40. 45.
greater than 1, subscript enter subsequent dates. .00 Does this facility qualif hospitals in accordance v 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr "N" for no in column 1, f no in column 2, for disch .00 Prospective Payment Syste Does this facility qualif with 42 CFR Section §412. .00 Is this facility eligible pursuant to 42 CFR §412.3 Pt. III.	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital fy and receive Capital payme 320? (see instructions) e for additional payment exc	al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter . (see inst ent for disp ception for st. L, Pt. I	n excess o djustment (iii)? En requireme in column er "Y" for ructions) proportiona extraordin II and Wks	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt.	1. ume 1 es or 1 for accordance tances I through	00 N N E N N	2 XVII 0 2.00 N	N N I XIX 0 3.00	39. 40.
greater than 1, subscript enter subsequent dates.	Fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital Fy and receive Capital payme 320? (see instructions) e for additional payment exo 348(f)? If yes, complete Wks	al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter l. (see inst ent for disp ception for st. L, Pt. I capital? E	n excess o djustment (iii)? En requireme in column er "Y" for ructions) proportiona extraordin II and Wks	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N	1. ume mn es or for accordance tances I through "for no.	00 I V 1.00 P N N	2 XVI I D 2.00 N N	N N 1 XIX 0 3.00 N N	40. 45. 46. 47.
greater than 1, subscript enter subsequent dates.	Fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i uctions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital Fy and receive Capital payme 320? (see instructions) e for additional payment exo 348(f)? If yes, complete Wks full federal capital paymer	of periods i al payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Enter 1. (see inst ception for st. L, Pt. I capital? E tt? Enter "	n excess o djustment (iii)? En requireme in column at? Enter "' ructions) roportiona extraordin II and Wks inter "Y for yes	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for	1. ume 1 mn es or 1 for 1 accordance tances I through " for no. no.	00 J V 1.00 P N N N N	2 XVII 0 2.00 N N N	N N 1 XIX 0 3.00 N N N	40. 45. 46. 47. 48.
greater than 1, subscript enter subsequent dates.	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital fy and receive Capital paymen 320? (see instructions) e for additional payment exc 348(f)? If yes, complete Wks hder 42 CFR §412.300(b) PPS	al payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Enter . (see inst cent for disp ception for st. L, Pt. I capital? Enter "	n excess o djustment (iii)? En e requireme in column at? Enter "' er "Y" for ructions) oroportiona extraordin II and Wks inter "Y fo Y" for yes	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y	1. ume 1 mn res or 1 for 1 accordance tances I through " for no. " for yes of	00 J V 1.00 P N N N N	2 XVII 0 2.00 N N N	N N 1 XIX 0 3.00 N N N	40. 45. 46. 47. 48.
greater than 1, subscript enter subsequent dates. 00 Does this facility qualif hospitals in accordance w 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr "N" for no in column 1, f no in column 2, for disch 00 Does this facility qualif with 42 CFR Section §412. 00 Is this facility eligible pursuant to 42 CFR §412. 01 Is this a new hospital ur 02 Is this a new hospital ur 03 Is this a new hospital ur 04 Is this a hospital s 05 Is this a hospital involv "N" for no in column 1. f was involved in training	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reductic for discharges prior to Octo harges on or after October 1 em (PPS)-Capital fy and receive Capital payme 320? (see instructions) e for additional payment exc 348(f)? If yes, complete Wks hder 42 CFR §412.300(b) PPS full federal capital payment red in training residents in for column 2, if the respons residents in approved GME p	al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter l. (see inst ent for disp ception for st. L, Pt. I capital? E tt? Enter " n approved C se to column programs in	n excess o djustment (iii)? En requireme in column rructions) rructions) oroportiona extraordin II and Wks inter "Y fo Y" for yes ME program 1 is "Y",	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen	1. ume mn es or for accordance tances I through for no. no. "for yes of hospital ultimate	00 1 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	2 XVII 0 2.00 N N N	N N 1 XIX 0 3.00 N N N	40. 45. 46. 47. 48.
greater than 1, subscript enter subsequent dates.	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital Fy and receive Capital paymen 320? (see instructions) e for additional payment exc 348(f)? If yes, complete Wks full federal capital paymen red in training residents in for column 2, if the respons residents in approved GME p poacted by CR 11642 (or appli	of periods i al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter ber 1. Enter con adjustmer ber 1. Enter con adjustmer ception for st. L, Pt. I capital? Enter n approved C se to column programs in cable CRs)	n excess o djustment (iii)? En requireme in column rructions) rructions) oroportiona extraordin II and Wks inter "Y fo Y" for yes ME program 1 is "Y",	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen	1. ume mn es or for accordance tances I through for no. no. "for yes of hospital ultimate	00 1 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	2 XVII 0 2.00 N N N	N N 1 XIX 0 3.00 N N N	40. 45. 46. 47. 48.
greater than 1, subscript enter subsequent dates.	Fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital fy and receive Capital payme 320? (see instructions) e for additional payment exc 348(f)? If yes, complete Wks full federal capital paymer ved in training residents in For column 2, if the respons residents in approved GME p pacted by CR 11642 (or appli wise, enter "N" for no in co	of periods i al payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Enter 1. (see inst ception for st. L, Pt. I capital? E tt? Enter " n approved C se to column orograms in cable CRS) olumn 2.	n excess o djustment (iii)? En requireme in column at? Enter "' ructions) roportiona extraordin II and Wks anter "Y for Y" for yes ME program 1 is "Y", the prior MA direct	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment	1. ume mn es or for accordance tances 1 through "for no. "for yes of hospital ultimate reduction"	00 1 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	2 XVII 0 2.00 N N N	N N 1 XIX 0 3.00 N N N	40. 40. 45. 46. 47. 48. 56.
greater than 1, subscript enter subsequent dates.	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i "uctions) to the HAC program reduction for discharges prior to Octo- harges on or after October 1 em (PPS)-Capital fy and receive Capital payment 320? (see instructions) e for additional payment exo 348(f)? If yes, complete Wks nder 42 CFR §412.300(b) PPS full federal capital payment ved in training residents in For column 2, if the response residents in approved GME p poacted by CR 11642 (or appli wise, enter "N" for no in co s the first cost reporting this facility? Enter "Y" for	al payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Enter con adjustmer ber 1. Enter ent for disp ception for st. L, Pt. I capital? Enter " n approved (C se to column programs in cable CRS) olumn 2. period duri or yes or "N	n excess o djustment (iii)? En requireme in column t? Enter "' ructions) proportiona extraordin II and Wks inter "Y for Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1.	1. ume mn res or for for accordance tances I through "for no. "no. "for yes of hospital ultimate reduction" approved If column	00 V 1.00 P N N N N N N N 1	2 XVII 0 2.00 N N N	N N 1 XIX 0 3.00 N N N	40. 40. 45. 46. 47. 48. 56.
greater than 1, subscript enter subsequent dates.	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo- harges on or after October 1 em (PPS)-Capital fy and receive Capital paymen 320? (see instructions) e for additional payment exo 348(f)? If yes, complete Wks ander 42 CFR §412.300(b) PPS full federal capital paymen residents in approved GME p pacted by CR 11642 (or appli wise, enter "N" for no in co s the first cost reporting this facility? Enter "Y" for t training in the first mor	al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter the second second ent for disp ception for st. L, Pt. I capital? E taptron for st. L, Pt. I capital? E taptron for second second second s	n excess o djustment (iii)? En requireme in column or 2 Enter "' rructions) or 2 Enter "Y for yes rructions) or 2 Enter "Y for yes rructions) or 2 Enter "Y for yes rructions) or 2 Enter "Y for yes rructions) or 2 Enter "Y for yes or 2 Enter "Y for yes or 2 Enter "Y for yes inter "Y for yes multis "Y", the prior MA direct in g which r " for no i cost repor	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or in for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period	1. ume mn es or for for accordance tances I through for no. no. for yes of hospital ultimate reduction approved If column ? Enter	00 1 1 1 0 1 0 1 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0	2 XVII 0 2.00 N N N	N N 1 XIX 0 3.00 N N N	40. 40. 45. 46. 47. 48. 56.
greater than 1, subscript enter subsequent dates. 0.00 Does this facility qualif hospitals in accordance w 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr "N" for no in column 1, f no in column 2, for disch Prospective Payment Syste 0.00 Is this facility qualif with 42 CFR Section §412. Does this facility eligible pursuant to 42 CFR §412. Pt. III. 100 Is this a new hospital ur 100 Is this a new hospital ur 100 Is this a hospital s 100 Is this a hospital involv "N" for no in column 1. f was involved in training year, and are you are imp Enter "Y" for yes; otherv 101 I ine 56 is yes, is thi 102 GME of the star 103 GME of the star 103 GME of the star 104 GME of the star 105 G	fy for the inpatient hospita with 42 CFR §412.101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i ructions) to the HAC program reduction for discharges prior to Octo- harges on or after October 1 em (PPS)-Capital fy and receive Capital paymen 320? (see instructions) e for additional payment exo 348(f)? If yes, complete Wks hder 42 CFR §412.300(b) PPS full federal capital payment residents in approved GME pro- poacted by CR 11642 (or appli- wise, enter "N" for no in co s the first cost reporting this facility? Enter "Y" for t training in the first mor column 2. If column 2 is "	al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter l. (see inst ent for disp ception for st. L, Pt. I capital? Enter " n approved C se to column orograms in cable CRs) olumn 2. period duri or yes or "N th of this	n excess o djustment (iii)? En requireme in column er "Y" for rructions) oroportiona extraordin II and Wks inter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or in for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period	1. ume mn es or for for accordance tances I through for no. no. for yes of hospital ultimate reduction approved If column ? Enter	00 1 1 1 0 1 0 1 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0	2 XVII 0 2.00 N N N	N N 1 XIX 0 3.00 N N N	39. 40. 45. 46.
greater than 1, subscript enter subsequent dates. .00 Does this facility qualif hospitals in accordance w 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr "N" for no in column 1, f no in column 2, for disch .00 Does this facility qualif with 42 CFR Section §412. .00 Is this facility eligible pursuant to 42 CFR §412. .01 Is this a new hospital ur Is the facility electing Teaching Hospitals .00 Is this a new hospital ur Is the facility electing Teaching Hospitals .00 Is this a hospital involv "N" for no in column 1. f was involved in training year, and are you are imp Enter "Y" for yes; otherv .00 If line 56 is yes, is thi GME programs trained at t is "Y" did residents star for yes or "N" for no in	Fy for the inpatient hospita with 42 CFR §412. 101(b)(2)(i no. Does the facility meet 12.101(b)(2)(i), (ii), or (i uctions) to the HAC program reduction for discharges prior to Octo harges on or after October 1 em (PPS)-Capital Fy and receive Capital payme 320? (see instructions) e for additional payment exco 348(f)? If yes, complete Wks hder 42 CFR §412.300(b) PPS full federal capital paymer ved in training residents in For column 2, if the respons residents in approved GME pacted by CR 11642 (or appli wise, enter "N" for no in co s the first cost reporting this facility? Enter "Y" for ro column 2. If column 2 is " arts III & IV and D-2, Pt. I	al payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Enter . (see inst . (see inst) . (see inst . (see inst) . (n excess o djustment (iii)? En requireme in column at? Enter "' rructions) roportiona extraordin II and Wks anter "Y for Y" for yes ME program 1 is "Y", the prior MA direct ng which r. " for no i cost repor e Workshee cable.	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If c	1. ume 1. mn 1. es 0 or 1. for 1. accordance 1. tances 1. I.through 1. "for no. 1. "for yes of hospital 1. ultimate reduction? reduction? approved If column ? Enter "	00 1 1 1 0 1 0 1 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0	2 XVII 0 2.00 N N N	N N 1 XIX 0 3.00 N N N	40. 40. 45. 46. 47. 48. 56.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CA			TER, INC. Provider CO	CN: 15-4009	Period:	u of Form CMS-2 Worksheet S-2	
					From 07/01/2021 To 06/30/2022	Part I	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
any programs that meet th instructions) Enter "Y" is "Y", are you impacted	and allied health education ne criteria under 42 CFR 413. for yes or "N" for no in col by CR 11642 (or subsequent (for yes or "N" for no in colu	85? (s umn 1. CR) NAHE	see If column 1	N			60.00
		Y/N	IME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive section 5503? Enter "Y" column 1. (see instruction 61.01 Enter the average number	for yes or "N" for no in ons)				0.00	0.00	61.00
	3 most recent cost reports						01.01
	otal unweighted primary care GYN, general surgery FTEs, ded under section 5503 of						61.02
61.03 Enter the base line FTE	esidents, which is used for						61.03
61.04 Enter the number of unwe surgery allopathic and/o	ighted primary care/or r osteopathic FTEs in the eriod.(see instructions).						61.04
	TEs and the current year's ral surgery FTE counts (line						61.05
61.06 Enter the amount of ACA	§5503 award that is being or FTEs that are nonprimary						61.06
		Pro	ogram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1 1 1 1
for each new program. (se column 1, the program na program code. Enter in ce	ne number of FTE residents ee instructions) Enter in me. Enter in column 2, the				0.00	0.00	61.10
51.20 Of the FTEs in line 61.02 program specialty, if any residents for each expan- instructions) Enter in co Enter in column 2, the p	y, and the number of FTE ded program. (see olumn 1, the program name. rogram code. Enter in column d count. Enter in column 4,				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting	the Health Resources and Se	rvi ces /	Admini <u>strat</u> ior	n (HRSA)			
2.00 Enter the number of FTE		traineo			eriod for which	0.00	62.00
52.01 Enter the number of FTE during in this cost repo	residents that rotated from a rting period of HRSA THC prog	a Teachi gram. (s	<u>see instructio</u>		o your hospital	0.00	62.01
63.00 Has your facility trained	Claim Residents in Nonprovid d residents in nonprovider se o in column 1. If yes, comple	ettings	during this o			N	63.00

ealth Financial Systems IOSPITAL AND HOSPITAL HEALTH CARE COMPL		<u>.TON CENTER, INC.</u> ATA Provider CO		In Lie eriod:	Worksheet S-2	
				om 07/01/2021	Part I	pared:
			Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider	FTEs in Hospital	1/ (col . 1 + col . 2))	
			Site	•		
Section 5504 of the ACA Base Yea	r ETE Docidonte in N	lonnrovi dor Sotti nac	1.00	2.00	<u>3.00</u>	
period that begins on or after J			- This base year	is your cost	reporting	
4.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0. 00	0. 00	0. 000000	64. OC
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
	J. J		FTEs Nonprovi der	FTEs in Hospital	3/ (col . 3 + col . 4))	
-	1 00	2.00	Site	1 00	5.00	-
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00		65.00
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)			Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	gsEffective f	or cost report	ing periods	
6.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of	unweighted non-prima ccurring in all nonp unweighted non-prima	rovider settings. ry care resident	0.00	0.00	0. 000000	66.00
FTEs that trained in your hospit (column 1 divided by (column 1 +						
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	Si te 3. 00	4.00	5.00	
77.00 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 3 divided by (column 3 + column	1. UU	2.00	0.00	<u> 4.00 0.00 </u>		67.00

Heal th	Financial Systems HAMILTON CENTER, INC.		In Lieu	of For	m CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4009	Period: From 07/0 To 06/30	1/2021 0/2022	Workshe Part I Date/Ti 11/30/2	me Pre	epared:
				2.00		
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF	subprovi der		1		70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program	·		N	0	71.00
71.00	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" Column 3: If column 2 is Y, indicate which program year began during this cost repo (see instructions)	for no. (see teaching for no.		N	0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an	RF	N			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program	in the most			0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for y no. Column 2: Did this facility train residents in a new teaching program in accord CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 indicate which program year began during this cost reporting period. (see instructi	es or "N" fo ance with 42 is Y,	r			
			-	1. 0)0	-
	Long Term Care Hospi tal PPS					00.00
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost repor "Y" for yes and "N" for no.	ting period?	Enter	N N		80.00 81.00
85.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for	yes or "N" f	or no.	N		85.00
	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Se §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under sect			N		86.00 87.00
	1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.	V		XI		07.00
		1.0	0	2. 0		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" f	or N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either i	n N		Y		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Ν		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Ent "Y" for yes or "N" for no in the applicable column.	er N		Ν		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		Ν		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. C N	0	0. C N		95.00 96.00
	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents pos stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in		0	0. 0 Y		97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on W C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2	kst. Y		Y		98.01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observatio bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column			Y		98.02
98.03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (C reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in colu			Ν		98.03
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V,	N		Ν		98.04
98.05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, an			Y		98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y		Y		98.06
	column 2 for title XIX. Rural Providers					1
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of pay	nent N				105.00 106.00
	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for 1&					107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems HAMILTON CEN	TER, INC.		In Lieu	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-4009 P F T	eriod: rom 07/01/2021 o 06/30/2022	Worksheet S- Part I Date/Time Pr 11/30/2022 8	repared:
		·	V	XIX	
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	1.00 N	2.00	108.00
-	Physi cal	Occupational	Speech	Respi ratory	<u>, </u>
109.00 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.	1.00	2.00	3.00	4.00	109.00
110.00 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 Wor applicable.	Y" for yes or	r "N" for no. I	f yes,	1.00 N	110.00
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the n column 2.	N		111.00
		1.00	2.00	3.00	-
112.00 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 ne	N			112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115.00
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 "9 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.	3, or E only) 93" percent (includes rs) based on				
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insur	ance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr		2	2		118.00
		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00	0118.01
		00,702			
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.			1.00 N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 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 Extension and use a "N" for your and "for your and "for your and".	ו column 1, "י ualifies for ז	Y" for yes or the Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	N		121.00
122.00 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.			N		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N	'for no. If	N		125.00
126.00 If this is a Medicare certified kidney transplant center, er		fication date			126.00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent		fication date			127.00
in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, en	2.				128.00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	2.				129.00

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE C	COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-4009		7/01/2021	Worksheet S- Part I	
				To 0	6/30/2022	Date/Time Pi 11/30/2022 8	
					1.00	2.00	-
0.00 If this is a Medicare certifi date in column 1 and terminat			ti fi cati on				130.
1.00 If this is a Medicare certifi	ied intestinal transplant cen	nter, enter the c	erti fi cati d	on			131.0
date in column 1 and terminat 2.00 f this is a Medicare certifi			ication dat				132.
in column 1 and termination c							
3.00Removed and reserved 4.00If this is an organ procureme	ent organization (OPO) enter	r the OPO number	in column 1				133. 134.
and termination date, if appl							134.
All Providers 0.00 Are there any related organiz	zation or home office costs :	as defined in CMS	Pub 15-1		N		140.
chapter 10? Enter "Y" for yes	s or "N" for no in column 1.	If yes, and home	office cos				110.
are claimed, enter in column 1.00		<u>ber. (see instruc</u> 2.00	tions)		3.00		
If this facility is part of a	a chain organization, enter	on lines 141 thro	ugh 143 the	e name ar		of the home	
office and enter the home off 1.00Name:	<u>Fice contractor name and con</u> Contractor's Name:		Contra	ctor's Nu	mber:		141.
2.00Street:	PO Box:						142.
3. 00 Ci ty:	State:		Zip Coo	de:			143.
						1.00	
4.00 Are provider based physicians	s' costs included in Workshee	et A?				Y	144.
					1.00	2.00	
5.00 f costs for renal services a inpatient services only? Ente							145.
	ty include Medicare utilizati						
period? Enter "Y" for yes or	r"N" for no in column 2.		t roport?		N		114
period? Enter "Y" for yes or	rّ"N" for no in column 2. odology changed from the prev	viously filed cos		lf	N		146.
period? Enter "Y" for yes or 6.00Has the cost allocation metho	r ["] N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul	viously filed cos		lf	N		146.
period? Enter "Y" for yes or 6.00Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date	r"N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2.	viously filed cos b. 15-2, chapter	40, §4020)	lf	N	1.00	146.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta	r"N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" fo	viously filed cos b. 15-2, chapter or yes or "N" for	40, §4020)	lf	N	N	147.
period? Enter "Y" for yes or 6.00Has the cost allocation metho Enter "Y" for yes or "N" for	r"N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y"	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f	40, §4020) no. or no.		N		147. 148.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc	r"N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y"	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A	40, §4020) no. or no. es or "N" f Part B	for no.	itle V	N N Title XIX	147. 148. 149.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc	r "N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" fo der of allocation? Enter "Y" mplified cost finding method?	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00	40, \$4020) no. or no. es or "N" f Part B 2.00	for no.	itle V 3.00	N N Title XIX 4.00	147. 148. 149.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc 9.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes	r "N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method provider that qualifies for	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli	For no. T	itle V 3.00 of the low 42 CFR §41	N N Title XIX 4.00 ver of costs 3.13)	147. 148. 149.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc 9.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5.00 Hospital	r "N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method provider that qualifies for	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption fro ponent for Part A N	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N	For no. T	itle V 3.00 of the low 12 CFR §41 N	N N Title XIX 4.00 er of costs 3.13) N	147. 148. 149. 155.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc 9.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF	r "N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method provider that qualifies for	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli	For no. T	itle V 3.00 of the low 42 CFR §41	N N Title XIX 4.00 ver of costs 3.13)	147. 148. 149. 155. 155. 156. 157.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc 9.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER	r "N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method provider that qualifies for	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N	40, §4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N N N	For no. T	itle V 3.00 of the low 12 CFR §41 N N N	N N Title XIX 4.00 ver of costs 3.13) N N N	147. 148. 149. 155. 155. 156. 157. 158.
period? Enter "Y" for yes or 5.00 Has the cost allocation methor Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 3.00 Was there a change in the orc 9.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF	r "N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method provider that qualifies for	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N	no. or no. es or "N" f Part B 2.00 m the appli and Part I N N	For no. T	itle V 3.00 of the low 12 CFR §41 N N	N N Title XIX 4.00 ver of costs 3.13) N N	147. 148. 149. 155. 156. 156. 157. 158. 159.
period? Enter "Y" for yes or 5. 00 Has the cost allocation methor Enter "Y" for yes or "N" for yes, enter the approval date 7. 00 Was there a change in the sta 3. 00 Was there a change in the orc 2. 00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 3. 00 SUBPROVIDER 2. 00 SNF 0. 00 HOME HEALTH AGENCY	r "N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method provider that qualifies for	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N N	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N N N N	For no. T	itle V 3.00 of the low 12 CFR §41 N N N N	N N Title XIX 4.00 Ver of costs 3.13) N N N	147. 148. 149. 155. 156. 157. 158. 157. 158. 159. 160.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc 9.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY	r "N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method provider that qualifies for	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N N	40, \$4020) no. or no. es or "N" f Part B 2.00 om the appli and Part I N N N N N	For no. T	itle V 3.00 of the low 12 CFR §41 N N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc 9.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus	r "N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" fo der of allocation? Enter "Y" mplified cost finding method provider that qualifies for s or "N" for no for each com	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f Part A 1.00 an exemption frc ponent for Part A N N N N N	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N	For no. T ication c B. (See 4	itle V 3.00 of the low 12 CFR §41 N N N N N N N	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc 9.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus	r "N" for no in column 2. odology changed from the prev no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method provider that qualifies for s or "N" for no for each com ulticampus hospital that has	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f Part A 1.00 an exemption frc ponent for Part A N N N N N	40, \$4020) no. for no. es or "N" f Part B 2.00 N the appli and Part I N N N N N N N N N	For no.	itle V 3.00 of the low 12 CFR §41 N N N N N N N	N N Title XIX 4.00 ver of costs 3.13) N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
period? Enter "Y" for yes or 5. 00 Has the cost allocation methor Enter "Y" for yes or "N" for yes, enter the approval date 7. 00 Was there a change in the sta 3. 00 Was there a change in the orc 9. 00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 5. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 Is this hospital part of a Mu	r "N" for no in column 2. odology changed from the prev- no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method? provider that qualifies for s or "N" for no for each com ulticampus hospital that has no. Name	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N N N N One or more camp County	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N S Uses in dif	For no. T ication c B. (See 4	itle V 3.00 of the low 12 CFR §41 N N N N N BSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N T.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
period? Enter "Y" for yes or 5. 00 Has the cost allocation method Enter "Y" for yes or "N" for yes, enter the approval date 7. 00 Was there a change in the sta 8. 00 Was there a change in the orc 9. 00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 9. 00 SNF 9. 00 SNF 9. 00 HOME HEALTH AGENCY 1. 00 CMHC 5. 00 Is this hospital part of a Mu Enter "Y" for yes or "N" for	r "N" for no in column 2. odology changed from the prev- no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method? provider that qualifies for s or "N" for no for each com ulticampus hospital that has no. Name 0	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f <u>Part A</u> <u>1.00</u> an exemption fro ponent for Part A N N N N N ON ON ON ON ON ON ON ON ON ON	40, \$4020) no. for no. es or "N" f Part B 2.00 N the appli and Part I N N N N N N N N N	For no.	itle V 3.00 of the low 12 CFR §41 N N N N N N N BSAS?	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
period? Enter "Y" for yes or 5. 00 Has the cost allocation methor Enter "Y" for yes or "N" for yes, enter the approval date 7. 00 Was there a change in the sta 3. 00 Was there a change in the orc 2. 00 Was there a change in the orc 2. 00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 7. 00 SUBPROVIDER 5. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 If this hospital part of a Mu Enter "Y" for yes or "N" for 5. 00 If line 165 is yes, for each campus enter the name in colu	r "N" for no in column 2. odology changed from the prev- no in column 1. (See CMS Pul- (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method? provider that qualifies for s or "N" for no for each com ulticampus hospital that has no. Name 0 umn	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N N N N One or more camp County	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N S Uses in dif	For no. T ication c B. (See 4	itle V 3.00 of the low 12 CFR §41 N N N N N BSAs? CBSA	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
period? Enter "Y" for yes or 0.00 Has the cost allocation methor Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc 0.00 Was there a change in the orc 0.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5.00 Hospital 0.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 0.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 5.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state	r "N" for no in column 2. odology changed from the prev- no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method provider that qualifies for s or "N" for no for each com ulticampus hospital that has no. Name 0 umn in	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N N N N One or more camp County	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N S Uses in dif	For no. T ication c B. (See 4	itle V 3.00 of the low 12 CFR §41 N N N N N BSAs? CBSA	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
period? Enter "Y" for yes or 5. 00 Has the cost allocation methor Enter "Y" for yes or "N" for yes, enter the approval date 7. 00 Was there a change in the sta 8. 00 Was there a change in the orc 9. 00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 9. 00 SNF 9. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus	r "N" for no in column 2. odology changed from the prev- no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method? provider that qualifies for s or "N" for no for each com ulticampus hospital that has no. Name 0 umn in 3,	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N N N N One or more camp County	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N S Uses in dif	For no. T ication c B. (See 4	itle V 3.00 of the low 12 CFR §41 N N N N N BSAs? CBSA	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
period? Enter "Y" for yes or 5. 00 Has the cost allocation methor Enter "Y" for yes or "N" for yes, enter the approval date 7. 00 Was there a change in the sta 8. 00 Was there a change in the orc 9. 00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 9. 00 SNF 9. 00 HOME HEALTH AGENCY 1. 00 CMHC 5. 00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column	r "N" for no in column 2. odology changed from the prev- no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method? provider that qualifies for s or "N" for no for each com ulticampus hospital that has no. Name 0 umn in 3,	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N N N N One or more camp County	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N S Uses in dif	For no. T ication c B. (See 4	itle V 3.00 of the low 12 CFR §41 N N N N N BSAs? CBSA	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
period? Enter "Y" for yes or 0.00 Has the cost allocation methor Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 3.00 Was there a change in the orc 0.00 Was there a change in the orc 0.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 0.00 Hospital 0.00 Subprovider - IPF 7.00 Subprovider - IRF 0.00 SUBPROVIDER 0.00 SNF 0.00 HOME HEALTH AGENCY 0.00 CMHC Multicampus 5.00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 0.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions)	r "N" for no in column 2. odology changed from the prev- no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method provider that qualifies for s or "N" for no for each com ulticampus hospital that has no. Name 0 umn in 3, in	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N N N N One or more camp County 1.00	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N N N	for no. T ication c B. (See 4 See 4 Ferent C Zip Code 3.00	itle V 3.00 of the low 12 CFR §41 N N N N N BSAs? CBSA	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
period? Enter "Y" for yes or 5. 00 Has the cost allocation methor Enter "Y" for yes or "N" for yes, enter the approval date 7. 00 Was there a change in the sta 8. 00 Was there a change in the ord 9. 00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 1. 00 CMHC 1. 00 CMHC 5. 00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Heal th Information Technology	r "N" for no in column 2. odology changed from the prev- no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method? provider that qualifies for s or "N" for no for each com ulticampus hospital that has no. Name 0 umn in 3, in y (HIT) incentive in the Ame	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" for ? Enter "Y" for y Part A 1.00 an exemption fro ponent for Part A N N N N N One or more camp County 1.00	40, \$4020) no. or no. es or "N" f Part B 2.00 N and Part I N N N N N Uses in dif State 2.00 d Reinvestr	For no. T ication c B. (See 4 B. (See 4 C Cip Code 3.00	itle V 3.00 of the low 12 CFR §41 N N N N N BSAs? CBSA	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 161. 165. 00 166.
period? Enter "Y" for yes or 6.00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7.00 Was there a change in the sta 8.00 Was there a change in the orc 9.00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 9.00 SNF 9.00 HOME HEALTH AGENCY 1.00 CMHC 5.00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Heal th Information Technology 7.00 Is this provider a meaningful 8.00 If this provider is a CAH (li	r "N" for no in column 2. odology changed from the prev- no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method? provider that qualifies for s or "N" for no for each com ulticampus hospital that has no. Name 0 umn in 3, in y (HIT) incentive in the Ame I user under §1886(n)? Enter ine 105 is "Y") and is a mean	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" f ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N N N N N N N N N N N N N N N N N N	40, \$4020) no. or no. or no. es or "N" f Part B 2.00 m the appli A and Part I N N N N N N N N N N N N N N N N N N N	ferent C Zip Code 3.00	itle V 3.00 of the low 12 CFR §41 N N N N BSAs? CBSA 4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.
 period? Enter "Y" for yes or 6. 00 Has the cost allocation metho Enter "Y" for yes or "N" for yes, enter the approval date 7. 00 Was there a change in the sta 8. 00 Was there a change in the sta 8. 00 Was there a change in the orc 9. 00 Was there a change to the sim Does this facility contain a or charges? Enter "Y" for yes 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVI DER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 Is this hospital part of a Mu Enter "Y" for yes or "N" for 6. 00 If line 165 is yes, for each campus enter the name in colu 0, county in column 1, state column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions)	r "N" for no in column 2. odology changed from the prev- no in column 1. (See CMS Pul (mm/dd/yyyy) in column 2. atistical basis? Enter "Y" for der of allocation? Enter "Y" mplified cost finding method' provider that qualifies for s or "N" for no for each com ulticampus hospital that has no. Name 0 umn in 3, in y (HIT) incentive in the Ame i user under §1886(n)? Enter ine 105 is "Y") and is a mear the HIT assets (see instruct	viously filed cos b. 15-2, chapter or yes or "N" for for yes or "N" for ? Enter "Y" for y Part A 1.00 an exemption frc ponent for Part A N N N N N N N N N N N N N N N N N N N	40, \$4020) no. or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N N N N N N N N N N N N N	For no. T ication c B. (See 4 Ferent C Zip Code 3.00	itle V 3.00 of the low 12 CFR §41 N N N N N N N N N N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	155. 156. 157. 158. 159. 160. 161. 165.

Health Financial Systems	HAMILTON CENTE	R, INC.	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA		Period:	Worksheet S-2	
				Part I	and the set
			To 06/30/2022	Date/Time Pre	
				11/30/2022 8:	<u>52 am</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	nning date and ending da	te for the reporting			170.00
			1.00	2.00	1
171.00 If line 167 is "Y", does this provide	r have any days for indi	viduals enrolled in	N	C	171.00
section 1876 Medicare cost plans repo	rted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column	1. If column 1 is ves. e	nter the number of sectio	n		
1876 Medicare days in column 2. (see					
To to meet care days in cordinit 2. (See			1	1	1

	Financial Systems HAMILTON CEN TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	ITER, INC. Provider C	CN: 15-4000	Peri od:	u of Form CMS Worksheet S-	
03FI	AL AND HUSTLIAL HEALTH VARE REIMDURSEMENT QUESTIUNNALKE		UN. 10-4007	From 07/01/2021 To 06/30/2022	Part II	epare
				Y/N	Date	. 52 a
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	I for all NU r	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	boginning of	the cost	N		1 1.
. 00	reporting period? If yes, enter the date of the change in of					1.
	<u> </u>		Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of 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 Cert	tified Dublic	Y	Δ		- ,
. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.
. 00	Are the cost report total expenses and total revenues diffe		N			5.
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1.00	2.00	+
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provid	er N		6.
. 00 . 00	is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		wed during t	N he N		7. 8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medi	cal educatio	n N		9.
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.	is.		Ν		10.
1.00	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	N		11.
					Y/N 1.00	+
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	N N	12. 13.
4.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	fyes, see i	nstructions.	Ν	14.
- 00	Bed Complement Did total beds available change from the prior cost reporti	na noni od2 Lf			N	115
5.00	The providence of the providen	<u> </u>	t A	Par	N t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data 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	Y	10/12/2022	Y Y	10/12/2022	16.
. 00	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		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		N		18
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

iospi t	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-4009	Period: From 07/01/2021 To 06/30/2022	Worksheet S Part II Date/Time F 11/30/2022	repared:
		Descri	iption	Y/N	Y/N	
		(0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS I	HOSPI TALS)			
	Capital Related Cost					_
	Have assets been relifed for Medicare purposes? If yes, se					22.0
3.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais made du	ring the cost		23.0
4.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost r	eporting period?		24.00
5.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repo	rting period	2 IF VAS SAA		25.00
5.00	instructions.	the cost repu	ting period	yos, see		23.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during t	he cost report	ng period?	lfyes, see		26.00
	instructions.	a aget reporti	na noriod2 l	f yoo oubmit		27.00
27.00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ig period? i	i yes, subiii t		27.00
	Interest Expense					
8.00	Were new loans, mortgage agreements or letters of credit e	ntered into du	ring the cos	t reporting		28.00
0 00	period? If yes, see instructions.	band funda (D	abt Carridaa	December Fund)		20.0
9.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		abt Service	Reserve Fund)		29.0
0.00	Has existing debt been replaced prior to its scheduled mat		debt? If ye	s, see		30.00
	instructions.	5	5			
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If ye	s, see		31.00
	instructions. Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	rvi ces furni sh	ed through c	ontractual		32.00
	arrangements with suppliers of services? If yes, see instr		-			
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertaini	ng to compet	itive bidding? If	2	33.0
	no, see instructions. Provider-Based Physicians					_
4.00	Are services furnished at the provider facility under an a	rrangement wit	h provider-b	ased physicians?		34.0
	If yes, see instructions.	0				
35.00	If line 34 is yes, were there new agreements or amended ex		nts with the	provi der-based		35.0
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date	_
				1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report?					36.0
37.00	If line 36 is yes, has a home office cost statement been p	repared by the	home office	?		37.0
8 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that o	f		38.0
0.00	the provider? If yes, enter in column 2 the fiscal year en					50.0
9.00	If line 36 is yes, did the provider render services to oth			S,		39.0
	see instructions.					
0.00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40.00
		1.	00	2.	00	
	Cost Report Preparer Contact Information	her an a		051/500		
FI. 00	Enter the first name, last name and the title/position	TI NA		SEVERS		41.00
	held by the cost report preparer in columns 1, 2, and 3, respectively.					
		1		1		10.00
2.00	Enter the employer/company name of the cost report	BLUE & CO., LL	C			42.00
	preparer.	BLUE & CO., LL 317-713-7946	.C	TSEVERS@BLUEAN		42.00

Health Financial Systems HAMILTON	CENTER, INC.	In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-4009	Period:	Worksheet S-2	
		From 07/01/2021 To 06/30/2022	Part II Date/Time Pre 11/30/2022 8:	pared: 52 am
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	MANAGER			41.00
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cost				43.00
report preparer in columns 1 and 2, respectively.				

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HAMILTON CEN		CN. 1E 4000		u of Form CMS-2 Worksheet S-3	
HUSPI	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	UN: 15-4009	Period: From 07/01/2021	Part I	
					To 06/30/2022	Date/Time Pre	
						11/30/2022 8:	<u>52 am</u>
						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, 84	40 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	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00 13.00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12.00
13.00	Total (see instructions)		16	5, 84	40 0.00	0	14.00
14.00	CAH visits		10	5, 64	+0 0.00	0	14.00
16.00	SUBPROVIDER - IPF					0	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	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
00.05	outpatient days (see instructions)						00.05
33.00	LTCH non-covered days						33.00
33. UI	LTCH site neutral days and discharges				1		33.01

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-4009	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part I Date/Time Pre 11/30/2022 8:	pared:
	I/P Days	/ O/P Visits	/ Trips	Full Time E		
Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
I.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)	782	514	4, 95			1.00
2.00HMO and other (see instructions)3.00HMO IPF Subprovider	0	414 0				2.00 3.00
H.OO HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF	0 0	0		0		4.00 5.00
 b. 00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 	782	0 514	4, 95	0 50		6.00 7.00
3. 00 INTENSIVE CARE UNIT 9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY)						8.00 9.00 10.00 11.00 12.00
 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 	782 0	514 0	4, 95	i0 0. 00 0	527. 34	13.00 14.00 15.00 16.00 17.00 18.00
9.00 SKILLED NURSING FACILITY 0.00 NURSING FACILITY 1.00 OTHER LONG TERM CARE 2.00 HOME HEALTH AGENCY 3.00 AMBULATORY SURGICAL CENTER (D.P.) 4.00 HOSPICE						19.0 20.0 21.0 22.0 23.0 24.0
24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC	О	О		0 0 0.00	0.00	24.1 25.0 26.0
6.25 FEDERALLY QUALIFIED HEALTH CENTER 7.00 Total (sum of lines 14-26)	О	0		0 0.00 0.00 0.00		26. 2
 8.00 Observation Bed Days 9.00 Ambulance Trips 0.00 Employee discount days (see instruction) 	0	0		0		28.0 29.0 30.0
 81.00 Employee discount days - IRF 82.00 Labor & delivery days (see instructions) 82.01 Total ancillary labor & delivery room outpatient days (see instructions) 	0	0		0 0 0		31.0 32.0 32.0
33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges	0 0					33. 0 33. 0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HAMILTON CENT	Provi der C	CN: 15-4009	Period:	u of Form CMS-2 Worksheet S-3	
					From 07/01/2021 To 06/30/2022	Part I Date/Time Pre 11/30/2022 8:	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	14.00	Patients	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00	14.00 12 88	15.00 878	1.00
2.00 3.00 4.00	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 69 0	070	2.00 3.00 4.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00	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						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 20.00 21.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	0	1'	12 88	878	12.00 13.00
$\begin{array}{c} 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 25\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00 \end{array}$	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) 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)	0.00 0.00 0.00					22.00 23.00 24.00 25.00 26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00
32. 01 33. 00 33. 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		32.01 33.00 33.01

Health Fina	uncial Systems	HAMILTON CENT	ER, INC.		In Lie	u of Form CMS-:	2552-10
RECLASSI FI (CATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider C		Peri od:	Worksheet A	
					From 07/01/2021		
					To 06/30/2022	Date/Time Pre 11/30/2022 8:	
	Cost Center Description	Sal ari es	Other	Total (col	Reclassi fi cat		
	bost bonton boschiption	Sururres	othor	+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENE	RAL SERVICE COST CENTERS						
1.00 0010	O CAP REL COSTS-BLDG & FIXT		0		0 1, 420, 943	1, 420, 943	1.00
3.00 0030	O OTHER CAP REL COSTS		0		0 0	0	3.00
4.00 0040	O EMPLOYEE BENEFITS DEPARTMENT	496, 500	501, 201	997, 70	1 0	997, 701	4.00
5.00 0050	O ADMINISTRATIVE & GENERAL	7, 186, 185	-7, 531, 492	-345, 30	7 14, 373, 907	14, 028, 600	5.00
7.00 0070	O OPERATION OF PLANT	172,056	165, 466			337, 522	7.00
9.00 0090	O HOUSEKEEPI NG	200, 872	95, 414	296, 28	6 0	296, 286	9.00
14.00 0140	O CENTRAL SERVICES & SUPPLY	0	0		o o	0	14.00
15.00 0150	O PHARMACY	0	0		o o	0	15.00
16.00 0160	MEDICAL RECORDS & LIBRARY	145, 993	115,099	261,09	2 0	261,092	16.00
I NPA	TIENT ROUTINE SERVICE COST CENTERS	· · · ·					1
30.00 0300	0 ADULTS & PEDIATRICS	1, 441, 810	4, 162, 296	5, 604, 10	6 -1, 933, 512	3, 670, 594	30.00
	LLARY SERVICE COST CENTERS						
54.00 0540	0 RADIOLOGY - DIAGNOSTIC	0	0		0 0	0	54.00
60.00 0600	0 LABORATORY	0	36, 867	36, 86	7 0	36, 867	60.00
69.00 0690	0 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 0700	0 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	O DRUGS CHARGED TO PATIENTS	0	121, 809	121, 80	9 0	121, 809	73.00
	ATIENT SERVICE COST CENTERS			1			
90.00 0900		10, 326, 339	12, 750, 201	23, 076, 54	0 -18, 160, 828	4, 915, 712	90.00
	R REIMBURSABLE COST CENTERS						
	O OTHER REIMBURSABLE COST CENTERS	0	0		0 0		98.00
99.00 0990		0	0		0 0	0	99.00
	I AL PURPOSE COST CENTERS				-		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	19, 969, 755	10, 416, 861	30, 386, 61	6 -4, 299, 490	26, 087, 126	118.00
	EIMBURSABLE COST CENTERS	· · ·					
	O OTHER NONREIMB COST CENTER	9, 303, 931	11, 727, 779				
	1 GRACE CLINIC HEALTH PROFESSIONAL	697, 637	1, 438, 221				
200.00	TOTAL (SUM OF LINES 118 through 199)	29, 971, 323	23, 582, 861	53, 554, 18	4 0	53, 554, 184	200.00

Heal th	Financial Systems	HAMILTON CEN	TER, INC.		In Lieu	u of Form CMS.	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider CCN: 15			Worksheet A	
					07/01/2021		
				То	06/30/2022	Date/Time Pr 11/30/2022 8	epared:
	Cost Center Description	Adjustments	Net Expenses			11/30/2022 0	
	cost center bescription	(See A-8)	For				
		(000 // 0)	Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	-41, 493	1, 379, 450				1.00
3.00	00300 OTHER CAP REL COSTS	0	0				3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	997, 701				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-3, 524, 198	10, 504, 402				5.00
7.00	00700 OPERATION OF PLANT	0	337, 522				7.00
9.00	00900 HOUSEKEEPI NG	0	296, 286				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	-13, 349	247, 743				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS		· · ·				
30.00	03000 ADULTS & PEDIATRICS	-1, 216, 361	2, 454, 233				30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY – DI AGNOSTI C	0	0				54.00
60.00	06000 LABORATORY	0	36, 867				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 PATIENTS	0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	121, 809				73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	-80, 908	4, 834, 804				90.00
	OTHER REIMBURSABLE COST CENTERS						
	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
99.00	09900 CMHC	0	0				99.00
	SPECIAL PURPOSE COST CENTERS						
118.00		-4, 876, 309	21, 210, 817				118.00
	NONREIMBURSABLE COST CENTERS						
	07950 OTHER NONREIMB COST CENTER	0	25, 703, 193				194.00
	07951 GRACE CLINIC HEALTH PROFESSIONAL	0	1, 763, 865				194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	-4, 876, 309	48, 677, 875				200.00

Heal th	Financial Systems		HAMILTON CENT	TER, INC.		In Lieu	u of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provider CC	CN: 15-4009	Period: From 07/01/2021 To 06/30/2022	Worksheet A-6 Date/Time Prepared: 11/30/2022 8:52 am
		Increases					
	Cost Center	Line #	Sal ary	Other			
	2.00	3.00	4.00	5.00			
	A - DEPRECIATION RECLASS			· · · · ·			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,014,147			1.00
2.00		0.00	0	0			2.00
3.00		0.00	0	0			3.00
4.00		0.00	0	0			4.00
	TOTALS	T	0	1,014,147			
	B - OVERHEAD ALLOCATION RECLA	ISS					
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	12, 617, 406			1.00
2.00		0.00	0	0			2.00
3.00		0.00	0	0			3.00
4.00		0.00	0	0			4.00
	TOTALS			12, 617, 406			
	C – PSYCHLATRY RECLASS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 654, 648			1.00
2.00		0.00	0	0			2.00
3.00		0.00	0	0			3.00
	TOTALS			2, 654, 648			
	D - MRO RECLASS						
1.00	OTHER NONREIMB COST CENTER	194.00	4, 458, 601	5, 505, 152			1.00
	TOTALS		4, 458, 601	5, 505, 152			
	E - INSURANCE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	406, 796			1.00
	TOTALS		0	406, 796			
500.00	Grand Total: Increases		4, 458, 601	22, 198, 149			500.00

Heal th	Financial Systems		HAMILTON CENT	TER, INC.		In Lieu	u of Form CMS-	2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-4009	Peri od:	Worksheet A-	5
						From 07/01/2021		
						To 06/30/2022	Date/Time Pre 11/30/2022 8:	52 am
		Decreases				I_,	1170072022 01	02 411
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A - DEPRECIATION RECLASS							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	491, 351		9		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	62, 709		0		2.00
3.00	CLINIC	90.00	0	440, 536		0		3.00
4.00	GRACE CLINIC HEALTH	194. 01	0	19, 551		0		4.00
	PROFESSI ONAL							
	TOTALS		0	1, 014, 147				
	B - OVERHEAD ALLOCATION RECLA	ASS						
1.00	ADULTS & PEDIATRICS	30.00	0	1, 527, 291		0		1.00
2.00	CLINIC	90.00	0	6, 296, 483		0		2.00
3.00	OTHER NONREIMB COST CENTER	194.00	0	4, 441, 190		0		3.00
4.00	GRACE CLINIC HEALTH	194. 01	0	352, 442		0		4.00
	PROFESSI ONAL							
	TOTALS		0	12, 617, 406				
	C – PSYCHIATRY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00		343, 512		0		1.00
2.00	CLINIC	90.00		1, 460, 056		0		2.00
3.00	OTHER NONREIMB COST CENTER	194.00		851, 080		0		3.00
	TOTALS		0	2,654,648				
	D - MRO RECLASS							
1.00	CLINIC	90.00	4, 458, 601	5, 505, 152		0		1.00
	TOTALS		4, 458, 601	5, 505, 152				
	E - INSURANCE RECLASS]
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	406, 796	1	2		1.00
	TOTALS			406, 796				
500.00	Grand Total: Decreases		4, 458, 601	22, 198, 149				500.00

Health Financial Systems	HAMILTON CEN	NTER, INC.			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-4009		iod: m 07/01/2021 06/30/2022		pared:
			Acquisition	S			
	Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00 Land	3, 187, 501	16, 225		0	16, 225	0	1.00
2.00 Land Improvements	0	0		0	0	0	2.00
3.00 Buildings and Fixtures	23, 536, 659	455, 923		0	455, 923	0	3.00
4.00 Building Improvements	1, 107, 249	5, 012		0	5, 012	371	4.00
5.00 Fixed Equipment	6, 966, 457	410, 848		0	410, 848	22, 016	5.00
6.00 Movable Equipment	3, 323, 564	343, 042		0	343, 042	4, 442	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	38, 121, 430	1, 231, 050		0	1, 231, 050	26, 829	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	38, 121, 430	1, 231, 050		0	1, 231, 050	26, 829	10.00
	Endi ng	Fully					
	Bal ance	Depreci ated					
		Assets					
	6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00 Land	3, 203, 726	0					1.00
2.00 Land Improvements	0	0					2.00
3.00 Buildings and Fixtures	23, 992, 582	0					3.00
4.00 Building Improvements	1, 111, 890	0					4.00
5.00 Fixed Equipment	7, 355, 289	0					5.00
6.00 Movable Equipment	3, 662, 164	0					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	39, 325, 651	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	39, 325, 651	0				l	10.00

Health Financial Systems	HAMILTON CEN	NTER, INC.		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-4009	Period: From 07/01/2021	Worksheet A-7 Part II	
				To 06/30/2022	Date/Time Pre	pared:
					11/30/2022 8:	<u>52 am</u>
		SU	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, COLUN	MN 2, LINES 1 a	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 CAPITAL				
Cost Center Description	0ther	Total (1)				
'	Capital -Relat					
	ed Costs (see	9 through 14)				
	instructions)	Ŭ,				
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	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 07/01/2021 To 06/30/2022		pared:
	COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	39, 325, 651	0	39, 325, 65			1.00
3.00 Total (sum of lines 1-2)	39, 325, 651	0	39, 325, 65			3.00
	ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum o [.]	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		-	1		-	
1.00 CAP REL COSTS-BLDG & FLXT	0			0 972, 654		1.00
3.00 Total (sum of lines 1-2)	0	0		0 972, 654	0	3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions			
		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	.,	1.00
3.00 Total (sum of lines 1-2)	0	406, 796	l	0 0	1, 379, 450	3.00

Health Financial Systems

Health Financial Systems		HAMILTON CEN			u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			F	eriod: rom 07/01/2021 o 06/30/2022	Worksheet A-8 Date/Time Prep 11/30/2022 8:5	
			Expense Classification on To/From Which the Amount is			
Cost Center Descrip		Amount	Cost Center	Li ne #	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 (chapt Investment income - CAP		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 COSTS-MVBLE EQUIP (chapt Investment income - othe	er 2)	0		0.00	0	3.00
(chapter 2)		0			_	
4.00 Trade, quantity, and tim discounts (chapter 8)	e	0		0.00	0	4.00
5.00 Refunds and rebates of		0		0.00	0	5.00
expenses (chapter 8) 6.00 Rental of provider space	by B	-41, 493	CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
 suppliers (chapter 8) Tel ephone services (pay stations excluded) (chap 	ter	Ο		0.00	0	7.00
21)8.00 Television and radio ser	vice	0		0.00	0	8.00
(chapter 21)		0			-	
9.00 Parking lot (chapter 21) 10.00 Provider-based physician adjustment	A-8-2	0 -2, 720, 234		0.00	0 0	9.00 10.00
11.00 Sale of scrap, waste, et (chapter 23)	с.	0		0.00	0	11.00
12.00 Related organization transactions (chapter 10	A-8-1	0			0	12.00
13.00 Laundry and Linen servic	e	0		0.00	0	
14.00 Cafeteria-employees and15.00 Rental of quarters to em		0		0. 00 0. 00	0	14.00 15.00
and others ' 16.00 Sale of medical and surg supplies to other than		0		0.00	0	
patients 17.00 Sale of drugs to other t	han	0		0.00	0	17.00
patients 18.00 Sale of medical records	and B	-13, 349	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
abstracts		0		0.00	0	19.00
19.00 Nursing and allied healt education (tuition, fees books, etc.)		0		0.00	0	19.00
20.00 Vending machines21.00 Income from imposition o interest, finance or pen		-225 0	ADMI NI STRATI VE & GENERAL	5.00 0.00	0 0	20. 00 21. 00
22.00 charges (chapter 21) Interest expense on Medi overpayments and borrowi	care ngs to	0		0. 00	0	22.00
23.00 repay Medicare overpayme Adjustment for respirato therapy costs in excess	ry A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
25.00 Utilization (chapter 14) physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
(chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetis	t	0	*** Cost Center Deleted ***	19.00		28.00
 29.00 Physicians' assistant 30.00 Adjustment for occupatio therapy costs in excess 		0	*** Cost Center Deleted ***	0.00 67.00	0	29.00 30.00
30.99 Himitation (chapter 14) Hospice (non-distinct) (instructions)	see	0	ADULTS & PEDIATRICS	30. 00		30. 99

	Financial Systems		HAMI LTON CEN			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				Period: From 07/01/2021	Worksheet A-8	3
					To 06/30/2022	Date/Time Pre 11/30/2022 8:	epared: 52 am
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	, and arre		21110 #	Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
	ADVERTI SI NG	A		ADMI NI STRATI VE & GENERAL	5.00		
	PUBLIC RELATIONS	А		ADMI NI STRATI VE & GENERAL	5.00		
	PUBLIC RELATIONS	А	-	CLINIC	90.00		
	REPRESENTATI VE PAYEE FEES	В		ADMI NI STRATI VE & GENERAL	5.00		
33.04	WABASH VALLEY HEALTH CENTER	В	-69, 190	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	I NCOME MISC I NCOME	р	25		5.00		33.05
	WABASH VALLEY HEALTH CENTER	B	-25 -79, 986	ADMINISTRATIVE & GENERAL	90.00		
33.00	INCOME	В	- /9, 980		90.00	0	33.00
33.07	MARKETING	А	-597 306	ADMI NI STRATI VE & GENERAL	5.00	0	33.07
	XIX HOSPITAL ASSESSMENT FEE	A		ADULTS & PEDIATRICS	30.00		
	DONATION EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		
	DONATION EXPENSE	A		ADULTS & PEDIATRICS	30.00		
	DONATION EXPENSE	A		CLINIC	90.00		
	SCHOOL BASED SERVICES	В		CLINIC	90.00		1
	MISC INCOME-A&G	В		ADMINISTRATIVE & GENERAL	5.00		33.13
33.14	PROJ-CHILD & ADOLESCENT	В	0	CLINIC	90.00	0	33.14
	SERVI CES						
50.00	TOTAL (sum of lines 1 thru 49)		-4, 876, 309				50.00
	(Transfer to Worksheet A,						
	column 6 line 200)		1	1		1	1

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.

Heal th	Financial Syste	ems	HAMI LTON CI	ENTER, INC.		In Lie	eu of Form CMS-	2552-10
	ER BASED PHYSIC		Provider CCN: 15-4009 Pe			Period: Worksheet A-8-2		
						From 07/01/2021		
						To 06/30/2022	2 Date/Time Pre 11/30/2022 8:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	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	2, 720, 234		(1.00
2.00	0.00		0	0	(2.00
3.00	0,00		0		(3.00
4.00	0.00		0		(°	4.00
5.00	0.00			0	(0	5.00
6.00	0.00		0	0	(-	0	6.00
7.00	0.00		0	0	(-	0	7.00
8.00	0.00		0	0	(0	8.00
			0	0	(0	
9.00	0.00		0	-	(-	0	9.00
10.00	0.00		0	0		0 0	0	
200.00			2, 720, 234		(-		200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	0			0 0		1.00
2.00	0.00		0			0 0	-	2.00
3.00	0.00		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	(0 0	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(o o	0	9.00
10.00	0.00		0	0	(ol o	0	10.00
200.00			0	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		ADMI NI STRATI VE & GENERAL	0		(1.00
2.00	0.00		0		(0 0		2.00
3.00	0.00		0	0	(3.00
4.00	0.00		0	0	(4.00
5.00	0.00		0		(-		5.00
6.00	0.00		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	0.00					2, 720, 234		200.00
200.00	I I		1 0		(ין 2,720,234		200.00

Health Financial Systems	HAMILTON CEN	ITER, INC.		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/30/2022 8:	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	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 00100 CAP REL COSTS-BLDG & FIXT	1, 379, 450	1, 379, 450				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	997, 701	28, 243				4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	10, 504, 402	527, 088				5.00
7.00 00700 OPERATION OF PLANT	337, 522	154, 138				
9. 00 00900 HOUSEKEEPI NG	296, 286	0	6, 99	2 303, 278	91, 492	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	247, 743	51, 256	5, 08	2 304, 081	91, 735	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30.00 03000 ADULTS & PEDIATRICS	2, 454, 233	348, 828	50, 18	5 2, 853, 246	860, 762	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	36, 867	25		0 36, 892	11, 130	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 PATIEN	NTS O	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	121, 809	25		0 121, 834	36, 755	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	4, 834, 804	240, 840	204, 23	8 5, 279, 882	1, 592, 824	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) 21, 210, 817	1, 350, 443	522, 61	6 20, 678, 482	2, 834, 828	118.00
NONREI MBURSABLE COST CENTERS						
194.00079500THER NONREIMB COST CENTER	25, 703, 193	0	479, 04	5 26, 182, 238	7, 898, 596	194.00
194.01 07951 GRACE CLINIC HEALTH PROFESSIONAL	1, 763, 865	29, 007	24, 28	3 1, 817, 155	548, 196	194.01
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	48, 677, 875	1, 379, 450	1, 025, 94	4 48, 677, 875	11, 281, 620	202.00
			-			

Health Financial Systems HAMILTON CENTER, INC. In Lieu of Form CMS-2	
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-4009 Period: Worksheet B From 07/01/2021 Part I To 06/30/2022 Date/Time Pre 11/30/2022 8:	bared:
Cost Center Description OPERATION OF PLANT HOUSEKEEPING SERVICES & SUPPLY CENTRAL PHARMACY PHARMACY MEDICAL RECORDS & LI BRARY	
<u>7.00</u> 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 ADMINI STRATI VE & GENERAL	5.00
7. 00 00700 OPERATION OF PLANT 647, 779	7.00
9. 00 00900 HOUSEKEEPING 0 394, 770	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 MEDI CAL RECORDS & LI BRARY 49, 558 30, 201 0 0 475, 575	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 337, 268 205, 538 0 0 164, 227	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 24 15 0 0 1, 235	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 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 PATI ENTS 24 15 0 0 4, 080	73.00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 232, 859 141, 909 0 0 306, 033	90.00
OTHER REIMBURSABLE COST CENTERS	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0	98.00
99.00 09900 CMHC 0 0 0 0	99.00
SPECIAL PURPOSE COST CENTERS	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 619,733 377,678 0 0 475,575	118.00
NONRELMBURSABLE COST CENTERS	
194.00 07950 OTHER NONREI MB COST CENTER 0 0 0 0 0 0	194.00
	194.01
200.00 Cross Foot Adjustments	200.00
	201.00
202.00 TOTAL (sum lines 118 through 201) 647,779 394,770 0 0 475,575	202.00

Heal th	Financial Systems	HAMILTON CEN	ITER. INC.		In Lieu	u of Form CMS-2552-10
	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od: From 07/01/2021 To 06/30/2022	Worksheet B Part I
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	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 ADMINI STRATI VE & GENERAL					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
16.00	01600 MEDI CAL RECORDS & LI BRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00		4, 421, 041	0	4, 421, C	041	30.00
F 4 00	ANCI LLARY SERVI CE COST CENTERS 05400 RADI OLOGY - DI AGNOSTI C	0	0	1	0	54.00
54.00 60.00	06000 LABORATORY	0 49, 296	0	49, 2	0	60.00
69.00	06900 ELECTROCARDI OLOGY		0	49,2	0	69.00
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0	0		0	70.00
70.00		0	0		0	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	71.00
	07300 DRUGS CHARGED TO PATIENTS	162, 708	0		100	72.00
75.00	OUTPATIENT SERVICE COST CENTERS	102,700	0	102,7	00	/3.00
90 00	09000 CLINIC	7, 553, 507	0	7, 553, 5	07	90.00
70.00	OTHER REIMBURSABLE COST CENTERS	1,000,001	0	1,000,0		,0.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	98.00
99.00		0	0		0	99.00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	12, 186, 552	0	12, 186, 5	52	118.00
	NONREI MBURSABLE COST CENTERS					
	07950 OTHER NONREIMB COST CENTER	34, 080, 834	0			194.00
	07951 GRACE CLINIC HEALTH PROFESSIONAL	2, 410, 489	0	2, 410, 4	.89	194.01
200.00		0	0		0	200.00
201.00		0	0		0	201.00
202.00) TOTAL (sum lines 118 through 201)	48, 677, 875	0	48, 677, 8	375	202.00

Heal th	Financial Systems	HAMILTON CEN	NTER, INC.		In Lie	eu of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-4009	Period: From 07/01/2021 To 06/30/2022		epared: 52 am
	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	
	1	0	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS				-	1	_
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	28, 243				4.00
5.00	00500 ADMINI STRATI VE & GENERAL	0	527, 088				
7.00	00700 OPERATION OF PLANT	0	154, 138	154, 1			
9.00	00900 HOUSEKEEPI NG	0	0		0 192	4, 331	9.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	
15.00	01500 PHARMACY	0	0		0 0	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	51, 256	51, 2	56 140	4, 342	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	348, 828	348, 8	28 1, 381	40, 741	30.00
	ANCILLARY SERVICE COST CENTERS					•	
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0		
60.00	06000 LABORATORY	0	25		25 C	527	
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
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	25		25 C	1, 740	73.00
	OUTPATIENT SERVICE COST CENTERS			-		-	
90.00	09000 CLINIC	0	240, 840	240, 8	40 5, 621	75, 391	90.00
	OTHER REIMBURSABLE COST CENTERS						
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
99.00	09900 CMHC	0	0		0 0	0	99.00
	SPECIAL PURPOSE COST CENTERS						
118.00		0	1, 350, 443	1, 350, 4	43 14, 383	134, 178	118.00
	NONREI MBURSABLE COST CENTERS						
	07950 OTHER NONREIMB COST CENTER	0	0		0 13, 192		
	07951 GRACE CLINIC HEALTH PROFESSIONAL	0	29, 007	29, 0	07 668	25, 947	194.01
200.00					0		200.00
201.00			0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 379, 450	1, 379, 4	50 28, 243	533, 972	202.00

Health Financial Systems	HAMILTON CENTER, INC.			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-4009	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II	epared:	
Cost Center Description	OPERATION OF PLANT	HOUSEKEEPI NG	CENTRAL SERVICES & SUPPLY		MEDI CAL RECORDS & 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	161, 409					7.00	
9. 00 00900 HOUSEKEEPI NG	0	4, 523				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	12, 348	346		0 0	68, 432	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS						1	
30. 00 03000 ADULTS & PEDI ATRI CS	84, 039	2,355		0 0	23, 632	30.00	
ANCILLARY SERVICE COST CENTERS						1	
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		0 0	0	54.00	
60. 00 06000 LABORATORY	6	0		0 0	178	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	6	0		0 0	587		
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	58, 022	1, 626		0 0	44,035	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		99.00	
SPECIAL PURPOSE COST CENTERS							
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	154, 421	4, 327		0 0	68, 432	118.00	
NONREI MBURSABLE COST CENTERS							
194.0007950 OTHER NONREIMB COST CENTER	0	0		0 0	0	194.00	
194. 01 07951 GRACE CLINIC HEALTH PROFESSIONAL	6, 988			0 0		194.01	
200.00 Cross Foot Adjustments					-	200.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	161, 409	4, 523		0 0		202.00	
			•			•	

Heal th	Financial Systems	HAMILTON CEN	TER. INC.		In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS			Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II	epared:
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
		24.00	25.00	26.00			
	GENERAL SERVICE COST CENTERS			1	r		
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						7.00
9.00	00900 HOUSEKEEPI NG						9.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
	INPATIENT ROUTINE SERVICE COST CENTERS		_				
30.00	03000 ADULTS & PEDIATRICS	500, 976	0	500, 9	76		30.00
	ANCI LLARY SERVICE COST CENTERS		-	1			
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0		54.00
60.00	06000 LABORATORY	736	0	/	36		60.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
/3.00	07300 DRUGS CHARGED TO PATIENTS	2, 358	0	2,3	58		73.00
00.00	OUTPATIENT SERVICE COST CENTERS	405 505	0	405.5	05		
90.00	09000 CLINIC	425, 535	0	425, 5	35		90.00
00.00	OTHER REIMBURSABLE COST CENTERS	0	0	1	0		00.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0		98.00 99.00
99.00		0	0		0		99.00
110 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	929, 605	0	929, 6	OF		110 00
118.00	NONREIMBURSABLE COST CENTERS	929, 605	0	929, 0	005		118.00
104 00	NONREIMBURSABLE COST CENTERS	387, 039	0	387,0	20		194.00
	07950 OTHER NONREIMB COST CENTER 07951 GRACE CLINIC HEALTH PROFESSIONAL	387,039 62,806					194.00
200.00		62, 806 0	0	1 · · · · · · · · · · · · · · · · · · ·	0		200.00
200.00		0	0		0		200.00
201.00		0 1, 379, 450			50		201.00
202.00	I I I I I I I I I I I I I I I I I I I	1, 379, 450	0	1, 3/9, 4	-50		1202.00

	Financial Systems	HAMILTON CEN				u of Form CMS-2	
COST AL	LOCATION - STATISTICAL BASIS		Provider C		eriod:	Worksheet B-1	
					rom 07/01/2021 o 06/30/2022	Date/Time Pre	narod
				'	0 00/30/2022	11/30/2022 8:	
	· · · ·	CAPI TAL				11/00/2022 01	
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
		(SQUARE FEET)	BENEFI TS	n	E & GENERAL	PLANT	
		(DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
			(GROSS		((
			SALARI ES)				
		1.00	4.00	5A	5.00	7.00	
	GENERAL SERVICE COST CENTERS			0,1	0.00	7100	
	00100 CAP REL COSTS-BLDG & FIXT	55, 925					1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 145	29, 474, 823				4.00
	00500 ADMI NI STRATI VE & GENERAL	21, 369	7, 186, 185		37, 396, 255		5.00
	00700 OPERATION OF PLANT	6, 249	172, 056			27, 162	
	00900 HOUSEKEEPING	0, 247	200, 872			27,102	
		0				-	
	01400 CENTRAL SERVICES & SUPPLY	Ŭ,	0	-	-	0	
	01500 PHARMACY	0	0	0	-	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	2, 078	145, 993	0	304, 081	2, 078	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	14, 142	1, 441, 810	C	2, 853, 246	14, 142	30.00
	ANCILLARY SERVICE COST CENTERS						
	05400 RADI OLOGY – DI AGNOSTI C	0	0			0	
	06000 LABORATORY	1	0	0		1	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	C	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	l a	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	1	0		121, 834	1	
	OUTPATIENT SERVICE COST CENTERS	· · · ·		-	,		1
	09000 CLINIC	9, 764	5, 867, 738	C	5, 279, 882	9, 764	90.00
	OTHER REIMBURSABLE COST CENTERS	.,	-,,	-		.,	1
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98.00
	09900 CMHC	0	0			0	
	SPECIAL PURPOSE COST CENTERS	0					///.00
118.00		54, 749	15,014,654	-11, 281, 620	9, 396, 862	25, 986	1118 00
	NONREI MBURSABLE COST CENTERS	34,747	13, 014, 034	11,201,020	7, 370, 002	23,700	110.00
	07950 OTHER NONREIMB COST CENTER	0	13, 762, 532	C	26, 182, 238	0	194.00
	07951 GRACE CLINIC HEALTH PROFESSIONAL	1, 176	697, 637				194.00
200.00	Cross Foot Adjustments	1, 170	077,037		1,017,155	1, 170	200.00
	5						
201.00	Negative Cost Centers	1 070 150	1 005 044		11 001 (00	(47 770	201.00
202.00	Cost to be allocated (per Wkst. B,	1, 379, 450	1, 025, 944		11, 281, 620	647, 779	202.00
000 00	Part I)	04 ///071	0 00/007		0.001/70	00.040700	
203.00	Unit cost multiplier (Wkst. B, Part I)	24. 666071	0. 034807		0. 301678	23.848722	
204.00	Cost to be allocated (per Wkst. B,		28, 243		533, 972	161, 409	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part		0. 000958		0. 014279	5.942456	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(por Wkst P 2)			1	1		1
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 1 5. 00 00500 ADMINISTRATIVE & GENERAL 1 7. 00 00700 OPERATION OF PLANT 27, 162 9. 00 00900 HOUSEKEEPING 27, 162 1 16. 00 1500 PHARMACY 0 0 1 16. 00 1500 PHARMACY 0 0 1 16. 00 1500 PHARMACY 2,078 0 0 1 16. 00 1600 LIBRARY 2,078 0 0 6 253,396 31 30. 00 00000 ADULTS & PEDI ATRICS 14,142 0 0 6 253,396 31 54. 00 05400 RADI OLOCY 1 AGNOSTIC 0 0 0 7 66 60.00 66000 LABORATORY 1 0 0 7 7 6 6 0 0 0 7 7 0 0 0 7 7 0 0	Heal th	Financial Systems	HAMILTON CEN	ITER, INC.		In Lie	u of Form CMS-2552-1
Cost Center Description HOUSEKEEPING (SOUARE FEED) SUPPLY (COSTED) CENTRAL (SOUARE FEED) (SOUSTED) PHARMACY (COSTED) (COSTED) MEDICAL (COSTOBS & LIBRARY (CROSS & ULBRARY (CROSS & ULBRARY	COST A	LLOCATION - STATISTICAL BASIS		Provider C	CN: 15-4009		Worksheet B-1
Cost Center Description HOUSEKEEPING (SOUARE FEET) SERVICES & PHARMACY (COSTED REOUIS,) CENTRAL SERVICES & PHARMACY (COSTED REOUIS,) CENTRAL RECORDS & LIBRARY (COSTED REOUIS,) LICIAL RECORDS & LIBRARY (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED REDUCTOR (COSTED (COSTED (COSTED REDUCTOR (COSTED REDUCTOR (COSTED (C							Date (Time Drawners)
Cost Center Description HOUSEKEEPING (SOUARE FEET) SUPLY (SOUARE FEET) CENTRAL SUPLY (SOUARE FEET) SUPLY (CSOS REQUIS.) MEDICAL (CSOS (CROSS CHARGES) (CROSS CHARGES) 0 0 0 15.00 16.00 10.0 00100 CAP REL COST S-BLOG & FLXT 4.00 0 15.00 16.00 7.00 000400 EMPLOYCE BNEFITS DEPARTMENT 5.00 0 0 16.00 11.00 00100 CAP REL COST S-BLOG & FLXT 4.00 27.152 0 16.00 13.00 00000 PMUSEKEEPINS 7.00 0 0 0 17.00 15.00 01500 PHARMACY 4.00 27.152 0 0 0 14.00 01400 CENTRAL SERVICES & SUPPLY 7.00 0 0 0 18.108,966 1 15.00 1500 OHUSEKEEPINS 7.00 2.078 0 0 6 25.396 3 30.00 00000 ADULTS & PEDIATRICS 5.00 14.142 0 0 6 6 6 60.00 00000 ADULTS & ARGED TO PATIENTS 7.00 0 0 0 7 7 7.00 000000000 CLAB						10 06/30/2022	
Image: stand		Cost Center Description	HOUSEKEEPING	CENTRAL	PHARMACY	MEDI CAL	117 007 2022 0. 02 dill
GENERAL SERVICE COST CENTERS 9.00 14.00 (CROSS (CROSS CHARGES) 1.00 COID CAP REL COSTS-BLDG & FLYT 9.00 14.00 15.00 16.00 1.00 COID CAP REL COSTS-BLDG & FLYT 9.00 14.00 15.00 16.00 1.00 COID CAP REL COSTS-BLDG & FLYT 9.00 14.00 16.00 16.00 1.00 COID CAP REL COSTS-BLDG & FLYT 9.00 14.00 16.00 16.00 1.00 OLGOD OPERATION OF PLANT 27.162 9.00 11.00 10.00 1.00 OLGOD OPERATION OF PLANT 27.162 9.00 11.00 11.00 1.00 OLGOD CENTRAL SERVICE COST CENTERS 9.00 0 0 11.00 1.00 OLGOD REDICATR RECONS & LIBRARY 2.078 0 0 0 1.00 OLGOD REDICATR RECONS & LIBRARY 2.078 0 0 0 0 1.00 OLGOD REDICATRON - DI AGNOSTIC 0 0 0 0 0 7 1.00 OLGORATORY - DI AGNOSTIC 0							
COSTED COSTED CROSS 9.00 14.00 15.00 16.00 1.00 00100 (AP REL COST- SLDG & FLXT 1.00 15.00 16.00 1.00 00100 (AP REL COST- SLDG & FLXT 1.00 16.00 16.00 1.00 00000 EMPLOYEE BENFEITS DEPARTMENT 0.00000 EMPLOYEE BENFEITS DEPARTMENT 1.00 1.00 16.00 5.00 00500 ADMI NI STRATI VE & GENERAL 0.00000 PERATION OF FLANT 0.00000 1.00 1.00 1.000 1.000 PERATION OF FLANT 0.0000 1.000 1.000 1.000 1.000 PERATION OF FLANT 0.0000 1.0000 1.0000 1.0000 1.0000 <td></td> <td></td> <td>, , , , , , , , , , , , , , , , , , ,</td> <td></td> <td>REQUIS.)</td> <td>LI BRARY</td> <td></td>			, , , , , , , , , , , , , , , , , , ,		REQUIS.)	LI BRARY	
9.00 14.00 15.00 16.00 Image: Control CAP REL COSTS CENTERS Image: CostS SeluC & FLXT Image: CostS SeluC & FLXT Image: CostS SeluC & FLXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT Image: CostS SeluC & FLXT Image: CostS SeluC & FLXT Image: CostS SeluC & FLXT 5.00 00500 ADMI NISTRATIVE & COSTS CENTERS Image: CostS SeluC & FLXT Image: CostS SeluC & FLXT Image: CostS SeluC & FLXT 7.00 00000 HOUSEKEEPIN G 27, 162 Image: CostS SeluC & FLXT Image: CostS SeluC & FLXT Image: CostS SeluC & FLXT 16.00 Oldoo CARDIOLOS & LIBRARY 2, 078 Image: CostS SeluC & FLXT Image: CostSeluC & FLXT <t< td=""><td></td><td></td><td></td><td>(COSTED</td><td>· ·</td><td>(GROSS</td><td></td></t<>				(COSTED	· ·	(GROSS	
CENERAL SERVICE COST CENTERS Control 1.00 00100 CAP REL COSTS-BLIDG & FLXT				REQUIS.)		CHARGES)	
1.00 ODTOQ CAP REL COSTS-BLDG & FIXT			9.00	14.00	15.00	16.00	
4. 00 00400 EMPLOYEE EENEFITS DEPARTMENT 1 5. 00 00500 ADMINISTRATIVE & CENERAL 1 7. 00 00700 OPERATION OF PLANT 27, 162 9. 00 00900 HOUSEKEEPING 27, 162 1 16. 00 1500 PHARMACY 0 0 0 1 16. 00 1500 PHARMACY 0 0 0 6 600 00000 14, 142 0 0 6 6 60. 00 0600 LARY SERVICE COST CENTERS 1 0 0 7 54. 00 06400 LARY REV 0 0 0 7 71. 00 00 0 <		GENERAL SERVICE COST CENTERS					
5 00 00500 ADMINI STRATI VE & GENERAL 1 7.00 00700 OPERATI ON OF PLANT 27, 162 1 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 15.00 10500 MEDI CAL RECORDS & LIBRARY 2,078 0 0 1 16.00 10500 MEDI CAL RECORDS & LIBRARY 2,078 0 0 6 18.00 03000 ADMIT IN ESERVICE COST CENTERS 3 3 3 3 30.00 03000 ADMIT NE SERVICE COST CENTERS 3 3 3 3 30.00 03000 ADMOT NE SERVICE COST CENTERS 3 3 3 30.00 03000 ADMORADILOS V 1 0 0 4 7 3 3 30.00 03000 ALBORATORY 1 0 0 4 7 3 3 3 3 3 3 3 3 3 3 3 3 3 3 <t< td=""><td>1.00</td><td>00100 CAP REL COSTS-BLDG & FIXT</td><td></td><td></td><td></td><td></td><td>1.00</td></t<>	1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
7 00 00700 DEPERATION OF PLANT 27, 162 1 9,00 00900 HOUSEKEEPINC 27, 162 0 1 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 1 16.00 1600 MEDICARECORDS & LIBRARY 2,078 0 0 18, 108, 986 11 16.00 1600 MEDICARECORDS & LIBRARY 2,078 0 0 6, 253, 396 31 0.00 2000 AUCILLARY SERVICE COST CENTERS	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
9.00 00900 HOUSEKEEPING 27, 162 0 11 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 11 15.00 01500 PHARMACY 0 0 0 11 16.00 01600 MCITINE SERVICE COST CENTERS 0 0 18, 108, 986 11 10 00 00 0 0 0 0 6, 253, 396 31 30.00 00 0 0 0 0 0 0 6, 253, 396 31 54.00 05400 RADIOLGY - DI ARNOSTIC 0 0 0 0 6 6 6 0 6000 6 6 6 6 6 0 6 6 6 6 6 6 6 6 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 <	5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
14.00 OI 400 (CENTRAL SERVICES & SUPPLY 0 0 1. 15.00 01500 (PHARMACY 0 0 0 1. 16.00 01600 (MEDICAL RECORDS & LIBRARY 2.078 0 0 1. 16.00 01600 (MEDICAL RECORDS & LIBRARY 2.078 0 0 0 1. 17.00 01600 (MEDICAL RECORDS & LIBRARY 2.078 0 0 6. 1. 18.00 000 (ADURTS & PEDIATRICS 14.142 0 0 6. 5. 54.00 05400 RADIOLGY - DIAGNOSTI C 0 0 0 0 7. 54.00 06900 ELECTROCARDIOLOGY 0 0 0 0 7. 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 7. 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1 0 0 1. 7. 73.00 07300 DRUGS CHARGED TO PATIENTS 1 0 0 1.5. 37. 73.00 7300 DRUGS CHARGED TO PATIENTS 1 0 0 0 0 7. <	7.00	00700 OPERATION OF PLANT					7.00
15.00 01500 PHARMACY 0 0 0 11 16.00 000 000 18, 108, 986 11 11 1000 000 18, 108, 986 11 11 000 000 18, 108, 986 11 11 000 000 0 0 18, 108, 986 11 30.00 03000 ADULTS & PEDIATRICS 14, 142 0 0 6, 253, 396 31 4000 05400 RADIOLOGY - DIAGNOSTIC 0 0 0 0 0 66 60.00 06900 ELECTROCARDIOLOGY 1 0 0 0 0 7 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 7 7 7 0 0 0 7 7 7 0 0 0 7			27, 162				9.00
16.00 01600 DIAD CAL RECORDS & LIBRARY 2,078 0 0 18,108,966 11 10701 INPATIENT ROUTINE SERVICE COST CENTERS	14.00	01400 CENTRAL SERVICES & SUPPLY	0	0			14.00
INPATI ENT ROUTINE SERVICE COST CENTERS 14,142 0 <td>15.00</td> <td>01500 PHARMACY</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>15.00</td>	15.00	01500 PHARMACY	0	0		0	15.00
30.00 CONCRETE Second Contraction			2, 078	0		0 18, 108, 986	16.00
ANCILLARY SERVICE COST CENTERS Image: Cost of							
54.00 05400 RADIOLOGY - DIAGNOSTIC 0 0 0 0 0 0 60.00 60.00 1 0 0 47,025 66 60.00 06000 LECTROCARDIOLOGY 0 0 0 0 0 66 70.00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 77 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 77 72.00 07200 IMEL DEV. CHARGED TO PATIENTS 0 0 0 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 1 0 0 155,370 77 90.00 00900 CLINC 9,764 0 0 11,653,195 96 01HER REI MBURSABLE COST CENTERS 97 0 0 0 0 99 9900 9900 9900 9900 0 0 0 97 97 9900 9900 0 0 0 111 111 111 111 111 111 <t< td=""><td>30.00</td><td></td><td>14, 142</td><td>0</td><td></td><td>0 6, 253, 396</td><td>30.00</td></t<>	30.00		14, 142	0		0 6, 253, 396	30.00
60.00 06000 LABORATORY 1 0 0 47,025 66 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 77 00 07000 ELECTROCARDIOLOGY 0 0 0 0 77 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 77 00 07000 CLINIC 9,764 0 0 11,653,195 94 00 09500 CLINIC 9,764 0 0 0 99 99.00 09550 0 0 0 99 99.00 09550 0 0 0 0 99 99.00 09550 0 0 0 0 99 0 09550 0 0 0 0 99 0 09950 0 0 0 0 99 0 09950 0 0 0 0 111 111 111 111 111							
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 77 77 0 0 0 0 0 0 0 0 0 0 77 77 00 0 0 0 0 0 0 77 77 00 0 0 0 0 0 77 77 00 0 0 0 0 77 77 0 0 0 0 0 0 77 77 0 0 0 0 0 0 77 77 77 0			0				54.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 77 70.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 77 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 1 0 0 155, 370 77 0017PATIENT SERVICE COST CENTERS 9, 764 0 0 11, 653, 195 91 90.00 099000 CHIER COST CENTERS 0 0 0 0 94 91.00 099500 CMHC 0 0 0 0 0 94 92.00 099500 CMHC 0 0 0 0 94 97 97 118.00 SUBTALS (SUM OF LINES 1 through 117) 25,986 0 0 194 194.00 0 0 194 194.00 O7951 GRACE CLINIC HEALTH PROFESIONAL 1,176 0 0 194 200			1	0		0 47,025	60.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 77 72.00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 155,370 77 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 155,370 77 70.00 09000 CLI NI C 0 0 11,653,195 91 90.00 09000 CHER REI MBURSABLE COST CENTERS 9,764 0 0 11,653,195 91 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 91 92 99.00 09900 CMHC 0 0 0 0 0 92 92 91.00 09500 THER REI MBURSABLE COST CENTERS 0 0 0 114 114 94.00 07950 GRACE CLINIC HEALTH PROFESSIONAL 1,176 0 0 0 19 200.00 Cross Foot A	69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 1 0 0 155,370 77 00 007300 DRUGS CHARGED TO PATIENTS 1 0 0 155,370 77 00 007300 DRUGS CHARGED TO PATIENTS 1 0 0 155,370 77 00 00700 CLINIC 97,764 0 0 11,653,195 91 90.00 09900 CHHER REIMBURSABLE COST CENTERS 0 0 0 91 91 98.00 09900 CHHC 0 0 0 0 91 91 99.00 O9900 CMHC 0 0 0 0 91 91 918.00 SUBTOTALS (SUM OF LINES 1 through 117) 25,986 0 0 18,108,986 114 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 25,986 0 0 0 19 194.00 07950 OTHER NONREI MB COST CENTER 0 0 0 <	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 1 0 0 155,370 73 00100 01000 CLINIC 0 0 11,653,195 94 00100 0110 0 0 0 11,653,195 94 00100 0110 0 0 0 0 11,653,195 94 00100 0110 09850 0THER REIMBURSABLE COST CENTERS 0 0 0 97 97 98.00 09900 CMHC 0 0 0 0 97 <t< td=""><td>71.00</td><td>07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td><td>0</td><td>0</td><td></td><td>0 0</td><td>71.00</td></t<>	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	71.00
OUTPATIENT SERVICE COST CENTERS 90.00 OPTOD OITLER REIMBURSABLE COST CENTERS 91.653,195,195 91.653,195,195,193,111 91.653,193,193,193,193,193,193,193,193,193,19			0	0		0 0	72.00
90.00 09000 CLINIC 9,764 0 11,653,195 94 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 97	73.00	07300 DRUGS CHARGED TO PATIENTS	1	0		0 155, 370	73.00
OTHER REI MBURSABLE COST CENTERS O </td <td></td> <td>OUTPATIENT SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td>		OUTPATIENT SERVICE COST CENTERS					
98.00 09850 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 94.00 09900 CMHC 0 </td <td>90.00</td> <td>09000 CLINIC</td> <td>9, 764</td> <td>0</td> <td></td> <td>0 11, 653, 195</td> <td>90.00</td>	90.00	09000 CLINIC	9, 764	0		0 11, 653, 195	90.00
99.00 09900 CMHC 0 0 0 0 99 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 25,986 0 0 18,108,986 118 NONREI MBURSABLE COST CENTERS 194.00 07950 OTHER NONREIMB COST CENTER 0 0 0 199 194.01 07951 GRACE CLINIC HEALTH PROFESSIONAL 1,176 0 0 199 200.00 Cross Foot Adjustments 200 202 0 Cost to be allocated (per Wkst. B, 394,770 0 0 475,575 203 201.00 Unit cost multiplier (Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 203 204.00 Cost to be allocated (per Wkst. B, 4,523 0 0 68,432 204 205.00 Unit cost multiplier (Wkst. B, Part I) 0.166519 0.000000 0.000000 0.003779 204							
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 25,986 0 0 18,108,986 114 NONREI MEURSABLE COST CENTERS 0 0 0 19,108,986 114 194.00 07950 OTHER NONREI MB COST CENTER 0 0 0 19,109 194.01 07951 GRACE CLINIC HEALTH PROFESSIONAL 1,176 0 0 19,200 200.00 Cross Foot Adjustments 200 0 475,575 200 201.00 Negative Cost Centers 200 200 0 475,575 200 202.00 Cost to be allocated (per Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 200 204.00 Cost to be allocated (per Wkst. B, A,523 0 0 68,432 200 205.00 Unit cost multiplier (Wkst. B, Part 0.166519 0.000000 0.000000 0.003779 205	98.00	09850 OTHER REIMBURSABLE COST CENTERS					98.00
SUBTOTALS SUBTOTALS <t< td=""><td>99.00</td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>99.00</td></t<>	99.00		0	0		0 0	99.00
NONREI MBURSABLE COST CENTERS 0 0 0 194. 194. 00 07950 OTHER NONREI MB COST CENTER 0 0 0 194. 194. 01 07951 GRACE CLINIC HEALTH PROFESSIONAL 1, 176 0 0 194. 200. 00 Cross Foot Adjustments 200 0 0 194. 201. 201. 00 Negative Cost Centers 200 202. 0 Cost to be allocated (per Wkst. B, 394,770 0 0 475,575 203. 203. 00 Unit cost multiplier (Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 204. 204. 00 Cost to be allocated (per Wkst. B, 4,523 0 0 68,432 204. 205. 00 Unit cost multiplier (Wkst. B, Part 0.166519 0.000000 0.000000 0.003779 204.		SPECIAL PURPOSE COST CENTERS					
194.00 07950 0THER NONREIMB COST CENTER 0 0 0 194.01 194.01 07951 GRACE CLINIC HEALTH PROFESSIONAL 1,176 0 0 0 194.01 200.00 Cross Foot Adjustments 1,176 0 0 0 194.01 201.00 Negative Cost Centers 200 200 0 475,575 200 202.00 Cost to be allocated (per Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 200 203.00 Unit cost multiplier (Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 200 204.00 Cost to be allocated (per Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 200 205.00 Unit cost multiplier (Wkst. B, Part I) 0.166519 0.000000 0.000000 0.003779 205	118.00		25, 986	0		0 18, 108, 986	118.00
194.01 07951 GRACE CLINIC HEALTH PROFESSIONAL 1,176 0 0 194 200.00 Cross Foot Adjustments 1,176 0 0 200 201.00 Negative Cost Centers 200 0 475,575 200 202.00 Cost to be allocated (per Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 200 203.00 Unit cost multiplier (Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 200 204.00 Cost to be allocated (per Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 200 205.00 Unit cost multiplier (Wkst. B, Part I) 0.166519 0.000000 0.000000 0.000000 0.000000 0.000000							
200.00 Cross Foot Adjustments 200 201.00 Negative Cost Centers 200 202.00 Cost to be allocated (per Wkst. B, Part I) 394,770 0 0 475,575 200 203.00 Unit cost multiplier (Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 200 204.00 Cost to be allocated (per Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 200 205.00 Unit cost multiplier (Wkst. B, Part 0.166519 0.000000 0.000000 0.003779 200			0			0 0	194.00
201.00 Negative Cost Centers 20 202.00 Cost to be allocated (per Wkst. B, Part I) 394,770 0 0 475,575 20 203.00 Unit cost multiplier (Wkst. B, Part I) 14.533908 0.000000 0.026262 20 204.00 Cost to be allocated (per Wkst. B, Part II) 4,523 0 0 68,432 20 205.00 Unit cost multiplier (Wkst. B, Part 0.166519 0.000000 0.000000 0.003779 20			1, 176	0		0 0	194. 01
202.00 Cost to be allocated (per Wkst. B, Part I) 394,770 0 0 475,575 203 203.00 Unit cost multiplier (Wkst. B, Part I) 14.533908 0.000000 0.0026262 203 204.00 Cost to be allocated (per Wkst. B, Part II) 9 4,523 0 0 68,432 204 205.00 Unit cost multiplier (Wkst. B, Part 0.166519 0.000000 0.000000 0.003779 205	200.00						200.00
Part I) Part I) 14.533908 0.000000 0.000000 0.026262 203 203.00 Unit cost multiplier (Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 203 204.00 Cost to be allocated (per Wkst. B, Part I) 4,523 0 0 68,432 204 205.00 Unit cost multiplier (Wkst. B, Part I) 0.166519 0.000000 0.000000 0.003779 204	201.00	Negative Cost Centers					201.00
203.00 Unit cost multiplier (Wkst. B, Part I) 14.533908 0.000000 0.000000 0.026262 203 204.00 Cost to be allocated (per Wkst. B, Part I) 4,523 0 0 68,432 204 205.00 Unit cost multiplier (Wkst. B, Part 0.166519 0.000000 0.000000 0.003779 204	202.00	Cost to be allocated (per Wkst. B,	394, 770	0		0 475, 575	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) 4,523 0 0 68,432 20 205.00 Unit cost multiplier (Wkst. B, Part 0.166519 0.000000 0.000000 0.003779 205							
Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0. 166519 0. 000000 0. 003779 205	203.00		14. 533908	0. 000000	0.0000	00 0. 026262	203.00
205.00 Unit cost multiplier (Wkst. B, Part 0.166519 0.000000 0.000000 0.003779 205	204.00	Cost to be allocated (per Wkst. B,	4, 523	0		0 68, 432	204.00
	205.00		0. 166519	0. 000000	0.0000	0. 003779	205.00
		11)					
	206.00						206.00
(per Wkst. B-2)							
	207.00						207.00
Parts III and IV)		Parts III and IV)	I				

Health Financial Systems	HAMILTON CEN	NTER, INC.		In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-4009	Period: From 07/01/2021	Worksheet C Part I		
				To 06/30/2022		pared: 52 am	
		Title	e 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 & PEDIATRICS	4, 421, 041		4, 421, 04	1 0	4, 421, 041	30.00	
ANCILLARY SERVICE COST CENTERS				-			
54.00 05400 RADI OLOGY – DI AGNOSTI C	0			0 0	0	54.00	
60. 00 06000 LABORATORY	49, 296		49, 29	06 0	49, 296		
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	162, 708		162, 70	0 8	162, 708	73.00	
OUTPATIENT SERVICE COST CENTERS			1				
90. 00 09000 CLINIC	7, 553, 507		7, 553, 50	07 0	7, 553, 507	90.00	
OTHER REIMBURSABLE COST CENTERS	r		1	- F			
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)	12, 186, 552	0	12, 186, 55	0	12, 186, 552		
201.00 Less Observation Beds	0			0		201.00	
202.00 Total (see instructions)	12, 186, 552	0	12, 186, 55	0	12, 186, 552	202.00	

<u>Health</u> Fina	Health Financial Systems		HAMILTON CENTER, INC.			In Lieu of Form CMS-2552-10			
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2021	Worksheet C Part I			
					To 06/30/2022	Date/Time Pre 11/30/2022 8:			
			Title	XVIII	Hospi tal	PPS			
			Charges						
	Cost Center Description	I npati ent	Outpati ent	Total (col.)	6 Cost or Other	TEFRA			
				+ col. 7)	Ratio	Inpati ent			
						Ratio			
		6.00	7.00	8.00	9.00	10.00			
	TIENT ROUTINE SERVICE COST CENTERS								
	0 ADULTS & PEDIATRICS	6, 253, 396		6, 253, 39	6		30.00		
	LLARY SERVICE COST CENTERS								
54.00 0540	0 RADI OLOGY – DI AGNOSTI C	0	0		0 0.000000	0.00000	54.00		
60.00 0600	0 LABORATORY	47, 025	0	47, 02	5 1.048293	0. 000000	60.00		
69.00 0690	0 ELECTROCARDI OLOGY	0	0		0.000000	0.00000	69.00		
70.00 0700	0 ELECTROENCEPHALOGRAPHY	0	0		0.000000	0. 000000	70.00		
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0. 000000	0. 000000	71.00		
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0. 000000	0. 000000	72.00		
73.00 0730	O DRUGS CHARGED TO PATIENTS	155, 370	0	155, 37	0 1.047229	0. 000000	73.00		
OUTP	ATIENT SERVICE COST CENTERS								
90.00 0900	O CLINIC	0	11, 653, 195	11, 653, 19	5 0. 648192	0. 000000	90.00		
OTHE	R REIMBURSABLE COST CENTERS								
98.00 0985	O OTHER REIMBURSABLE COST CENTERS	0	0		0 0.000000	0. 000000	98.00		
99.00 0990	о смнс	0	0		0		99.00		
200.00	Subtotal (see instructions)	6, 455, 791	11, 653, 195	18, 108, 98	6		200.00		
201.00	Less Observation Beds						201.00		
202.00	Total (see instructions)	6, 455, 791	11, 653, 195	18, 108, 98	6		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 07/01/2021	Worksheet C Part I	
			To 06/30/2022		
		Title XVIII	Hospi tal	PPS	<u>Jz alli</u>
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
54.00 05400 RADI OLOGY – DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	1. 048293				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	1.047229				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 648192				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 CEM	NTER, INC.		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-4009	Period: From 07/01/2021	Worksheet C Part I	
				To 06/30/2022		pared: 52 am
		Ti tl	e XIX	Hospi tal	Cost	
				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	4, 421, 041		4, 421, 04	1 0	4, 421, 041	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	49, 296		49, 29	06 0	49, 296	
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	162, 708		162, 70	0 8	162, 708	73.00
OUTPATIENT SERVICE COST CENTERS			-	-		
90. 00 09000 CLINIC	7, 553, 507		7, 553, 50	07 0	7, 553, 507	90.00
OTHER REIMBURSABLE COST CENTERS			-	- 1		
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)	12, 186, 552	0	12, 186, 55	52 0	12, 186, 552	
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	12, 186, 552	0	12, 186, 55	52 0	12, 186, 552	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 CO		Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/30/2022 8:	epared: 52 am
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. (+ col. 7)	6 Cost or Other Ratio	TEFRA I npati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDIATRICS	6, 253, 396		6, 253, 39	6		30.00
ANCI LLARY SERVI CE COST CENTERS						_
54.00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0. 000000		
60. 00 06000 LABORATORY	47, 025	0	47, 02		0. 000000	
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0. 000000	0. 000000	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000	0. 000000	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	155, 370	0	155, 37	0 1.047229	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	11, 653, 195	11, 653, 19	5 0. 648192	0. 000000	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, 455, 791	11, 653, 195	18, 108, 98	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	6, 455, 791	11, 653, 195	18, 108, 98	6		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-4009 Period: From 07/01/2021 Worksheet C Part I Title XIX Hospital Cost Cost Center Description PPS Inpatient Ratio Title XIX Hospital Cost Cost Center Description PPS Inpatient Ratio Title XIX Hospital Cost INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ANCILLARY SERVICE COST CENTERS 30.00 ANCILLARY SERVICE COST CENTERS 54.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 70.00 54.00 60.00 60.00 66.00 70.00 70.00 71.00 70.00 71.00 70.00 71.00 70.00 71.00 71.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00	Health Financial Systems	HAMILTON CENT	FER, INC.	In Lieu	u of Form CMS-2	2552-10
Cost Center Description PPS Inpatient Ratio PPS Inpatient Ratio State 30.00 03000 ADULTS & PEDIATRICS 30.00 ANCILLARY SERVICE COST CENTERS 30.00 60.00 06000 LABORATORY 0.000000 60.00 06000 LABORATORY 0.000000 60.00 06900 ELECTROCARDIOLOGY - DIAGNOSTIC 0.000000 69.00 06900 ELECTROCARDIOLOGY 0.000000 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 072.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 001701 INFL SERVICE COST CENTERS 0.000000 73.00 001702 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73.00 0017030 DRUGS CHARGED TO PATIENTS 0.000000 73.00 001704 INFL SERVICE COST CENTERS 0.000000 90.00 001705 DRUGS CHARGED TO CENTERS 0.000000 90.00 001704 INFL SERVICE COST CENTERS 0.000000 90.00 001704 INFL SERVICE COST CENTERS 0.0000000 90.00	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4009	From 07/01/2021	Part I Date/Time Pre	
Ratio Ratio 11.00 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 ANCILLARY SERVICE COST CENTERS 30.00 60.00 05400 RADIOLOGY - DIAGNOSTIC 0.000000 60.00 06000 LABORATORY 0.000000 69.00 GECTROCARDIOLOGY 0.000000 69.00 OTOOD ELECTROCARDIOLOGY 0.000000 70.00 OTOOD ELECTROCARDIOLOGY 0.000000 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 07200 DRUGS CHARGED TO PATIENTS 0.000000 0UTPATIENT SERVICE COST CENTERS 0.000000 72.00 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 73.00 90.00 09000 CLINIC 0.000000 99.00 99.00 98.00 09880 OTHER REIMBURSABLE COST CENTERS 0.000000 99.00 99.00 99.00 Subtotal (see instructions) 200.00 201.00 201.00			Title XIX	Hospi tal	Cost	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 30.00 ANCILLARY SERVICE COST CENTERS 0.000000 54.00 54.00 05400 RADIOLOGY - DIAGNOSTIC 0.000000 60.00 60.00 064000 LABORATORY 0.000000 69.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 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 D7300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 90.00 O99000 CLINIC 0.000000 90.00 00 099000 CMHC 90.00 99.00 99.00 Subtotal (see instructions) 90.00 <td>Cost Center Description</td> <td>Ratio</td> <td></td> <td></td> <td></td> <td></td>	Cost Center Description	Ratio				
ANCI LLARY SERVICE COST CENTERS	INPATIENT ROUTINE 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 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 017401 NET SERVI CE COST CENTERS 0.000000 73.00 90.00 09000 CLI NI C 0.000000 90.00 0017401 ER TEI MBURSABLE COST CENTERS 90.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 99.00 99.00 09900 CHHC 99.00 99.00 99.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	30. 00 03000 ADULTS & PEDI ATRI CS					30.00
60.00 06000 LABORATORY 0.000000 60.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 73.00 73.00 01700 09000 CLINIC 0.000000 90.00 01700 09000 CHRE REIMBURSABLE COST CENTERS 0.000000 90.00 98.00 09900 CHHC 99.00 99.00 99.00 200.00 Subtotal (see instructions) 99.00 99.00 200.00 201.00 201.00 201.00	ANCILLARY SERVICE COST CENTERS	· ·				1
69.00 06900 ELECTROCARDIOLOGY 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 001704TIENT SERVICE COST CENTERS 0.000000 73.00 90.00 09000 CLINIC 0.000000 90.00 91.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 90.00 92.00 09900 CMHC 99.00 99.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000				54.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.000000 73.00 0.007300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 0.007400 D9000 CLINIC 0.000000 73.00 0.00850 OTHER REIMBURSABLE COST CENTERS 0.000000 90.00 99.00 99.00 O9900 CMHC 99.00 99.00 99.00 99.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00	60.00 06000 LABORATORY	0. 000000				60.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 73.00 90.00 OP9000 CLINIC 0.000000 90.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 99.00 09900 CMHC 0.000000 99.00 99.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 0THER REIMBURSABLE COST CENTERS 0.000000 90.00 90.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 99.00 09900 CMHC 99.00 99.00 99.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00	70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.00000 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 90.00 <t< td=""><td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td><td>0. 000000</td><td></td><td></td><td></td><td>71.00</td></t<>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0THER REIMBURSABLE COST CENTERS 0.000000 98.00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 99.00 09900 CMHC 99.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
90. 00 09000 CLINIC 0.00000 90. 00 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 98.00 98.00 99.00 09900 CMHC 99.00 99.00 200.00 Subtotal (see instructions) 200.00 201.00<	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OTHER REI MBURSABLE COST CENTERS98. 0009850OTHER REI MBURSABLE COST CENTERS0. 00000098. 0099. 0009900CMHC99. 0099. 00200. 00Subtotal (see instructions)200. 00200. 00201. 00Less Observation Beds201. 00201. 00						
98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 99.00 09900 CMHC 99.00 200.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00 20	90. 00 09000 CLINIC	0. 000000				90.00
99.00 09900 CMHC 99.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.00
201.00 Less Observation Beds 201.00	99.00 09900 CMHC					99.00
	200.00 Subtotal (see instructions)					200.00
202.00 Total (see instructions) 202.00	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 07/01/2021	Worksheet D Part I	
				To 06/30/2022		pared: 52 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	500, 976	0	500, 97	6 4, 950	101. 21	30.00
200.00 Total (lines 30 through 199)	500, 976		500, 97	6 4, 950		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	782	79, 146				30.00
200.00 Total (lines 30 through 199)	782	79, 146				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 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Pre 11/30/2022 8:	pared:
		Title	XVIII	Hospi tal	PPS	<u>52 ani</u>
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 RADIOLOGY – DIAGNOSTIC	0	0	0. 00000		0	54.00
60. 00 06000 LABORATORY	736	47, 025			27	60.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.0000	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		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	2, 358	155, 370	0. 0151	14, 644	222	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	425, 535	11, 653, 195	0. 03651	7 0	0	90.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.0000		0	
200.00 Total (lines 50 through 199)	428, 629	11, 855, 590		16, 361	249	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 07/01/2021		
				To 06/30/2022	Date/Time Pre 11/30/2022 8:	
		Title	XVIII	Hospi tal	PPS	<u>JZ dili</u>
Cost Center Description	Nursi ng	Nursing		Allied Health	All Other	
	Program	Program	Post-Stepdow		Medical	
	Post-Stepdown		Adjustments		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		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien		Inpati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)	(00	7.00		
	4.00	5.00	6.00	7.00	8.00	_
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1.05	0 0 00	700	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	4,95			
200.00 Total (lines 30 through 199)	Lanati ant	0	4, 95	0	/82	200.00
Cost Center Description	Inpatient Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDI ATRI CS	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 SEF	RVICE OTHER PAS	S Provider C	CN: 15-4009	Period:	Worksheet D	
THROUGH COSTS				From 07/01/2021 To 06/30/2022		pared [.]
				10 00/00/2022	11/30/2022 8:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	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	HAMI LTON CEI	NTER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2021	Part IV	
				To 06/30/2022		
		T: +1 -		lleasthal	11/30/2022 8:	52 am
			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	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		0 0	0.00000	54.00
60. 00 06000 LABORATORY	0	0		0 47, 025	0.000000	60.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		o o	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o o	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		0 155, 370		
OUTPATIENT SERVICE COST CENTERS					0.000000	/ 01 00
90. 00 09000 CLI NI C	0	0		0 11, 653, 195	0.000000	90.00
OTHER REIMBURSABLE COST CENTERS	•	•	•			1
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0.000000	98.00
200.00 Total (lines 50 through 199)	0	0		0 11, 855, 590		200.00

Health Financial Systems	HAMILTON CENT	ER, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 07/01/2021	Worksheet D Part IV	
				To 06/30/2022		pared: 52 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	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	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	1, 717		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		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	14, 644		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 429, 740	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)		16, 361		0 429, 740	0	200.00

Health Financial Systems	HAMI LTON CEN	ITER, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2021 To 06/30/2022	Date/Time Pre 11/30/2022 8:	
		Title	XVIII	Hospi tal	PPS	
	.		Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9	0.00	(see inst.)	(see inst.)	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0,000000	0	1	0	0	54.00
54.00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	0		0 0	0	
60. 00 06000 LABORATORY	1.048293	0		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		0 0	0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 000000	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 047229	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLINIC	0. 648192	429, 740		0 0	278, 554	90.00
OTHER REIMBURSABLE COST CENTERS			1			
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			0 0	0	1 101 00
200.00 Subtotal (see instructions)		429, 740		0 0	278, 554	•
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		429, 740		0 0	278, 554	202.00

Health Financial Systems	HAMILTON CE	NTER, INC.		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-4009	Peri od:	Worksheet D	
				From 07/01/2021 To 06/30/2022	Part V Date/Time Pre	enared.
				10 00/00/2022	11/30/2022 8:	52 am
			XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)				
ANCILLARY SERVICE COST CENTERS	6.00	7.00				
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROCKRDTOLOGT	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS						72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS						73.00
OUTPATIENT SERVICE COST CENTERS		0				/ 5.00
90. 00 09000 CLINIC	0	0				90.00
OTHER REIMBURSABLE COST CENTERS	1	1	1			
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00

	Financial Systems HAMILTON CENTI ATION OF INPATIENT OPERATING COST	Provider CCN: 15-4009	Period: From 07/01/2021	u of Form CMS-2 Worksheet D-1	
			To 06/30/2022	Date/Time Pre 11/30/2022 8:	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed da			4, 950	
00 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d	5,5	rivate room dave	4, 950 0	
00	do not complete this line.		i i vate i ooni days,	0	
00	Semi-private room days (excluding swing-bed and observation			4, 950	4
00	Total swing-bed SNF type inpatient days (including private r reporting period	oom days) through Decemb	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)		- 01 -6 the east	0	-
00	Total swing-bed NF type inpatient days (including private ro reporting period	om days) through Decembe	er 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Drogram (oveludin	a cwing had and	782	9
00	newborn days) (see instructions)	to the riogram (excrudin	iy switty-bed alld	162	`
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10
. 00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	1
	December 31 of the cost reporting period (if calendar year,	enter 0 on this line)	•	0	·
. 00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar	year, enter 0 on this li	ne)		
	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bec	days)	0	
	Nursery days (title V or XIX only)			-	16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
00	reporting period	and the set of the set of the		0.00	
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es through December 31 c	or the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instructio	nc)		4, 421, 041	21
			ting period (line		
	5 x line 17)	·			
. 00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	r 31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24
	7 x line 19)	· · · · · · · · · · · · · · · · · · ·			
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	ig period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 421, 041	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation bed o	harges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)	Line 20		0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- IINE 20)		0. 000000 0. 00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 m	, ,	icti ons)	0.00	
	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35)	1110 31)		0. 00 0	35
	General inpatient routine service cost net of swing-bed cost	and private room cost c	lifferential (line	-	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
	Adjusted general inpatient routine service cost per diem (se	e instructions)		893.14	
	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog			698, 435	
	IMEDICALLY DECESSARY DELVALE FOOD COST ADDITCADLE TO THE PROD	iam (IIIIe 14 X IIIIe 35)		0	40

	Financial Systems	HAMILTON CEN			In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-4009	Period: From 07/01/2021	Worksheet D-1	
					To 06/30/2022		
			Title	e XVIII	Hospi tal	11/30/2022 8: PPS	52 alli
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		<u>Cost</u> 1.00	Days 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units			1			
43.00							43.00
44.00 45.00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T						44.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1 00	
48.00	Program inpatient ancillary service cost (Wk	st D-3 col 7	3 line 200)			1.00 17,136	48.00
	Total Program inpatient costs (sum of lines			ons)		715, 571	
	PASS THROUGH COST ADJUSTMENTS		·				
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, su	m of Parts I and	79, 146	50.00
51.00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancilla	rv services (f	rom Wkst D	sum of Parts II	249	51.00
	and IV)		, <u></u> ,			247	
52.00	Total Program excludable cost (sum of lines					79, 395	
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		elated, non-pr	iysi ci an anest	hetist, and	636, 176	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	
56.00 57.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	arget amount (lino E4 minus	Lino E2)	0	
58.00	Bonus payment (see instructions)	The cost and ta	arget amount (inne so minus	THE 55)	0	1
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the		
	market basket						
60.00 61.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0. 00 0	1
01.00	which operating costs (line 53) are less that					0	01.00
	amount (line 56), otherwise enter zero (see			,.	5		
	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
	instructions)(title XVIII only)					_	
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	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II onlv). For	0	66.00
	CAH (see instructions)						
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost r	eporting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after ()ecember 31 of	the cost ren	orting period	0	68.00
00.00	(line 13 x line 20)			the cost rep	or tring period	0	00.00
69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N				<u>\</u>		70.00
70.00 71.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70.00
72.00	Program routine service cost (line 9 x line			- /			72.00
	Medically necessary private room cost applic	able to Program	m (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv				Dept 11 1.		74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	worksneet B,	Part II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line	76)					77.00
78.00	Inpatient routine service cost (line 74 minu	,					78.00
79.00 80.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			· · · · · · · · · · · · · · · · · · ·	nus line 79)		79.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 8					82.00
83.00	Reasonable inpatient routine service costs (าร)				83.00
84.00 85.00	Program inpatient ancillary services (see in		anc)				84.00 85.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00
20.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						30.00
87.00	Total observation bed days (see instructions)				0	
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se						88.00 89.00
	IVUSEIVATIVI VEN COST LITTE &/ X LITE &&) (SE	e instructions,	1				1 04 11

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 07/01/2021 To 06/30/2022		pared: 52 am
		Title	XVIII	Hospi tal	PPS	
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	500, 976	4, 421, 041	0. 11331	6 0	0	90.00
91.00 Nursing Program cost	0	4, 421, 041	0.0000	0 0	0	91.00
92.00 Allied health cost	0	4, 421, 041	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 421, 041	0.0000	0 0	0	93.00

	Financial Systems HAMILTON CENTER, INC ATION OF INPATIENT OPERATING COST Provi	der CCN: 15-4009	Peri od:	of Form CMS-2 Worksheet D-1	
			From 07/01/2021 To 06/30/2022	Date/Time Prep 11/30/2022 8:	
	Cost Center Description	Title XIX	Hospi tal	Cost	
				1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, exc			4, 950	
2.00 3.00	Inpatient days (including private room days, excluding swing-bed an Private room days (excluding swing-bed and observation bed days). I		private room days,	4, 950 0	2.0 3.0
4 00	do not complete this line.			4 050	1 1 0
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed day Total swing-bed SNF type inpatient days (including private room day		per 31 of the cost	4, 950 0	4.C 5.C
6.00	Total swing-bed SNF type inpatient days (including private room day	s) after December	31 of the cost	0	6.0
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through Decembe	er 31 of the cost	0	7. C
8.00	reporting period Total swing-bed NF type inpatient days (including private room days) after December	31 of the cost	0	8.0
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the	Program (excludir	ng swing-bed and	514	9.0
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (i		room days)	0	10.0
11.00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (i	ncluding private	room days) after	0	11. C
12.00	5 51 1 5 11		ite room days)	0	12.0
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only			0	13.0
	after December 31 of the cost reporting period (if calendar year, e Medically necessary private room days applicable to the Program (ex			о	14.(
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services thr reporting period	ough December 31	of the cost	0.00	17.0
18.00	Medicare rate for swing-bed SNF services applicable to services aft reporting period	er December 31 of	the cost	0.00	18.0
19. 00	Medicaid rate for swing-bed NF services applicable to services thro reporting period	ugh December 31 c	of the cost	0.00	19. (
20. 00	Medicaid rate for swing-bed NF services applicable to services after reporting period	r December 31 of	the cost	0.00	20.
21.00 22.00	Total general inpatient routine service cost (see instructions)	of the cost repor	ting period (line	4, 421, 041 0	
	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of	•		0	23.
	x line 18) Swing-bed cost applicable to NF type services through December 31 o			0	
	7×1 ine 19) Swing-bed cost applicable to NF type services after December 31 of		0 1 1	0	
26.00	x line 20) Total swing-bed cost (see instructions)	the cost reportin	ig period (inne o	0	26.0
	General inpatient routine service cost net of swing-bed cost (line	21 minus line 26)		4, 421, 041	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and	observation bed o	charges)	0	28.0
29.00	Private room charges (excluding swing-bed charges)		<u> </u>	0	29.0
	Semi-private room charges (excluding swing-bed charges)	20)		0	30.0
	General inpatient routine service cost/charge ratio (line 27 ÷ line Average private room per diem charge (line 29 ÷ line 3)	2ð)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minus li	ne 33)(see instru	ictions)	0.00	
	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 pr 27 minus line 36)	ivate room cost o	lifferential (line	4, 421, 041	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN			000.44	20
	Adjusted general inpatient routine service cost per diem (see instr Program general inpatient routine service cost (line 0 x line 22)	uctions)		893.14	
	Program general inpatient routine service cost (line 9 x line 38)			459, 074	
	Medically necessary private room cost applicable to the Program (li	ne 14 v line 25)	I	0	40.0

Health Financial Systems	HAMILTON CEN	NTER, INC.		In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider (Period: From 07/01/2021	Worksheet D-1	l
				To 06/30/2022		
		Tit	le XIX	Hospi tal	11/30/2022 8: Cost	52 am
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpati ent	Inpati ent	Diem (col. 1		(col. 3 x	
	<u>Cost</u> 1.00	Days 2.00	÷ col. 2) 3.00	4.00	<u>col.4)</u> 5.00	
42.00 NURSERY (title V & XIX only)		2100	0.00		0100	42.00
Intensive Care Type Inpatient Hospital Units	6	F	1		F	
43. 00 I NTENSI VE CARE UNI T 44. 00 CORONARY CARE UNI T						43.00
45. 00 BURN I NTENSI VE CARE UNI T						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (W	kst. D-3, col. 3	3, line 200)			0	48.00
49.00 Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		459, 074	49.00
PASS THROUGH COST ADJUSTMENTS	nationt routing	annul and (fre	m Wkot D ou	m of Donto L one		50.00
50.00 Pass through costs applicable to Program in	patient routine	services (rrd	DM WKSI. D, SU	m or Parts I and	0	50.00
51.00 Pass through costs applicable to Program in	patient ancilla	ry services (1	rom Wkst. D,	sum of Parts II	0	51.00
and IV)						
52.00 Total Program excludable cost (sum of lines 53.00 Total Program inpatient operating cost exclu		alatad non n	weleien enest	botict and		
medical education costs (line 49 minus line		erateu, non-pi	iysi ci all'allest	netist, and	0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION)					
54.00 Program di scharges					0	
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)					0.00	
57.00 Difference between adjusted inpatient opera	ting cost and ta	arget amount (line 56 minus	line 53)	0	
58.00 Bonus payment (see instructions)	3	5		,	C	58.00
59.00 Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year	cost report u	ndated by the	market basket		0.00	60.00
61.00 If line 53/54 is less than the lower of line					0.00	1
which operating costs (line 53) are less the		ts (lines 54 >	(60), or 1% o	f the target		
amount (line 56), otherwise enter zero (see 62.00 Relief payment (see instructions)	instructions)				C	62.00
63.00 Allowable Inpatient cost plus incentive pay	ment (see instru	uctions)				
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of th	ne cost report	ing period (See	0	64.00
<pre>instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine cost</pre>	sts after Decem	her 31 of the	cost reportin	a period (See	C	65.00
instructions)(title XVIII only)						
66.00 Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routin	ne costs through	h December 31	of the cost r	eporting period	o	67.00
(line 12 x line 19)	ne costs through	December 31	of the cost f	eporting period		07.00
68.00 Title V or XIX swing-bed NF inpatient routin	ne costs after l	December 31 of	ີ the cost rep	orting period	0	68.00
(line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient	routing costs	(lino 47 · lir	20 69)		C	40.00
69.00 Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00 Skilled nursing facility/other nursing faci	lity/ICF/IID rou	utine service	cost (line 37)		70.00
71.00 Adjusted general inpatient routine service		line 70 ÷ line	2)			71.00
72.00 Program routine service cost (line 9 x line 73.00 Medically necessary private room cost appli		m (line 14 v l	ine 35)			72.00
74.00 Total Program general inpatient routine serv	, e	•				74.00
75.00 Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B,	Part II, column		75.00
26, line 45) 76.00 Per diam capital related costs (line 75 - 1	ino 2)					74 00
76.00 Per diem capital-related costs (line 75 ÷ 1 77.00 Program capital-related costs (line 9 x line						76.00
78.00 Inpatient routine service cost (line 74 min						78.00
79.00 Aggregate charges to beneficiaries for exce						79.00
80.00 Total Program routine service costs for com 81.00 Inpatient routine service cost per diem lim	•	cost limitatio	on (line 78 mi	nus line 79)		80.00
82.00 Inpatient routine service cost per drem rim		1)				81.00
83.00 Reasonable inpatient routine service costs						83.00
84.00 Program inpatient ancillary services (see in						84.00
85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (su						85.00 86.00
PART IV - COMPUTATION OF OBSERVATION BED PAS						00.00
87.00 Total observation bed days (see instructions					0	87.00
88.00 Adjusted general inpatient routine cost per	diem (line 27 ·	÷line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (si					-	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 07/01/2021 To 06/30/2022		pared: 52 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	500, 976	4, 421, 041	0. 11331	6 0	0	90.00
91.00 Nursing Program cost	0	4, 421, 041	0.0000	0 0	0	91.00
92.00 Allied health cost	0	4, 421, 041	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 421, 041	0.0000	0 0	0	93.00

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 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
				11/30/2022 8:	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			077.000		
30. 00 03000 ADULTS & PEDI ATRI CS			977, 200		30.00
ANCI LLARY SERVI CE COST CENTERS		0.0000		0	F4 00
54. 00 05400 RADIOLOGY - DIAGNOSTIC		0.00000		0	54.00
		1.04829			60.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1.04722	9 14, 644	15, 336	73.00
OUTPATI ENT SERVI CE COST CENTERS		0 (4010		0	00.00
90. 00 09000 CLINIC		0. 64819	2 0	0	90.00
OTHER REIMBURSABLE COST CENTERS		0.00000		0	00.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	brough (Q)	0. 00000			
200.00 Total (sum of lines 50 through 94 and 96 t			16, 361	17, 136	
201.00 Less PBP Clinic Laboratory Services-Progra	im only charges (IThe 61)		1()(1		201.00
202.00 Net charges (line 200 minus line 201)			16, 361		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 07/01/2021 To 06/30/2022	Date/Time Pre 11/30/2022 8:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			700 (70		00.00
30. 00 03000 ADULTS & PEDI ATRI CS			728, 678		30.00
ANCI LLARY SERVI CE COST CENTERS		0.00000		0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0.00000		0	54.00
60. 00 06000 LABORATORY 69. 00 06900 ELECTROCARDI OLOGY		1.04829		0	60.00 69.00
		0.00000		U U	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	70.00 71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		1. 04722		0	73.00
OUTPATIENT SERVICE COST CENTERS		1.04722	7 0	0	73.00
90. 00 09000 CLINIC		0. 64819	2 0	0	90.00
OTHER REI MBURSABLE COST CENTERS		0.04017	2 0	0	70.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS		0, 00000	0 0	0	98.00
200.00 Total (sum of lines 50 through 94 and 96	through 98)		0		200.00
201.00 Less PBP Clinic Laboratory Services-Progr			0		201.00
202.00 Net charges (line 200 minus line 201)			0		202.00
		•	1		

	Financial Systems HAMILTON CENTE TION OF REIMBURSEMENT SETTLEMENT	ER, INC. Provider CCN: 15-4009	Period:	u of Form CMS-2 Worksheet E	2552-10
			From 07/01/2021 To 06/30/2022	Date/Time Pre	
		Title XVIII	Hospi tal	11/30/2022 8: PPS	<u>52 am</u>
F	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			0	
1	Medical and other services reimbursed under OPPS (see instru OPPS payments	ictions)		278, 554 325, 656	2.00
	Outlier payment (see instructions)			0	1
	Outlier reconciliation amount (see instructions)	unti ana)		0	
	Enter the hospital specific payment to cost ratio (see instr Line 2 times line 5	uctions)		0.000	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	
	Organ acquisitions	10, 601. 13, 1116 200		0	
	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	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Total reasonable charges (sum of lines 12 and 13)	line 69)		0	
	Customary charges			0	14.00
	Aggregate amount actually collected from patients liable for	1 5	Ų	0	
	Amounts that would have been realized from patients liable fo had such payment been made in accordance with 42 CFR §413.13		on a chargebasi s	0	16.00
17.00 I	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	•
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete o	nly if line 19 exceeds l	ino 11) (soo	0	
	instructions)	in y i i ine to exceeds i		0	19.00
	Excess of reasonable cost over customary charges (complete o	nly if line 11 exceeds l	ine 18) (see	0	20.00
	instructions) Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	22.00
	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 325, 656	23.00 24.00
_	COMPUTATION OF REIMBURSEMENT SETTLEMENT			323, 030	24.00
	Deductibles and coinsurance amounts (for CAH, see instruction	-		0	
	Deductibles and Coinsurance amounts relating to amount on li Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	-		91, 298 234, 358	•
li	instructions)		(
	Direct graduate medical education payments (from Wkst. E-4, ESRD direct medical education costs (from Wkst. E-4, line 36			0	
	Subtotal (sum of lines 27 through 29)	·)		234, 358	•
	Primary payer payments			0	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	ICES)		234, 358	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	•
	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	
1	Subtotal (see instructions)			234, 358	•
1	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS			0 153	
39. 50 I	Pioneer ACO demonstration payment adjustment (see instruction				39.50
1	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl		ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	•
	Subtotal (see instructions)			234, 511	•
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			586 0	1
40.03	Sequestration adjustment-PARHM pass-throughs				40.03
	Interim payments Interim payments-PARHM			233, 925	41.00
	Tentative settlement (for contractors use only)			0	•
	Tentative settlement-PARHM (for contractor use only)			0	42.01
	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			0	43.00
44. 00 I	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	chapter 1,	0	•
-	§115.2 TO BE COMPLETED BY CONTRACTOR				-
	Driginal outlier amount (see instructions)			0	90.00
1	Outlier reconciliation adjustment amount (see instructions)			0	
1	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00 0	1
	Total (sum of lines 91 and 93)			0	•

Health Financial Systems	HAMILTON CENTER, INC.	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4009	Period:	Worksheet E	
		From 07/01/2021 To 06/30/2022	Date/Time Pre	nared
		10 00/30/2022	11/30/2022 8:	
	Title XVIII	Hospi tal	PPS	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200.00

	n Financial Systems HAMILTON CEN SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-4009	Period: From 07/01/202 ⁻	eu of Form CMS-2 Worksheet E-1 I Part I	
				To 06/30/2022	2 Date/Time Pre 11/30/2022 8:	pared: 52 am
			XVIII	Hospi tal	PPS	
		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		503, 6	0 0	233, 925 0	1.00 2.00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					2.00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					3.00
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVI DER			0	0	3.0
3.02 3.03				0	0	3.02 3.03
3. 03 3. 04				0	0	3.0
3. 05				0	0	3.0
3.50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.5
3.50 3.51	ADJUSTMENTS TU PROGRAM			0	0	3.5
3.52				0	0	3.5
8.53				0	0	3.5
3.54				0	0	3.5
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.9
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		503, 6	38	233, 925	4.0
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.0
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
. 01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.0
. 02				0	0	5.0
. 03				0	0	5.C
5. 50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.5
5. 51				0	0	5.5
5. 52				0	0	5.5
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
. 01	SETTLEMENT TO PROVIDER			0	0	6.0
. 02 . 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		503,6	0	0 233, 925	6.0 7.0
				Contractor	NPR Date	7.0
		()	Number 1.00	(Mo/Day/Yr) 2.00	
. 00	Name of Contractor	l)	1.00	2.00	8.0

	Financial Systems HAMILTON C	ENTER, INC.		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4009	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part II Date/Time Pre 11/30/2022 8:	pared:
		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	medical education payments	;)	637, 640	1.00
2.00 3.00	Net IPF PPS Outlier Payments Net IPF PPS ECT Payments			509 0	2.00 3.00
4.00	Unweighted intern and resident FTE count in the most rece	nt cost report filed on or	before November	0.00	4.00
4.01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE			0.00	4.01
	program or hospital closure, that would not be counted wi CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	thout a temporary cap adjus	tment under 42		
5.00	New Teaching program adjustment. (see instructions)			0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth	period of a "new	0.00	6.00
7.00	teaching program" (see instuctions) Current year's unweighted I&R FTE count for residents wit teaching program" (see instuctions)	hin the new program growth	period of a "new	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education a	djustment (see instructions	.)	0.00	8.00
9.00	Average Daily Census (see instructions)		,	13. 561644	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	to the power of .5150 -1}.		0.000000	
11.00	Teaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and	11)		628 140	11.00 12.00
12.00 13.00	Nursing and Allied Health Managed Care payment (see instr	·		638, 149 0	12.00
14.00	Organ acqui si ti on (DO NOT USE THIS LINE)			0	14.00
15.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	15.00
16.00	Subtotal (see instructions)			638, 149	
17.00	Primary payer payments			0	17.00
18.00 19.00	Subtotal (line 16 less line 17). Deductibles			638, 149 101, 372	
20.00	Subtotal (line 18 minus line 19)			536, 777	
21.00	Coi nsurance			32, 313	
22.00	Subtotal (line 20 minus line 21)			504, 464	22.00
23.00	Allowable bad debts (exclude bad debts for professional s	ervices) (see instructions)		0	23.00
24.00 25.00	Adjusted reimbursable bad debts (see instructions)	i petructi ope)		0	24.00 25.00
	Allowable bad debts for dual eligible beneficiaries (see Subtotal (sum of lines 22 and 24)	instructions)		504, 464	
27.00	Direct graduate medical education payments (see instructi	ons)		0	
28.00	Other pass through costs (see instructions)			0	28.00
	Outlier payments reconciliation			0	29.00
30.00	OTHER ADJUSTMENTS			436	
30. 50 30. 98	Pioneer ACO demonstration payment adjustment (see instruc Recovery of accelerated depreciation.	tions)		0	30. 50 30. 98
30.98	Demonstration payment adjustment amount before sequestrat	ion		0	30.98
31.00	Total amount payable to the provider (see instructions)			504, 900	
31.01	Sequestration adjustment (see instructions)			1, 262	
	Demonstration payment adjustment amount after sequestrati	on		0	
	Interim payments			503, 638	
33.00 34.00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01,	21 02 22 and 22		0	33.00 34.00
34.00	Protested amounts (nonallowable cost report items) in acc		chapter 1	0	34.00
00.00	S115.2 TO BE COMPLETED BY CONTRACTOR				00.00
50.00	Original outlier amount from Worksheet E-3, Part II, line	2		509	50.00
51.00	Outlier reconciliation adjustment amount (see instruction			0	51.00
52.00	The rate used to calculate the Time Value of Money			0.00	
53.00	Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020			0 9 DHF	53.00
99.00	Teaching Adjustment Factor for the cost reporting period			0.000000	99.00
	Calculated Teaching Adjustment Factor for the current yea	3.		0.000000	
			ľ		

	Financial Systems HAMILTON CENTE ATION OF REIMBURSEMENT SETTLEMENT	R, INC. Provider CCN: 15-4009	Peri od:	u of Form CMS-2 Worksheet E-3	
LOOL			From 07/01/2021 To 06/30/2022	Part VII	epare
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR 2	KIX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		459, 074		1 1
00	Medical and other services		437,074	0	
00	Organ acquisition (certified transplant centers only)		0	0	3
00	Subtotal (sum of lines 1, 2 and 3)		459, 074	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)		459, 074	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
~ ~	Reasonabl e Charges				
00	Routi ne servi ce charges		728, 678	0	
00 . 00	Ancillary service charges Organ acquisition charges, net of revenue		0	0	10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		728, 678	0	1
. 00	CUSTOMARY CHARGES		720,070		1 ' '
. 00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13
	basi s	5			
. 00	Amounts that would have been realized from patients liable for	or payment for services (on 0	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
. 00	Total customary charges (see instructions)		728, 678	0	
. 00	Excess of customary charges over reasonable cost (complete or	nly if line 16 exceeds	269, 604	0	1
8. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete or	ly if line 4 exceeds li		0	18
. 00	16) (see instructions)	il y 11 1111e 4 exceeds 111	0	0	
9.00	Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		459, 074	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS provi	ders.		
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0	_	2
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00 . 00	Customary charges (title V or XIX PPS covered services only)		450.074	0	
. 00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		459, 074	0	2
0. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	5)	459, 074	0	
. 00	Deductibles		0	0	
	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	nd 33)	459, 074	0	36
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37
. 00	Subtotal (line 36 ± line 37)		459, 074	0	
0. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39
0. 00	Total amount payable to the provider (sum of lines 38 and 39)	1	459, 074	0	
. 00	Interim payments		566, 912	0	
2.00	Balance due provider/program (line 40 minus line 41)		-107, 838	0	42
3.00	Protested amounts (nonallowable cost report items) in accorda			0	43

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	Fr	eriod: com 07/01/2021	Worksheet G	
nl y)			Tc		11/30/2022 8:	pared: 52 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	4, 311, 381	0	0	0	1.0
. 00	Temporary investments	19, 723, 557		0	0	
. 00 . 00	Notes receivable Accounts receivable	0 2, 768, 100	-	0	0	
. 00	Other receivable	1, 805, 253		0	0	
. 00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
. 00	Inventory	0	0	0	0	
. 00 . 00	Prepaid expenses Other current assets	281, 520 0		0	0	
	Due from other funds	0	0	0	0	
1. 00	Total current assets (sum of lines 1-10)	28, 889, 811	0	0	0	11. (
2.00	FI XED ASSETS Land	10, 828, 566	0	o	0	1 12.0
3.00	Land improvements	0	0	0	0	13.0
	Accumulated depreciation	0	-	0	0	
	Buildings	0	0	0	0	
	Accumulated depreciation Leasehold improvements		0	0	0	
	Accumul ated depreciation	0	0	0	0	18.0
	Fixed equipment	0	0	0	0	19.0
	Accumulated depreciation	0	0	0	0	20.
	Automobiles and trucks Accumulated depreciation		0	0	0	21. 22.
	Major movable equipment	0	0	0	0	
4.00	Accumulated depreciation	C	0	0	0	
	Minor equipment depreciable	0	0	0	0	
	Accumulated depreciation HIT designated Assets	7, 681, 229	0	0	0	26. 27.
	Accumulated depreciation	001,227	0	0	0	27.
	Minor equipment-nondepreciable	C	0	0	0	29.
0. 00	Total fixed assets (sum of lines 12-29)	18, 509, 795	0	0	0	30. (
1.00	OTHER ASSETS Investments	381, 231	0	0	0	31.0
	Deposits on Leases	001,201	0	0	0	
	Due from owners/officers	3, 392, 313	1	0	0	
	Other assets Tatal ather appate (our of lines 21,24)		0	0	0	
	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	3, 773, 544 51, 173, 150		0	0	35.0 36.0
0.00	CURRENT LIABILITIES	01, 170, 100				00.
	Accounts payable	569, 525		0	0	
8.00 9.00	Salaries, wages, and fees payable	4, 355, 495 0		0	0	
	Payroll taxes payable Notes and loans payable (short term)		0	0	0	
	Deferred income	1, 260, 129	0	0	0	41.
	Accelerated payments	0			_	42.
	Due to other funds Other current liabilities	0	0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	6, 185, 149		0	0	
	LONG TERM LI ABI LI TI ES	2,	-	-1	-	
	Mortgage payable	1, 940, 328		0	0	
	Notes payable Unsecured Loans	0	0	0	0	
	Other long term liabilities		0	0	0	
	Total long term liabilities (sum of lines 46 thru 49)	1, 940, 328	0	0	0	
1.00	Total liabilities (sum of lines 45 and 50)	8, 125, 477	0	0	0	51.
2.00	CAPITAL ACCOUNTS General fund balance	43, 047, 673	1			52.
	Specific purpose fund	43, 047, 073	0			53.
4.00	Donor created - endowment fund balance - restricted			0		54.
	Donor created - endowment fund balance - unrestricted			0		55.
	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56. 57.
	Plant fund balance - reserve for plant improvement,				0	57.
	replacement, and expansion					
9.00	Total fund balances (sum of lines 52 thru 58)	43,047,673		0	0	
0.00	Total liabilities and fund balances (sum of lines 51 and 59)	51, 173, 150	y 0	0	0	60.

Health Financial Systems	HAMILTON CENT	ER, INC.		In Lie	eu of Form CMS-	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-4009	Period: From 07/01/2021 To 06/30/2022		epared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.006.007.008.009.0010.0010.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (specify)13.0015.0014.0015.0015.0016.0017.00Fund balance at end of period per balance sheet (line 11 minus line 18)		2.00 38,585,852 4,461,821 43,047,673 0 43,047,673 0 43,047,673	3.00			5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
	Endowment Fund	PI ant	Fund	_	1	
	6.00	7.00	8.00			1.00
 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 6.00 7.00 8.00 9.00 	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 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 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		9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATE	Financial Systems HAMILTON CEN MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-4009	Period:	Worksheet G-2	2
				From 07/01/20 To 06/30/20		
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1 00	General Inpatient Routine Services	1	6 04E 7	F /	6 04E 7E4	1 1 00
1.00 2.00	Hospital SUBPROVIDER - IPF		6, 945, 7	50	6, 945, 756	1.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		6, 945, 7	56	6, 945, 756	10.00
11 00	Intensive Care Type Inpatient Hospital Services	I				1 11 00
11.00 12.00	CORONARY CARE UNIT					11.00
12.00	BURN INTENSIVE CARE UNIT					12.00
14.00						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00		oflines		0	0	
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and	16)	6, 945, 7		6, 945, 756	
18.00	Ancillary services		202, 39		0 202, 395	
19.00	Outpatient services			0 24, 617, 2		
	RURAL HEALTH CLINIC			0	0 0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0	0 0	21.00
22.00	AMBULANCE SERVICES					22.00
23.00					0 0	
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	PROFESSI ONAL FEES			0	0 0	27.00
27.01	OTHER OUTPATIENT SERVICES			0 1, 528, 0	95 1, 528, 095	27.01
27.02				0 5, 860, 8		
27.03	FQHC			0 1, 243, 1		
27.04	MRO	0.1.1.111.1.1	7 4 40 41	0 6, 821, 9		
28.00	Total patient revenues (sum of lines 17-27)(transfer column G-3, line 1)	1 3 to WKST.	7, 148, 1	51 40, 071, 2	10 47, 219, 361	28.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			53, 554, 1	34	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	Tatal additions (sum of lines 20.25)			0	0	35.00
36.00	Total additions (sum of lines 30-35)			0	0	36.00
37.00 38.00	DEDUCT (SPECI FY)			0		37.00 38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)				0	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	e 42)(transfer		53, 554, 1	34	43.00
	to Wkst. G-3, line 4)			1		1

Heal th	Financial Systems	HAMILTON CENTER, INC.	In Lie	u of Form CMS-2	2552-10
	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-4009	Peri od:	Worksheet G-3	
			From 07/01/2021		
			To 06/30/2022	Date/Time Pre 11/30/2022 8:	
				1173072022 0.	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Par	t L. column 3. line 28)		47, 219, 361	1.00
2.00	Less contractual allowances and discounts o			17, 475, 650	2.00
3.00	Net patient revenues (line 1 minus line 2)			29, 743, 711	3.00
4.00	Less total operating expenses (from Wkst. G	-2, Part II, line 43)		53, 554, 184	4.00
5.00	Net income from service to patients (line 3	minus line 4)		-23, 810, 473	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 miscellan	eous 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
14.00	Revenue from meals sold to employees and gu	ests		0	14.00
15.00	5 1			0	15.00
16.00				0	16.00
	Revenue from sale of drugs to other than pa			0	17.00
18.00				0	18.00
	Tuition (fees, sale of textbooks, uniforms,			0	19.00
20.00	5	and canteen		0	20.00
	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00				0	23.00
24.00	INTEREST INCOME			567, 011	24.00
24.01 24.02				13, 561, 543	
24.02				1, 410, 312 921	24.02 24.03
	NET UNREALIZED ON INVESTMENT			-1, 453, 740	
24.04	INTEREST INCOME WITH DONOR RESTR.			-1, 455, 740	24.04
24.05				11, 556	
24.00	NET REALIZED GAIN ON INVEST			-166, 578	
	NET UNREALIZED GAIN ON INVEST			-118, 012	
24.09	MENTAL HEALTH FUNDS RECOVERY			5, 647, 995	
	GAIN ON SALE ON DISPOSITION OF ASSET			-68	
24.11	NET ASSETS RELEASED FROM DONOR RESTR			0	24.11
	OTHER I NCOME			594, 272	
24.50				1, 217, 082	
	Total other income (sum of lines 6-24)			21, 272, 294	
26.00				-2, 538, 179	
27.00				-7,000,000	
28.00	Total other expenses (sum of line 27 and su	bscripts)		-7,000,000	28.00
29.00	Net income (or loss) for the period (line 2	6 minus line 28)		4, 461, 821	29.00