

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
 CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
 PARTS I & II

INTERMEDIARY [] AUDITED DATE RECEIVED [XX] INITIAL [] RE-OPENING
 USE ONLY: [] DESK REVIEWED INTERMEDIARY NO. [] FINAL [XX] MCR CODE 3

PART I - CERTIFICATION

CHECK XX ELECTRONICALLY FILED COST REPORT DATE: 11/25/2009
 APPLICABLE BOX MANUALLY SUBMITTED COST REPORT TIME: 11:57

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY KIRBY HOSPITAL (14-1301) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2008 AND ENDING 06/30/2009, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/25/2009 11:57
 JoiLaYgytDlZW39Vx9mLbHcJR.V8G0
 H7F9.0cvy3.m9jJlPtK.Lhqy::fQ4A
 H7Cp0wMkEx0Xmmrh

(SIGNED) David Harris
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)
 CFO
 TITLE
 11/25/2009
 DATE

PI Encryption: 11/25/2009 11:57
 FBaVAaJyg6oBYPbpJzIk8WBp3zvLa0
 RtTNU0:9CCX0XBjOMRmZD5J960W7ol
 Lvnc6gNkHV0:t3yY

PART II - SETTLEMENT SUMMARY

TITLE V	TITLE XVIII		TITLE XIX	
	PART A	PART B		
1 HOSPITAL	2 40100	3 -72955	4	1
2 SUBPROVIDER I				2
3 SWING BED - SNF	6575			3
4 SWING BED - NF				4
5 SKILLED NURSING FACILITY				5
6 NURSING FACILITY				6
7 HOME HEALTH AGENCY				7
8 OUTPATIENT REHABILITATION PROVIDER				8
9 RURAL HEALTH CLINIC I		7384		9
9.01 RURAL HEALTH CLINIC II		135452		9.01
100 TOTAL	46675	69881		100

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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 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 THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
 CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
 PARTS I & II

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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(SIGNED) _____
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII	TITLE XIX
		PART A	PART B
	1	2	3
1	HOSPITAL	40100	-72955
2	SUBPROVIDER I		
3	SWING BED - SNF	6575	
4	SWING BED - NF		
5	SKILLED NURSING FACILITY		
6	NURSING FACILITY		
7	HOME HEALTH AGENCY		
8	OUTPATIENT REHABILITATION PROVIDER		
9	RURAL HEALTH CLINIC I		7384
9.01	RURAL HEALTH CLINIC II		135452
100	TOTAL	46675	69881

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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO		25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO		25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO		25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO		25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO		25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:			26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.			26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:			26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	08/08/1999	27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st			28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.			28.02
A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)				
28.03	STAFFING	0.00	N	28.03
28.04	RECRUITMENT	0.00	N	28.04
28.05	RETENTION OF EMPLOYEES	0.00	N	28.05
28.06	TRAINING	0.00	N	28.06
28.07	OTHER (SPECIFY)			28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO		29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES		30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO		30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	YES		30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO		30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO		30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO		31

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO			32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	NO			33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO			34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO			35

		V	XVIII	XIX	
		1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	NO	NO	NO	37.01

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES			38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO			38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO			38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO			38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO			38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	NO			40
40.01	NAME:	FI/CONTRACTOR'S NAME:	FI/CONTRACTOR'S NUMBER:		40.01
40.02	STREET:		P.O.BOX:		40.02
40.03	CITY:		STATE:	ZIP CODE:	40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES			41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO			42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES			42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES			42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO			43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO			44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO			45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?				45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?				45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?				45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.				46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
	1	2	3	4	5	
47	HOSPITAL	Y	Y	N	N	47
48	SUBPROVIDER I	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N	N	N	49
50	HOME HEALTH AGENCY	N	N	N	N	50
52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?					52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.					52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE					53
53.01	FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					
53.01	MDH PERIOD:	BEGINNING:		ENDING:		53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:					54
54.01	PREMIUMS: 87920 PAID LOSSES: AND/OR SELF INSURANCE:					54.01
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.					54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.					55

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

		DATE	Y/N	LIMIT	Y/N	FEE\$	
		0	1	2	3	4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		NO				58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.						58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				59
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)						60.01
MULTICAMPUS							
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.		NO				61
	COUNTY:	STATE:	ZIP CODE	CBSA	FTE/ CAMPUS		
	1	2	3	4	5		
SETTLEMENT DATA							
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)		NO				63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

		-----DISCHARGES-----				
COMPONENT	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15		
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		154	3	185	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		154	3	185	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
24.01	RHC II					24.01
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION

PART II - WAGE DATA	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST.	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	WORKSHEET S-3 PART II
		A-6	3	4	5		6
1 SALARIES							1
2 TOTAL SALARIES	7331574						2
3 NON-PHYSICIAN ANESTHETIST PART A							3
4 NON-PHYSICIAN ANESTHETIST PART B							4
4.01 PHYSICIAN - PART A							4.01
5 TEACHING PHYSICIAN SALARIES							5
5.01 PHYSICIAN - PART B							5.01
6 NON-PHYSICIAN - PART B							6
6.01 INTERNS & RESIDENTS (IN APPR PGM)							6.01
7 CONTRACT SERVICES, I&R							7
8 HOME OFFICE PERSONNEL							8
8.01 SNF							8.01
9 EXCLUDED AREA SALARIES	344992						9
9.01 OTHER WAGES & RELATED COSTS							9.01
9.02 CONTRACT LABOR							9.02
9.03 PHARMACY SERVICES UNDER CONTRACT							9.03
10 LABORATORY SERVICES UNDER CONTRACT							10
10.01 MANAGEMENT AND ADMINISTRATIVE SERVICES'							10.01
11 CONTRACT LABOR: PHYSICIAN PART A							11
12 TEACHING PHYSICIAN UNDER CONTRACT							12
13 HOME OFFICE SALARIES & WAGE REL COSTS							13
14 HOME OFFICE: PHYSICIAN PART A							14
15 TEACHING PHYSICIAN SALARIES							15
16 WAGE-RELATED COSTS							16
17 WAGE RELATED COSTS (CORE)						CMS 339	17
18 WAGE RELATED COSTS (OTHER)						CMS 339	18
19 EXCLUDED AREAS						CMS 339	19
20 NON-PHYSICIAN ANESTHETIST PART A						CMS 339	20
21 NON-PHYSICIAN ANESTHETIST PART B						CMS 339	21
22 PHYSICIAN PART A						CMS 339	22
23 PART A TEACHING PHYSICIANS						CMS 339	23
24 PHYSICIAN PART B						CMS 339	24
25 WAGE RELATED COSTS (RHC/FQHC)						CMS 339	25
26 INTERNS & RESIDENTS (IN APPR PGM)							26
27 OVERHEAD COSTS - DIRECT SALARIES							27
28 EMPLOYEE BENEFITS							28
29 ADMINISTRATIVE & GENERAL	1371139						29
30 ADMINISTRATIVE & GENERAL UNDER CONTACT							30
31 MAINTENANCE & REPAIRS	169839						31
32 OPERATION OF PLANT							32
33 LAUNDRY & LINEN SERVICE	141490						33
34 HOUSEKEEPING	176533						34
35 HOUSEKEEPING UNDER CONTRACT							35
36 DIETARY	3828						36
37 DIETARY UNDER CONTRACT							37
38 CAFETERIA							38
39 MAINTENANCE OF PERSONNEL							39
40 NURSING ADMINISTRATION		65993					40
41 CENTRAL SERVICES AND SUPPLY	64986						41
42 PHARMACY	28132						42
43 MEDICAL RECORDS & MEDICAL RECORDS LIBR	319414						43
44 SOCIAL SERVICE							44
45 OTHER GENERAL SERVICE							45

HOSPITAL WAGE INDEX INFORMATION

PART III - HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST.	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	WORKSHEET S-3 PART III
		A-6	3	4	5	
1 NET SALARIES	7331574		7331574			1
2 EXCLUDED AREA SALARIES	344992		344992			2
3 SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	6986582		6986582			3
4 SUBTOTAL OTHER WAGES & REL COSTS						4
5 SUBTOTAL WAGE-RELATED COSTS						5
6 TOTAL (SUM OF LINES 3 THRU 5)	6986582		6986582			6
7 NET SALARIES						7
8 EXCLUDED AREA SALARIES						8
9 SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10 SUBTOTAL OTHER WAGES & REL COSTS						10
11 SUBTOTAL WAGE-RELATED COSTS						11
12 TOTAL (SUM OF LINES 9 THRU 11)						12
13 TOTAL OVERHEAD COSTS	2275361	65993	2341354	18160.00	128.93	13

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
	GENERAL SERVICE COST CENTERS								
1	0100 OLD CAP REL COSTS-BLDG & FIXT								1
2	0200 OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300 NEW CAP REL COSTS-BLDG & FIXT		207702	207702	89858	297560	20635	318195	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		405467	405467	28992	434459	-3908	430551	4
5	0500 EMPLOYEE BENEFITS		51775	51775	40233	92008		92008	5
6	0600 ADMINISTRATIVE & GENERAL	1371139	3159385	4530524	-142797	4387727	-1298028	3089699	6
7	0700 MAINTENANCE & REPAIRS	169839	231257	401096		401096		401096	7
8	0800 OPERATION OF PLANT		188779	188779		188779	-5361	183418	8
9	0900 LAUNDRY & LINEN SERVICE	141490	94608	236098		236098	-223240	12858	9
10	1000 HOUSEKEEPING	176533	97422	273955		273955		273955	10
11	1100 DIETARY	3828	77126	80954	-16286	64668		64668	11
12	1200 CAFETERIA								12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION				87549	87549		87549	14
15	1500 CENTRAL SERVICES & SUPPLY	64986	158468	223454	-137196	86258		86258	15
16	1600 PHARMACY	28132	514083	542215	-467056	75159		75159	16
17	1700 MEDICAL RECORDS & LIBRARY	319414	199831	519245		519245	-1048	518197	17
18	1800 SOCIAL SERVICE								18
20	2000 NONPHYSICIAN ANESTHETISTS								20
21	2100 NURSING SCHOOL								21
22	2200 I&R SERVICES-SALARY & FRINGES A								22
23	2300 I&R SERVICES-OTHER PRGM COSTS A								23
24	2400 PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	2500 ADULTS & PEDIATRICS	991473	443752	1435225	-95991	1339234	-40195	1299039	25
	ANCILLARY SERVICE COST CENTERS								
37	3700 OPERATING ROOM	131289	242970	374259	4832	379091	-26004	353087	37
40	4000 ANESTHESIOLOGY	19720	2324	22044		22044		22044	40
41	4100 RADIOLOGY-DIAGNOSTIC	446554	472896	919450		919450		919450	41
44	4400 LABORATORY	361348	732234	1093582		1093582		1093582	44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
50	5000 PHYSICAL THERAPY	412383	180683	593066		593066	-2165	590901	50
51	5100 OCCUPATIONAL THERAPY								51
52	5200 SPEECH PATHOLOGY								52
53	5300 ELECTROCARDIOLOGY	16780	4264	21044		21044	-16980	4064	53
55	5500 MEDICAL SUPPLIES CHARGED TO PAT				137196	137196		137196	55
55.30	5530 IMPL. DEV. CHARGED TO PATIENT								55.30
56	5600 DRUGS CHARGED TO PATIENTS				467056	467056		467056	56
59	5900 ULTRASOUND		44298	44298		44298		44298	59
	OUTPATIENT SERVICE COST CENTERS								
60	6000 CLINIC	1010002	552840	1562842	-1021761	541081	-202225	338856	60
61	6100 EMERGENCY	1106454	522641	1629095	2442	1631537	-389796	1241741	61
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 RHC	215218	127533	342751		342751		342751	63.50
63.51	6311 RHC II				1022929	1022929		1022929	63.51
63.60	6320 FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	6500 AMBULANCE SERVICES	344992	383084	728076		728076	-10216	717860	65
69.10	6910 CMHC								69.10
69.20	6920 OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940 OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100 HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	8510 PANCREAS ACQUISITION								85.01
85.02	8520 INTESTINAL ACQUISITION								85.02
85.03	8530 ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	7331574	9095422	16426996		16426996	-2198531	14228465	95
	NONREIMBURSABLE COST CENTERS								
96	9600 GIFT, FLOWER, COFFEE SHOP & CAN								96
96.01	9601 MANDHAN CLINIC								96.01
96.02	9602 MANINT CLINIC								96.02
101	TOTAL	7331574	9095422	16426996		16426996	-2198531	14228465	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE				
		COST CENTER	LINE #	SALARY	OTHER	
1		2	3	4	5	
1 MEDICAL SUPPLIES	A	MEDICAL SUPPLIES CHARGED TO P	55		137196	1
2 PHARMACY SUPPLIES	B	DRUGS CHARGED TO PATIENTS	56		467056	2
3 DIETART EXPENSE	C	EMPLOYEE BENEFITS	5		16286	3
4 PROPERTY INSURANCE	D	NEW CAP REL COSTS-BLDG & FIXT	3		10923	4
5 PROPERTY INSURANCE	D	NEW CAP REL COSTS-MVBLE EQUIP	4		28992	5
6 INTEREST	E	NEW CAP REL COSTS-BLDG & FIXT	3		78935	6
7 WORKMAN'S COMP INSURANCE	F	EMPLOYEE BENEFITS	5		23947	7
8 GENERAL LIABILITY INSURANCE	F	ADMINISTRATIVE & GENERAL	6		247628	8
9 NURSING ADMINISTRATION	G	NURSING ADMINISTRATION	14	65993	21556	9
10 NURSING ADMINISTRATION	G	ADULTS & PEDIATRICS	25	10885	3556	10
11 NURSING ADMINISTRATION	G	OPERATING ROOM	37	3642	1190	11
12 NURSING ADMINISTRATION	G	CLINIC	60	560	183	12
13 NURSING ADMINISTRATION	G	EMERGENCY	61	1841	601	13
14 NURSINGS ADMINISTRATION	G	RHC II	63.51	320	105	14
15 RHC II COSTS	H	RHC II	63.51	675147	347357	15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				758388	1385511	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF. 10
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	
1 MEDICAL SUPPLIES	A	CENTRAL SERVICES & SUPPLY	15		137196	1
2 PHARMACY SUPPLIES	B	PHARMACY	16		467056	2
3 DIETART EXPENSE	C	DIETARY	11		16286	3
4 PROPERTY INSURANCE	D	ADMINISTRATIVE & GENERAL	6		10923	9 4
5 PROPERTY INSURANCE	D	ADMINISTRATIVE & GENERAL	6		28992	9 5
6 INTEREST	E	ADMINISTRATIVE & GENERAL	6		78935	9 6
7 WORKMAN'S COMP INSURANCE	F	ADMINISTRATIVE & GENERAL	6		23947	7
8 GENERAL LIABILITY INSURANCE	F	ADMINISTRATIVE & GENERAL	6		247628	8
9 NURSING ADMINISTRATION	G	ADULTS & PEDIATRICS	25	65993	21556	9
10 NURSING ADMINISTRATION	G	ADULTS & PEDIATRICS	25	10885	3556	10
11 NURSING ADMINISTRATION	G	ADULTS & PEDIATRICS	25	3642	1190	11
12 NURSING ADMINISTRATION	G	ADULTS & PEDIATRICS	25	560	183	12
13 NURSING ADMINISTRATION	G	ADULTS & PEDIATRICS	25	1841	601	13
14 NURSINGS ADMINISTRATION	G	ADULTS & PEDIATRICS	25	320	105	14
15 RHC II COSTS	H	CLINIC	60	675147	347357	15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				758388	1385511	36

ANALYSIS OF CHANGES DURING COST REPORTING
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3					
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL								7
8 RECONCILING ITEMS								8
9 TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3					
1 LAND	493705	20036		20036		513741		1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES	4809914	99412		99412		4909326		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	6904969	486044		486044	6900	7384113		6
7 SUBTOTAL	12208588	605492		605492	6900	12807180		7
8 RECONCILING ITEMS								8
9 TOTAL	12208588	605492		605492	6900	12807180		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF		OTHER CAPITAL	TOTAL
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	RELATED COSTS	
	1	2	3	4	5	6	7	8
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT	4909326		4909326	.399345				3
4 NEW CAP REL COSTS-MVBLE EQUIP	7384113		7384113	.600655				4
5 TOTAL	12293439		12293439	1.000000				5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	297560		-35216			55851	318195 3
4 NEW CAP REL COSTS-MVBLE EQUIP	434459					-3908	430551 4
5 TOTAL	732019		-35216			51943	748746 5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	207702						207702 3
4 NEW CAP REL COSTS-MVBLE EQUIP	405467						405467 4
5 TOTAL	613169						613169 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES	B	-35216	NEW CAP REL COSTS-BLDG & FIXT	3	11 3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5 INVESTMENT INCOME-OTHER					5
6 TRADE, QUANTITY, AND TIME DISCOUNTS					6
7 REFUNDS AND REBATES OF EXPENSES					7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)					9
10 TELEVISION AND RADIO SERVICE					10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2	-644619			12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST				
	A-8-1				14
15 LAUNDRY AND LINEN SERVICE	B	-223240	LAUNDRY & LINEN SERVICE	9	15
16 CAFETERIA - EMPLOYEES AND GUESTS					16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19 SALE OF DRUGS TO OTHER THAN PATIENTS					19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-1048	MEDICAL RECORDS & LIBRARY	17	20
21 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					21
22 VENDING MACHINES					22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST				
	A-8-3		HOME HEALTH AGENCY	71	27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		OCCUPATIONAL THERAPY	51	35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				
	WKST A-8-4		SPEECH PATHOLOGY	52	36
37 MISC INCOME	B	-166995	ADMINISTRATIVE & GENERAL	6	37
38 BAD DEBTS & PROVISION FOR UNCOLLE	A	-848004	ADMINISTRATIVE & GENERAL	6	38
39 AMBULANCE MISC INCOME	A	-10216	AMBULANCE SERVICES	65	39
40 CANCER CLINIC INCOME	A	-10242	ADMINISTRATIVE & GENERAL	6	40
41 CARDIAC REHAB MISC REVENUE	A	-11472	PHYSICAL THERAPY	50	41
42					42
43 ADVERTISING	A	-220554	ADMINISTRATIVE & GENERAL	6	43
43.01 LOBBYING PORTION OF DUES	A	-5755	ADMINISTRATIVE & GENERAL	6	43.01
44 TRUST DEPRECIATION	B	9307	PHYSICAL THERAPY	50	44
45 TRUST DEPRECIATION	B	9614	CLINIC	60	45
46 LIFE INSURANCE ON KEY PERSONNEL	B	-28430	ADMINISTRATIVE & GENERAL	6	46
47 AHA USEFUL LIVES ADJUSTMENT	B	55851	NEW CAP REL COSTS-BLDG & FIXT	3	14 47
48 AHA USEFUL LIVES ADJUSTMENT	B	-3908	NEW CAP REL COSTS-MVBLE EQUIP	4	14 48
48.01 PROPERTY TAXES	B	-18048	ADMINISTRATIVE & GENERAL	6	48.01
48.02 NON ALLOWABLE BLDG UTILITIES	B	-5361	OPERATION OF PLANT	8	48.02
49 REVENUE OFFSET	A	-40195	ADULTS & PEDIATRICS	25	49
50 TOTAL		-2198531			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ- USTMENTS	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS					5

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
1						1
2						2
3						3
4						4
5						5

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER NO. 14-1301 KIRBY HOSPITAL
 PERIOD FROM 07/01/2008 TO 06/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2009.08
 11/25/2009 11:30

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.	1	2		3	4	5	6	7	8	9
1	37	OPERATING ROOM	AGGREGATE	26004	26004					
2	53	ELECTROCARDIOLOGY	AGGREGATE	16980	16980					
3	60	CLINIC	AGGREGATE	211839	211839					
4	61	EMERGENCY	AGGREGATE	720680	389796	330884				
5	63.50	RHC	AGGREGATE	137596		137596				
6	63.51	RHC II	AGGREGATE	569604						
101		TOTAL		1682703	644619	468480				

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP	NEW CAP	NEW CAP	EMPLOYEE	SUBTOTAL	ADMINIS-	MAIN-	OPERATION	
	FOR COST	BLDGS &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OF PLANT	
	ALLOCATION	FIXTURES	EQUIPMENT			GENERAL	REPAIRS		
	0	3	4	5	5A	6	7	8	
GENERAL SERVICE COST CENTERS									
1									1
2									2
3									3
4	318195	318195							4
5	430551		430551						5
6	92008	9526		101534					6
7	3089699	65278	104301	18987	3278265	3278265			7
8	401096	10549	2506	2352	416503	124692	541195		8
9	183418	17483			200901	60146	30629	291676	9
10	12858	18870	3838	1959	37525	11234	33058	18885	10
11	273955	3516	338	2445	280254	83902	6160	3519	11
12	64668			53	64721	19376			12
13									13
14	87549	2427		914	90890	27211	4252	2429	14
15	86258	20025		900	107183	32088	35083	20042	15
16	75159	5597		390	81146	24293	9805	5601	16
17	518197	16476	4261	4424	543358	162670	28865	16490	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
INPATIENT ROUTINE SERV COST CENTERS									
25	1299039	44558	30793	12729	1387119	415280	75922	43374	25
ANCILLARY SERVICE COST CENTERS									
37	353087	24962	31370	1869	411288	123131	37194	21248	37
40	22044			273	22317	6681			40
41	919450	31483	205858	6184	1162975	348170	61662	35226	41
44	1093582	18011	22542	5004	1139139	341034	31554	18026	44
46.30									46.30
50	590901		6601	5711	603213	180589	66637	38068	50
51									51
52									52
53	4064	759	2813	232	7868	2356	1330	760	53
55	137196	1040			138236	41385	1822	1041	55
55.30									55.30
56	467056				467056	139827			56
59	44298	759			45057	13489	1330	760	59
OUTPATIENT SERVICE COST CENTERS									
60	338856			4645	343523	102844	26753	15284	60
61	1241741	20025	15308	15349	1292423	386924	35083	20042	61
62									62
63.50	342751			2981	345732	103505			63.50
63.51	1022929			9355	1032284	309044	42053	24024	63.51
63.60									63.60
OTHER REIMBURSABLE COST CENTERS									
65	717860			4778	722638	216343			65
69.10									69.10
69.20									69.20
69.30									69.30
69.40									69.40
71									71
SPECIAL PURPOSE COST CENTERS									
85.01									85.01
85.02									85.02
85.03									85.03
95	14228465	311344	430551	101534	14221614	3276214	529192	284819	95
NONREIMBURSABLE COST CENTERS									
96		6851			6851	2051	12003	6857	96
96.01									96.01
96.02									96.02
101									101
102									102
103	14228465	318195	430551	101534	14228465	3278265	541195	291676	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	DIETARY 11	NURSING ADMINIS-TRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SUBTOTAL 25
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE	100702							9
10 HOUSEKEEPING	7174	381009						10
11 DIETARY			84097					11
12 CAFETERIA								12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION		3437		128219				14
15 CENTRAL SERVICES & SUPPLY		28359			222755			15
16 PHARMACY		7926				128771		16
17 MEDICAL RECORDS & LIBRARY		23332			3439		778154	17
18 SOCIAL SERVICE								18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	56153	61370	84097	84692	6508		160545	2375060 25
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	6364	30066		4166	35247		38512	707216 37
40 ANESTHESIOLOGY					363			29361 40
41 RADIOLOGY-DIAGNOSTIC		49844			21958		98761	1778596 41
44 LABORATORY		25507			7350		1181	1563791 44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
50 PHYSICAL THERAPY		53865			5049		116127	1063548 50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY		1075			883			14272 53
55 MEDICAL SUPPLIES CHARGED TO PAT		1473			66757			250714 55
55.30 IMPL. DEV. CHARGED TO PATIENT								55.30
56 DRUGS CHARGED TO PATIENTS						128771		735654 56
59 ULTRASOUND		1075			207		21382	83300 59
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		21626		470	19021			529521 60
61 EMERGENCY	25614	28359		38891	7511		333377	2168224 61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC					16776			466013 63.50
63.51 RHC II		33993			19610			1461008 63.51
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES	2015				12001		8269	961266 65
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	97320	371307	84097	128219	222680	128771	778154	14187544 95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN	3382	9702			75			40921 96
96.01 MANDHAN CLINIC								96.01
96.02 MANINT CLINIC								96.02
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	100702	381009	84097	128219	222755	128771	778154	14228465 103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	26	27	
GENERAL SERVICE COST CENTERS			
1 OLD CAP REL COSTS-BLDG & FIXT			1
2 OLD CAP REL COSTS-MVBLE EQUIP			2
3 NEW CAP REL COSTS-BLDG & FIXT			3
4 NEW CAP REL COSTS-MVBLE EQUIP			4
5 EMPLOYEE BENEFITS			5
6 ADMINISTRATIVE & GENERAL			6
7 MAINTENANCE & REPAIRS			7
8 OPERATION OF PLANT			8
9 LAUNDRY & LINEN SERVICE			9
10 HOUSEKEEPING			10
11 DIETARY			11
12 CAFETERIA			12
13 MAINTENANCE OF PERSONNEL			13
14 NURSING ADMINISTRATION			14
15 CENTRAL SERVICES & SUPPLY			15
16 PHARMACY			16
17 MEDICAL RECORDS & LIBRARY			17
18 SOCIAL SERVICE			18
20 NONPHYSICIAN ANESTHETISTS			20
21 NURSING SCHOOL			21
22 I&R SERVICES-SALARY & FRINGES A			22
23 I&R SERVICES-OTHER PRGM COSTS A			23
24 PARAMED ED PRGM-(SPECIFY)			24
INPATIENT ROUTINE SERV COST CENTERS			
25 ADULTS & PEDIATRICS	2375060		25
ANCILLARY SERVICE COST CENTERS			
37 OPERATING ROOM	707216		37
40 ANESTHESIOLOGY	29361		40
41 RADIOLOGY-DIAGNOSTIC	1778596		41
44 LABORATORY	1563791		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO			46.30
50 PHYSICAL THERAPY	1063548		50
51 OCCUPATIONAL THERAPY			51
52 SPEECH PATHOLOGY			52
53 ELECTROCARDIOLOGY	14272		53
55 MEDICAL SUPPLIES CHARGED TO PAT	250714		55
55.30 IMPL. DEV. CHARGED TO PATIENT			55.30
56 DRUGS CHARGED TO PATIENTS	735654		56
59 ULTRASOUND	83300		59
OUTPATIENT SERVICE COST CENTERS			
60 CLINIC	529521		60
61 EMERGENCY	2168224		61
62 OBSERVATION BEDS (NON-DISTINCT)			62
63.50 RHC	466013		63.50
63.51 RHC II	1461008		63.51
63.60 FQHC			63.60
OTHER REIMBURSABLE COST CENTERS			
65 AMBULANCE SERVICES	961266		65
69.10 CMHC			69.10
69.20 OUTPATIENT PHYSICAL THERAPY			69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY			69.30
69.40 OUTPATIENT SPEECH PATHOLOGY			69.40
71 HOME HEALTH AGENCY			71
SPECIAL PURPOSE COST CENTERS			
85.01 PANCREAS ACQUISITION			85.01
85.02 INTESTINAL ACQUISITION			85.02
85.03 ISLET CELL ACQUISITION			85.03
95 SUBTOTALS	14187544		95
NONREIMBURSABLE COST CENTERS			
96 GIFT, FLOWER, COFFEE SHOP & CAN	40921		96
96.01 MANDHAN CLINIC			96.01
96.02 MANINT CLINIC			96.02
101 CROSS FOOT ADJUSTMENTS			101
102 NEGATIVE COST CENTER			102
103 TOTAL	14228465		103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	EMPLOYEE BENEFITS 5	ADMINIS- TRATIVE & GENERAL 6	MAIN- TENANCE & REPAIRS 7	OPERATION OF PLANT 8	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT									3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS		9526		9526	9526				5
6 ADMINISTRATIVE & GENERAL		65278	104301	169579	1782	171361			6
7 MAINTENANCE & REPAIRS		10549	2506	13055	221	6518	19794		7
8 OPERATION OF PLANT		17483		17483		3144	1120	21747	8
9 LAUNDRY & LINEN SERVICE		18870	3838	22708	184	587	1209	1408	9
10 HOUSEKEEPING		3516	338	3854	229	4386	225	262	10
11 DIETARY					5	1013			11
12 CAFETERIA									12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION		2427		2427	86	1422	156	181	14
15 CENTRAL SERVICES & SUPPLY		20025		20025	84	1677	1283	1494	15
16 PHARMACY		5597		5597	37	1270	359	418	16
17 MEDICAL RECORDS & LIBRARY		16476	4261	20737	415	8503	1056	1229	17
18 SOCIAL SERVICE									18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS		44558	30793	75351	1194	21710	2777	3235	25
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM		24962	31370	56332	175	6436	1360	1584	37
40 ANESTHESIOLOGY					26	349			40
41 RADIOLOGY-DIAGNOSTIC		31483	205858	237341	580	18199	2255	2626	41
44 LABORATORY		18011	22542	40553	469	17826	1154	1344	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
50 PHYSICAL THERAPY			6601	6601	536	9440	2437	2838	50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY		759	2813	3572	22	123	49	57	53
55 MEDICAL SUPPLIES CHARGED TO PAT		1040		1040		2163	67	78	55
55.30 IMPL. DEV. CHARGED TO PATIENT									55.30
56 DRUGS CHARGED TO PATIENTS						7309			56
59 ULTRASOUND		759		759		705	49	57	59
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC			22	22	436	5376	978	1140	60
61 EMERGENCY		20025	15308	35333	1440	20225	1283	1494	61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC					280	5410			63.50
63.51 RHC II					877	16154	1538	1791	63.51
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
65 AMBULANCE SERVICES					448	11309			65
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS		311344	430551	741895	9526	171254	19355	21236	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN		6851		6851		107	439	511	96
96.01 MANDHAN CLINIC									96.01
96.02 MANINT CLINIC									96.02
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL		318195	430551	748746	9526	171361	19794	21747	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL
	9	10	11	14	15	16	17	25
GENERAL SERVICE COST CENTERS								
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9	26096							9
10	1859	10815						10
11			1018					11
12								12
13								13
14		98		4370				14
15		805			25368			15
16		225				7906		16
17		662			392		32994	17
18								18
20								20
21								21
22								22
23								23
24								24
INPATIENT ROUTINE SERV COST CENTERS								
25	14551	1741	1018	2886	741		6807	132011 25
ANCILLARY SERVICE COST CENTERS								
37	1649	853		142	4014		1633	74178 37
40					41			416 40
41		1415			2501		4187	269104 41
44		724			837		50	62957 44
46.30								46.30
50		1529			575		4924	28880 50
51								51
52								52
53		31			101			3955 53
55		42			7602			10992 55
55.30								55.30
56						7906		15215 56
59		31			24		907	2532 59
OUTPATIENT SERVICE COST CENTERS								
60		614		16	2166			10748 60
61	6638	805		1326	855		14135	83534 61
62								62
63.50					1910			7600 63.50
63.51		965			2233			23558 63.51
63.60								63.60
OTHER REIMBURSABLE COST CENTERS								
65	522				1367		351	13997 65
69.10								69.10
69.20								69.20
69.30								69.30
69.40								69.40
71								71
SPECIAL PURPOSE COST CENTERS								
85.01								85.01
85.02								85.02
85.03								85.03
95	25219	10540	1018	4370	25359	7906	32994	739677 95
NONREIMBURSABLE COST CENTERS								
96	877	275			9			9069 96
96.01								96.01
96.02								96.02
101								101
102								102
103	26096	10815	1018	4370	25368	7906	32994	748746 103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	26	27	
GENERAL SERVICE COST CENTERS			
1 OLD CAP REL COSTS-BLDG & FIXT			1
2 OLD CAP REL COSTS-MVBLE EQUIP			2
3 NEW CAP REL COSTS-BLDG & FIXT			3
4 NEW CAP REL COSTS-MVBLE EQUIP			4
5 EMPLOYEE BENEFITS			5
6 ADMINISTRATIVE & GENERAL			6
7 MAINTENANCE & REPAIRS			7
8 OPERATION OF PLANT			8
9 LAUNDRY & LINEN SERVICE			9
10 HOUSEKEEPING			10
11 DIETARY			11
12 CAFETERIA			12
13 MAINTENANCE OF PERSONNEL			13
14 NURSING ADMINISTRATION			14
15 CENTRAL SERVICES & SUPPLY			15
16 PHARMACY			16
17 MEDICAL RECORDS & LIBRARY			17
18 SOCIAL SERVICE			18
20 NONPHYSICIAN ANESTHETISTS			20
21 NURSING SCHOOL			21
22 I&R SERVICES-SALARY & FRINGES A			22
23 I&R SERVICES-OTHER PRGM COSTS A			23
24 PARAMED ED PRGM-(SPECIFY)			24
INPATIENT ROUTINE SERV COST CENTERS			
25 ADULTS & PEDIATRICS	132011		25
ANCILLARY SERVICE COST CENTERS			
37 OPERATING ROOM	74178		37
40 ANESTHESIOLOGY	416		40
41 RADIOLOGY-DIAGNOSTIC	269104		41
44 LABORATORY	62957		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO			46.30
50 PHYSICAL THERAPY	28880		50
51 OCCUPATIONAL THERAPY			51
52 SPEECH PATHOLOGY			52
53 ELECTROCARDIOLOGY	3955		53
55 MEDICAL SUPPLIES CHARGED TO PAT	10992		55
55.30 IMPL. DEV. CHARGED TO PATIENT			55.30
56 DRUGS CHARGED TO PATIENTS	15215		56
59 ULTRASOUND	2532		59
OUTPATIENT SERVICE COST CENTERS			
60 CLINIC	10748		60
61 EMERGENCY	83534		61
62 OBSERVATION BEDS (NON-DISTINCT)			62
63.50 RHC	7600		63.50
63.51 RHC II	23558		63.51
63.60 FQHC			63.60
OTHER REIMBURSABLE COST CENTERS			
65 AMBULANCE SERVICES	13997		65
69.10 CMHC			69.10
69.20 OUTPATIENT PHYSICAL THERAPY			69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY			69.30
69.40 OUTPATIENT SPEECH PATHOLOGY			69.40
71 HOME HEALTH AGENCY			71
SPECIAL PURPOSE COST CENTERS			
85.01 PANCREAS ACQUISITION			85.01
85.02 INTESTINAL ACQUISITION			85.02
85.03 ISLET CELL ACQUISITION			85.03
95 SUBTOTALS	739677		95
NONREIMBURSABLE COST CENTERS			
96 GIFT, FLOWER, COFFEE SHOP & CAN	9069		96
96.01 MANDHAN CLINIC			96.01
96.02 MANINT CLINIC			96.02
101 CROSS FOOT ADJUSTMENTS			101
102 NEGATIVE COST CENTER			102
103 TOTAL	748746		103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		OLD CAP BLDGS & FIXTURES SQUARE FEET	NEW CAP BLDGS & FIXTURES SQUARE FEET	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	3	4	5	6A	6	7	
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I		318195	430551	101534		3278265	541195	103
104	UNIT COST MULT-WS B PT I		16.509028		.013849		.299379		104
104	UNIT COST MULT-WS B PT I			.942884				28.922349	104
105	COST TO BE ALLOC PER B PT II								105
106	UNIT COST MULT-WS B PT II								106
106	UNIT COST MULT-WS B PT II								106
107	COST TO BE ALLOC PER B PT III				9526		171361	19794	107
108	UNIT COST MULT-WS B PT III				.001299		.015649		108
108	UNIT COST MULT-WS B PT III							1.057824	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	NURSING	CENTRAL	PHARMACY	MEDICAL
	OF PLANT	& LINEN	KEEPING		ADMINIS-	SERVICES &		RECORDS &
	SQUARE	SERVICE	SQUARE	MEALS	TRATION	SUPPLY	COSTED	LIBRARY
	FEET	POUNDS OF	FEET	SERVED	DIRECT	COSTED	REQUIS.	TIME
	8	LAUNDRY	10	11	NRSING HRS	REQUIS.	16	SPENT
		9			14	15	16	17
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	291676	100702	381009	84097	128219	222755	128771	778154 103
104 UNIT COST MULT-WS B PT I	16.522744		23.379088		3.153676		1287.710000	104
104 UNIT COST MULT-WS B PT I		1.415229		840.970000		.481699		118.134811 104
105 COST TO BE ALLOC PER B PT II								105
106 UNIT COST MULT-WS B PT II								106
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III	21747	26096	10815	1018	4370	25368	7906	32994 107
108 UNIT COST MULT-WS B PT III	1.231915		.663619		.107485		79.060000	108
108 UNIT COST MULT-WS B PT III		.366743		10.180000		.054857		5.008957 108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

GENERAL SERVICE COST CENTERS		
1	OLD CAP REL COSTS-BLDG & FIXT	1
2	OLD CAP REL COSTS-MVBLE EQUIP	2
3	NEW CAP REL COSTS-BLDG & FIXT	3
4	NEW CAP REL COSTS-MVBLE EQUIP	4
5	EMPLOYEE BENEFITS	5
6	ADMINISTRATIVE & GENERAL	6
7	MAINTENANCE & REPAIRS	7
8	OPERATION OF PLANT	8
9	LAUNDRY & LINEN SERVICE	9
10	HOUSEKEEPING	10
11	DIETARY	11
12	CAFETERIA	12
13	MAINTENANCE OF PERSONNEL	13
14	NURSING ADMINISTRATION	14
15	CENTRAL SERVICES & SUPPLY	15
16	PHARMACY	16
17	MEDICAL RECORDS & LIBRARY	17
18	SOCIAL SERVICE	18
20	NONPHYSICIAN ANESTHETISTS	20
21	NURSING SCHOOL	21
22	I&R SERVICES-SALARY & FRINGES	22
23	I&R SERVICES-OTHER PRGM COSTS	23
24	PARAMED ED PRGM-(SPECIFY)	24
25	INPATIENT ROUTINE SERV COST CENTERS	
	ADULTS & PEDIATRICS	25
ANCILLARY SERVICE COST CENTERS		
37	OPERATING ROOM	37
40	ANESTHESIOLOGY	40
41	RADIOLOGY-DIAGNOSTIC	41
44	LABORATORY	44
46.30	BLOOD CLOTTING FACTORS ADMIN	46.30
50	PHYSICAL THERAPY	50
51	OCCUPATIONAL THERAPY	51
52	SPEECH PATHOLOGY	52
53	ELECTROCARDIOLOGY	53
55	MEDICAL SUPPLIES CHARGED TO P	55
55.30	IMPL. DEV. CHARGED TO PATIENT	55.30
56	DRUGS CHARGED TO PATIENTS	56
59	ULTRASOUND	59
OUTPATIENT SERVICE COST CENTERS		
60	CLINIC	60
61	EMERGENCY	61
62	OBSERVATION BEDS (NON-DISTINC	62
63.50	RHC	63.50
63.51	RHC II	63.51
63.60	FQHC	63.60
OTHER REIMBURSABLE COST CENTERS		
65	AMBULANCE SERVICES	65
69.10	CMHC	69.10
69.20	OUTPATIENT PHYSICAL THERAPY	69.20
69.30	OUTPATIENT OCCUPATIONAL THERA	69.30
69.40	OUTPATIENT SPEECH PATHOLOGY	69.40
71	HOME HEALTH AGENCY	71
SPECIAL PURPOSE COST CENTERS		
85.01	PANCREAS ACQUISITION	85.01
85.02	INTESTINAL ACQUISITION	85.02
85.03	ISLET CELL ACQUISITION	85.03
95	SUBTOTALS	95
NONREIMBURSABLE COST CENTERS		
96	GIFT, FLOWER, COFFEE SHOP & C	96
96.01	MANDHAN CLINIC	96.01
96.02	MANINT CLINIC	96.02

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

101	CROSS FOOT ADJUSTMENTS	101
102	NEGATIVE COST CENTER	102
103	COST TO BE ALLOC PER B PT I	103
104	UNIT COST MULT-WS B PT I	104
104	UNIT COST MULT-WS B PT I	104
105	COST TO BE ALLOC PER B PT II	105
106	UNIT COST MULT-WS B PT II	106
106	UNIT COST MULT-WS B PT II	106
107	COST TO BE ALLOC PER B PT III	107
108	UNIT COST MULT-WS B PT III	108
108	UNIT COST MULT-WS B PT III	108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 27)	LIMIT ADJUSTMENT		DISALLOWANCE		
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	2375060		2375060		2375060	25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	707216		707216		707216	37
40 ANESTHESIOLOGY	29361		29361		29361	40
41 RADIOLOGY-DIAGNOSTIC	1778596		1778596		1778596	41
44 LABORATORY	1563791		1563791		1563791	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
50 PHYSICAL THERAPY	1063548		1063548		1063548	50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	14272		14272		14272	53
55 MEDICAL SUPPLIES CHARGED TO	250714		250714		250714	55
55.30 IMPL. DEV. CHARGED TO PATIE						55.30
56 DRUGS CHARGED TO PATIENTS	735654		735654		735654	56
59 ULTRASOUND	83300		83300		83300	59
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	529521		529521		529521	60
61 EMERGENCY	2168224		2168224		2168224	61
62 OBSERVATION BEDS (NON-DISTI	184573		184573		184573	62
63.50 RHC	466013		466013		466013	63.50
63.51 RHC II	1461008		1461008		1461008	63.51
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES	961266		961266		961266	65
101 SUBTOTAL	14372117		14372117		14372117	101
102 LESS OBSERVATION BEDS	184573		184573		184573	102
103 TOTAL	14187544		14187544		14187544	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
25 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	1259625		1259625			25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM		723230	723230	.977858	.977858	.977858 37
40 ANESTHESIOLOGY		18617	18617	1.577107	1.577107	1.577107 40
41 RADIOLOGY-DIAGNOSTIC	119169	4033189	4152358	.428334	.428334	.428334 41
44 LABORATORY	298554	3906719	4205273	.371864	.371864	.371864 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
50 PHYSICAL THERAPY	108230	1289214	1397444	.761067	.761067	.761067 50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	10200	28445	38645	.369310	.369310	.369310 53
55 MEDICAL SUPPLIES CHARGED TO	335340	797236	1132576	.221366	.221366	.221366 55
55.30 IMPL. DEV. CHARGED TO PATIE						55.30
56 DRUGS CHARGED TO PATIENTS	434575	799221	1233796	.596253	.596253	.596253 56
59 ULTRASOUND	18440	504807	523247	.159198	.159198	.159198 59
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC		209336	209336	2.529527	2.529527	2.529527 60
61 EMERGENCY	12177	2916070	2928247	.740451	.740451	.740451 61
62 OBSERVATION BEDS (NON-DISTI	2002	183730	185732	.993760	.993760	.993760 62
63.50 RHC		526172	526172	.885667	.885667	.885667 63.50
63.51 RHC II		1174014	1174014	1.244455	1.244455	1.244455 63.51
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES		833268	833268	1.153610	1.153610	1.153610 65
101 SUBTOTAL	2598312	17943268	20541580			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	2598312	17943268	20541580			103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1301) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	.977858	.977858	.977858			37
40 ANESTHESIOLOGY	1.577107	1.577107	1.577107			40
41 RADIOLOGY-DIAGNOSTIC	.428334	.428334	.428334			41
44 LABORATORY	.371864	.371864	.371864			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
50 PHYSICAL THERAPY	.761067	.761067	.761067			50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	.369310	.369310	.369310			53
55 MEDICAL SUPPLIES CHARGED TO PAT	.221366	.221366	.221366			55
55.30 IMPL. DEV. CHARGED TO PATIENT						55.30
56 DRUGS CHARGED TO PATIENTS	.596253	.596253	.596253			56
59 ULTRASOUND	.159198	.159198	.159198			59
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	2.529527	2.529527	2.529527			60
61 EMERGENCY	.740451	.740451	.740451			61
62 OBSERVATION BEDS (NON-DISTINCT	.993760	.993760	.993760			62
63.50 RHC	.885667	.885667	.885667			63.50
63.51 RHC II	1.244455	1.244455	1.244455			63.51
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES	1.153610	1.153610	1.153610			65
65.01 AMBULANCE CHARGES (S-2 LINE 56.	1.153610	1.153610				65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.	1.153610	1.153610				65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.	1.153610	1.153610				65.03
101 SUBTOTAL						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.596253	1
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)	28780	2
2.01 VACCINE CHARGES - HEPATITIS B		2.01
3 VACCINE COSTS (OTHER THAN HEPATITIS B)	17160	3
3.01 VACCINE COSTS - HEPATITIS B		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1301) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL OTHER (1)	PPS SER- VICES	ALL OTHER (SEE INSTRU.)	PPS SER- VICES	PPS SER- VICES	OUTPATIENT AMBULATORY CENTER	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	6	7	8
37 ANCILLARY SERVICE COST CENTERS								
40 OPERATING ROOM	133984							37
41 ANESTHESIOLOGY	7586							40
44 RADIOLOGY-DIAGNOSTIC	1146239							41
44 LABORATORY	1284940							44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
50 PHYSICAL THERAPY	326560							50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY	23762							53
55 MEDICAL SUPPLIES CHARGED TO PA	240188							55
55.30 IMPL. DEV. CHARGED TO PATIENT								55.30
56 DRUGS CHARGED TO PATIENTS	204204							56
59 ULTRASOUND	51424							59
60 OUTPATIENT SERVICE COST CENTERS								
60 CLINIC	85010							60
61 EMERGENCY	876482							61
62 OBSERVATION BEDS (NON-DISTINCT	128359							62
63.50 RHC								63.50
63.51 RHC II								63.51
63.60 FQHC								63.60
65 OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES								65
65.01 AMBULANCE CHARGES (S-2 LINE 56								65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56								65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56								65.03
101 SUBTOTAL	4508738							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	4508738							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1301) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL	
	ALL OTHER (COLS 1x5) 9	PPS SERVICES (COLUMNS 1.01x5.01) 9.01	ALL OTHER (COLUMNS 1.01x5.02) 9.02	PPS SERVICES (COLUMNS 1.01x5.03) 9.03	PPS SERVICES (COLUMNS 1.01x5.04) 9.04	I/P PART B CHARGES (SEE INSTRU.) 10	I/P PART B COST (COLUMNS 1.02x10) 11
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	131017						37
40 ANESTHESIOLOGY	11964						40
41 RADIOLOGY-DIAGNOSTIC	490973						41
44 LABORATORY	477823						44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
50 PHYSICAL THERAPY	248534						50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY	8776						53
55 MEDICAL SUPPLIES CHARGED TO PAT	53169						55
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS	121757						56
59 ULTRASOUND	8187						59
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC	215035						60
61 EMERGENCY	648992						61
62 OBSERVATION BEDS (NON-DISTINCT	127558						62
63.50 RHC							63.50
63.51 RHC II							63.51
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
65.01 AMBULANCE CHARGES (S-2 LINE 56.							65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.							65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.							65.03
101 SUBTOTAL	2543785						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	2543785						104

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1301)	SUB I	SUB II	SUB III	SUB IV	SNF
INPATIENT DAYS	1	1	1	1	1	1
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	1583					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	702					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)						3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	702					4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	251					5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	250					6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	190					7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	190					8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	506					9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	251					10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	250					11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)						14
15 TOTAL NURSERY DAYS						15
16 TITLE V OR XIX NURSERY DAYS						16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1301)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT							
	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	98.89						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	99.99						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2375060						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	18789						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	18998						25
26 TOTAL SWING-BED COST	1011165						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1363895						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1261627						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1261627						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.081060						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1797.19						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1363895						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1301)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1942.87					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	983092					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	983092					41
	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-1301)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	232517					48
49 TOTAL PROGRAM INPATIENT COSTS	1215609					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST						52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1301)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	1	1	1	1	1	54
54						PROGRAM DISCHARGES
55						TARGET AMOUNT PER DISCHARGE
56						TARGET AMOUNT
57						DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58						BONUS PAYMENT
58.01						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET
58.02						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET
58.03						IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT
58.04						RELIEF PAYMENT
59						ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01						ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)
59.02						PROGRAM DISCHARGES PRIOR TO JULY 1
59.03						PROGRAM DISCHARGES AFTER JULY 1
59.04						PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05						REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1
59.06						REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
59.07						REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)
59.08						REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)
PROGRAM INPATIENT ROUTINE SWING BED COST						
60	487660					MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
61	485718					MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
62	973378					TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65						TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

PROVIDER NO. 14-1301 KIRBY HOSPITAL
PERIOD FROM 07/01/2008 TO 06/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08
11/25/2009 11:30

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

SNF

1

66 SNF/NF/ICF/MR ROUTINE SERVICE COST	66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	67
68 PROGRAM ROUTINE SERVICE COST	68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	71
72 PER DIEM CAPITAL RELATED COSTS	72
73 PROGRAM CAPITAL RELATED COSTS	73
74 INPATIENT ROUTINE SERVICE COST	74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	77
78 INPATIENT ROUTINE SERVICE COST LIMITATION	78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS	79
80 PROGRAM INPATIENT ANCILLARY SERVICES	80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION	81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS	82

PROVIDER NO. 14-1301 KIRBY HOSPITAL
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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-1301)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	95	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1942.87	84
85 OBSERVATION BED COST	184573	85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-1301)	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
25 INPATIENT ROUTINE SERVICE COST CENTERS		480195		25
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.977858			37
40 ANESTHESIOLOGY	1.577107			40
41 RADIOLOGY-DIAGNOSTIC	.428334	69294	29681	41
44 LABORATORY	.371864	137780	51235	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
50 PHYSICAL THERAPY	.761067	11374	8656	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	.369310	6972	2575	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.221366	147660	32687	55
55.30 IMPL. DEV. CHARGED TO PATIENT				55.30
56 DRUGS CHARGED TO PATIENTS	.596253	163006	97193	56
59 ULTRASOUND	.159198	1918	305	59
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	2.529527			60
61 EMERGENCY	.740451	11067	8195	61
62 OBSERVATION BEDS (NON-DISTINCT	.993760	2002	1990	62
OTHER REIMBURSABLE COST CENTERS				
63.50 RHC	.885667			63.50
63.51 RHC II	1.244455			63.51
63.60 FOHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		551073	232517	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		551073		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input checked="" type="checkbox"/> S/B-SNF (14-Z301)	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.977858			37
40 ANESTHESIOLOGY	1.577107			40
41 RADIOLOGY-DIAGNOSTIC	.428334	13559	5808	41
44 LABORATORY	.371864	55496	20637	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
50 PHYSICAL THERAPY	.761067	57928	44087	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	.369310	2640	975	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.221366	92238	20418	55
55.30 IMPL. DEV. CHARGED TO PATIENT				55.30
56 DRUGS CHARGED TO PATIENTS	.596253	130607	77875	56
59 ULTRASOUND	.159198	1193	190	59
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	2.529527			60
61 EMERGENCY	.740451	1110	822	61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.993760			62
63.50 RHC	.885667			63.50
63.51 RHC II	1.244455			63.51
63.60 FOHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		354771	170812	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		354771		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1301)	HOSPITAL (14-1301)	HOSPITAL (14-1301)	
	1	1.01	1.02	
1 MEDICAL AND OTHER SERVICES	2560945			1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04 LINE 1.01 TIMES LINE 1.03				1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST	2560945			5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES				6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10 TOTAL REASONABLE CHARGES				10
CUSTOMARY CHARGES				
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13 RATIO OF LINE 11 TO LINE 12				13
14 TOTAL CUSTOMARY CHARGES				14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES	2586554			17
17.01 TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1301)	HOSPITAL (14-1301)	HOSPITAL (14-1301)
	1	1.01	1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES	27218		18
18.01 COINSURANCE	647502		18.01
19 SUBTOTAL	1911834		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	1911834		23
24 PRIMARY PAYER PAYMENTS	875		24
25 SUBTOTAL	1910959		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS			27
27.01 REDUCED REIMBURSABLE BAD DEBTS			27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			27.02
28 SUBTOTAL	1910959		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
OTHER ADJUSTMENTS			
30 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	1910959		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	1983914		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	-72955		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONILIATION AMOUNT (SEE INSTRUCT			51
52 THE RATE USED TO CALCULATE THE TIME VALUE			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

	HOSPITAL (14-1301) OCTOBER 1, 1997 PRIOR TO ON OR AFTER	
	1 1.01	
1 STANDARD OVERHEAD AMOUNTS (ASC FEES)		1
2 DEDUCTIBLES		2
3 SUBTOTAL		3
4 80 PERCENT OF LINE 3		4
5 ASC PORTION OF BLEND		5
6 OUTPATIENT ASC COST		6
COMPUTATION OF LESSER OF COST OR CHARGES		
7 TOTAL CHARGES		7
CUSTOMARY CHARGES		
8 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		8
9 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)		9
10 RATIO OF LINE 8 TO LINE 9		10
11 TOTAL CUSTOMARY CHARGES		11
12 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		12
13 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		13
14 LESSER OF COST OR CHARGES		14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15 DEDUCTIBLES AND COINSURANCE		15
16 TOTAL		16
17 HOSPITAL SPECIFIC PORTION OF BLEND		17
18 ASC BLENDED AMOUNT		18
19 LESSER OF LINES 16 OR 18		19
20 PART B DEDUCTIBLES AND COINSURANCE		20
21 ASC PAYMENT AMOUNT		21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(14-1301)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

1	PREVAILING CHARGES	1
2	62 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OUTPATIENT RADIOLOGY	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	RADIOLOGY PAYMENT AMOUNT	21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
 (14-1301)
 OCTOBER 1, 1997
 PRIOR TO ON OR AFTER
 1 1.01

1	PREVAILING CHARGES	1
2	42 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	DIAGNOSTIC PAYMENT AMOUNT	21

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 HOSPITAL (14-1301)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B		
	PART A		PART B		
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		820156		1901114	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		NONE	2
3 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 PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 .05 .50 PROVIDER .51 TO .52 PROGRAM .53 .54	02/01/2009 25800 11/03/2009 216100	02/01/2009	82800	3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54
SUBTOTAL	.99	241900		82800	3.99
4 TOTAL INTERIM PAYMENTS		1062056		1983914	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52				5.01 5.02 5.03 5.50 5.51 5.52
SUBTOTAL	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01 PROVIDER TO .02 PROGRAM				6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY					7

NAME OF INTERMEDIARY: _____
 SIGNATURE OF AUTHORIZED PERSON: _____

INTERMEDIARY NUMBER: _____
 DATE (MO/DAY/YR): _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 SWING BED SKILLED NURSING FACILITY (14-Z301)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B	
	PART A			
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		852740		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		2
3 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 PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	02/01/2009 43500		3.01
	TO .02	11/03/2009 246400		3.02
	PROVIDER .03		NONE	3.03
	TO .04			3.04
	PROVIDER .05			3.05
	TO .50			3.50
	PROVIDER .51			3.51
	TO .52	NONE		3.52
	PROVIDER .53		NONE	3.53
	PROGRAM .54			3.54
SUBTOTAL	.99	289900		3.99
4 TOTAL INTERIM PAYMENTS		1142640		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02			5.02
	PROVIDER .03			5.03
	PROVIDER .50			5.50
	TO .51			5.51
	PROGRAM .52			5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01			6.01
	PROVIDER TO .02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				7

NAME OF INTERMEDIARY: _____
 SIGNATURE OF AUTHORIZED PERSON: _____

INTERMEDIARY NUMBER: _____
 DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT
 SWING BEDS

SUPPLEMENTAL
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

	TITLE V	--- TITLE XVIII ---		--- TITLE XIX ---		
	S/B NF	S/B SNF	S/B SNF	S/B SNF	S/B NF	
	1	1	2	1	1	
		PART A	PART B	(14-Z301)	(14-Z301)	
		(14-Z301)				
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		983112			1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF					2
3	ANCILLARY SERVICES		172520			3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					4
5	PROGRAM DAYS		501			5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY					7
8	SUBTOTAL		1155632			8
9	PRIMARY PAYER PAYMENTS					9
10	SUBTOTAL		1155632			10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)					11
12	SUBTOTAL		1155632			12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		6417			13
14	80% OF PART B COSTS					14
15	SUBTOTAL		1149215			15
16	OTHER ADJUSTMENTS					16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)					17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES					17.01
18	TOTAL		1149215			18
19	SEQUESTRATION ADJUSTMENT					19
20	INTERIM PAYMENTS		1142640			20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					20.01
21	BALANCE DUE PROVIDER/PROGRAM		6575			21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1301)	SUB I	SUB II	SUB III	SUB IV	SNF I
1	INPATIENT SERVICES	1215609				1
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)					1.01
2	ORGAN ACQUISITION					2
3	COST OF TEACHING PHYSICIANS					3
4	SUBTOTAL	1215609				4
5	PRIMARY PAYER PAYMENTS					5
6	TOTAL COST	1227765				6
COMPUTATION OF LESSER OF COST OR CHARGES						
REASONABLE CHARGES						
7	ROUTINE SERVICE CHARGES					7
8	ANCILLARY SERVICE CHARGES					8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE					9
10	TEACHING PHYSICIANS					10
11	TOTAL REASONABLE CHARGES					11
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS					12
13	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)					13
14	RATIO OF LINE 12 TO LINE 13					14
15	TOTAL CUSTOMARY CHARGES					15
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST					16
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES					17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1301)	SUB I	SUB II	SUB III	SUB IV	SNF I
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
18						18
19						19
20	1227765					20
21	125609					21
22						22
23	1102156					23
24						24
25	1102156					25
25.01						25.01
25.02						25.02
26						26
27	1102156					27
28						28
29						29
30						30
31	1102156					31
32						32
32.01	1062056					32.01
33						33
34	40100					34

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	724131			1
2	TEMPORARY INVESTMENTS	512099			2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	3629632			4
5	OTHER RECEIVABLES	840824			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-704000			6
7	INVENTORY	197019			7
8	PREPAID EXPENSES	122861			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS	5322566			11
FIXED ASSETS					
12	LAND				12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS	513741			13
13.01	ACCUMULATED DEPRECIATION	-194814			13.01
14	BUILDINGS	6814972			14
14.01	ACCUMULATED DEPRECIATION	-1861801			14.01
15	LEASEHOLD IMPROVEMENTS				15
15.01	ACCUMULATED AMORTIZATION				15.01
16	FIXED EQUIPMENT	7428650			16
16.01	ACCUMULATED DEPRECIATION	-5832218			16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT				18
18.01	ACCUMULATED DEPRECIATION				18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	6868530			21
OTHER ASSETS					
22	INVESTMENTS				22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	9869103			25
26	TOTAL OTHER ASSETS	9869103			26
27	TOTAL ASSETS	22060199			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	1158053			28
29	SALARIES, WAGES & FEES PAYABLE	1127328			29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)	339100			31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS				34
35	OTHER CURRENT LIABILITIES				35
36	TOTAL CURRENT LIABILITIES	2624481			36
LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE	849076			37
38	NOTES PAYABLE				38
39	UNSECURED LOANS				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41	OTHER LONG TERM LIABILITIES	249362			41
42	TOTAL LONG TERM LIABILITIES	1098438			42
43	TOTAL LIABILITIES	3722919			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	18337280			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES	18337280			51
52	TOTAL LIABILITIES AND FUND BALANCES	22060199			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	17530404			1
2 NET INCOME (LOSS)	1871911			2
3 TOTAL	19402315			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	19402315			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13 DECR IN RESTRICTED ASSETS	368642			13
14 REDUCTION IN TRUST ASSETS	696393			14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS	1065035			18
19 FUND BALANCE AT END OF PERIOD	18337280			19
PER BALANCE SHEET				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	1261627		1261627	2
4 SUBPROVIDER I				4
5 SWING BED - SNF				5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES	1261627		1261627	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES	1261627		1261627	18
19 ANCILLARY SERVICES	1324508	14954201	16278709	19
20 OUTPATIENT SERVICES				20
18.50 RHC		526172	526172	18.50
18.51 RHC II		1174014	1174014	18.51
18.60 FQHC				18.60
19 HOME HEALTH AGENCY				19
20 AMBULANCE		833268	833268	20
21 CORF				21
22 ASC				22
23 HOSPICE				23
24				24
24.03 PROFESSIONAL FEE REVENUE	1620	1957223	1958843	24.03
24.04 KIRBY MEDICAL GROUP		652036	652036	24.04
25 TOTAL PATIENT REVENUES	2587755	20096914	22684669	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		16426996	26
27 AUXILIARY EXPENSE	29299		27
28 ROUNDING			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS		29299	33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		16456295	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	22684669	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	6462051	2
3	NET PATIENT REVENUES	16222618	3
4	LESS - TOTAL OPERATING EXPENSES	16456295	4
5	NET INCOME FROM SERVICE TO PATIENTS	-233677	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	GRANT REVENUE	82823	24
24.01	ASSETS RELEASED FROM RESTRICTION	370576	24.01
24.02	OTHER REVENUE	2015895	24.02
24.03	OTHER REVENUE		24.03
24.04	INVESTMENT INCOME	-794845	24.04
24.05	CHANGE IN UNREALIZED GAINS/LOSSES	431139	24.05
24.14	NET ASSETS RELEASED FROM RESTRICTIO		24.14
24.15	TRUST INCOME AND SALE OF LAND		24.15
24.16	RECOVERY UNCOLLECT AMBULANCE		24.16
25	TOTAL OTHER INCOME	2105588	25
26	TOTAL	1871911	26
27			27
28			28
29			29
29.25	ROUNDING		29.25
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	1871911	31

PROVIDER NO. 14-1301 KIRBY HOSPITAL
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KPMG LLP COMPU-MAX MICRO SYSTEM
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ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
 FEDERALLY QUALIFIED HEALTH CENTER COSTS

RHC I
 COMPONENT NO: 14-3438

WORKSHEET M-1

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	49575		49575		49575		49575	1
2 PHYSICIAN ASSISTANT	98003		98003		98003		98003	2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE	36162		36162		36162		36162	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9) COSTS UNDER AGREEMENT	183740		183740		183740		183740	10
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS								14
15 MEDICAL SUPPLIES		32473	32473		32473		32473	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		32473	32473		32473		32473	21
22 TOTAL COSTS OF HEALTH CARE SERVICES COSTS OTHER THAN RHC/FQHC SERVICES	183740	32473	216213		216213		216213	22
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS FACILITY OVERHEAD								28
29 FACILITY COSTS	2648	34772	37420		37420		37420	29
30 ADMINISTRATIVE COSTS	28830	60288	89118		89118		89118	30
31 TOTAL FACILITY OVERHEAD	31478	95060	126538		126538		126538	31
32 TOTAL FACILITY COSTS	215218	127533	342751		342751		342751	32

PROVIDER NO. 14-1301 KIRBY HOSPITAL
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RHC I
 COMPONENT NO: 14-3438

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1 PHYSICIANS	0.20		4200	840		1
2 PHYSICIAN ASSISTANTS	1.00	3967	2100	2100		2
3 NURSE PRACTITIONERS			2100			3
4 SUBTOTAL	1.20	3967		2940	3967	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	1.20	3967			3967	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					216213	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					216213	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD					126538	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					123262	15
16 TOTAL OVERHEAD					249800	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					249800	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					249800	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					466013	20

RHC I
 COMPONENT NO: 14-3438

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

CHECK [XX] RHC [] TITLE V
 APPLICABLE BOX: [] FQHC [XX] TITLE XVIII
 [] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	466013	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	11969	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	454044	3
4	TOTAL VISITS	3967	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	3967	6
7	ADJUSTED COST PER VISIT	114.46	7

CALCULATION OF LIMIT(1)
 PRIOR TO ON OR AFTER
 JANUARY 1 JANUARY 1 (SEE INSTR.)
 1 2 3

8	PER VISIT PAYMENT LIMIT	66.72	66.72	8
9	RATE FOR PROGRAM COVERED VISITS	114.46	114.46	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	332	245	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	38001	28043	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES			14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST			15
16	TOTAL PROGRAM COST		66044	16
16.01	PRIMARY PAYOR PAYMENTS			16.01
17	LESS: BENEFICIARY DEDUCTIBLE		4525	17
18	NET PROGRAM COST EXCLUDING VACCINES		61519	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE		49215	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION		4511	20
21	TOTAL REIMBURSABLE PROGRAM COST		53726	21
22	REIMBURSABLE BAD DEBTS			22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			22.01
23	OTHER ADJUSTMENTS			23
24	NET REIMBURSABLE AMOUNT		53726	24
25	INTERIM PAYMENTS		46342	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE COMPONENT/PROGRAM		7384	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			27

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

PROVIDER NO. 14-1301 KIRBY HOSPITAL
PERIOD FROM 07/01/2008 TO 06/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
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RHC I
COMPONENT NO: 14-3438

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [XX] RHC [] TITLE V
APPLICABLE BOX: [] FQHC [XX] TITLE XVIII
[] TITLE XIX

	PNEUMOCOCCAL 1	INFLUENZA 2	
1 HEALTH CARE STAFF COSTS	183740	183740	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.001100	0.009400	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	202	1727	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	1157	2467	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	1359	4194	5
6 TOTAL DIRECT COST OF THE FACILITY	216213	216213	6
7 TOTAL OVERHEAD	249800	249800	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.006285	0.019398	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	1570	4846	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	2929	9040	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	29	257	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	101.00	35.18	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	6	111	13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	606	3905	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		11969	15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		4511	16

PROVIDER NO. 14-1301 KIRBY HOSPITAL
PERIOD FROM 07/01/2008 TO 06/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08
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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER
FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC I
COMPONENT NO: 14-3438

WORKSHEET M-5

CHECK [XX] RHC
APPLICABLE BOX: [] FQHC

DESCRIPTION	PART B		AMOUNT	
	1 MM/DD/YYYY	2		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER			46342	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.			NONE	2
3 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 PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 TO .05 PROVIDER .50 TO .51 PROGRAM .52 PROGRAM .53 PROGRAM .54	04/20/2007		3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54
SUBTOTAL	.99			3.99
4 TOTAL INTERIM PAYMENTS			46342	4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52			5.01 5.02 5.03 5.50 5.51 5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER .01 PROVIDER TO .02 PROGRAM			6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				7

NAME OF INTERMEDIARY: _____
SIGNATURE OF AUTHORIZED PERSON: _____

INTERMEDIARY NUMBER: _____
DATE (MO/DAY/YR): _____

PROVIDER NO. 14-1301 KIRBY HOSPITAL
 PERIOD FROM 07/01/2008 TO 06/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

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ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
 FEDERALLY QUALIFIED HEALTH CENTER COSTS

RHC II
 COMPONENT NO: 14-3495

WORKSHEET M-1

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	277263		277263		277263		277263	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	113434		113434		113434		113434	3
4 VISITING NURSE								4
5 OTHER NURSE	154601		154601		154601		154601	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9) COSTS UNDER AGREEMENT	545298		545298		545298		545298	10
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS								14
15 MEDICAL SUPPLIES		38185	38185		38185		38185	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		38185	38185		38185		38185	21
22 TOTAL COSTS OF HEALTH CARE SERVICES COSTS OTHER THAN RHC/FQHC SERVICES	545298	38185	583483		583483		583483	22
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS FACILITY OVERHEAD								28
29 FACILITY COSTS		76276	76276		76276		76276	29
30 ADMINISTRATIVE COSTS	130169	233001	363170		363170		363170	30
31 TOTAL FACILITY OVERHEAD	130169	309277	439446		439446		439446	31
32 TOTAL FACILITY COSTS	675467	347462	1022929		1022929		1022929	32

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RHC II
 COMPONENT NO: 14-3495

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1 PHYSICIANS	1.04	5291	4200	4368		1
2 PHYSICIAN ASSISTANTS			2100			2
3 NURSE PRACTITIONERS	1.15	2913	2100	2415		3
4 SUBTOTAL	2.19	8204		6783	8204	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	2.19	8204			8204	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					583483	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					583483	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD					439446	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					438079	15
16 TOTAL OVERHEAD					877525	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					877525	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					877525	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					1461008	20

RHC II
 COMPONENT NO: 14-3495

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

CHECK [XX] RHC [] TITLE V
 APPLICABLE BOX: [] FQHC [XX] TITLE XVIII
 [] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1461008	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	15933	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	1445075	3
4	TOTAL VISITS	8204	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	8204	6
7	ADJUSTED COST PER VISIT	176.14	7

CALCULATION OF LIMIT(1)
 PRIOR TO ON OR AFTER
 JANUARY 1 JANUARY 1 (SEE INSTR.)
 1 2 3

8	PER VISIT PAYMENT LIMIT	66.72	66.72	8
9	RATE FOR PROGRAM COVERED VISITS	176.14	176.14	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	754	1638	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	132810	288517	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES			14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST			15
16	TOTAL PROGRAM COST		421327	16
16.01	PRIMARY PAYOR PAYMENTS		40	16.01
17	LESS: BENEFICIARY DEDUCTIBLE		16417	17
18	NET PROGRAM COST EXCLUDING VACCINES		404870	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE		323896	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION		7636	20
21	TOTAL REIMBURSABLE PROGRAM COST		331532	21
22	REIMBURSABLE BAD DEBTS			22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			22.01
23	OTHER ADJUSTMENTS			23
24	NET REIMBURSABLE AMOUNT		331532	24
25	INTERIM PAYMENTS		196080	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE COMPONENT/PROGRAM		135452	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			27

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

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RHC II
 COMPONENT NO: 14-3495

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [XX] RHC [] TITLE V
 APPLICABLE BOX: [] FQHC [XX] TITLE XVIII
 [] TITLE XIX

	PNEUMOCOCCAL 1	INFLUENZA 2	
1 HEALTH CARE STAFF COSTS	545298	545298	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.001200	0.002000	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	654	1091	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	3312	1306	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	3966	2397	5
6 TOTAL DIRECT COST OF THE FACILITY	583483	583483	6
7 TOTAL OVERHEAD	877525	877525	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.006797	0.004108	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	5965	3605	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	9931	6002	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	83	136	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	119.65	44.13	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	38	70	13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	4547	3089	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		15933	15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		7636	16

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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER
FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC II
COMPONENT NO: 14-3495

WORKSHEET M-5

CHECK [XX] RHC
APPLICABLE BOX: [] FQHC

DESCRIPTION	PART B	
	1 MM/DD/YYYY	2 AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		196080
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	PROGRAM .01	3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .02	3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .03	NONE
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .04	3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.05	3.05
	.50	3.50
	PROVIDER .51	3.51
	TO .52	NONE
	PROGRAM .53	3.53
	.54	3.54
SUBTOTAL	.99	3.99
4 TOTAL INTERIM PAYMENTS		196080
TO BE COMPLETED BY INTERMEDIARY		
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	5.01
	TO .02	5.02
	PROVIDER .03	5.03
	PROVIDER .50	5.50
	TO .51	5.51
	PROGRAM .52	5.52
SUBTOTAL	.99	5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01	6.01
	PROVIDER TO .02	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY	PROGRAM	7

NAME OF INTERMEDIARY: _____
SIGNATURE OF AUTHORIZED PERSON: _____

INTERMEDIARY NUMBER: _____
DATE (MO/DAY/YR): _____