DR. JOHN WARNER HOSPITAL

CLINTON, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED APRIL 30, 2009

September 15, 2009

National Government Services, Inc.
P.O. Box 2952
Milwaukee, WI 53201

Re: Provider: Dr. John Warner Hospital
Provider Numbers: 14-1303, 14-2303, 14-3404
Period ended: 4-30-09
Protested amount claimed on submitted cost report.

Dear Sir or Madam:

The cost report for Dr. John Warner Hospital, for the year ended April 30, 2009, claims additional amounts due the provider for an expense paid by the provider, but currently not classified as a reimbursable cost by National Government Services, Inc. The expenses in question relate to the CRNA pass through cost in the amount of $214,380, which we have included as adjustments to line 40 (Anesthesiology) on worksheet A-8. We feel as though the tax should be, and is, allowed as a reimbursable cost under Medicare Guidelines.

The calculation of the additional amounts due the provider was calculated by removing the adjustments on worksheet A-8. The protested amounts claimed for the period ended April 30, 2009 are as follows:

Worksheet E, part B, line 36	$ 30,598
Worksheet E-2, line 22	(753)
Worksheet E-3, part II, line 34	(1,459)
Worksheet M-3, line 27	(1,466)
Total	$ 26,920

Sincerely,

Donna Wisner, CFO
Dr. John Warner Hospital
422 West White Street
Clinton, Illinois 61727
(217) 935-9571

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

WORKSHEET S
PARTS I & II

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

PART I - CERTIFICATION

CHECK APPLICABLE BOX
XX ELECTRONICALLY FILED COST REPORT
__ MANUALLY SUBMITTED COST REPORT

DATE: _09/15/2009
TIME: _09:58____

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 DR JOHN WARNER HOSPITAL (14-1303) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 05/01/2008 AND ENDING 04/30/2009, 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: 09/15/2009 09:58
Fy.TJS1HfcfiUGYZn249EHvL71:tc0
ODhfY0slum2LOk74:63WkJ7Z..jB9g
1dHn0XFi9W0dZ.nd

PI Encryption: 09/15/2009 09:58
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(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
		1	2	3	4	
1	HOSPITAL		10815	294		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		4088			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			80978		9
100	TOTAL		14903	81272		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 OMB 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 HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 422 WEST WHITE STREET P.O.BOX: 1
1.01 CITY: CLINTON STATE: IL ZIP CODE: 61727- COUNTY: DEWITT 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N) V 4	XVIII 5	XIX 6	
2	HOSPITAL	DR JOHN WARNER HOSPITAL	14-1303	03/01/2000	N	O	N	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	SWING BED	14-Z303	03/01/2000	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA							9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC	RURAL HEALTH CENTER	14-3404	07/03/1995	N	O	N	14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 05/01/2008 TO: 04/30/2009 17
1 2

18 TYPE OF CONTROL 12 18

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1 19
20 SUBPROVIDER I 20

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. 21

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? 21.01

21.02 HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE. 21.02

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y 21.03

21.04 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. 2 21.04

21.05 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. 2 21.05

21.06 DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO. NO 21.06

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? NO 22

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW NO 23

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.01

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.02

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.03

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.04

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. 23.05

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.06

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.07

24 IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3. 24

24.01 IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3. 24.01

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) NO 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) NO 25.06

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

OTHER INFORMATION

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 03/01/2000	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?	NO	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

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 (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO	35

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL	V 1	XVIII 2	XIX 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?				37.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

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.	YES	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?	YES	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	Y	Y	Y	47
48	SUBPROVIDER I	N	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N				49
50	HOME HEALTH AGENCY	N	N				50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?	NO	52
52.03	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.	NO	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 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		53
53.01	MDH PERIOD: BEGINNING: ENDING:		53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 120896 PAID LOSSES: AND/OR SELF INSURANCE:		54
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.	NO	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.	NO	55

		DATE	Y/N	LIMIT	Y/N	FEES	
		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. (SEE INSTRUCTIONS)		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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

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: 1	STATE: 2	ZIP CODE 3	CBSA 4	FTE/ CAMPUS 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)	YES	04/30/2009	63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	LTCH NONCOVERED DAYS 4.01	TITLE XIX 5	OBS. BEDS ADMITTED 5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	20	7300	29043.00		978		39		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					123				3
4	HOSPITAL ADULTS & PEDS SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	20	7300	29043.00		1101		39		5
6	INTENSIVE CARE UNIT	2	730	638.00		21				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	22	8030	29681.00		1122		39		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
25	TOTAL	22								25
26	OBSERVATION BED DAYS							37	6	26
27	AMBULANCE TRIPS									27
28	EMPLOYEE DISCOUNT DAYS									28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	-----I/P DAYS / O/P VISITS / TRIPS---- OBS. BEDS NOT ADMITTED 5.02	TOTAL ALL PATIENTS 6	OBS. BEDS ADMITTED 6.01	OBS. BEDS NOT ADMITTED 6.02	---INTERNS & RES FTES---- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8	NET 9	--FULL TIME EQUIV-- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		1224								1
2	HMO XIX										2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		123								3
4	HOSPITAL ADULTS & PEDS - SWING BED NF										4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		1347								5
6	INTENSIVE CARE UNIT		32								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		1379						151.48		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		12507						15.90		24
25	TOTAL								167.38		25
26	OBSERVATION BED DAYS	31	217	43	174						26
27	AMBULANCE TRIPS										27
28	EMPLOYEE DISCOUNT DAYS										28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S 3
PART I
(CONTINUED)

	COMPONENT	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		287	10	384	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		287	10	384	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
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART II

	PART II - WAGE DATA	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	
	SALARIES	1	2	3	4	5	6	
1	TOTAL SALARIES	6009086						1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES	674201	52848					8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS							11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)						CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS						CMS 339	15
16	NON PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)							19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS							21
22	ADMINISTRATIVE & GENERAL	1027262	10800					22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	164766						24
25	LAUNDRY & LINEN SERVICE	5697						25
26	HOUSEKEEPING	94120						26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	179941	-11336					27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA		11336					28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	138538						30
31	CENTRAL SERVICES AND SUPPLY	13672						31
32	PHARMACY	87038						32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	126628						33
34	SOCIAL SERVICE	30398						34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART III

	PART III HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	
		1	2	3	4	5	
1	NET SALARIES	6009086		6009086			1
2	EXCLUDED AREA SALARIES	674201	52848	727049			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5334885	52848	5282037			3
4	SUBTOTAL OTHER WAGES & REL COSTS						4
5	SUBTOTAL WAGE-RELATED COSTS						5
6	TOTAL (SUM OF LINES 3 THRU 5)	5334885	-52848	5282037			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	1868060	10800	1878860			13

PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER
PROVIDER STATISTICAL DATA

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 422 W WHITE STREET	1
1.01	CITY: CLINTON STATE: IL ZIP CODE: 61727 COUNTY: DEWITT	1.01
2	DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN	2

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD 1	DATE 2	
3	COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)		/ /	3
4	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /	4
5	HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)		/ /	5
6	APPALACHIAN REGIONAL COMMISSION		/ /	6
7	LOOK-ALIKES		/ /	7
8	OTHER		/ /	8

PHYSICIAN INFORMATION:

		PHYSICIAN NAME	BILLING NO.	
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	TRICIA SCERBA	1467534065	9
9.01		BRIT WILLIAMS	1780667816	9.01
9.02		SUBRANABUAN KOLANDAVELU	1770509671	9.02
9.03		SOHA SATTAR	1033327143	9.03
9.04		ATIKA KAHN	1174713648	9.04
9.05		MUHIB ALATTAR	1053396044	9.05
9.06		SUDHIR HANSALIA	1427279611	9.06

		PHYSICIAN NAME	HOURS	
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD			10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11
IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2
(ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
12	CLINIC			830	1700	830	1700	830	1700	830	1700	830	1700			12

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS OF OPERATION)
LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? NO 13
14 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? NO 14
IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.
LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.
15 PROVIDER NAME: PROVIDER NUMBER: - 15
V XVIII XIX
16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. NO 16
17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, SEE INSTRUCTIONS. NO 17

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		375869	375869	123390	499259	-100963	398296	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		392798	392798	12758	405556		405556	4
5	0500	EMPLOYEE BENEFITS		1743966	1743966		1743966		1743966	5
6	0600	ADMINISTRATIVE & GENERAL	1027262	763670	1790932	47963	1838895	44235	1794660	6
7	0700	MAINTENANCE & REPAIRS								7
8	0800	OPERATION OF PLANT	164766	363072	527838	196	528034		528034	8
9	0900	LAUNDRY & LINEN SERVICE	5697	33580	39277		39277		39277	9
10	1000	HOUSEKEEPING	94120	19821	113941		113941		113941	10
11	1100	DIETARY	179941	186244	366185	-23069	343116	-296867	46249	11
12	1200	CAFETERIA				23069	23069	-17875	5194	12
13	1300	MAINTENANCE OF PERSONNEL								13
14	1400	NURSING ADMINISTRATION	138538	5687	144225		144225		144225	14
15	1500	CENTRAL SERVICES & SUPPLY	13672	288840	302512	-286102	16410		16410	15
16	1600	PHARMACY	87038	591367	678405	-285703	392702		392702	16
17	1700	MEDICAL RECORDS & LIBRARY	126628	77799	204427		204427	-4490	199937	17
18	1800	SOCIAL SERVICE	30398	2467	32865		32865		32865	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	804010	188973	992983	-9715	983268		983268	25
26	2600	INTENSIVE CARE UNIT	14671	14233	28904		28904		28904	26
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	258374	72054	330428		330428	-2061	328367	37
40	4000	ANESTHESIOLOGY		219392	219392		219392	-214380	5012	40
41	4100	RADIOLOGY DIAGNOSTIC	275296	638999	914295		914295		914295	41
44	4400	LABORATORY	321976	603186	925162		925162	-3888	921274	44
46	4600	WHOLE BLOOD & PACKED RED BLOOD				3811	3811		3811	46
46.30	4650	BLOOD CLOTTING FACTORS ADMIN CO								46.30
48	4800	INTRAVENOUS THERAPY				5165	5165		5165	48
49	4900	RESPIRATORY THERAPY	144000	59464	203464	-24079	179385		179385	49
50	5000	PHYSICAL THERAPY	24542	270631	295173		295173	-5433	289740	50
51	5100	OCCUPATIONAL THERAPY								51
52	5200	SPEECH PATHOLOGY								52
53	5300	ELECTROCARDIOLOGY	34771	28355	63126		63126	-38336	24790	53
55	5500	MEDICAL SUPPLIES CHARGED TO PAT				310181	310181	-1647	308534	55
56	5600	DRUGS CHARGED TO PATIENTS				285703	285703	-7275	278428	56
59	3950	CARDIAC REHAB	42631	1806	44437		44437		44437	59
		OUTPATIENT SERVICE COST CENTERS								
60	6000	CLINIC	52848	3818	56666	-55927	739		739	60
61	6100	EMERGENCY	468959	492761	961720	-20253	941467	-18438	923029	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RURAL HEALTH CLINIC	1024747	253202	1277949	-60705	1217244	-105444	1111800	63.50
63.60	6320	FQHC								63.60
		OTHER REIMBURSABLE COST CENTERS								
65	6500	AMBULANCE SERVICES	666738	82393	749131		749131		749131	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
88	8800	INTEREST EXPENSE		100963	100963	-100963				88
90	9000	OTHER CAPITAL RELATED COSTS								90
95		SUBTOTALS	6001623	7875410	13877033	-54280	13822753	-861332	12961421	95
		NONREIMBURSABLE COST CENTERS								
98	9800	PHYSICIANS' PRIVATE OFFICES				56666	56666		56666	98
98.01	9801	LIFELINE	2400	12228	14628		14628		14628	98.01
98.02	9802	HOME MEDICAL EQUIPMENT	5063	3587	8650	-2386	6264		6264	98.02
101		TOTAL	6009086	7891225	13900311		13900311	-861332	13038979	101

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA COSTS FROM DIET	A	CAFETERIA	12	11336	11733	1
2	TO RECLASS DRUGS SOLD TO PATIENTS	B	DRUGS CHARGED TO PATIENTS	56		285703	2
3	TO RECLASS LEASE EXPENSE	C	NEW CAP REL COSTS-MVBLE EQUIP	4		2190	3
4	TO RECLASS INTEREST EXPENSE	D	NEW CAP REL COSTS-BLDG & FIXT	3		100963	4
5	TO RECLASS SUPPLIES CHARGED TO PTS	E	MEDICAL SUPPLIES CHARGED TO P	55		286102	5
6	TO RECLASS ER PHYSICIAN CONTRACTED	F	ADMINISTRATIVE & GENERAL	6		20253	6
7	TO RECLSS PROPERTY INS EXP	G	OTHER CAPITAL RELATED COSTS	90		32995	7
8	TO RECLASS RHC ADMIN EXPENSES	H	ADMINISTRATIVE & GENERAL	6		49905	8
9	TO RECLASS UTILITY EXPENSES	I	OPERATION OF PLANT	8		196	9
10	TO RECLASS OXYGEN SUPPLIES	J	MEDICAL SUPPLIES CHARGED TO P	55		24079	10
11	TO RECLASS PHYSICIAN CLINIC EXPENSE	K	PHYSICIANS' PRIVATE OFFICES	98	52848	3818	11
12	TO RECLASS NURSING COST	L	INTRAVENOUS THERAPY	48	5165		12
13	TO RECLASS NURSING COST	M	WHOLE BLOOD & PACKED RED BLOO	46	3811		13
14	TO RECLASS NURSING COST	N	ADMINISTRATIVE & GENERAL	6	10800		14
15	TO RECLASS NURSING COST	O	CLINIC	60	739		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				84699	817937	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE 1	COST CENTER 6	DECREASE LINE # 7	SALARY 8	OTHER 9	WKST A-7 REF. 10
1	TO RECLASS CAFETERIA COSTS FROM D	A	DIETARY	11	11336	11733	1
2	TO RECLASS DRUGS SOLD TO PATIENTS	B	PHARMACY	16		285703	2
3	TO RECLASS LEASE EXPENSE	C	HOME MEDICAL EQUIPMENT	98.02		2190	I0 3
4	TO RECLASS INTEREST EXPENSE	D	INTEREST EXPENSE	88		100963	10 4
5	TO RECLASS SUPPLIES CHARGED TO PT	E	CENTRAL SERVICES & SUPPLY	15		286102	5
6	TO RECLASS ER PHYSICIAN CONTRACTE	F	EMERGENCY	61		20253	6
7	TO RECLSS PROPERTY INS EXP	G	ADMINISTRATIVE & GENERAL	6		32995	7
8	TO RECLASS RHC ADMIN EXPENSES	H	RURAL HEALTH CLINIC	63.50		49905	8
9	TO RECLASS UTILITY EXPENSES	I	HOME MEDICAL EQUIPMENT	98.02		196	9
10	TO RECLASS OXYGEN SUPPLIES	J	RESPIRATORY THERAPY	49		24079	10
11	TO RECLASS PHYSICIAN CLINIC EXPEN	K	CLINIC	60	52848	3818	11
12	TO RECLASS NURSING COST	L	ADULTS & PEDIATRICS	25	5165		12
13	TO RECLASS NURSING COST	M	ADULTS & PEDIATRICS	25	3811		13
14	TO RECLASS NURSING COST	N	RURAL HEALTH CLINIC	63.50	10800		14
15	TO RECLASS NURSING COST	O	ADULTS & PEDIATRICS	25	739		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				84699	817937	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 PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
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 PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	300187					300187		1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	8921558				49140	8872418		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	154060				12046	142014		5
6	MOVABLE EQUIPMENT	4823456	729569		729569	1305144	4247881		6
7	SUBTOTAL	14199261	729569		729569	1366330	13562500		7
8	RECONCILING ITEMS								8
9	TOTAL	14199261	729569		729569	1366330	13562500		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	COMPUTATION OF RATIOS: GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL: INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		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	9014432		9014432	.679703	22427			22427	3
4	NEW CAP REL COSTS-MVBLE EQUIP	4247881		4247881	.320297	10568			10568	4
5	TOTAL	13262313		13262313	1.000000	32995			32995	5

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	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	375869	100963	-100963	22427			398296	3
4	NEW CAP REL COSTS-MVBLE EQUIP	392798	2190		10568			405556	4
5	TOTAL	768667	103153	-100963	32995			803852	5

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	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	375869						375869	3
4	NEW CAP REL COSTS-MVBLE EQUIP	392798						392798	4
5	TOTAL	768667						768667	5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A 7 REF 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	-100963	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	-159092				12
13	SALE OF SCRAP, WASTE, ETC.						13
14	RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1	49179				14
15	LAUNDRY AND LINEN SERVICE						15
16	CAFETERIA - EMPLOYEES AND GUESTS	B	-17875	CAFETERIA	12		16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-1647	MEDICAL SUPPLIES CHARGED TO PAT	55		18
19	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-7275	DRUGS CHARGED TO PATIENTS	56		19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4490	MEDICAL RECORDS & LIBRARY	17		20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						21
22	VENDING MACHINES	A	-6227	DIETARY	11		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 A-8-4		RESPIRATORY THERAPY	49		25
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		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	A		NEW CAP REL COSTS-MVBLE EQUIP	4	9	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 WKST A-8-4		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	OTHER INCOME	B	-5672	ADMINISTRATIVE & GENERAL	6		37
38	OUTSIDE DIETARY SERVICES	B	-290640	DIETARY	11		38
39							39
40							40
41	FITNESS MGMT	B	-5433	PHYSICAL THERAPY	50		41
42	OUTSIDE LAB SERVICES	B	-3888	LABORATORY	44		42
43							43
44	HELIPAD	B	-12500	ADMINISTRATIVE & GENERAL	6		44
45	OTHER REVENUE- RHC	B	-5187	RURAL HEALTH CLINIC	63.50		45
46							46
47	CONTRIBUTIONS	A	-7123	ADMINISTRATIVE & GENERAL	6		47
48	LOBBYING EXPENSE	A	-9130	ADMINISTRATIVE & GENERAL	6		48
49	ADVERTISING EXPENSE	A	-31646	ADMINISTRATIVE & GENERAL	6		49
49.01	MARKETING OTHER EXPENSE	A	-27343	ADMINISTRATIVE & GENERAL	6		49.01
49.02	2009 CRNA EXPENSE	A	-214380	ANESTHESIOLOGY	40		49.02
50	TOTAL		-861332				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. 1	COST CENTER 2	EXPENSE ITEMS 3	AMOUNT OF ALLOWABLE COST 4	AMOUNT (INCL IN WKST A, COL 5) 5	NET ADJUSTMENTS 6	WKST A-7 REF 7	
1	6	ADMINISTRATIVE & GENERAL	ADMINISTRATION & GENERAL	49179		49179		1
2								2
3								3
4								4
5		TOTALS		49179		49179		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) 1	NAME 2	RELATED ORGANIZATION(S) AND/OR HOME OFFICE: PERCENT OF OWNERSHIP 3	NAME 4	PERCENT OF OWNERSHIP 5	TYPE OF BUSINESS 6	
1	B			CITY OF CLINTON	100.00	CITY GOVERNMENT	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-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERATION INCL FRINGES 3	PROFESSIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	PERCENT OF UNADJUSTED RCE LIMIT 9
1	44	LABORATORY		2644		2644				
2	53	ELECTROCARDIOLOGY	AGGREGATE	38336	38336					
3	61	EMERGENCY	AGGREGATE	361141	18438	342703				
4	63.50	RURAL HEALTH CLINIC	AGGREGATE	111057	100257	10800				
5	37	OPERATING ROOM	AGGREGATE	2061	2061					
101		TOTAL		515239	159092	356147				

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A 8 2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS- ALLOWANCE 17	ADJUST- MENT 18
1	44	LABORATORY								
2	53	ELECTROCARDIOLOGY	AGGREGATE							38336
3	61	EMERGENCY	AGGREGATE							18438
4	63.50	RURAL HEALTH CLINIC	AGGREGATE							100257
5	37	OPERATING ROOM	AGGREGATE							2061
101		TOTAL								159092

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS I & II

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	2	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	30	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	2	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		3.75	26.25			9
10	AHSEA		59.78	44.84			10
11	STANDARD TRAVEL ALLOWANCE	29.89	29.89	22.42			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	224	15
16	ASSISTANTS	1177	16
17	SUBTOTAL ALLOWANCE AMOUNT	1401	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	1401	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	46.70	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	1401	22
23	TOTAL SALARY EQUIVALENCY	1401	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS III & IV

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	60	24
25	ASSISTANTS		25
26	SUBTOTAL	60	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	60	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	60	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE	
36	THERAPISTS	36
37	ASSISTANTS	37
38	SUBTOTAL	38
39	STANDARD TRAVEL EXPENSE	39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
40	THERAPISTS	40
41	ASSISTANTS	41
42	SUBTOTAL	42
43	OPTIONAL TRAVEL EXPENSE	43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES	
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	1401	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	60	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	1461	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	772	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	772	66
67	TOTAL COST	772	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS I & II

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	199	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE	179	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	3.45	8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		1957.00	1458.00			9
10	AHSEA		63.07	47.30			10
11	STANDARD TRAVEL ALLOWANCE	31.54	31.54	23.65			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	123428	15
16	ASSISTANTS	68963	16
17	SUBTOTAL ALLOWANCE AMOUNT	192391	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	192391	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	192391	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A 8-4
PARTS III & IV

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	6276	24
25	ASSISTANTS	4233	25
26	SUBTOTAL	10509	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	10509	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	10509	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE	
36	THERAPISTS	36
37	ASSISTANTS	37
38	SUBTOTAL	38
39	STANDARD TRAVEL EXPENSE	39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
40	THERAPISTS	40
41	ASSISTANTS	41
42	SUBTOTAL	42
43	OPTIONAL TRAVEL EXPENSE	43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES	
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	192391	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	10509	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	202900	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	150226	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	150226	66
67	TOTAL COST	150226	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	
	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	398296	398296							3
4	NEW CAP REL COSTS-MVBLE EQUIP	405556		405556						4
5	EMPLOYEE BENEFITS	1743966	2486		1746452					5
6	ADMINISTRATIVE & GENERAL	1794660	55429	82431	298557	2231077	2231077			6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT	528034	71388	4542	47887	651851	134562	786413		8
9	LAUNDRY & LINEN SERVICE	39277	4907		1656	45840	9463	14617	69920	9
10	HOUSEKEEPING	113941	2254		27355	143550	29633	6715		10
11	DIETARY	46249	12836	3349	49003	111437	23004	38235		11
12	CAFETERIA	5194			3295	8489	1752			12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	144225	2813		40264	187302	38665	15379		14
15	CENTRAL SERVICES & SUPPLY	16410	8369	532	3974	29285	6045	24929		15
16	PHARMACY	392702	7137	3712	25296	428847	88527	21262		16
17	MEDICAL RECORDS & LIBRARY	199937	9243	10019	36803	256002	52846	27534		17
18	SOCIAL SERVICE	32865			8835	41700	8608			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	983268	47006	12902	230850	1274026	262997	140027	23264	25
26	INTENSIVE CARE UNIT	28904	3694	10033	4264	46895	9681	11003	936	26
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	328367	28550	48083	75093	480093	99106	85046	8812	37
40	ANESTHESIOLOGY	5012	1065	6962		13039	2692	3172		40
41	RADIOLOGY-DIAGNOSTIC	914295	27051	106472	80011	1127829	232818	80581	12256	41
44	LABORATORY	921274	6281	44389	93577	1065521	219956	18710		44
46	WHOLE BLOOD & PACKED RED BLOOD	3811			1108	4919	1015			46
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
48	INTRAVENOUS THERAPY	5165			1501	6666	1376			48
49	RESPIRATORY THERAPY	179385	2926	2876	41851	227038	46867	8713	2116	49
50	PHYSICAL THERAPY	289740		343	7133	297216	61354		952	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	24790			10106	34896	7204			53
55	MEDICAL SUPPLIES CHARGED TO PAT	308534				308534	63691			55
56	DRUGS CHARGED TO PATIENTS	278428				278428	57476			56
59	CARDIAC REHAB	44437	1701	1778	12390	60306	12449	5067	18	59
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC	739			215	954	197			60
61	EMERGENCY	923029	16714	5930	136296	1081969	223351	49788	13981	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	1111800	40862	4738	297827	1455227	300403	117665	3818	63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES	749131	16184	53537	193777	1012629	209037	26329	3065	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	12961421	368896	402628	1728924	12911565	2204775	694776	69218	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	56666	27176	697	15359	99898	20622	85011	732	98
98.01	LIFELINE	14628	1112		698	16438	3393	850		98.01
98.02	HOME MEDICAL EQUIPMENT	6264	1112	2231	1471	11078	2287	5776		98.02
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	13038979	398296	405556	1746452	13038979	2231077	786413	69920	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10	11	12	14	15	16	17	18	
	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	179898								10
11	DIETARY	8991	181667							11
12	CAFETERIA			10241						12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	3616		213	245175					14
15	CENTRAL SERVICES & SUPPLY	5862		69		66190				15
16	PHARMACY	4999		160		137	543932			16
17	MEDICAL RECORDS & LIBRARY	6474		355		27		343238		17
18	SOCIAL SERVICE			44	1598				51950	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	32925	178288	1517	54837	2634		65750	51213	25
26	INTENSIVE CARE UNIT	2587	3379	22	779	33		279		26
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	19997		1104	39889	2384		3065		37
40	ANESTHESIOLOGY	746				1		279		40
41	RADIOLOGY-DIAGNOSTIC	18948		686		8998		107262		41
44	LABORATORY	4399		778		19981		78287		44
46	WHOLE BLOOD & PACKED RED BLOOD									46
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
48	INTRAVENOUS THERAPY									48
49	RESPIRATORY THERAPY	2050		753		728		2786		49
50	PHYSICAL THERAPY			85		490		836		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY			70		100				53
55	MEDICAL SUPPLIES CHARGED TO PAT					26181				55
56	DRUGS CHARGED TO PATIENTS						543932			56
59	CARDIAC REHAB	1192		71	2556	35				59
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
61	EMERGENCY	11707		989	35737	2079		65750	737	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	27667		1310	47356	1264		2507		63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES	6191		1727	62423	1067		1114		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	158351	181667	9953	245175	66139	543932	327915	51950	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	19989		209				15323		98
98.01	LIFELINE	200		8						98.01
98.02	HOME MEDICAL EQUIPMENT	1358		71		51				98.02
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	179898	181667	10241	245175	66190	543932	343238	51950	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 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	2087478		2087478	25
26	INTENSIVE CARE UNIT	75594		75594	26
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	739496		739496	37
40	ANESTHESIOLOGY	19929		19929	40
41	RADIOLOGY-DIAGNOSTIC	1589378		1589378	41
44	LABORATORY	1407632		1407632	44
46	WHOLE BLOOD & PACKED RED BLOOD	5934		5934	46
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
48	INTRAVENOUS THERAPY	8042		8042	48
49	RESPIRATORY THERAPY	291055		291055	49
50	PHYSICAL THERAPY	360933		360933	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	42270		42270	53
55	MEDICAL SUPPLIES CHARGED TO PAT	398406		398406	55
56	DRUGS CHARGED TO PATIENTS	879836		879836	56
59	CARDIAC REHAB	81694		81694	59
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC	1151		1151	60
61	EMERGENCY	1486088		1486088	61
62	OBSERVATION BEDS (NON-DISTINCT				62
63.50	RURAL HEALTH CLINIC	1957217		1957217	63.50
63.60	FQHC				63.60
	OTHER REIMBURSABLE COST CENTERS				
65	AMBULANCE SERVICES	1323582		1323582	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	12755715		12755715	95
	NONREIMBURSABLE COST CENTERS				
98	PHYSICIANS' PRIVATE OFFICES	241754		241754	98
98.01	LIFELINE	20889		20889	98.01
98.02	HOME MEDICAL EQUIPMENT	20621		20621	98.02
101	CROSS FOOT ADJUSTMENTS				101
102	NEGATIVE COST CENTER				102
103	TOTAL	13038979		13038979	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	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	
	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		2486		2486	2486				5
6	ADMINISTRATIVE & GENERAL		55429	82431	137860	424	138284			6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT		71388	4542	75930	68	8340	84338		8
9	LAUNDRY & LINEN SERVICE		4907		4907	2	587	1568	7064	9
10	HOUSEKEEPING		2254		2254	39	1837	720		10
11	DIETARY		12836	3349	16185	70	1426	4101		11
12	CAFETERIA					5	109			12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION		2813		2813	57	2397	1649		14
15	CENTRAL SERVICES & SUPPLY		8369	532	8901	6	375	2674		15
16	PHARMACY		7137	3712	10849	36	5487	2280		16
17	MEDICAL RECORDS & LIBRARY		9243	10019	19262	52	3276	2953		17
18	SOCIAL SERVICE					13	534			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		47006	12902	59908	329	16301	15016	2350	25
26	INTENSIVE CARE UNIT		3694	10033	13727	6	600	1180	95	26
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		28550	48083	76633	107	6143	9121	890	37
40	ANESTHESIOLOGY		1065	6962	8027		167	340		40
41	RADIOLOGY-DIAGNOSTIC		27051	106472	133523	114	14431	8642	1238	41
44	LABORATORY		6281	44389	50670	133	13633	2007		44
46	WHOLE BLOOD & PACKED RED BLOOD					2	63			46
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
48	INTRAVENOUS THERAPY					2	85			48
49	RESPIRATORY THERAPY		2926	2876	5802	60	2905	935	214	49
50	PHYSICAL THERAPY			343	343	10	3803		96	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY					14	446			53
55	MEDICAL SUPPLIES CHARGED TO PAT						3948			55
56	DRUGS CHARGED TO PATIENTS						3562			56
59	CARDIAC REHAB		1701	1778	3479	18	772	543	2	59
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC						12			60
61	EMERGENCY		16714	5930	22644	194	13844	5339	1412	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC		40862	4738	45600	424	18614	12619	386	63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES		16184	53537	69721	276	12957	2824	310	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		368896	402628	771524	2461	136654	74511	6993	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		27176	697	27873	22	1278	9117	71	98
98.01	LIFELINE		1112		1112	1	210	91		98.01
98.02	HOME MEDICAL EQUIPMENT		1112	2231	3343	2	142	619		98.02
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		398296	405556	803852	2486	138284	84338	7064	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	HOUSE-KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINIS-TRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	
	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	4850								10
11	DIETARY	242	22024							11
12	CAFETERIA			114						12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	97		2	7015					14
15	CENTRAL SERVICES & SUPPLY	158		1		12115				15
16	PHARMACY	135		2		25	18814			16
17	MEDICAL RECORDS & LIBRARY	175		4		5		25727		17
18	SOCIAL SERVICE				46				593	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	887	21614	17	1569	482		4928	585	25
26	INTENSIVE CARE UNIT	70	410		22	6		21		26
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	539		12	1141	436		230		37
40	ANESTHESIOLOGY	20						21		40
41	RADIOLOGY-DIAGNOSTIC	511		8		1647		8038		41
44	LABORATORY	119		9		3657		5868		44
46	WHOLE BLOOD & PACKED RED BLOOD									46
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
48	INTRAVENOUS THERAPY									48
49	RESPIRATORY THERAPY	55		8		133		209		49
50	PHYSICAL THERAPY			1		90		63		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY			1		18				53
55	MEDICAL SUPPLIES CHARGED TO PAT					4794				55
56	DRUGS CHARGED TO PATIENTS						18814			56
59	CARDIAC REHAB	32		1	73	6				59
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
61	EMERGENCY	316		11	1023	381		4928	8	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	746		15	1355	231		188		63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES	167		19	1786	195		84		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	4269	22024	111	7015	12106	18814	24578	593	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	539		2				1149		98
98.01	LIFELINE	5								98.01
98.02	HOME MEDICAL EQUIPMENT	37		1		9				98.02
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	4850	22024	114	7015	12115	18814	25727	593	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 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	123986		123986	25
26	INTENSIVE CARE UNIT	16137		16137	26
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	95252		95252	37
40	ANESTHESIOLOGY	8575		8575	40
41	RADIOLOGY-DIAGNOSTIC	168152		168152	41
44	LABORATORY	76096		76096	44
46	WHOLE BLOOD & PACKED RED BLOOD	65		65	46
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
48	INTRAVENOUS THERAPY	87		87	48
49	RESPIRATORY THERAPY	10321		10321	49
50	PHYSICAL THERAPY	4406		4406	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	479		479	53
55	MEDICAL SUPPLIES CHARGED TO PAT	8742		8742	55
56	DRUGS CHARGED TO PATIENTS	22376		22376	56
59	CARDIAC REHAB	4926		4926	59
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC	12		12	60
61	EMERGENCY	50100		50100	61
62	OBSERVATION BEDS (NON-DISTINCT				62
63.50	RURAL HEALTH CLINIC	80178		80178	63.50
63.60	FQHC				63.60
	OTHER REIMBURSABLE COST CENTERS				
65	AMBULANCE SERVICES	88339		88339	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	758229		758229	95
	NONREIMBURSABLE COST CENTERS				
98	PHYSICIANS' PRIVATE OFFICES	40051		40051	98
98.01	LIFELINE	1419		1419	98.01
98.02	HOME MEDICAL EQUIPMENT	4153		4153	98.02
101	CROSS FOOT ADJUSTMENTS				101
102	NEGATIVE COST CENTER				102
103	TOTAL	803852		803852	103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B 1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	
	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	66964							3
4	NEW CAP REL COSTS-MVBLE EQUIP		398018						4
5	EMPLOYEE BENEFITS	418		6009086					5
6	ADMINISTRATIVE & GENERAL	9319	80899	1027262	-2231077	10807902			6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT	12002	4458	164766		651851	44385		8
9	LAUNDRY & LINEN SERVICE	825		5697		45840	825	68057	9
10	HOUSEKEEPING	379		94120		143550	379		10
11	DIETARY	2158	3287	168605		111437	2158		11
12	CAFETERIA			13336		8489			12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION	473		138538		187302	868		14
15	CENTRAL SERVICES & SUPPLY	1407	522	13672		29285	1407		15
16	PHARMACY	1200	3643	87038		428847	1200		16
17	MEDICAL RECORDS & LIBRARY	1554	9833	126628		256002	1554		17
18	SOCIAL SERVICE			30398		41700			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
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	7903	12662	794295		1274026	7903	22645	25
26	INTENSIVE CARE UNIT	621	9847	14671		46895	621	911	26
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	4800	47189	258374		480093	4800	8577	37
40	ANESTHESIOLOGY	179	6833			13039	179		40
41	RADIOLOGY-DIAGNOSTIC	4548	104490	275296		1127829	4548	11929	41
44	LABORATORY	1056	43564	321976		1065521	1056		44
46	WHOLE BLOOD & PACKED RED BLOO			3811		4919			46
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
48	INTRAVENOUS THERAPY			5165		6666			48
49	RESPIRATORY THERAPY	492	2823	144000		227038	492	2060	49
50	PHYSICAL THERAPY		337	24542		297216		927	50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY			34771		34896			53
55	MEDICAL SUPPLIES CHARGED TO P					308534			55
56	DRUGS CHARGED TO PATIENTS					278428			56
59	CARDIAC REHAB	286	1745	42631		60306	286	18	59
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC			739		954			60
61	EMERGENCY	2810	5820	468959		1081969	2810	13608	61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RURAL HEALTH CLINIC	6870	4650	1024747		1455227	6641	3716	63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES	2721	52542	666738		1012629	1486	2983	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	62021	395144	5948775	-2231077	10680488	39213	67374	95
	NONREIMBURSABLE COST CENTERS								
98	PHYSICIANS' PRIVATE OFFICES	4569	684	52848		99898	4798	683	98
98.01	LIFELINE	187		2400		16438	48		98.01
98.02	HOME MEDICAL EQUIPMENT	187	2190	5063		11078	326		98.02

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	398296	405556	1746452		2231077	786413	69920	103
104	UNIT COST MULT-WS B PT I		1.018939				17.717990		104
104	UNIT COST MULT-WS B PT I	5.947912		.290635		.206430		1.027374	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			2486		138284	84338	7064	107
108	UNIT COST MULT-WS B PT III						1.900146		108
108	UNIT COST MULT-WS B PT III			.000414		.012795		.103795	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	HOUSE-KEEPING SQUARE FEET 10	DIETARY MEALS SERVED 11	CAFETERIA PAID HOURS 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 14	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 15	PHARMACY COSTED REQUIS. 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	SOCIAL SERVICE TIME SPENT 18	
	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	43181								10
11	DIETARY	2158	5161							11
12	CAFETERIA			247641						12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	868		5162	164036					14
15	CENTRAL SERVICES & SUPPLY	1407		1662		723281				15
16	PHARMACY	1200		3858		1492	285703			16
17	MEDICAL RECORDS & LIBRARY	1554		8594		292		1232		17
18	SOCIAL SERVICE			1069	1069				282	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
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	7903	5065	36689	36689	28782		236	278	25
26	INTENSIVE CARE UNIT	621	96	521	521	365		1		26
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	4800		26688	26688	26049		11		37
40	ANESTHESIOLOGY	179				14		1		40
41	RADIOLOGY-DIAGNOSTIC	4548		16599		98322		385		41
44	LABORATORY	1056		18821		218335		281		44
46	WHOLE BLOOD & PACKED RED BLOO									46
46.30	BLOOD CLOTTING FACTORS ADMIN									46.30
48	INTRAVENOUS THERAPY									48
49	RESPIRATORY THERAPY	492		18197		7952		10		49
50	PHYSICAL THERAPY			2057		5356		3		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY			1687		1098				53
55	MEDICAL SUPPLIES CHARGED TO P					286102				55
56	DRUGS CHARGED TO PATIENTS						285703			56
59	CARDIAC REHAB	286		1710	1710	377				59
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
61	EMERGENCY	2810		23910	23910	22720		236	4	61
62	OBSERVATION BEDS (NON-DISTINC									62
63.50	RURAL HEALTH CLINIC	6641		31684	31684	13813		9		63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES	1486		41765	41765	11659		4		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	38009	5161	240673	164036	722728	285703	1177	282	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	4798		5058				55		98
98.01	LIFELINE	48		187						98.01
98.02	HOME MEDICAL EQUIPMENT	326		1723		553				98.02

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B 1

	COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		SQUARE FEET	MEALS SERVED	PAID HOURS	DIRECT NRSING HRS	COSTED REQUIS.	COSTED REQUIS.	TIME SPENT	TIME SPENT	
		10	11	12	14	15	16	17	18	
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	COST TO BE ALLOC PER B PT I	179898	181667	10241	245175	66190	543932	343238	51950	103
104	UNIT COST MULT-WS B PT I	4.166138		.041354		.091514		278.602273		104
104	UNIT COST MULT-WS B PT I		35.199961		1.494641		1.903837		184.219858	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	4850	22024	114	7015	12115	18814	25727	593	107
108	UNIT COST MULT-WS B PT III	.112318		.000460		.016750		20.882305		108
108	UNIT COST MULT-WS B PT III		4.267390		.042765		.065852		2.102837	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
	INPATIENT ROUTINE SERV COST CENTERS	
25	ADULTS & PEDIATRICS	25
26	INTENSIVE CARE UNIT	26
	ANCILLARY SERVICE COST CENTERS	
37	OPERATING ROOM	37
40	ANESTHESIOLOGY	40
41	RADIOLOGY-DIAGNOSTIC	41
44	LABORATORY	44
46	WHOLE BLOOD & PACKED RED BLOO	46
46.30	BLOOD CLOTTING FACTORS ADMIN	46.30
48	INTRAVENOUS THERAPY	48
49	RESPIRATORY THERAPY	49
50	PHYSICAL THERAPY	50
51	OCCUPATIONAL THERAPY	51
52	SPEECH PATHOLOGY	52
53	ELECTROCARDIOLOGY	53
55	MEDICAL SUPPLIES CHARGED TO P	55
56	DRUGS CHARGED TO PATIENTS	56
59	CARDIAC REHAB	59
	OUTPATIENT SERVICE COST CENTERS	
60	CLINIC	60
61	EMERGENCY	61
62	OBSERVATION BEDS (NON-DISTINC	62
63.50	RURAL HEALTH CLINIC	63.50
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	
98	PHYSICIANS' PRIVATE OFFICES	98
98.01	LIFELINE	98.01
98.02	HOME MEDICAL EQUIPMENT	98.02

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-I

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 (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS	2087478					25
26	INTENSIVE CARE UNIT	75594					26
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	739496					37
40	ANESTHESIOLOGY	19929					40
41	RADIOLOGY-DIAGNOSTIC	1589378					41
44	LABORATORY	1407632					44
46	WHOLE BLOOD & PACKED RED BL	5934					46
46.30	BLOOD CLOTTING FACTORS ADMI						46.30
48	INTRAVENOUS THERAPY	8042					48
49	RESPIRATORY THERAPY	291055					49
50	PHYSICAL THERAPY	360933					50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY	42270					53
55	MEDICAL SUPPLIES CHARGED TO	398406					55
56	DRUGS CHARGED TO PATIENTS	879836					56
59	CARDIAC REHAB	81694					59
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC	1151					60
61	EMERGENCY	1486088					61
62	OBSERVATION BEDS (NON-DISTI	289632		289632		289632	62
63.50	RURAL HEALTH CLINIC	1957217					63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES	1323582					65
101	SUBTOTAL	13045347		289632		289632	101
102	LESS OBSERVATION BEDS	289632		289632		289632	102
103	TOTAL	12755715					103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	CHARGES TOTAL 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	948821		948821				25
26	INTENSIVE CARE UNIT	38598		38598				26
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	81702	752942	834644	.886002			37
40	ANESTHESIOLOGY	13945	116149	130094	.153189			40
41	RADIOLOGY-DIAGNOSTIC	490292	3615277	4105569	.387127			41
44	LABORATORY	630092	3212430	3842522	.366330			44
46	WHOLE BLOOD & PACKED RED BL		20064	20064	.295754			46
46.30	BLOOD CLOTTING FACTORS ADMI							46.30
48	INTRAVENOUS THERAPY		106007	106007	.075863			48
49	RESPIRATORY THERAPY	255111	174599	429710	.677329			49
50	PHYSICAL THERAPY	34633	925595	960228	.375883			50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	76239	353145	429384	.098443			53
55	MEDICAL SUPPLIES CHARGED TO	313207	642082	955289	.417053			55
56	DRUGS CHARGED TO PATIENTS	968084	1144542	2112626	.416466			56
59	CARDIAC REHAB	203	46696	46899	1.741913			59
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC		3856	3856	.298496			60
61	EMERGENCY	33995	1857067	1891062	.785848			61
62	OBSERVATION BEDS (NON-DISTI	15283	155737	171020	1.693556	1.693556	1.693556	62
63.50	RURAL HEALTH CLINIC	161335	1227844	1389179	1.408902			63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES	14658	1001091	1015749	1.303060			65
101	SUBTOTAL	4076198	15355123	19431321				101
102	LESS OBSERVATION BEDS							102
103	TOTAL			19431321				103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES					
[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1303)	[ ]	SNF
[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
[ ]	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, PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	PROGRAM CHARGES: OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4	
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	.886002	.886002	.886002				37
40	ANESTHESIOLOGY	.153189	.153189	.153189				40
41	RADIOLOGY-DIAGNOSTIC	.387127	.387127	.387127				41
44	LABORATORY	.366330	.366330	.366330				44
46	WHOLE BLOOD & PACKED RED BLOOD	.295754	.295754	.295754				46
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
48	INTRAVENOUS THERAPY	.075863	.075863	.075863				48
49	RESPIRATORY THERAPY	.677329	.677329	.677329				49
50	PHYSICAL THERAPY	.375883	.375883	.375883				50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	.098443	.098443	.098443				53
55	MEDICAL SUPPLIES CHARGED TO PAT	.417053	.417053	.417053				55
56	DRUGS CHARGED TO PATIENTS	.416466	.416466	.416466				56
59	CARDIAC REHAB	1.741913	1.741913	1.741913				59
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC	.298496	.298496	.298496				60
61	EMERGENCY	.785848	.785848	.785848				61
62	OBSERVATION BEDS (NON-DISTINCT	1.693556	1.693556	1.693556				62
63.50	RURAL HEALTH CLINIC	1.408902	1.408902	1.408902				63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES	1.303060	1.303060	1.303060				65
65.01	AMBULANCE SERVICES (2ND PERIOD)	1.303060	1.303060					65.01
65.02	AMBULANCE SERVICES (3RD PERIOD)	1.303060	1.303060					65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.	1.303060	1.303060					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	
1	DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.416466	1
2	VACCINE CHARGES (OTHER THAN HEPATITIS B)		2
2.01	VACCINE CHARGES - HEPATITIS B		2.01
3	VACCINE COSTS (OTHER THAN HEPATITIS B)		3
3.01	VACCINE COSTS - HEPATITIS B		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES						
	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1303)	[ ]	SNF
	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
			[ ]	SUB III	[ ]	S/B-NF
			[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	PROGRAM CHARGES: ALL OTHER (1) (SEE INSTRU.) 5	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.01	PROGRAM CHARGES: ALL OTHER (SEE INSTRU.) 5.02	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.03	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST: OUTPATIENT AMBULATORY SURGICAL CENTER 6	PROGRAM COST: OUTPATIENT RADIOLOGY 7	PROGRAM COST: OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	149605								37
40	ANESTHESIOLOGY	22783								40
41	RADIOLOGY-DIAGNOSTIC	1452757								41
44	LABORATORY	1236230								44
46	WHOLE BLOOD & PACKED RED BLOOD	16795								46
46.30	BLOOD CLOTTING FACTORS ADMIN C									46.30
48	INTRAVENOUS THERAPY	65774								48
49	RESPIRATORY THERAPY	55604								49
50	PHYSICAL THERAPY	249148								50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	166494								53
55	MEDICAL SUPPLIES CHARGED TO PA	54640								55
56	DRUGS CHARGED TO PATIENTS	454676								56
59	CARDIAC REHAB	28014								59
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC	3800								60
61	EMERGENCY	595984								61
62	OBSERVATION BEDS (NON-DISTINCT	52131								62
63.50	RURAL HEALTH CLINIC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES									65
65.01	AMBULANCE SERVICES (2ND PERIOD									65.01
65.02	AMBULANCE SERVICES (3RD PERIOD									65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56									65.03
101	SUBTOTAL	4604435								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	4604435								104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES						
	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1303)	[ ]	SNF
	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
			[ ]	SUB III	[ ]	S/B-NF
			[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	PROGRAM COST ALL OTHER (COLS 1x5) 9	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.01) 9.01	PROGRAM COST ALL OTHER (COLUMNS 1.01x5.02) 9.02	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.03 9.03	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.04 9.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.) 10	HOSPITAL I/P PART B COST (COLUMNS 1.02x10) 11	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	132550							37
40	ANESTHESIOLOGY	3490							40
41	RADIOLOGY-DIAGNOSTIC	562401							41
44	LABORATORY	452868							44
46	WHOLE BLOOD & PACKED RED BLOOD	4967							46
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
48	INTRAVENOUS THERAPY	4990							48
49	RESPIRATORY THERAPY	37662							49
50	PHYSICAL THERAPY	93650							50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY	16390							53
55	MEDICAL SUPPLIES CHARGED TO PAT	22788							55
56	DRUGS CHARGED TO PATIENTS	189357							56
59	CARDIAC REHAB	48798							59
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC	1134							60
61	EMERGENCY	468353							61
62	OBSERVATION BEDS (NON-DISTINCT	88287							62
63.50	RURAL HEALTH CLINIC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
65.01	AMBULANCE SERVICES (2ND PERIOD)								65.01
65.02	AMBULANCE SERVICES (3RD PERIOD)								65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.								65.03
101	SUBTOTAL	2127685							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	2127685							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) (14-1303)	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)	1564						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1441						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1441						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	82						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	41						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	978						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	82						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	41						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) (14-1303)	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							19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2087478						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							24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26	TOTAL SWING-BED COST	164168						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1923310						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	925100						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	925100						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.079029						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	641.98						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	1923310						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) (14-1303)	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	1334.70					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1305337					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1305337					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
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	75594	32	2362.31	21	49609	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		HOSPITAL (OTHER) (14-1303)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	816853					48
49	TOTAL PROGRAM INPATIENT COSTS	2171799					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

	TARGET AMOUNT AND LIMITATION COMPUTATION	HOSPITAL (OTHER) (14-1303)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
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						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	109445	60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	54723	61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	164168	62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS		65

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

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

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

	HOSPITAL (OTHER) (14-1303)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	217					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1334.71					84
85 OBSERVATION BED COST	289632					85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D 4

[ ] TITLE V
[XX] TITLE XVIII-PT A
[ ] TITLE XIX

[XX] HOSPITAL (14-1303)
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

[ ] SNF
[ ] NF
[ ] S/B-SNF
[ ] S/B-NF
[ ] ICF/MR

[ ] PPS
[ ] TEFRA
[XX] OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		679570		25
26	INTENSIVE CARE UNIT		11238		26
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.886002	22065	19550	37
40	ANESTHESIOLOGY	.153189	4551	697	40
41	RADIOLOGY-DIAGNOSTIC	.387127	321422	124431	41
44	LABORATORY	.366330	470124	172221	44
46	WHOLE BLOOD & PACKED RED BLOOD	.295754			46
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
48	INTRAVENOUS THERAPY	.075863			48
49	RESPIRATORY THERAPY	.677329	176623	119632	49
50	PHYSICAL THERAPY	.375883	16229	6100	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.098443	54973	5412	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.417053	212145	88476	55
56	DRUGS CHARGED TO PATIENTS	.416466	661988	275695	56
59	CARDIAC REHAB	1.741913	116	202	59
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC	.298496			60
61	EMERGENCY	.785848			61
62	OBSERVATION BEDS (NON-DISTINCT	1.693556	2620	4437	62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.408902			63.50
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL		1942856	816853	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		1942856		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V
[XX] TITLE XVIII-PT A
[ ] TITLE XIX

[ ] HOSPITAL
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

[ ] SNF
[ ] NF
[XX] S/B-SNF (14-2303)
[ ] S/B-NF
[ ] ICF/MR

[ ] PPS
[ ] TEFRA
[XX] OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
26	INTENSIVE CARE UNIT				26
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.886002			37
40	ANESTHESIOLOGY	.153189			40
41	RADIOLOGY-DIAGNOSTIC	.387127	3175	1229	41
44	LABORATORY	.366330	21371	7829	44
46	WHOLE BLOOD & PACKED RED BLOOD	.295754			46
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
48	INTRAVENOUS THERAPY	.075863			48
49	RESPIRATORY THERAPY	.677329	15960	10810	49
50	PHYSICAL THERAPY	.375883	15330	5762	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.098443	158	16	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.417053	17172	7162	55
56	DRUGS CHARGED TO PATIENTS	.416466	64899	27028	56
59	CARDIAC REHAB	1.741913			59
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC	.298496			60
61	EMERGENCY	.785848			61
62	OBSERVATION BEDS (NON-DISTINCT	1.693556			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.408902			63.50
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL		138065	59836	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		138065		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1303) 1	HOSPITAL (14-1303) 1.01	HOSPITAL (14-1303) 1.02	
1	MEDICAL AND OTHER SERVICES	2127685			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	2127685			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	2148962			17
17.01	TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1303) 1	HOSPITAL (14-1303) 1.01	HOSPITAL (14-1303) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES	14200			18
18.01	COINSURANCE	673769			18.01
19	SUBTOTAL	1460993			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	1460993			23
24	PRIMARY PAYER PAYMENTS	740			24
25	SUBTOTAL	1460253			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	128875			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	128875			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	106042			27.02
28	SUBTOTAL	1589128			28
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				29
30	OTHER ADJUSTMENTS				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	1589128			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	1588834			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	294			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15 II, SECTION 115.2	30598			36

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1

HOSPITAL (14-1303)

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1749714		1625572	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.		.01			04/24/2009	9243	3.01
	PROGRAM	.02	04/24/2009	229441	04/24/2009	25344	3.02
	TO	.03	04/24/2009	45172			3.03
	PROVIDER	.04					3.04
		.05					3.05
		.50					3.50
	PROVIDER	.51					3.51
	TO	.52					3.52
	PROGRAM	.53					3.53
		.54					3.54
		.57	11/06/2008	8903	11/06/2008	35452	3.57
		.58	04/24/2009	7854	04/24/2009	35673	3.58
SUBTOTAL		.99		257856		-36738	3.99
4 TOTAL INTERIM PAYMENTS				2007570		1588834	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		NONE		NONE	5.02
	PROVIDER	.03					5.03
	PROVIDER	.50					5.50
	TO	.51		NONE		NONE	5.51
	PROGRAM	.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01		10815		294	6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				2018385		1589128	7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1

SWING BED SKILLED NURSING FACILITY (14-Z303)

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				199112			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 TO PROVIDER	.01	12/03/2008	3913			3.01
		.02	04/24/2009	32048			3.02
		.03				NONE	3.03
		.04					3.04
		.05					3.05
		.50					3.50
	PROVIDER TO PROGRAM	.51					3.51
		.52		NONE		NONE	3.52
		.53					3.53
		.54					3.54
SUBTOTAL		.99		35961			3.99
4 TOTAL INTERIM PAYMENTS				235073			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 TO PROVIDER	.01					5.01
		.02		NONE		NONE	5.02
		.03					5.03
	PROVIDER TO PROGRAM	.50					5.50
		.51		NONE		NONE	5.51
		.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01		4088			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				239161			7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

SUPPLEMENTAL
WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

		TITLE V S/B NF	--- TITLE XVIII --- S/B SNF PART A (14-Z303)	S/B SNF PART B	--- TITLE XIX --- S/B SNF (14-Z303)	S/B NF	
		1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		165810				1
2	INPATIENT ROUTINE SERVICES - SWING BED NF						2
3	ANCILLARY SERVICES		60434				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		123				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		226244				8
9	PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL		226244				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		226244				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		6788				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		219456				15
16	OTHER ADJUSTMENTS						16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)		19705				17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		19705				17.01
18	TOTAL		239161				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		235073				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		4088				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		-753				22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL (14-1303)	SUB I	SUB II	SUB III	SUB IV	SNF I	
1	INPATIENT SERVICES	2171799						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	2171799						4
5	PRIMARY PAYER PAYMENTS							5
6	TOTAL COST	2193517						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 (14-1303)	SUB I	SUB II	SUB III	SUB IV	SNF I	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							18
19	COST OF COVERED SERVICES	2193517						19
20	DEDUCTIBLES	198701						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	1994816						22
23	COINSURANCE	299						23
24	SUBTOTAL	1994517						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	23868						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	23868						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)							25.02
26	SUBTOTAL	2018385						26
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION							27
28	OTHER ADJUSTMENTS							28
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS							29
30	SUBTOTAL	2018385						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	2007570						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	10815						33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	-1459						34

BALANCE SHEET

WORKSHEET G

	ASSETS	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1193475				1
2	TEMPORARY INVESTMENTS	1715774				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	4777593				4
5	OTHER RECEIVABLES	236000				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2637720				6
7	INVENTORY	345665				7
8	PREPAID EXPENSES	176911				8
9	OTHER CURRENT ASSETS	147099				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS	5954797				11
	FIXED ASSETS					
12	LAND	300187				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS					13
13.01	ACCUMULATED DEPRECIATION					13.01
14	BUILDINGS	8872418				14
14.01	ACCUMULATED DEPRECIATION	-5579584				14.01
15	LEASEHOLD IMPROVEMENTS					15
15.01	ACCUMULATED AMORTIZATION					15.01
16	FIXED EQUIPMENT					16
16.01	ACCUMULATED DEPRECIATION					16.01
17	AUTOMOBILES AND TRUCKS					17
17.01	ACCUMULATED DEPRECIATION					17.01
18	MAJOR MOVABLE EQUIPMENT	4389894				18
18.01	ACCUMULATED DEPRECIATION	-2878928				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	5103987				21
	OTHER ASSETS					
22	INVESTMENTS	1116517				22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	353030				25
26	TOTAL OTHER ASSETS	1469547				26
27	TOTAL ASSETS	12528331				27

	LIABILITIES AND FUND BALANCES	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	383470				28
29	SALARIES, WAGES & FEES PAYABLE	731659				29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)	213532				31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES	94439				35
36	TOTAL CURRENT LIABILITIES	1423100				36
	LONG TERM LIABILITIES					
37	MORTGAGE PAYABLE					37
38	NOTES PAYABLE	1715000				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					41
42	TOTAL LONG TERM LIABILITIES	1715000				42
43	TOTAL LIABILITIES	3138100				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	9390231				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	9390231				51
52	TOTAL LIABILITIES AND FUND BALANCES	12528331				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	9712556				1
2	NET INCOME (LOSS)	405431				2
3	TOTAL	9307125				3
4	ADDITIONS (CREDIT ADJUSTMENTS)					4
5	CAPITAL GRANTS	83106				5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS	83106				10
11	SUBTOTAL	9390231				11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	9390231				19

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	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	1249627		1249627	1
2	SUBPROVIDER I				2
4	SWING BED - SNF				4
5	SWING BED - NF				5
6	SKILLED NURSING FACILITY				6
7	NURSING FACILITY				7
8	OTHER LONG TERM CARE				8
9	TOTAL GENERAL INPATIENT CARE SERVICES	1249627		1249627	9
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10	INTENSIVE CARE UNIT	38598		38598	10
11	CORONARY CARE UNIT				11
12	BURN INTENSIVE CARE UNIT				12
13	SURGICAL INTENSIVE CARE UNIT				13
14	OTHER SPECIAL CARE (SPECIFY)				14
15	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE	38598		38598	15
16	TOTAL INPATIENT ROUTINE CARE SERVICES	1288225		1288225	16
17	ANCILLARY SERVICES	2954757		2954757	17
18	OUTPATIENT SERVICES		13360190	13360190	18
18.50	RURAL HEALTH CLINIC		1407708	1407708	18.50
18.60	FQHC				18.60
19	HOME HEALTH AGENCY				19
20	AMBULANCE		1015749	1015749	20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24					24
25	TOTAL PATIENT REVENUES	4242982	15783647	20026629	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		13900311	26
27	BAD DEBT EXPENSE			27
28				28
29				29
30				30
31				31
32				32
33	TOTAL ADDITIONS			33
34	DEDUCT (SPECIFY)			34
35	INTEREST EXPENSE	-100963		35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS	-100963		39
40	TOTAL OPERATING EXPENSES		13799348	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	20026629	1
2	LESS CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	7381781	2
3	NET PATIENT REVENUES	12644848	3
4	LESS - TOTAL OPERATING EXPENSES	13799348	4
5	NET INCOME FROM SERVICE TO PATIENTS	-1154500	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	16605	6
7	INCOME FROM INVESTMENTS	119251	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	17875	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	1647	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	7275	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	9677	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	10095	21
22	RENTAL OF HOSPITAL SPACE	15650	22
23	GOVERNMENTAL APPROPRIATIONS	256496	23
24	OTHER DIETARY REVENUE	290641	24
24.01	GRANT REVENUE	64999	24.01
24.02	FITNESS CENTER	5433	24.02
24.03	BODY TRANSPORT FEES	2100	24.03
24.04	HOME MEDICAL EQUIP	5865	24.04
24.05	LIFELINE	17910	24.05
24.06	MISC OTHER	8513	24.06
25	TOTAL OTHER INCOME	850032	25
26	TOTAL	-304468	26
27	INTEREST EXPENSE	100963	27
28			28
29			29
30	TOTAL OTHER EXPENSES	100963	30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-405431	31

RHC I
COMPONENT NO: 14-3404

WORKSHEET M-1

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

CHECK APPLICABLE BOX: [XX] RHC
[ ] 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	613737		613737	-10800	602937	-100257	502680	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	64028		64028		64028		64028	3
4 VISITING NURSE								4
5 OTHER NURSE	186764		186764		186764		186764	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	160218		160218		160218		160218	9
10 SUBTOTAL (SUM OF LINES 1-9)	1024747		1024747	-10800	1013947	-100257	913690	10
COSTS UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT		66479	66479		66479		66479	11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13)		66479	66479		66479		66479	14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		5413	5413		5413		5413	15
16 TRANSPORTATION (HEALTH CARE STAFF)		3937	3937		3937		3937	16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSINAL LIABILITY INSURANCE		48417	48417	-49905	-1488		-1488	18
19 OTHER HEALTH CARE COSTS		41918	41918		41918		41918	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		99685	99685	-49905	49780		49780	21
22 TOTAL COSTS OF HEALTH CARE SERVICES	1024747	166164	1190911	-60705	1130206	-100257	1029949	22
COSTS OTHER THAN RHC/FQHC SERVICES								33
23 PHARMACY								24
24 DENTAL								25
25 OPTOMETRY								26
26 ALL OTHER NONREIMBURSABLE COSTS								27
27 NONALLOWABLE GME COSTS								28
28 TOTAL NONREIMBURSABLE COSTS								
FACILITY OVERHEAD								29
29 FACILITY COSTS		87038	87038		87038	-5187	81851	30
30 ADMINISTRATIVE COSTS		87038	87038		87038	-5187	81851	31
31 TOTAL FACILITY OVERHEAD								
32 TOTAL FACILITY COSTS	1024747	253202	1277949	-60705	1217244	-105444	1111800	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX: [XX] RHC
[ ] 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	2.74	10431	4200	11508		1
2 PHYSICIAN ASSISTANTS			2100			2
3 NURSE PRACTITIONERS	0.57	1561	2100	1197		3
4 SUBTOTAL	3.31	11992		12705	12705	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	3.31	11992			12705	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS		515			515	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES	1029949	10
11 TOTAL NONREIMBURSABLE COSTS		11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)	1029949	12
13 RATIO OF RHC/FQHC SERVICES	1.000000	13
14 TOTAL FACILITY OVERHEAD	81851	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	845417	15
16 TOTAL OVERHEAD	927268	16
17 ALLOWABLE GME OVERHEAD		17
18 SUBTRACT LINE 17 FROM LINE 16	927268	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	927268	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1957217	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES		1957217	1
2	COST OF VACCINES AND THEIR ADMINISTRATION		20666	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE		1936551	3
4	TOTAL VISITS		12705	4
5	PHYSICIANS VISITS UNDER AGREEMENT		515	5
6	TOTAL ADJUSTED VISITS		13220	6
7	ADJUSTED COST PER VISIT		146.49	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2	(SEE INSTR.) 3	
8	PER VISIT PAYMENT LIMIT	132.35	132.35		8
9	RATE FOR PROGRAM COVERED VISITS	146.49	146.49		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	2466	1233		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	361244	180622		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			541866	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			48764	17
18	NET PROGRAM COST EXCLUDING VACCINES			493102	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			394482	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			5193	20
21	TOTAL REIMBURSABLE PROGRAM COST			399675	21
22	REIMBURSABLE BAD DEBTS			19705	22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES				22.01
23	OTHER ADJUSTMENTS				23
24	NET REIMBURSABLE AMOUNT			419380	24
25	INTERIM PAYMENTS			338402	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			80978	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER 1, SECTION 115.2			-1466	27

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK APPLICABLE BOX: { XX } RHC { } FQHC { } TITLE V { XX } TITLE XVIII { } TITLE XIX

		PNEUMOCOCCAL 1	INFLUENZA 2	
1	HEALTH CARE STAFF COSTS	913690	913690	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000130	0.005800	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	119	5299	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	262	5195	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	381	10494	5
6	TOTAL DIRECT COST OF THE FACILITY	1029949	1029949	6
7	TOTAL OVERHEAD	927268	927268	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.000370	0.010189	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	343	9448	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	724	19942	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	8	389	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	90.50	51.26	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	3	96	13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	272	4921	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		20666	15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		5193	16

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

RHC I
COMPONENT NO: 14-3404

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC
[ ] FQHC

DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				304779	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.		.01	04/30/2009	33623	3.01
	PROGRAM TO PROVIDER	.02			3.02
		.03			3.03
		.04			3.04
		.05			3.05
		.50			3.50
	PROVIDER TO PROGRAM	.51			3.51
		.52		NONE	3.52
		.53			3.53
		.54			3.54
SUBTOTAL		.99		33623	3.99
4 TOTAL INTERIM PAYMENTS				338402	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 TO PROVIDER	.01			5.01
		.02		NONE	5.02
		.03			5.03
	PROVIDER TO PROGRAM	.50			5.50
		.51		NONE	5.51
		.52			5.52
SUBTOTAL		.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01		80978	6.01
	PROVIDER TO PROGRAM	.02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				419380	7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

***** REPORT 97 ***** UTILIZATION STATISTICS ***** HOSPITAL

	COST CENTERS	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE XIX INPATIENT 3	TITLE XIX OUTPATIENT 4	TITLE V INPATIENT 5	TITLE V OUTPATIENT 6	TOTAL THIRD PARTY UTIL 7	
UTILIZATION PERCENTAGES BASED ON DAYS									
25	ADULTS & PEDIATRICS	67.87						67.87	25
26	INTENSIVE CARE UNIT	65.63						65.63	26
UTILIZATION PERCENTAGES BASED ON CHARGES									
37	OPERATING ROOM	2.64	17.92					20.56	37
40	ANESTHESIOLOGY	3.50	17.51					21.01	40
41	RADIOLOGY-DIAGNOSTIC	7.83	35.39					43.22	41
44	LABORATORY	12.23	32.17					44.40	44
46	WHOLE BLOOD & PACKED RED BLOOD		83.71					83.71	46
48	INTRAVENOUS THERAPY		62.05					62.05	48
49	RESPIRATORY THERAPY	41.10	12.94					54.04	49
50	PHYSICAL THERAPY	1.69	25.95					27.64	50
53	ELECTROCARDIOLOGY	12.80	38.78					51.58	53
55	MEDICAL SUPPLIES CHARGED TO PAT	22.21	5.72					27.93	55
56	DRUGS CHARGED TO PATIENTS	31.33	21.52					52.85	56
59	CARDIAC REHAB	0.25	59.73					59.98	59
60	CLINIC		98.55					98.55	60
61	EMERGENCY		31.52					31.52	61
62	OBSERVATION BEDS (NON-DISTINCT	1.53	30.48					32.01	62
101	TOTAL CHARGES	10.00	23.70					33.70	101

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	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	398296	3.05	-398296	-6.80			3
4	NEW CAP REL COSTS-MVBLE EQUIP	405556	3.11	-405556	-6.92			4
5	EMPLOYEE BENEFITS	1743966	13.38	-1743966	-29.75			5
6	ADMINISTRATIVE & GENERAL	1794660	13.76	-1794660	-30.62			6
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT	528034	4.05	-528034	-9.01			8
9	LAUNDRY & LINEN SERVICE	39277	.30	-39277	-.67			9
10	HOUSEKEEPING	113941	.87	-113941	-1.94			10
11	DIETARY	46249	.35	-46249	-.79			11
12	CAFETERIA	5194	.04	-5194	-.09			12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION	144225	1.11	-144225	-2.46			14
15	CENTRAL SERVICES & SUPPLY	16410	.13	-16410	-.28			15
16	PHARMACY	392702	3.01	-392702	-6.70			16
17	MEDICAL RECORDS & LIBRARY	199937	1.53	-199937	-3.41			17
18	SOCIAL SERVICE	32865	.25	-32865	-.56			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	983268	7.54	1104210	18.84	2087478	16.01	25
26	INTENSIVE CARE UNIT	28904	.22	46690	.80	75594	.58	26
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	328367	2.52	411129	7.01	739496	5.67	37
40	ANESTHESIOLOGY	5012	.04	14917	.25	19929	.15	40
41	RADIOLOGY-DIAGNOSTIC	914295	7.01	675083	11.52	1589378	12.19	41
44	LABORATORY	921274	7.07	486358	8.30	1407632	10.80	44
46	WHOLE BLOOD & PACKED RED BLOOD	3811	.03	2123	.04	5934	.05	46
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
48	INTRAVENOUS THERAPY	5165	.04	2877	.05	8042	.06	48
49	RESPIRATORY THERAPY	179385	1.38	111670	1.91	291055	2.23	49
50	PHYSICAL THERAPY	289740	2.22	71193	1.21	360933	2.77	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	24790	.19	17480	.30	42270	.32	53
55	MEDICAL SUPPLIES CHARGED TO PAT	308534	2.37	89872	1.53	398406	3.06	55
56	DRUGS CHARGED TO PATIENTS	278428	2.14	601408	10.26	879836	6.75	56
59	CARDIAC REHAB	44437	.34	37257	.64	81694	.63	59
60	CLINIC	739	.01	412	.01	1151	.01	60
61	EMERGENCY	923029	7.08	563059	9.61	1486088	11.40	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RURAL HEALTH CLINIC	1111800	8.53	845417	14.42	1957217	15.01	63.50

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES	749131	5.75	574451	9.80	1323582	10.15	65
	OUTPATIENT SERVICE COST CENTERS							
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
	NONREIMBURSABLE COST CENTERS							
98	PHYSICIANS' PRIVATE OFFICES	56666	.43	185088	3.16	241754	1.85	98
98.01	LIFELINE	14628	.11	6261	.11	20889	.16	98.01
98.02	HOME MEDICAL EQUIPMENT	6264	.05	14357	.24	20621	.16	98.02
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	13038979	100.00	0	.00	13038979	100.00	103

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	2034035
2.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	4355287
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.467