

**MEDICARE COST REPORT**

**COMMUNITY MEMORIAL HOSPITAL**

**Year ended June 30, 2009**



Kerber, Eck & Braeckel LLP

CPAs and  
Management Consultants

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Board of Directors  
Community Memorial Hospital

We have compiled the Hospital and Hospital Health Care Complex Cost Report, Form CMS 2552-96 of Community Memorial Hospital for the year ended June 30, 2009, included in the accompanying prescribed form in accordance with Statements on Standard for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form prescribed by the Centers for Medicare & Medicaid Services information that is the representation of management. We have not audited or reviewed the cost report referred to above and, accordingly; do not express an opinion or any other form of assurance on it.

The Hospital and Hospital Health Care Complex Cost Report, Form CMS 2552-96 is presented in accordance with the requirements of the Centers for Medicare & Medicaid Services, which differ from generally accepted accounting principles. Accordingly, the cost report is not designed for those who are not informed about such differences.

*Kerber, Eck & Braeckel LLP*

St. Louis, Missouri  
November 5, 2009

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Other Locations

Belleville, IL • Carbondale, IL • Springfield, IL • Jacksonville, IL • Cape Girardeau, MO • Milwaukee, WI

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

WORKSHEET 5  
 PARTS I & II

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

PART I - CERTIFICATION

CHECK XX ELECTRONICALLY FILED COST REPORT DATE: 11/05/2009  
 APPLICABLE BOX MANUALLY SUBMITTED COST REPORT TIME: 09:59

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 WERE 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 COMMUNITY MEMORIAL HOSPITAL (14-1306) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2008 AND ENDING 06/30/2009, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

EGR Encryption: 11/05/2009 09:59  
 7:V88NcePYLq2x4Dprana6jUd7hac0  
 za3L6UfawndJanwOABu4tCUtOKLkf  
 N0sn06h8Gc0ZQCpw

(SIGNED)

*[Signature]*  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVII	TITLE XIX
	1	PART A 2	PART B 3
1	HOSPITAL		4
2	SUBPROVIDER 1	263034	
3	SWING BED - SNF		
4	SWING BED - NF	44659	
5	SKILLED NURSING FACILITY		
6	NURSING FACILITY		
7	HOME HEALTH AGENCY	-1	
8	OUTPATIENT REHABILITATION PROVIDER		
9	HEALTH CLINIC		
100	TOTAL	307692	-61162

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 0928-0050. 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: 400 CALDWELL STREET P.O. BOX: 1  
 1.01 CITY: STAUNTON STATE: IL ZIP CODE: 62088-1499 COUNTY: MACOUPIN 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	14-1306	08/01/2000	N	O	P	2
3	SUBPROVIDER I						3
4	SWING BEDS - SNF	COMMUNITY MEMORIAL HOSPITAL - S/B	08/01/2000	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	COMMUNITY MEMORIAL HOSPITAL - HHA	09/16/1978	N	P	N	9
11	SEPARATELY CERTIFIED ASC						11
12	HOSPITAL-BASED HOSPICE						12
14	HOSP-BASED RHC						14
15	OUTPATIENT REHABILITATION PROVID						15
16	RENAL DIALYSIS						16

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 07/01/2008 TO: 06/30/2009 17  
 18 TYPE OF CONTROL 18

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 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 N 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 OR MIPPA 147? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES AND 'N' FOR NO. NO 21.06

21.07 DOES THIS HOSPITAL QUALIFY AS AN SCH WITH UNDER 100 BEDS OR FEWER BEDS UNDER MIPPA 147? ENTER 'Y' FOR YES AND 'N' FOR NO (SEE INSTRUCTIONS). NO 21.07

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. 15-1, 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. 15-1, 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 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 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:		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	12/15/1993		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
<p>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)</p>					
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).	YES			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 (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO			35
<p style="text-align: right;">V            XVIII        XIX</p> <p style="text-align: right;">1            2            3</p>					
PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL					
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	NO	NO	NO	37.01

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.	NO	40
40.01	NAME:	FI/CONTRACTOR'S NAME:	FI/CONTRACTOR'S NUMBER:
40.02	STREET:		P.O. BOX:
40.03	CITY:		STATE: ZIP CODE:
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?	YES	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 NHCMP DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.		46

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

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC		
	1	2	3	4	5		
47	HOSPITAL	Y	Y	N	N	47	
48	SUBPROVIDER I	N	Y	N	N	48	
49	SKILLED NURSING FACILITY	Y	Y			49	
50	HOME HEALTH AGENCY	Y	Y			50	
52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?			NO		52	
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.			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:					54	
	PREMIUMS: 135098	PAID LOSSES:		AND/OR SELF INSURANCE:			
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	FEE\$
			0	1	2	3	4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		/ /	NO	0.00	NO	56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?			NO		57	
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.			NO		58	
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (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:	STATE:	ZIP CODE	CBSA	FTE/ CAMPUS		
	1	2	3	4	5		
SETTLEMENT DATA							
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)		YES	08/31/2009			63





HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I  
 (CONTINUED)

-----DISCHARGES-----						
COMPONENT	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15		
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		298	20	389	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		298	20	389	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

PART II - WAGE DATA		AMOUNT	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	WORKSHEET S-3 PART II
		1	2	3	4	5	6	
1	SALARIES							
1	TOTAL SALARIES	5324526			248748.00			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	1043039	-22957		38987.00			8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR	457528			7639.00			9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'	234200			3134.00			9.03
10	CONTRACT LABOR: PHYSICIAN PART A	625077			7196.00			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)	1056747					CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	250428					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)						CMS 339	19.01
20	INTERNS & RESIDENTS (IN APPR PGM)							20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS							21
22	ADMINISTRATIVE & GENERAL	524902	22957		32451.00			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	147167			6431.00			24
25	LAUNDRY & LINEN SERVICE	18501			2310.00			25
26	HOUSEKEEPING	153733			13458.00			26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	147502	-98525		4322.00			27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA		98525		8674.00			28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	197035			6570.00			30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	140908			9211.00			33
34	SOCIAL SERVICE	53208			1997.00			34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

PART III - HOSPITAL WAGE INDEX SUMMARY		AMOUNT	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	WORKSHEET S-3 PART III
		1	2	3	4	5	6	
1	NET SALARIES	5324526		5324526	248748.00	21.41		1
2	EXCLUDED AREA SALARIES	1043039	-22957	1020082	38987.00	26.16		2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	4281487	22957	4304444	209761.00	20.52		3
4	SUBTOTAL OTHER WAGES & REL COSTS	1316805		1316805	17969.00	73.28		4
5	SUBTOTAL WAGE-RELATED COSTS	1056747		1056747		24.55%		5
6	TOTAL (SUM OF LINES 3 THRU 5)	6655039	22957	6677996	227730.00	29.32		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	1382956	22957	1405913	85424.00	16.46		13

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7166

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		5796		56	5852	1
2 UNDUPLICATED CENSUS COUNT		340.00		106.00	446.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK:	STAFF 1	CONTRACT 2	TOTAL 3	
40.00				
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	.96		.96	3
4 DIRECTORS AND ASSISTANT DIRECTOR(S)				4
5 OTHER ADMINISTRATIVE PERSONNEL	1.74		1.74	5
6 DIRECT NURSING SERVICE	7.08		7.08	6
7 NURSING SUPERVISOR	1.75		1.75	7
8 PHYSICAL THERAPY SERVICE	.98	.23	1.21	8
9 PHYSICAL THERAPY SUPERVISOR				9
10 OCCUPATIONAL THERAPY SERVICE		.02	.02	10
11 OCCUPATIONAL THERAPY SUPERVISOR				11
12 SPEECH PATHOLOGY SERVICE		.07	.07	12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE	.73		.73	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE	2.81		2.81	16
17 HOME HEALTH AIDE SUPERVISOR				17
18 OTHER (SPECIFY)				18

HOME HEALTH AGENCY MSA CODES

19 HOW MANY MSAs IN COLUMN 1 OR CBSAs IN COLUMN 1.01 DID YOU PROVIDE SERVICES TO DURING THIS COST REPORTING PERIOD	1	1.01	2	19
20 LIST THOSE MSA CODE(S) IN COLUMN 1 AND CBSA CODE(S) IN COLUMN 1.01 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE)		99914		20
20.01		41180		20.01

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7166

WORKSHEET S-4  
 (CONTINUED)

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 2000

		FULL EPISODES		LUPA	PEP ONLY	SCIC	SCIC ONLY	TOTAL	
		WITHOUT	WITH	EPISODES	EPISODES	WITHIN	EPISODES		
		1	2	3	4	A PEP	6	7	
21	SKILLED NURSING VISITS	3822		315	54			4191	21
22	SKILLED NURSING VISIT CHARGES	556134		45930	7878			609942	22
23	PHYSICAL THERAPY VISITS	914		4	13			931	23
24	PHYSICAL THERAPY VISIT CHARGES	144651		636	2067			147354	24
25	OCCUPATIONAL THERAPY VISITS	9						9	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	1414						1414	26
27	SPEECH PATHOLOGY VISITS	104						104	27
28	SPEECH PATHOLOGY VISIT CHARGES	17232						17232	28
29	MEDICAL SOCIAL SERVICE VISITS	130		2	2			134	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	25049		379	388			25816	30
31	HOME HEALTH AIDE VISITS	952		4	6			962	31
32	HOME HEALTH AIDE VISIT CHARGES	62832		264	396			63492	32
33	TOTAL VISITS	5931		325	75			6331	33
34	OTHER CHARGES								34
35	TOTAL CHARGES	807312		47209	10729			865250	35
36	TOTAL NUMBER OF EPISODES	531		115	10			656	36
37	TOTAL NUMBER OF OUTLIER EPISODES								37
38	TOTAL MEDICAL SUPPLY CHARGES	33512		877	255			34644	38

NHCMQ DEMONSTRATION STATISTICAL DATA  
 STATISTICAL DATA

WORKSHEET S-7

GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO JANUARY 1		SERVICES ON OR AFTER JANUARY 1		TOTAL
		RATE	DAYS	RATE	DAYS	
1	2	3	3.01	4	4.01	5
1	RVC/RUC					1
2	RVB/RUB					2
3	RVA/RUA					3
3.01	RUX					3.01
3.02	RUL					3.02
4	RHD/RVC					4
5	RHC/RVB					5
6	RHB/RVA					6
6.01	RVX					6.01
6.02	RVL					6.02
7	RHA/RHC					7
8	RMC/RHB					8
9	RMB/RHA					9
9.01	RHX					9.01
9.02	RHL					9.02
10	RMA/RMC					10
11	RLB/RMB					11
12	RLA/RMA					12
12.01	RMX					12.01
12.02	RML					12.02
13	SE3/RLB					13
14	SE2/RLA					14
14.01	RLX					14.01
15	SE1/SE3					15
16	SSC/SE2					16
17	SSB/SE1					17
18	SSA/SSC					18
19	CD2/SSB					19
20	CD1/SSA					20
21	CC2					21
22	CC1					22
23	CB2					23
24	CB1					24
25	CA2					25
26	CA1					26
27	IB2					27
28	IB1					28
29	IA2					29
30	IA1					30
31	BB2					31
32	BB1					32
33	BA2					33
34	BA1					34
35	PE2					35
36	PE1					36
37	PD2					37
38	PD1					38
39	PC2					39
40	PC1					40
41	PB2					41
42	PB1					42
43	PA2					43
44	PA1					44
45	DEFAULT RATE					45
46	TOTAL					46

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		522212	522212	-510502	11710		11710	3
3.01	0301 NEW CAPITAL - BUILDING 1				17806	17806		17806	3.01
3.02	0302 NEW CAPITAL - BUILDING 2				84672	84672		84672	3.02
4	0400 NEW CAP REL COSTS-MVBLE EQUIP				460316	460316	-18025	442291	4
5	0500 EMPLOYEE BENEFITS				1307175	1307175		1307175	5
6	0600 ADMINISTRATIVE & GENERAL	524902	2453114	2978016	-1285408	1692608	-186071	1506537	6
7	0700 MAINTENANCE & REPAIRS								7
8	0800 OPERATION OF PLANT	147167	472606	619773	-42603	577170	-581	576589	8
9	0900 LAUNDRY & LINEN SERVICE	18501	7840	26341		26341		26341	9
10	1000 HOUSEKEEPING	153733	18784	172517		172517		172517	10
11	1100 DIETARY	147502	81400	228902	-152896	76006	-1165	74841	11
12	1200 CAFETERIA				152896	152896	-38683	114213	12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION	197035	7061	204096		204096	-1420	202676	14
15	1500 CENTRAL SERVICES & SUPPLY								15
16	1600 PHARMACY								16
17	1700 MEDICAL RECORDS & LIBRARY	140908	26342	167250		167250	-5226	162024	17
18	1800 SOCIAL SERVICE	53208		53208		53208		53208	18
19	1950 OTHER GENERAL SERVICE COST CENT		24336	24336	-24336				19
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	651864	47490	699354		699354		699354	25
26	2600 INTENSIVE CARE UNIT	288989	21177	310166		310166		310166	26
ANCILLARY SERVICE COST CENTERS									
37	3700 OPERATING ROOM	222705	34402	257107		257107		257107	37
38	3800 RECOVERY ROOM	39763	385	40148		40148		40148	38
40	4000 ANESTHESIOLOGY		251580	251580		251580	-123000	128580	40
41	4100 RADIOLOGY-DIAGNOSTIC	404205	520785	924990		924990	-370	924620	41
44	4400 LABORATORY	461179	616438	1077617		1077617	-58110	1019507	44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
48	4800 INTRAVENOUS THERAPY		10520	10520		10520		10520	48
49	4900 RESPIRATORY THERAPY	146874	146465	293339	-23987	269352	-18182	251170	49
50	5000 PHYSICAL THERAPY	24036	378983	403019		403019		403019	50
51	5100 OCCUPATIONAL THERAPY								51
52	5200 SPEECH PATHOLOGY		8140	8140		8140		8140	52
55	5500 MEDICAL SUPPLIES CHARGED TO PAT	78480	218880	297360	23987	321347	1854	323201	55
56	5600 DRUGS CHARGED TO PATIENTS	146672	927377	1074049		1074049	-973	1073076	56
59	3140 RADIOLOGY	58198	1179	59377		59377	-6690	52687	59
OUTPATIENT SERVICE COST CENTERS									
60	6000 CLINIC	39458	2609	42067		42067	-17425	24642	60
61	6100 EMERGENCY	336108	800615	1136723		1136723	-135840	1000883	61
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 RURAL HEALTH CLINIC								63.50
63.60	6320 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS									
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	708509	145282	853791	-23756	830035	-7000	823035	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		14501	14501	-14501				88
90	9000 OTHER CAPITAL RELATED COSTS		20788	20788	-20788				90
95	SUBTOTALS	4989996	7781291	12771287	-51925	12719362	-616907	12102455	95
NONREIMBURSABLE COST CENTERS									
96	9600 GIFT, FLOWER, COFFEE SHOP & CAN								96
98	9800 PHYSICIANS' PRIVATE OFFICES	334530	85174	419704	49420	469124		469124	98
100	7951 RENTAL PROPERTY				-114	-114		-114	100
100.01	7953 MEDICAL OFFICE BUILDINGS		52980	52980	2619	55599		55599	100.01
101	TOTAL	5324526	7919445	13243971		13243971	-616907	12627064	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE				
		COST CENTER	LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 DEPRECIATION EXPENSE	A	NEW CAPITAL - BUILDING 1	3.01		15623	1
2 DEPRECIATION EXPENSE	A	NEW CAPITAL - BUILDING 2	3.02		76513	2
3 DEPRECIATION EXPENSE	A	HOME HEALTH AGENCY	71		4872	3
4 DEPRECIATION EXPENSE	A	MEDICAL OFFICE BUILDINGS	100.01		2619	4
5 DEPRECIATION EXPENSE	A	OPERATION OF PLANT	8		828	5
6 DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-MVBLE EQUIP	4		411882	6
7 DEPRECIATION EXPENSE	A					7
8 EMPLOYEE BENEFITS	B	EMPLOYEE BENEFITS	5		1307175	8
9 INTEREST EXPENSE	C	NEW CAP REL COSTS-MVBLE EQUIP	4		14501	9
10 EQUIPMENT RENTAL	D	NEW CAP REL COSTS-MVBLE EQUIP	4		24336	10
11 INSURANCE EXPENSE	E					11
12 INSURANCE EXPENSE	E	RENTAL PROPERTY	100		1190	12
13 CAFETERIA EXPENSE	F	CAFETERIA	12	98525	54371	13
14 HOME HEALTH UTILITIES	G	OPERATION OF PLANT	8		5960	14
15 OXYGEN EXPENSE	H	MEDICAL SUPPLIES CHARGED TO P	55		23987	15
16 HHA BILLER SALARY	I	ADMINISTRATIVE & GENERAL	6	22957		16
17 PLANT OPERATION MAINTENANCE	J	PHYSICIANS' PRIVATE OFFICES	98		49420	17
18 MAINTENANCE - BMB	K					18
19 CAPITAL INSURANCE	K	NEW CAP REL COSTS-BLDG & FIXT	3		531	19
20 CAPITAL INSURANCE	K	NEW CAPITAL - BUILDING 1	3.01		2183	20
21 CAPITAL INSURANCE	K	NEW CAPITAL - BUILDING 2	3.02		8159	21
22 CAPITAL INSURANCE	K	HOME HEALTH AGENCY	71		289	22
23 CAPITAL INSURANCE	K	OPERATION OF PLANT	8		29	23
24 CAPITAL INSURANCE	K	NEW CAP REL COSTS-MVBLE EQUIP	4		9597	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				121482	2014065	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		15623	9 1
2 DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		76513	9 2
3 DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		4872	9 3
4 DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		2143	9 4
5 DEPRECIATION EXPENSE	A	RENTAL PROPERTY	100		1304	9 5
6 DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		411882	9 6
7 DEPRECIATION EXPENSE	A					9 7
8 EMPLOYEE BENEFITS	B	ADMINISTRATIVE & GENERAL	6		1307175	8
9 INTEREST EXPENSE	C	INTEREST EXPENSE	88		14501	11 9
10 EQUIPMENT RENTAL	D	OTHER GENERAL SERVICE COST CE	19		24336	10 10
11 INSURANCE EXPENSE	E					11
12 INSURANCE EXPENSE	E	ADMINISTRATIVE & GENERAL	6		1190	12
13 CAFETERIA EXPENSE	F	DIETARY	11	98525	54371	13
14 HOME HEALTH UTILITIES	G	HOME HEALTH AGENCY	71		5960	14
15 OXYGEN EXPENSE	H	RESPIRATORY THERAPY	49		23987	15
16 HHA BILLER SALARY	I	HOME HEALTH AGENCY	71	22957		16
17 PLANT OPERATION MAINTENANCE	J	OPERATION OF PLANT	8		49420	17
18 MAINTENANCE - BMB	K					18
19 CAPITAL INSURANCE	K	OTHER CAPITAL RELATED COSTS	90		531	12 19
20 CAPITAL INSURANCE	K	OTHER CAPITAL RELATED COSTS	90		2183	12 20
21 CAPITAL INSURANCE	K	OTHER CAPITAL RELATED COSTS	90		8159	12 21
22 CAPITAL INSURANCE	K	OTHER CAPITAL RELATED COSTS	90		289	12 22
23 CAPITAL INSURANCE	K	OTHER CAPITAL RELATED COSTS	90		29	12 23
24 CAPITAL INSURANCE	K	OTHER CAPITAL RELATED COSTS	90		9597	12 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				121482	2014065	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 -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
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 -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	335504	140500		140500	102500	373504		1
2 LAND IMPROVEMENTS	312399				74480	237919	126475	2
3 BUILDINGS AND FIXTURES	6133370	51254		51254	1454727	4729897	2800402	3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	146679	38260		38260	22698	162241	101131	5
6 MOVABLE EQUIPMENT	3170622	1022636		1022636	342317	3850941	1397656	6
7 SUBTOTAL	10098574	1252650		1252650	1996722	9354502	4425664	7
8 RECONCILING ITEMS								8
9 TOTAL	10098574	1252650		1252650	1996722	9354502	4425664	9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF		OTHER CAPITAL	TOTAL
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	RELATED COSTS	
	1	2	3	4	5	6	7	8
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT	237919		237919	.026988				3
3.01 NEW CAPITAL - BUILDING 1	4729896		4729896	.536535				3.01
3.02 NEW CAPITAL - BUILDING 2				.000000				3.02
4 NEW CAP REL COSTS-MVBLE EQUIP	3847828		3847828	.436477				4
5 TOTAL	8815643		8815643	1.000000				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	11179			531			11710 3
3.01 NEW CAPITAL - BUILDING 1	15623			2183			17806 3.01
3.02 NEW CAPITAL - BUILDING 2	76513			8159			84672 3.02
4 NEW CAP REL COSTS-MVBLE EQUIP	411882	24336		9597		-3524	442291 4
5 TOTAL	515197	24336		20470		-3524	556479 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	522212						522212 3
3.01 NEW CAPITAL - BUILDING 1							3.01
3.02 NEW CAPITAL - BUILDING 2							3.02
4 NEW CAP REL COSTS-MVBLE EQUIP							4
5 TOTAL	522212						522212 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT	B	-14501	NEW CAP REL COSTS-MVBLE EQUIP	4	11 4
5 INVESTMENT INCOME-OTHER					5
6 TRADE, QUANTITY, AND TIME DISCOUNTS					6
7 REFUNDS AND REBATES OF EXPENSES	B	-24062	ADMINISTRATIVE & GENERAL	6	7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS	B	-16010	CLINIC	60	8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-5389	ADMINISTRATIVE & GENERAL	6	9
10 TELEVISION AND RADIO SERVICE	A	-581	OPERATION OF PLANT	8	10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2	-213547			12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST				
	A-8-1				14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-38683	CAFETERIA	12	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	1854	MEDICAL SUPPLIES CHARGED TO PAT	55	18
19 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-973	DRUGS CHARGED TO PATIENTS	56	19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-2440	MEDICAL RECORDS & LIBRARY	17	20
21 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					21
22 VENDING MACHINES					22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST		HOME HEALTH AGENCY	71	27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION	A-8-3		UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		OCCUPATIONAL THERAPY	51	35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		SPEECH PATHOLOGY	52	36
37 AHA FEES RELATED TO LOBBYING	WKST A-8-4	-424	ADMINISTRATIVE & GENERAL	6	37
38 IHA FEES RELATED TO LOBBYING	A	-6187	ADMINISTRATIVE & GENERAL	6	38
39 TRANSCRIPTION SERVICE	B	-2786	MEDICAL RECORDS & LIBRARY	17	39
40 TELEVISION SATELLITE	A	-3524	NEW CAP REL COSTS-MVBLE EQUIP	4	14 40
41 MISC. OPERATING REVENUE	B	-340	ADMINISTRATIVE & GENERAL	6	41
42 X-RAY FILM COPYING	B	-370	RADIOLOGY-DIAGNOSTIC	41	42
43 INSERVICE EDUCATION	B	-1420	NURSING ADMINISTRATION	14	43
44 CARDIAC REHAB	B	-6690	CARDIOLOGY	59	44
45 DIABETIC CONSULTATION	B	-1165	DIETARY	11	45
46 PUBLIC RELATIONS	B	-170	ADMINISTRATIVE & GENERAL	6	46
47 PUBLIC RELATIONS	A	-24699	ADMINISTRATIVE & GENERAL	6	47
48 HOME HEALTH CONSULTATION	B	-7000	HOME HEALTH AGENCY	71	48
49 TAXES	A	-11689	ADMINISTRATIVE & GENERAL	6	49
49.01 NON-PHYSICIAN ANESTHETIST	A	-123000	ANESTHESIOLOGY	40	49.01
49.02 PROVIDER TAX ASSESSMENT	A	-75123	ADMINISTRATIVE & GENERAL	6	49.02
49.03 PHYSICIAN RECRUITMENT	A	-37988	ADMINISTRATIVE & GENERAL	6	49.03
50 TOTAL		-616907			50

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

WORKSHEET A-8-1

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

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

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

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

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

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

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

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2009.08  
 11/05/2009 09:56

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.	1	2		3	4	5	6	7	8	9
1	44	LABORATORY	AGGREGATE	58110	58110					
2	49	RESPIRATORY THERAPY	AGGREGATE	18182	18182					
3	60	CLINIC	AGGREGATE	1415	1415					
4	61	EMERGENCY	AGGREGATE	760917	135840	625077				
101		TOTAL		838624	213547	625077				



PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
 11/05/2009 09:56

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)								1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK								2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE								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						27		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS								6
7	STANDARD TRAVEL EXPENSE RATE						3.45		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE								8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES			
		1	2	3	4	5			
9	TOTAL HOURS WORKED		32.00						9
10	AHSEA		62.29	46.72					10
11	STANDARD TRAVEL ALLOWANCE	31.15	31.15	23.36					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					1993			15
16	ASSISTANTS								16
17	SUBTOTAL ALLOWANCE AMOUNT					1993			17
18	AIDES								18
19	TRAINEES								19
20	TOTAL ALLOWANCE AMOUNT					1993			20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES								21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES								22
23	TOTAL SALARY EQUIVALENCY					1993			23

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
11/05/2009 09:56

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		24
25	ASSISTANTS		25
26	SUBTOTAL		26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE		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		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	841	36
37	ASSISTANTS		37
38	SUBTOTAL	841	38
39	STANDARD TRAVEL EXPENSE	93	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	934	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
11/05/2009 09:56

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	ASSISTANTS	AIDES	TRAINEES	TOTAL	
	1	2	3	4	5	
47	OVERTIME HOURS WORKED				47	
	DURING REPORTING PERIOD					
48	OVERTIME RATE				48	
49	TOTAL OVERTIME				49	
CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME				50	
	HOURS BY CATEGORY					
51	ALLOCATION OF PROVIDER'S				51	
	STANDARD WORKYEAR FOR ONE					
	FULL TIME EMPLOYEE TIMES					
	THE PERCENTAGES ON LINE 50					
DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY				52	
	EQUIVALENCY AMOUNT					
53	OVERTIME COST LIMITATION				53	
54	MAXIMUM OVERTIME COST				54	
55	PORTION OF OVERTIME ALREADY				55	
	INCLUDED IN HOURLY					
56	COMPUTATION AT THE AHSEA				56	
	OVERTIME ALLOWANCE					
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT						
57	SALARY EQUIVALENCY AMOUNT				1993	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE					58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES				934	59
60	OVERTIME ALLOWANCE					60
61	EQUIPMENT COST					61
62	SUPPLIES					62
63	TOTAL ALLOWANCE				2927	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES				2885	64
65	EXCESS OVER LIMITATION					65

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
11/05/2009 09:56

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		66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	2885	66.31
67	TOTAL COST	2885	67
68	RATIO OF HOSPITAL COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL		68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	1.000000	68.31
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
 11/05/2009 09:56

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					255	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					478	5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					3.45	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		3676.00	3058.00			9
10	AHSEA		65.73	49.30			10
11	STANDARD TRAVEL ALLOWANCE	32.87	32.87	24.65			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					241623	15
16	ASSISTANTS					150759	16
17	SUBTOTAL ALLOWANCE AMOUNT					392382	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					392382	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					392382	23

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
11/05/2009 09:56

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	8382	24
25 ASSISTANTS		25
26 SUBTOTAL	8382	26
27 STANDARD TRAVEL EXPENSE	880	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	9262	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	9262	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	15712	36
37 ASSISTANTS		37
38 SUBTOTAL	15712	38
39 STANDARD TRAVEL EXPENSE	1649	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	17361	44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
 11/05/2009 09:56

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	ASSISTANTS	AIDES	TRAINEES	TOTAL	
	1	2	3	4	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				392382	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE				9262	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES				17361	59
60	OVERTIME ALLOWANCE					60
61	EQUIPMENT COST					61
62	SUPPLIES					62
63	TOTAL ALLOWANCE				419005	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES				397140	64
65	EXCESS OVER LIMITATION					65

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
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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	368700	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	28440	66.31
67	TOTAL COST	397140	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.928388	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.071612	68.31
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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 11/05/2009 09:56

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

WORKSHEET A-8-4  
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					29	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					435	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					54	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					122	5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					3.45	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		268.50				9
10	AHSEA		59.86				10
11	STANDARD TRAVEL ALLOWANCE	29.93	29.93				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					16072	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					16072	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					16072	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					59.86	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					26039	22
23	TOTAL SALARY EQUIVALENCY					26039	23

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
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VERSION: 2009.08  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	1616	24
25	ASSISTANTS		25
26	SUBTOTAL	1616	26
27	STANDARD TRAVEL EXPENSE	186	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	1802	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	1802	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	3651	36
37	ASSISTANTS		37
38	SUBTOTAL	3651	38
39	STANDARD TRAVEL EXPENSE	421	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	4072	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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 11/05/2009 09:56

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 [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					26039	57
58					1802	58
59					4072	59
60						60
61						61
62						62
63					31913	63
64					16419	64
65						65

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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VERSION: 2009.08  
11/05/2009 09:56

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 [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	8140	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	8279	66.31
67	TOTAL COST	16419	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.495767	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.504233	68.31
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	NEW CAP	NEW CAPITA	NEW CAPITA	NEW CAP	EMPLOYEE	SUBTOTAL	ADMINIS-
	FOR COST	BLDGS &	L - BUILDI	L - BUILDI	MOVABLE	BENEFITS		TRATIVE &
	ALLOCATION	FIXTURES	NG 1	NG 2	EQUIPMENT		5A	GENERAL
	0	3	3.01	3.02	4	5		6
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	11710	11710						3
3.01 NEW CAPITAL - BUILDING 1	17806		17806					3.01
3.02 NEW CAPITAL - BUILDING 2	84672			84672				3.02
4 NEW CAP REL COSTS-MVBLE EQUIP	442291				442291			4
5 EMPLOYEE BENEFITS	1307175					1307175		5
6 ADMINISTRATIVE & GENERAL	1506537	1161	3718	3206	44126	134500	1693248	6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT	576589	2726	5189	16942	103622	36130	741198	8
9 LAUNDRY & LINEN SERVICE	26341	236	1000		8964	4542	41083	9
10 HOUSEKEEPING	172517	211	327	1504	8004	37742	220305	10
11 DIETARY	74841	300		3378	11391	12024	101934	11
12 CAFETERIA	114213	211		2382	8032	24188	149026	12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION	202676	117		1317	4443	48372	256925	14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY								16
17 MEDICAL RECORDS & LIBRARY	162024	219	112	2172	8327	34593	207447	17
18 SOCIAL SERVICE	53208	47		530	1786	13063	68634	18
19 OTHER GENERAL SERVICE COST CENT								19
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	699354	1726		19450	65592	160033	946155	25
26 INTENSIVE CARE UNIT	310166	209		2360	7959	70947	391641	26
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	257107	608		6857	23123	54674	342369	37
38 RECOVERY ROOM	40148	140		1576	5313	9762	56939	38
40 ANESTHESIOLOGY	128580	16		182	614		129392	40
41 RADIOLOGY-DIAGNOSTIC	924620	829		9348	31523	99233	1065553	41
44 LABORATORY	1019507	308	1308		11721	113220	1146064	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
48 INTRAVENOUS THERAPY	10520						10520	48
49 RESPIRATORY THERAPY	251170	214		2407	8115	36058	297964	49
50 PHYSICAL THERAPY	403019	387	1643		14723	5901	425673	50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY	8140						8140	52
55 MEDICAL SUPPLIES CHARGED TO PAT	323201	233	987		8841	19267	352529	55
56 DRUGS CHARGED TO PATIENTS	1073076	112		1258	4242	36008	1114696	56
59 CARDIOLOGY	52687	294		3309	11157	14288	81735	59
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC	24642	199		2244	7568	9687	44340	60
61 EMERGENCY	1000883	337		3800	12815	82515	1100350	61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RURAL HEALTH CLINIC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE 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	823035				17860	168301	1009196	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	12102455	10840	14284	84222	429861	1225048	12003056	95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN		40		450			490	96
98 PHYSICIANS' PRIVATE OFFICES	469124	830	3522		12430	82127	568033	98
100 RENTAL PROPERTY	-114						-114	100
100.01 MEDICAL OFFICE BUILDINGS	55599						55599	100.01
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	12627064	11710	17806	84672	442291	1307175	12627064	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	8	9	10	11	12	14	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
3.01 NEW CAPITAL - BUILDING 1									3.01
3.02 NEW CAPITAL - BUILDING 2									3.02
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS									5
6 ADMINISTRATIVE & GENERAL									6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	855981								8
9 LAUNDRY & LINEN SERVICE	27052	74497							9
10 HOUSEKEEPING	24154		278576						10
11 DIETARY	34379		11370	163469					11
12 CAFETERIA	24239		8017		204360				12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	13408		4434		11110	325665			14
15 CENTRAL SERVICES & SUPPLY									15
16 PHARMACY									16
17 MEDICAL RECORDS & LIBRARY	25131		8312		7945		280961		17
18 SOCIAL SERVICE	5390		1783		3000			89436	18
19 OTHER GENERAL SERVICE COST CENT									19
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	197949	58919	65471	129287	36759	134455	13922	70768	25
26 INTENSIVE CARE UNIT	24020	15578	7944	34182	16295	59607	7468	18668	26
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	69785		23080		12558	45936	11185		37
38 RECOVERY ROOM	16036		5304		2242	8202	966		38
40 ANESTHESIOLOGY	1853		613				4920		40
41 RADIOLOGY-DIAGNOSTIC	95135		31465		22792		62940		41
44 LABORATORY	35373		11699		26005		79424		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
48 INTRAVENOUS THERAPY							3115		48
49 RESPIRATORY THERAPY	24491		8100		8282		17890		49
50 PHYSICAL THERAPY	44435		14696		1355		17722		50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY							125		52
55 MEDICAL SUPPLIES CHARGED TO PAT	26681		8824		4425		11156		55
56 DRUGS CHARGED TO PATIENTS	12801		4234		8270		28677		56
59 CARDIOLOGY	33671		11136		3282		1743		59
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC	22841		7554		2225	8139	211		60
61 EMERGENCY	38674		12791		18952	69326	12349		61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RURAL HEALTH CLINIC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE 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	53901		17827						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	851399	74497	264654	163469	185497	325665	273813	89436	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN	4582		1515						96
98 PHYSICIANS' PRIVATE OFFICES			12407		18863		7148		98
100 RENTAL PROPERTY									100
100.01 MEDICAL OFFICE BUILDINGS									100.01
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	855981	74497	278576	163469	204360	325665	280961	89436	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	25	26	27	
GENERAL SERVICE COST CENTERS				
1 OLD CAP REL COSTS-BLDG & FIXT				1
2 OLD CAP REL COSTS-MVBLE EQUIP				2
3 NEW CAP REL COSTS-BLDG & FIXT				3
3.01 NEW CAPITAL - BUILDING 1				3.01
3.02 NEW CAPITAL - BUILDING 2				3.02
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
19 OTHER GENERAL SERVICE COST CENT				19
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	1800208		1800208	25
26 INTENSIVE CARE UNIT	636053		636053	26
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	557933		557933	37
38 RECOVERY ROOM	98507		98507	38
40 ANESTHESIOLOGY	156816		156816	40
41 RADIOLOGY-DIAGNOSTIC	1442899		1442899	41
44 LABORATORY	1476044		1476044	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
48 INTRAVENOUS THERAPY	15264		15264	48
49 RESPIRATORY THERAPY	402870		402870	49
50 PHYSICAL THERAPY	569802		569802	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY	9526		9526	52
55 MEDICAL SUPPLIES CHARGED TO PAT	458208		458208	55
56 DRUGS CHARGED TO PATIENTS	1341302		1341302	56
59 CARDIOLOGY	144225		144225	59
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	92177		92177	60
61 EMERGENCY	1422844		1422844	61
62 OBSERVATION BEDS (NON-DISTINCT)				62
63.50 RURAL HEALTH CLINIC				63.50
63.60 FQHC				63.60
OTHER REIMBURSABLE 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	1237210		1237210	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	11861888		11861888	95
NONREIMBURSABLE COST CENTERS				
96 GIFT, FLOWER, COFFEE SHOP & CAN	6663		6663	96
98 PHYSICIANS' PRIVATE OFFICES	694418		694418	98
100 RENTAL PROPERTY	-114		-114	100
100.01 MEDICAL OFFICE BUILDINGS	64209		64209	100.01
101 CROSS FOOT ADJUSTMENTS				101
102 NEGATIVE COST CENTER				102
103 TOTAL	12627064		12627064	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	DIR ASSGND	NEW CAP	NEW CAPITA	NEW CAPITA	NEW CAP	CAP REL	ADMINIS-	OPERATION
	CAP-REL COSTS 0	BLDGS & FIXTURES 3	L - BUILDI NG 1 3.01	L - BUILDI NG 2 3.02	MOVABLE EQUIPMENT 4	COST TO BE ALLOC 4A	TRATIVE & GENERAL 6	OF PLANT 8
GENERAL SERVICE COST CENTERS								
1								1
2								2
3								3
3.01								3.01
3.02								3.02
4								4
5								5
6		1161	3718	3206	44126	52211	52211	6
7								7
8		2726	5189	16942	103622	128479	3539	132018 8
9		236	1000		8964	10200	196	4172 9
10		211	327	1504	8004	10046	1052	3725 10
11		300		3378	11391	15069	487	5302 11
12		211		2382	8032	10625	712	3738 12
13								13
14		117		1317	4443	5877	1227	2068 14
15								15
16								16
17		219	112	2172	8327	10830	991	3876 17
18		47		530	1786	2363	328	831 18
19								19
20								20
21								21
22								22
23								23
24								24
INPATIENT ROUTINE SERV COST CENTERS								
25		1726		19450	65592	86768	4518	30530 25
26		209		2360	7959	10528	1870	3705 26
ANCILLARY SERVICE COST CENTERS								
37		608		6857	23123	30588	1635	10763 37
38		140		1576	5313	7029	272	2473 38
40		16		182	614	812	618	286 40
41		829		9348	31523	41700	5088	14673 41
44		308	1308		11721	13337	5473	5456 44
46.30								46.30
48							50	48
49		214		2407	8115	10736	1423	3777 49
50		387	1643		14723	16753	2033	6853 50
51								51
52							39	52
55		233	987		8841	10061	1683	4115 55
56		112		1258	4242	5612	5323	1974 56
59		294		3309	11157	14760	390	5193 59
OUTPATIENT SERVICE COST CENTERS								
60		199		2244	7568	10011	212	3523 60
61		337		3800	12815	16952	5254	5965 61
62								62
63.50								63.50
63.60								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10								69.10
69.20								69.20
69.30								69.30
69.40								69.40
71					17860	17860	4819	8313 71
SPECIAL PURPOSE COST CENTERS								
85.01								85.01
85.02								85.02
85.03								85.03
95		10840	14284	84222	429861	539207	49232	131311 95
NONREIMBURSABLE COST CENTERS								
96		40		450		490	2	707 96
98		830	3522		12430	16782	2712	100 98
100								100
100.01							265	100.01
101								101
102								102
103		11710	17806	84672	442291	556479	52211	132018 103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL
	9	10	11	12	14	17	18	
GENERAL SERVICE COST CENTERS								
1								1
2								2
3								3
3.01								3.01
3.02								3.02
4								4
5								5
6								6
7								7
8								8
9	14568							9
10		14823						10
11		605	21463					11
12		427		15502				12
13								13
14		236		843	10251			14
15								15
16								16
17		442		603		16742		17
18		95		228			3845	18
19								19
20								20
21								21
22								22
23								23
24								24
INPATIENT ROUTINE SERV COST CENTERS								
25	11522	3481	16975	2787	4233	830	3042	164686 25
26	3046	423	4488	1236	1876	445	803	28420 26
ANCILLARY SERVICE COST CENTERS								
37		1228		953	1446	667		47280 37
38		282		170	258	58		10542 38
40		33				293		2042 40
41		1674		1729		3752		68616 41
44		623		1972		4727		31588 44
46.30								46.30
48						186		236 48
49		431		628		1066		18061 49
50		782		103		1057		27581 50
51								51
52						7		46 52
55		470		336		665		17330 55
56		225		627		1710		15471 56
59		593		249		104		21289 59
OUTPATIENT SERVICE COST CENTERS								
60		402		169	256	13		14586 60
61		681		1438	2182	736		33208 61
62								62
63.50								63.50
63.60								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10								69.10
69.20								69.20
69.30								69.30
69.40								69.40
71		949						31941 71
SPECIAL PURPOSE COST CENTERS								
85.01								85.01
85.02								85.02
85.03								85.03
95	14568	14082	21463	14071	10251	16316	3845	532923 95
NONREIMBURSABLE COST CENTERS								
96		81						1280 96
98		660		1431		426		22011 98
100								100
100.01								265 100.01
101								101
102								102
103	14568	14823	21463	15502	10251	16742	3845	556479 103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	I&R COST &	TOTAL	
	POST STEP- DOWN ADJS		
	26	27	
GENERAL SERVICE COST CENTERS			
1 OLD CAP REL COSTS-BLDG & FIXT			1
2 OLD CAP REL COSTS-MVBLE EQUIP			2
3 NEW CAP REL COSTS-BLDG & FIXT			3
3.01 NEW CAPITAL - BUILDING 1			3.01
3.02 NEW CAPITAL - BUILDING 2			3.02
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
19 OTHER GENERAL SERVICE COST CENT			19
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	164686		25
26 INTENSIVE CARE UNIT	28420		26
ANCILLARY SERVICE COST CENTERS			
37 OPERATING ROOM	47280		37
38 RECOVERY ROOM	10542		38
40 ANESTHESIOLOGY	2042		40
41 RADIOLOGY-DIAGNOSTIC	68616		41
44 LABORATORY	31588		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO			46.30
48 INTRAVENOUS THERAPY	236		48
49 RESPIRATORY THERAPY	18061		49
50 PHYSICAL THERAPY	27581		50
51 OCCUPATIONAL THERAPY			51
52 SPEECH PATHOLOGY	46		52
55 MEDICAL SUPPLIES CHARGED TO PAT	17330		55
56 DRUGS CHARGED TO PATIENTS	15471		56
59 CARDIOLOGY	21289		59
OUTPATIENT SERVICE COST CENTERS			
60 CLINIC	14586		60
61 EMERGENCY	33208		61
62 OBSERVATION BEDS (NON-DISTINCT)			62
63.50 RURAL HEALTH CLINIC			63.50
63.60 FQHC			63.60
OTHER REIMBURSABLE 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	31941		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	532923		95
NONREIMBURSABLE COST CENTERS			
96 GIFT, FLOWER, COFFEE SHOP & CAN	1280		96
98 PHYSICIANS' PRIVATE OFFICES	22011		98
100 RENTAL PROPERTY			100
100.01 MEDICAL OFFICE BUILDINGS	265		100.01
101 CROSS FOOT ADJUSTMENTS			101
102 NEGATIVE COST CENTER			102
103 TOTAL	556479		103







COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	NURSING	MEDICAL	SOCIAL	
	OF PLANT	& LINEN	KEEPING			ADMINIS-	RECORDS &	SERVICE	
	SQUARE FEE	PATIENT DA	SQUARE FEE	PATIENT DA	GROSS SALA	NURSING SA	GROSS REVE	PATIENT DA	
	T	YS	T	YS	RIES	LARIES	NUE	YS	
	8	9	10	11	12	14	17	18	
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 COST TO BE ALLOC PER B PT I	855981	74497	278576	163469	204360	325665	280961	89436	103
104 UNIT COST MULT-WS B PT I	16.844051		5.570963		.056387		.012799		104
104 UNIT COST MULT-WS B PT I		33.572330		73.667868		.206262		40.232119	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	132018	14568	14823	21463	15502	10251	16742	3845	107
108 UNIT COST MULT-WS B PT III	2.597859		.296430		.004277		.000763		108
108 UNIT COST MULT-WS B PT III		6.565119		9.672375		.006493		1.729645	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
3.01	NEW CAPITAL - BUILDING 1	3.01
3.02	NEW CAPITAL - BUILDING 2	3.02
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
19	OTHER GENERAL SERVICE COST CE	19
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
38	RECOVERY ROOM	38
40	ANESTHESIOLOGY	40
41	RADIOLOGY-DIAGNOSTIC	41
44	LABORATORY	44
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
55	MEDICAL SUPPLIES CHARGED TO P	55
56	DRUGS CHARGED TO PATIENTS	56
59	CARDIOLOGY	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		
69.10	CMHC	69.10
69.20	OUTPATIENT PHYSICAL THERAPY	69.20
69.30	OUTPATIENT OCCUPATIONAL THERA	69.30
69.40	OUTPATIENT SPEECH PATHOLOGY	69.40
71	HOME HEALTH AGENCY	71
SPECIAL PURPOSE COST CENTERS		
85.01	PANCREAS ACQUISITION	85.01
85.02	INTESTINAL ACQUISITION	85.02
85.03	ISLET CELL ACQUISITION	85.03
95	SUBTOTALS	95
NONREIMBURSABLE COST CENTERS		
96	GIFT, FLOWER, COFFEE SHOP & C	96
98	PHYSICIANS' PRIVATE OFFICES	98
100	RENTAL PROPERTY	100
100.01	MEDICAL OFFICE BUILDINGS	100.01

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

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

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 27)	LIMIT ADJUSTMENT				
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	1800208		1800208		1800208	25
26 INTENSIVE CARE UNIT	636053		636053		636053	26
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	557933		557933		557933	37
38 RECOVERY ROOM	98507		98507		98507	38
40 ANESTHESIOLOGY	156816		156816		156816	40
41 RADIOLOGY-DIAGNOSTIC	1442899		1442899		1442899	41
44 LABORATORY	1476044		1476044		1476044	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
48 INTRAVENOUS THERAPY	15264		15264		15264	48
49 RESPIRATORY THERAPY	402870		402870		402870	49
50 PHYSICAL THERAPY	569802		569802		569802	50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY	9526		9526		9526	52
55 MEDICAL SUPPLIES CHARGED TO	458208		458208		458208	55
56 DRUGS CHARGED TO PATIENTS	1341302		1341302		1341302	56
59 CARDIOLOGY	144225		144225		144225	59
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	92177		92177		92177	60
61 EMERGENCY	1422844		1422844		1422844	61
62 OBSERVATION BEDS (NON-DISTI	270048		270048		270048	62
63.50 RURAL HEALTH CLINIC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	10894726		10894726		10894726	101
102 LESS OBSERVATION BEDS	270048		270048		270048	102
103 TOTAL	10624678		10624678		10624678	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	725940		725940			25
26 INTENSIVE CARE UNIT	583477		583477			26
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	116580	757300	873880	.638455	.638455	.638455 37
38 RECOVERY ROOM	12250	63225	75475	1.305161	1.305161	1.305161 38
40 ANESTHESIOLOGY	63354	321084	384438	.407910	.407910	.407910 40
41 RADIOLOGY-DIAGNOSTIC	346992	4570552	4917544	.293419	.293419	.293419 41
44 LABORATORY	807521	5397588	6205109	.237876	.237876	.237876 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
48 INTRAVENOUS THERAPY	153570	89820	243390	.062714	.062714	.062714 48
49 RESPIRATORY THERAPY	462703	935029	1397732	.288231	.288231	.288231 49
50 PHYSICAL THERAPY	97163	1287511	1384674	.411506	.411506	.411506 50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY	4110	5621	9731	.978933	.978933	.978933 52
55 MEDICAL SUPPLIES CHARGED TO	355935	515665	871600	.525709	.525709	.525709 55
56 DRUGS CHARGED TO PATIENTS	552188	1688347	2240535	.598653	.598653	.598653 56
59 CARDIOLOGY	14668	121518	136186	1.059030	1.059030	1.059030 59
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	10	16439	16449	5.603806	5.603806	5.603806 60
61 EMERGENCY	310	964502	964812	1.474737	1.474737	1.474737 61
62 OBSERVATION BEDS (NON-DISTI		361797	361797	.746408	.746408	.746408 62
63.50 RURAL HEALTH CLINIC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	4296771	17095998	21392769			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	4296771	17095998	21392769			103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1306) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			----- PROGRAM CHARGES -----			
	PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4	
37 ANCILLARY SERVICE COST CENTERS							37
38 OPERATING ROOM	.638455	.638455	.638455				38
40 RECOVERY ROOM	1.305161	1.305161	1.305161				40
41 ANESTHESIOLOGY	.407910	.407910	.407910				41
44 RADIOLOGY-DIAGNOSTIC	.293419	.293419	.293419				44
46.30 LABORATORY	.237876	.237876	.237876				46.30
48 BLOOD CLOTTING FACTORS ADMIN CO							48
49 INTRAVENOUS THERAPY	.062714	.062714	.062714				49
50 RESPIRATORY THERAPY	.288231	.288231	.288231				50
51 PHYSICAL THERAPY	.411506	.411506	.411506				51
52 OCCUPATIONAL THERAPY							52
55 SPEECH PATHOLOGY	.978933	.978933	.978933				55
56 MEDICAL SUPPLIES CHARGED TO PAT	.525709	.525709	.525709				56
59 DRUGS CHARGED TO PATIENTS	.598653	.598653	.598653				59
60 RADIOLOGY	1.059030	1.059030	1.059030				60
61 OUTPATIENT SERVICE COST CENTERS							61
62 CLINIC	5.603806	5.603806	5.603806				62
63.50 EMERGENCY	1.474737	1.474737	1.474737				63.50
63.60 OBSERVATION BEDS (NON-DISTINCT)	.746408	.746408	.746408				63.60
65.01 RURAL HEALTH CLINIC							65.01
65.02 FQHC							65.02
65.03 OTHER REIMBURSABLE COST CENTERS							65.03
101 AMBULANCE SERVICES (2ND PERIOD)							101
102 AMBULANCE SERVICES (3RD PERIOD)							102
103 AMBULANCE SERVICES (4TH PERIOD)							103
104 SUBTOTAL							104
105 CRNA CHARGES							105
106 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							106
107 NET CHARGES							107

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	1	
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)	.598653	1
2.01 VACCINE CHARGES - HEPATITIS B		2
3 VACCINE COSTS (OTHER THAN HEPATITIS B)		2.01
3.01 VACCINE COSTS - HEPATITIS B		3
		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1306) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
	ALL OTHER (1)	PPS SER-VICES	ALL OTHER	PPS SER-VICES	PPS SER-VICES	OUTPATIENT AMBULATORY CENTER	OUTPATIENT RADIOLOGY	OUTPATIENT OTHER DIAGNOSTIC
	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	6	7	8
	5	5.01	5.02	5.03	5.04			
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	394360							37
38 RECOVERY ROOM	27768							38
40 ANESTHESIOLOGY	142476							40
41 RADIOLOGY-DIAGNOSTIC	1867991							41
44 LABORATORY	2412940							44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
48 INTRAVENOUS THERAPY	49691							48
49 RESPIRATORY THERAPY	463018							49
50 PHYSICAL THERAPY	466362							50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY	5446							52
55 MEDICAL SUPPLIES CHARGED TO PA	283141							55
56 DRUGS CHARGED TO PATIENTS	1351826							56
59 CARDIOLOGY	105561							59
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC	9546							60
61 EMERGENCY	345699							61
62 OBSERVATION BEDS (NON-DISTINCT	239247							62
63.50 RURAL HEALTH CLINIC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65.01 AMBULANCE SERVICES (2ND PERIOD								65.01
65.02 AMBULANCE SERVICES (3RD PERIOD								65.02
65.03 AMBULANCE SERVICES (4TH PERIOD								65.03
101 SUBTOTAL	8165072							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	8165072							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1306) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL	
	ALL OTHER (COLS 1x5) 9	PPS SERVICES (COLUMNS 1.01x5.01) 9.01	ALL OTHER (COLUMNS 1.01x5.02) 9.02	PPS SERVICES (COLUMNS 1.01x5.03) 9.03	PPS SERVICES (COLUMNS 1.01x5.04) 9.04	I/P PART B CHARGES (SEE INSTRU.) 10	I/P PART B COST (COLUMNS 1.02x10) 11
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	251781						37
38 RECOVERY ROOM	36242						38
40 ANESTHESIOLOGY	58117						40
41 RADIOLOGY-DIAGNOSTIC	548104						41
44 LABORATORY	573981						44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
48 INTRAVENOUS THERAPY	3116						48
49 RESPIRATORY THERAPY	133456						49
50 PHYSICAL THERAPY	191911						50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY	5331						52
55 MEDICAL SUPPLIES CHARGED TO PAT	148850						55
56 DRUGS CHARGED TO PATIENTS	809275						56
59 CARDIOLOGY	111792						59
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC	53494						60
61 EMERGENCY	509815						61
62 OBSERVATION BEDS (NON-DISTINCT)	178576						62
63.50 RURAL HEALTH CLINIC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)							65.03
101 SUBTOTAL	3613841						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	3613841						104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL			
	CAPITAL RELATED COST 1	SWING-BED ADJUSTMENT 2	REDUCED CAPITAL RELATED COST 3	CAPITAL RELATED COST 4	SWING-BED ADJUSTMENT 5	REDUCED CAPITAL RELATED COST 6	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS				164686	50087	114599	25
26 INTENSIVE CARE UNIT				28420		28420	26
27 CORONARY CARE UNIT							27
28 BURN INTENSIVE CARE UNIT							28
29 SURGICAL INTENSIVE CARE UNIT							29
30 OTHER SPECIAL CARE (SPECIFY)							30
31 SUBPROVIDER I							31
33 NURSERY							33
101 TOTAL				193106		143019	101

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL			
	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	PER DIEM 9	INPATIENT PROGRAM CAPITAL COST 10	PER DIEM 11	INPATIENT PROGRAM CAPITAL COST 12	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS	1220	63			93.93	5918	25
26 INTENSIVE CARE UNIT	464	17			61.25	1041	26
27 CORONARY CARE UNIT							27
28 BURN INTENSIVE CARE UNIT							28
29 SURGICAL INTENSIVE CARE UNIT							29
30 OTHER SPECIAL CARE (SPECIFY)							30
31 SUBPROVIDER I							31
33 NURSERY							33
101 TOTAL	1684	80				6959	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-1306) [ ] SUB III [XX] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SUB IV [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [ ] OTHER

COST CENTER DESCRIPTION	OLD	NEW	TOTAL	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----	
	CAPITAL RELATED COST 1	CAPITAL RELATED COST 2			RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		47280	873880			.054104		37
38 RECOVERY ROOM		10542	75475			.139675		38
40 ANESTHESIOLOGY		2042	384438			.005312		40
41 RADIOLOGY-DIAGNOSTIC		68616	4917544			.013953		41
44 LABORATORY		31588	6205109			.005091		44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
48 INTRAVENOUS THERAPY		236	243390			.000970		48
49 RESPIRATORY THERAPY		18061	1397732			.012922		49
50 PHYSICAL THERAPY		27581	1384674			.019919		50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY		46	9731			.004727		52
55 MEDICAL SUPPLIES CHARGED TO P		17330	871600			.019883		55
56 DRUGS CHARGED TO PATIENTS		15471	2240535			.006905		56
59 CARDIOLOGY		21289	136186			.156323		59
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		14586	16449			.886741		60
61 EMERGENCY		33208	964812			.034419		61
62 OBSERVATION BEDS (NON-DISTINC			361797					62
63.50 RURAL HEALTH CLINIC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
101 TOTAL		307876	20083352					101

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
 11/05/2009 09:56

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL COSTS	TOTAL	PER DIEM	INPATIENT	INPATIENT
	ANESTHETIST COST	EDUCATION COST	ADJUSTMENT AMOUNT		PATIENT DAYS		PROGRAM DAYS	PROGRAM PASS THRU COSTS
	1	2	3	4	5	6	7	8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					1220		63	25
26 INTENSIVE CARE UNIT					464		17	26
27 CORONARY CARE UNIT								27
28 BURN INTENSIVE CARE UNIT								28
29 SURGICAL INTENSIVE CARE UNIT								29
30 OTHER SPECIAL CARE (SPECIFY)								30
31 SUBPROVIDER I								31
33 NURSERY								33
34 SKILLED NURSING FACILITY								34
35 NURSING FACILITY								35
101 TOTAL					1684		80	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-1306) [ ] SUB IV [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [ ] NF [ ] OTHER  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
38 RECOVERY ROOM							38
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
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
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
59 CARDIOLOGY							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							
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-1306) [ ] SUB IV [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [ ] NF [ ] OTHER  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	PROGRAM
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		873880					37
38 RECOVERY ROOM		75475					38
40 ANESTHESIOLOGY		384438					40
41 RADIOLOGY-DIAGNOSTIC		4917544					41
44 LABORATORY		6205109					44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
48 INTRAVENOUS THERAPY		243390					48
49 RESPIRATORY THERAPY		1397732					49
50 PHYSICAL THERAPY		1384674					50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY		9731					52
55 MEDICAL SUPPLIES CHARGED TO P		871600					55
56 DRUGS CHARGED TO PATIENTS		2240535					56
59 CARDIOLOGY		136186					59
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		16449					60
61 EMERGENCY		964812					61
62 OBSERVATION BEDS (NON-DISTINC		361797					62
63.50 RURAL HEALTH CLINIC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		20083352					101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1306)	[ ]	SUB IV	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER
			[ ]	SUB III	[ ]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS
	8.01	8.02	9	9.01	9.02
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
38 RECOVERY ROOM					38
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
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
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
59 CARDIOLOGY					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					
101 TOTAL					101

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) (14-1306)	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)	1755					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1220					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	23					3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1197					4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	313					5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	220					6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	2					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)	764					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	313					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	220					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) (14-1306)	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	112.36						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	112.36						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1800208						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	225						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST	547509						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1252699						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	927237						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	13915						29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	913322						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.351002						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE	605.00						32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	763.01						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	1252699						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) (14-1306)	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	1026.80					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	784475					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	784475					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
44 INTENSIVE CARE UNIT	636053	464	1370.80	394	540095	43
45 CORONARY CARE UNIT						44
46 BURN INTENSIVE CARE UNIT						45
47 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-1306)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	727616					48
49 TOTAL PROGRAM INPATIENT COSTS	2052186					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST						52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II (CONT)

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1306)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	1	1	1	1	1	54
54						PROGRAM DISCHARGES
55						TARGET AMOUNT PER DISCHARGE
56						TARGET AMOUNT
57						DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58						BONUS PAYMENT
58.01						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET
58.02						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET
58.03						IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT
58.04						RELIEF PAYMENT
59						ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01						ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)
59.02						PROGRAM DISCHARGES PRIOR TO JULY 1
59.03						PROGRAM DISCHARGES AFTER JULY 1
59.04						PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05						REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1
59.06						REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
59.07						REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)
59.08						REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)
PROGRAM INPATIENT ROUTINE SWING BED COST						
60	321388					MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
61	225896					MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
62	547284					TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65						TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

[ ] TITLE V-INPT

[XX] TITLE XVIII-PART A

[ ] TITLE XIX-INPT

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

SNF

1

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

PROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2008 TO 06/30/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
11/05/2009 09:56

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-1306)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	263	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1026.80	84
85 OBSERVATION BED COST	270048	85

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I

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

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (14-1306)	SUB I	SUB II	SUB III	SUB IV	NF
INPATIENT DAYS	1	1	1	1	1	1
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	1755					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1220					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	23					3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1197					4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	313					5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	220					6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	2					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)	63					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						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						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 [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (14-1306)	SUB I	SUB II	SUB III	SUB IV	NF	
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	112.36						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	112.36						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1800208						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	225						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST	547509						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1252699						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	927237						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	13915						29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	913322						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.351002						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE	605.00						32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	763.01						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	1252699						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (14-1306)	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	1026.80					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	64688					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	64688					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
44 INTENSIVE CARE UNIT	636053	464	1370.80	17	23304	43
45 CORONARY CARE UNIT						44
46 BURN INTENSIVE CARE UNIT						45
47 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (PPS) (14-1306)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST						48
49 TOTAL PROGRAM INPATIENT COSTS	87992					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	6959					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST	6959					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	81033					53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II (CONT)

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (14-1306)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	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						60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						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 [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

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

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

HOSPITAL (PPS) (14-1306)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	263	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1026.80	84
85 OBSERVATION BED COST	270048	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

	COST 1	ROUTINE COST (FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5
86 OLD CAPITAL-RELATED COST		1252699		270048	86
87 NEW CAPITAL-RELATED COST		1252699		270048	87
88 NON PHYSICIAN ANESTHETIST		1252699		270048	88
89 MEDICAL EDUCATION		1252699		270048	89

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-1306)	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		453150		25
26 INTENSIVE CARE UNIT		494666		26
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.638455	77740	49633	37
38 RECOVERY ROOM	1.305161	7492	9778	38
40 ANESTHESIOLOGY	.407910	42756	17441	40
41 RADIOLOGY-DIAGNOSTIC	.293419	265183	77810	41
44 LABORATORY	.237876	569766	135534	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
48 INTRAVENOUS THERAPY	.062714	101865	6388	48
49 RESPIRATORY THERAPY	.288231	303811	87568	49
50 PHYSICAL THERAPY	.411506	23966	9862	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY	.978933	1986	1944	52
55 MEDICAL SUPPLIES CHARGED TO PAT	.525709	232950	122464	55
56 DRUGS CHARGED TO PATIENTS	.598653	337391	201980	56
59 CARDIOLOGY	1.059030	6812	7214	59
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	5.603806			60
61 EMERGENCY	1.474737			61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.746408			62
63.50 RURAL HEALTH CLINIC				63.50
63.60 FQHC				63.60
101 TOTAL		1971718	727616	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		1971718		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input checked="" type="checkbox"/> S/B-SNF (14-Z306)	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
26 INTENSIVE CARE UNIT				26
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.638455			37
38 RECOVERY ROOM	1.305161			38
40 ANESTHESIOLOGY	.407910			40
41 RADIOLOGY-DIAGNOSTIC	.293419	20928	6141	41
44 LABORATORY	.237876	107839	25652	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
48 INTRAVENOUS THERAPY	.062714	19273	1209	48
49 RESPIRATORY THERAPY	.288231	88581	25532	49
50 PHYSICAL THERAPY	.411506	68977	28384	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY	.978933	1998	1956	52
55 MEDICAL SUPPLIES CHARGED TO PAT	.525709	68241	35875	55
56 DRUGS CHARGED TO PATIENTS	.598653	139845	83719	56
59 CARDIOLOGY	1.059030	7156	7578	59
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	5.603806	10	56	60
61 EMERGENCY	1.474737			61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.746408			62
63.50 RURAL HEALTH CLINIC				63.50
63.60 FQHC				63.60
101 TOTAL		522848	216102	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		522848		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-1306)	<input type="checkbox"/> SNF	<input checked="" type="checkbox"/> PPS
<input type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input checked="" type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	3
INPATIENT ROUTINE SERVICE COST CENTERS			
25 ADULTS & PEDIATRICS			25
26 INTENSIVE CARE UNIT			26
ANCILLARY SERVICE COST CENTERS			
37 OPERATING ROOM	.638455		37
38 RECOVERY ROOM	1.305161		38
40 ANESTHESIOLOGY	.407910		40
41 RADIOLOGY-DIAGNOSTIC	.293419		41
44 LABORATORY	.237876		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO			46.30
48 INTRAVENOUS THERAPY	.062714		48
49 RESPIRATORY THERAPY	.288231		49
50 PHYSICAL THERAPY	.411506		50
51 OCCUPATIONAL THERAPY			51
52 SPEECH PATHOLOGY	.978933		52
55 MEDICAL SUPPLIES CHARGED TO PAT	.525709		55
56 DRUGS CHARGED TO PATIENTS	.598653		56
59 CARDIOLOGY	1.059030		59
OUTPATIENT SERVICE COST CENTERS			
60 CLINIC	5.603806		60
61 EMERGENCY	1.474737		61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.746408		62
63.50 RURAL HEALTH CLINIC			63.50
63.60 FQHC			63.60
101 TOTAL			101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			102
103 NET CHARGES			103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL	SUB I	SUB II	SUB III	SUB IV
DRG AMOUNT				
1				1
1.01				1.01
1.02				1.02
1.03				1.03
1.04				1.04
1.05				1.05
1.06				1.06
1.07				1.07
1.08				1.08
2				2
2.01				2.01
3				3
3.01				3.01
3.02				3.02
3.03				3.03
3.04				3.04
3.05				3.05
3.06				3.06
3.07		0.00	0.00	3.07
3.08				3.08
3.09				3.09
3.10				3.10
3.11				3.11
3.12				3.12
3.13				3.13
3.14				3.14
3.15				3.15
3.16				3.16
3.17		0.00		3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A  
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
3.18						3.18
3.19						3.19
3.20						3.20
3.21						3.21
3.22						3.22
3.23						3.23
3.24						3.24
4						4
4.01						4.01
4.02						4.02
4.03						4.03
4.04						4.04
5						5
5.01						5.01
5.02						5.02
5.03						5.03
5.04						5.04
5.05						5.05
5.06						5.06
6						6
7						7
7.01						7.01
8						8
9						9
10						10
11						11
11.01						11.01
11.02						11.02
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
21.01						21.01
21.02						21.02
22						22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A  
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
23						23
	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					
24						24
	OTHER ADJUSTMENTS					
25						25
	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					
26						26
	AMOUNT DUE PROVIDER					
27						27
	SEQUESTRATION ADJUSTMENT					
28						28
	INTERIM PAYMENTS					
28.01						28.01
	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					
29						29
	BALANCE DUE PROVIDER (PROGRAM)					
30						30
	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					
	TO BE COMPLETED BY INTERMEDIARY					
50						50
	OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01					
51						51
	CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01					
52						52
	OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTR.)					
53						53
	CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)					
54						54
	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY					
55						55
	TIME VALUE OF MONEY (SEE INSTRUCTIONS)					
56						56
	CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)					

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1306) 1	HOSPITAL (14-1306) 1.01	HOSPITAL (14-1306) 1.02	
1 MEDICAL AND OTHER SERVICES	3613841			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	3613841			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	3649979			17
17.01 TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1306) 1	HOSPITAL (14-1306) 1.01	HOSPITAL (14-1306) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES	33150		18
18.01 COINSURANCE	1152349		18.01
19 SUBTOTAL	2464480		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	2464480		23
24 PRIMARY PAYER PAYMENTS	462		24
25 SUBTOTAL	2464018		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	110687		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	110687		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			27.02
28 SUBTOTAL	2574705		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
OTHER ADJUSTMENTS			
30 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	2574705		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	2635867		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	-61162		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	57006		36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONILIATION AMOUNT (SEE INSTRUCT			51
52 THE RATE USED TO CALCULATE THE TIME VALUE			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

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

	HOSPITAL (14-1306) OCTOBER 1, 1997 PRIOR TO    ON OR AFTER	
	1            1.01	
1 STANDARD OVERHEAD AMOUNTS (ASC FEES)		1
2 DEDUCTIBLES		2
3 SUBTOTAL		3
4 80 PERCENT OF LINE 3		4
5 ASC PORTION OF BLEND		5
6 OUTPATIENT ASC COST		6
COMPUTATION OF LESSER OF COST OR CHARGES		
7 TOTAL CHARGES		7
CUSTOMARY CHARGES		
8 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		8
9 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)		9
10 RATIO OF LINE 8 TO LINE 9		10
11 TOTAL CUSTOMARY CHARGES		11
12 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		12
13 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		13
14 LESSER OF COST OR CHARGES		14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15 DEDUCTIBLES AND COINSURANCE		15
16 TOTAL		16
17 HOSPITAL SPECIFIC PORTION OF BLEND		17
18 ASC BLENDED AMOUNT		18
19 LESSER OF LINES 16 OR 18		19
20 PART B DEDUCTIBLES AND COINSURANCE		20
21 ASC PAYMENT AMOUNT		21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

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

HOSPITAL  
(14-1306)  
OCTOBER 1, 1997  
PRIOR TO ON OR AFTER  
1 1.01

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

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

HOSPITAL  
(14-1306)  
OCTOBER 1, 1997  
PRIOR TO ON OR AFTER  
1 1.01

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 HOSPITAL (14-1306)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B		
	PART A		PART B		
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1622113		2725184	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.		50112		12365	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	.01				3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .02				3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .03	NONE		NONE	3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .04				3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.05				3.05
	.50	02/24/2009		02/24/2009	3.50
	PROVIDER .51	05/29/2009		05/29/2009	3.51
	TO .52				3.52
	PROGRAM .53				3.53
	.54				3.54
SUBTOTAL	.99	-55387		-101682	3.99
4 TOTAL INTERIM PAYMENTS		1616838		2635867	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY-	PROGRAM .01				5.01
MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH	TO .02	NONE		NONE	5.02
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	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	PROGRAM TO				
(BALANCE DUE) BASED ON THE COST	PROVIDER .01	263034			6.01
REPORT.	PROVIDER TO .02			-61162	6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		1879872		2574705	7
NAME OF INTERMEDIARY: _____			INTERMEDIARY NUMBER: _____		
SIGNATURE OF AUTHORIZED PERSON: _____			DATE (MO/DAY/YR): _____		

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 SWING BED SKILLED NURSING FACILITY (14-Z306)

WORKSHEET E-1

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		665794		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.		4894	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 02/24/2009	34770		3.01
PROGRAM .02 05/29/2009		13681		3.02
TO .03			NONE	3.03
PROVIDER .04				3.04
.05				3.05
.50				3.50
PROVIDER .51				3.51
TO .52		NONE	NONE	3.52
PROGRAM .53				3.53
.54				3.54
SUBTOTAL .99		48451		3.99
4 TOTAL INTERIM PAYMENTS		719139		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 .01	44659		6.01
	PROVIDER TO .02			6.02
	PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY		763798		7

NAME OF INTERMEDIARY: \_\_\_\_\_  
 SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

INTERMEDIARY NUMBER: \_\_\_\_\_  
 DATE (MO/DAY/YR): \_\_\_\_\_

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 SWING BEDS

SUPPLEMENTAL  
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

	TITLE V	--- TITLE XVIII ---		--- TITLE XIX ---		
	S/B NF	S/B SNF	S/B SNF	S/B SNF	S/B NF	
	1	1	2	1	1	
		(14-Z306)		(14-Z306)		
		PART A	PART B			
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		552757			1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF					2
3	ANCILLARY SERVICES		218263			3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					4
5	PROGRAM DAYS		533			5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY					7
8	SUBTOTAL		771020			8
9	PRIMARY PAYER PAYMENTS					9
10	SUBTOTAL		771020			10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)					11
12	SUBTOTAL		771020			12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		7222			13
14	80% OF PART B COSTS					14
15	SUBTOTAL		763798			15
16	OTHER ADJUSTMENTS					16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)					17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES					17.01
18	TOTAL		763798			18
19	SEQUESTRATION ADJUSTMENT					19
20	INTERIM PAYMENTS		719139			20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					20.01
21	BALANCE DUE PROVIDER/PROGRAM		44659			21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		3915			22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1306)	SUB I	SUB II	SUB III	SUB IV	SNF I
1	INPATIENT SERVICES	2052186				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	2052186				4
5	PRIMARY PAYER PAYMENTS					5
6	TOTAL COST	2072708				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 (14-1306)	SUB I	SUB II	SUB III	SUB IV	SNF I
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
18						18
19						19
20	2072708					20
21	217740					21
22						22
23	1854968					23
24						24
25	1854968					25
25.01	24904					25.01
25.02						25.02
26						26
27	1879872					27
28						28
29						29
30						30
31	1879872					31
32						32
32.01	1616838					32.01
33						33
34	263034					34
	17241					

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3  
 PART III

	[ ] TITLE V	[ ] TITLE XVIII	[XX] TITLE XIX				
		HOSPITAL (14-1306) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1
1	INPATIENT HOSPITAL/SNF/NF SERVICES						1
2	MEDICAL AND OTHER SERVICES						2
3	INTERNS AND RESIDENTS						3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O						4
5	COST OF TEACHING PHYSICIANS						5
6	SUBTOTAL						6
7	INPATIENT PRIMARY PAYER PAYMENTS						7
8	OUTPATIENT PRIMARY PAYER PAYMENTS						8
9	SUBTOTAL						9
	COMPUTATION OF LESSER OF COST OR CHARGES						
10	ROUTINE SERVICE CHARGES						10
11	ANCILLARY SERVICE CHARGES						11
12	INTERNS AND RESIDENTS SERVICE CHARGES						12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE						13
14	TEACHING PHYSICIANS						14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION						15
16	TOTAL REASONABLE CHARGES						16
	CUSTOMARY CHARGES						
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						18
19	RATIO OF LINE 17 TO LINE 18						19
20	TOTAL CUSTOMARY CHARGES						20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						22
23	COST OF COVERED SERVICES						23
	PROSPECTIVE PAYMENT AMOUNT						
24	OTHER THAN OUTLIER PAYMENTS						24
25	OUTLIER PAYMENTS						25
26	PROGRAM CAPITAL PAYMENTS						26
27	CAPITAL EXCEPTION PAYMENTS						27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS						28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						29
30	SUBTOTAL						30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED)						31
32	LESSER OF LINES 30 OR 31						32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)						33

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3  
 PART III

	[ ] TITLE V	[ ] TITLE XVIII	[XX] TITLE XIX			
	HOSPITAL (14-1306) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I
	1	1	1	1	1	1
34	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
35	EXCESS OF REASONABLE COST					34
36	SUBTOTAL					35
37	COINSURANCE					36
38	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,					37
38	REIMBURSABLE BAD DEBTS					38
38.01	REDUCED REIMBURSABLE BAD DEBTS					38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)					38.02
39	UTILIZATION REVIEW					39
40	SUBTOTAL					40
41	INPATIENT ROUTINE SERVICE COST					41
42	MEDICARE INPATIENT ROUTINE CHARGES					42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE					43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)					44
45	RATIO OF LINE 43 TO LINE 44					45
46	TOTAL CUSTOMARY CHARGES					46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST					47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES					48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION					49
50	OTHER ADJUSTMENTS					50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS					51
52	SUBTOTAL					52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT					53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS					54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER					55
56	SEQUESTRATION ADJUSTMENT					56
57	INTERIM PAYMENTS					57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					57.01
58	BALANCE DUE PROVIDER/PROGRAM					58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2					59

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	2635837			1
2 TEMPORARY INVESTMENTS	1500000			2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	3830325			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2038489			6
7 INVENTORY	277279			7
8 PREPAID EXPENSES	199460			8
9 OTHER CURRENT ASSETS	194090			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS	6598502			11
FIXED ASSETS				
12 LAND	373504			12
12.01 ACCUMULATED DEPRECIATION				12.01
13 LAND IMPROVEMENTS	237919			13
13.01 ACCUMULATED DEPRECIATION	-168196			13.01
14 BUILDINGS	2688781			14
14.01 ACCUMULATED DEPRECIATION	-2115560			14.01
15 LEASEHOLD IMPROVEMENTS				15
15.01 ACCUMULATED AMORTIZATION				15.01
16 FIXED EQUIPMENT	2041115			16
16.01 ACCUMULATED DEPRECIATION	-1931421			16.01
17 AUTOMOBILES AND TRUCKS				17
17.01 ACCUMULATED DEPRECIATION				17.01
18 MAJOR MOVABLE EQUIPMENT	4013182			18
18.01 ACCUMULATED DEPRECIATION	-2387093			18.01
19 MINOR EQUIPMENT DEPRECIABLE				19
19.01 ACCUMULATED DEPRECIATION				19.01
20 MINOR EQUIPMENT-NONDEPRECIABLE				20
21 TOTAL FIXED ASSETS	2752231			21
OTHER ASSETS				
22 INVESTMENTS	2022409			22
23 DEPOSITS ON LEASES				23
24 DUE FROM OWNERS/OFFICERS				24
25 OTHER ASSETS				25
26 TOTAL OTHER ASSETS	2022409			26
27 TOTAL ASSETS	11373142			27
LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	601391			28
29 SALARIES, WAGES & FEES PAYABLE	569896			29
30 PAYROLL TAXES PAYABLE				30
31 NOTES & LOANS PAYABLE (SHORT TERM)	117371			31
32 DEFERRED INCOME				32
33 ACCELERATED PAYMENTS				33
34 DUE TO OTHER FUNDS				34
35 OTHER CURRENT LIABILITIES				35
36 TOTAL CURRENT LIABILITIES	1288658			36
LONG-TERM LIABILITIES				
37 MORTGAGE PAYABLE	326561			37
38 NOTES PAYABLE				38
39 UNSECURED LOANS				39
40 LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41 OTHER LONG TERM LIABILITIES				41
42 TOTAL LONG TERM LIABILITIES	326561			42
43 TOTAL LIABILITIES	1615219			43
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	9757923			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	9757923			51
52 TOTAL LIABILITIES AND FUND BALANCES	11373142			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	9500386			1
2 NET INCOME (LOSS)	257537			2
3 TOTAL	9757923			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	9757923			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	9757923			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	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	1148917		1148917	2
4 SUBPROVIDER I				4
5 SWING BED - SNF	160500		160500	5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES	1309417		1309417	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE	1309417		1309417	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES	3019716		3019716	18
18.50 ANCILLARY SERVICES		18886854	18886854	18.50
18.60 OUTPATIENT SERVICES				18.60
19 RURAL HEALTH CLINIC				19
20 FQHC				20
21 HOME HEALTH AGENCY		1137565	1137565	21
22 AMBULANCE				22
23 CORF				23
24 ASC				24
25 HOSPICE				25
25 TOTAL PATIENT REVENUES	4329133	20024419	24353552	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		13243971	26
27 BAD DEBT EXPENSE	589276		27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS		589276	33
34 ROUNDING			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		13833247	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	24353552	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	10421862	2
3	NET PATIENT REVENUES	13931690	3
4	LESS - TOTAL OPERATING EXPENSES	13833247	4
5	NET INCOME FROM SERVICE TO PATIENTS	98443	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	31602	6
7	INCOME FROM INVESTMENTS	123666	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	24062	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	38683	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	-881	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	5226	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	61300	22
23	GOVERNMENTAL APPROPRIATIONS	54704	23
24	DIABETIC CONSULTANT	1165	24
24.01	X-RAY FILM COPYING	370	24.01
24.02	INSERVICE EDUCATION	1420	24.02
24.03	CARDIAC REHAB	6690	24.03
24.04	PUBIC RELATIONS	170	24.04
24.05	LOSS ON DISPOSAL OF ASSETS	-199625	24.05
24.06	MISCELLANEOUS	3539	24.06
24.07	HOME HEALTH CONSULTANT	7000	24.07
24.08	ROUNDING	3	24.08
25	TOTAL OTHER INCOME	159094	25
26	TOTAL	257537	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	257537	31

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7166

WORKSHEET H

	SALARIES	EMPLOYEE	TRANS-	CONTRACTED/	OTHER	TOTAL HHA	
	1	BENEFITS	PORTATION	PURCH SVCS	COSTS	COST	
		2	3	4	5	6	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDG & FIXTURES					5161	5161	1
2 CAPITAL RELATED-MOVABLE EQUIPMENT							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION			69393			69393	4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	94432				7029	101461	5
6 SKILLED NURSING CARE	450205					450205	6
7 PHYSICAL THERAPY	42496			28440		70936	7
8 OCCUPATIONAL THERAPY				2885		2885	8
9 SPEECH PATHOLOGY				8279		8279	9
10 MEDICAL SOCIAL SERVICES	31125					31125	10
11 HOME HEALTH AIDE	67295					67295	11
12 SUPPLIES					16295	16295	12
13 DRUGS							13
13.20 COST OF ADMINISTERING VACCINES							13.20
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING							17
18 CLINIC							18
19 HEALTH PROMOTION ACTIVITIES							19
20 DAY CARE PROGRAM							20
21 HOME DELIVERED MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL	685553		69393	39604	28485	823035	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7166

WORKSHEET H  
 (CONTINUED)

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10	
1					1
2		5161		5161	2
3					3
4		69393		69393	4
5		101461		101461	5
6		450205		450205	6
7		70936		70936	7
8		2885		2885	8
9		8279		8279	9
10		31125		31125	10
11		67295		67295	11
12		16295		16295	12
13					13
13.20					13.20
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
23.50					23.50
24		823035		823035	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7166

WORKSHEET H-4  
 PART I

	NET EXPENSES FOR COST ALLOCATION 0	CAP REL BLDGS & FIXTURES 1	CAP REL MOVABLE EQUIPMENT 2	PLANT OPERATN & MAINT 3	TRANSPORT- ATION 4	SUBTOTAL 4A	ADMIN & GENERAL 5	TOTAL 6
GENERAL SERVICE COST CENTER								
1 CAPITAL RELATED-BLDG & FIXT	5161	5161						1
2 CAPITAL RELATED-MOVABLE EQUIP								2
3 PLANT OPERATION & MAINTENANCE		5161		5161				3
4 TRANSPORTATION	69393				69393			4
5 ADMINISTRATIVE AND GENERAL	101461			5161		106622	106622	5
HHA REIMBURSABLE SERVICES								
6 SKILLED NURSING CARE	450205				46460	496665	73918	570583
7 PHYSICAL THERAPY	70936				11004	81940	12195	94135
8 OCCUPATIONAL THERAPY	2885				176	3061	456	3517
9 SPEECH PATHOLOGY	8279				1559	9838	1464	11302
10 MEDICAL SOCIAL SERVICES	31125				1318	32443	4828	37271
11 HOME HEALTH AIDE	67295				8876	76171	11336	87507
12 SUPPLIES	16295					16295	2425	18720
13 DRUGS								13
13.20 COST OF ADMINISTERING VACCINES								13.20
14 DME								14
HHA NONREIMBURSABLE SERVICES								
15 HOME DIALYSIS AIDE SERVICES								15
16 RESPIRATORY THERAPY								16
17 PRIVATE DUTY NURSING								17
18 CLINIC								18
19 HEALTH PROMOTION ACTIVITIES								19
20 DAY CARE PROGRAM								20
21 HOME DELIVERED MEALS PROGRAM								21
22 HOMEMAKER SERVICE								22
23 ALL OTHERS								23
23.50 TELEMEDICINE								23.50
24 TOTAL	823035	5161		5161	69393	823035		823035

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7166

WORKSHEET H-4  
 PART II

	CAP REL BLDGS & FIXTURES (SQUARE FEET) 1	CAP REL MOVABLE EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
1							1
2	3200						2
3			3200				3
4				69393			4
5			3200		-106622	716413	5
6				46460		496665	6
7				11004		81940	7
8				176		3061	8
9				1559		9838	9
10				1318		32443	10
11				8876		76171	11
12						16295	12
13							13
13.20							13.20
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
23.50							23.50
24	3200		3200	69393	-106622	716413	24
25	5161		5161	69393		106622	25
26	1.612813		1.612813	1.000000		.148828	26









ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7166

WORKSHEET H-5  
PART I

HHA COST CENTER	TOTAL HHA COSTS 29	
1 ADMINISTRATIVE AND GENERAL		1
2 SKILLED NURSING CARE	870390	2
3 PHYSICAL THERAPY	133629	3
4 OCCUPATIONAL THERAPY	4495	4
5 SPEECH PATHOLOGY	14443	5
6 MEDICAL SOCIAL SERVICES	57393	6
7 HOME HEALTH AIDE	132938	7
8 SUPPLIES	23922	8
9 DRUGS		9
9.20 COST OF ADMINISTERING VACC		9.20
10 DME		10
11 HOME DIALYSIS AIDE SERVICE		11
12 RESPIRATORY THERAPY		12
13 PRIVATE DUTY NURSING		13
14 CLINIC		14
15 HEALTH PROMOTION ACTIVITIE		15
16 DAY CARE PROGRAM		16
17 HOME DELIVERED MEALS PROGR		17
18 HOMEMAKER SERVICE		18
19 ALL OTHERS		19
19.50 TELEMEDICINE		19.50
20 TOTALS	1237210	20
21 UNIT COST MULTIPLIER		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7166

WORKSHEET H-5  
 PART II

HHA COST CENTER	OLD CAP BLDGS & FIXTURES NO ASSIGNM ENT	OLD CAP MOVABLE EQUIPMENT NO ASSIGNM ENT	NEW CAP BLDGS & FIXTURES SQUARE FEE T	NEW CAPITA L - BUILDI NG 1 SQUARE FEE T	NEW CAPITA L - BUILDI NG 2 SQUARE FEE T	NEW CAP MOVABLE EQUIPMENT SQUARE FEE T	EMPLOYEE BENEFITS GROSS SALA RIES	RECON- CILLIATION
	1	2	3	3.01	3.02	4	5	6A
1 ADMINISTRATIVE AND GENERAL						3200	94430	1
2 SKILLED NURSING CARE							450205	2
3 PHYSICAL THERAPY							42496	3
4 OCCUPATIONAL THERAPY								4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES							31125	6
7 HOME HEALTH AIDE							67295	7
8 SUPPLIES								8
9 DRUGS								9
9.20 COST OF ADMINISTERING VACC								9.20
10 DME								10
11 HOME DIALYSIS AIDE SERVICE								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIE								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGR								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTALS						3200	685551	20
21 TOTAL COST TO BE ALLOCATED						17860	168301	21
22 UNIT COST MULTIPLIER							.245497	22
22 UNIT COST MULTIPLIER						5.581250		22





ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7166

WORKSHEET H-5  
 PART II

HHA COST CENTER	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	
	22	23	24	
1 ADMINISTRATIVE AND GENERAL				1
2 SKILLED NURSING CARE				2
3 PHYSICAL THERAPY				3
4 OCCUPATIONAL THERAPY				4
5 SPEECH PATHOLOGY				5
6 MEDICAL SOCIAL SERVICES				6
7 HOME HEALTH AIDE				7
8 SUPPLIES				8
9 DRUGS				9
9.20 COST OF ADMINISTERING VACC				9.20
10 DME				10
11 HOME DIALYSIS AIDE SERVICE				11
12 RESPIRATORY THERAPY				12
13 PRIVATE DUTY NURSING				13
14 CLINIC				14
15 HEALTH PROMOTION ACTIVITIE				15
16 DAY CARE PROGRAM				16
17 HOME DELIVERED MEALS PROGR				17
18 HOMEMAKER SERVICE				18
19 ALL OTHERS				19
19.50 TELEMEDICINE				19.50
20 TOTALS				20
21 TOTAL COST TO BE ALLOCATED				21
22 UNIT COST MULTIPLIER				22
22 UNIT COST MULTIPLIER				22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7166

WORKSHEET H-6  
 PARTS I & II

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

PART I - APPORTIONMENT OF HHA COST CENTERS: COMPUTATION OF THE LESSER OF AGGREGATE PROGRAM COST OR THE AGGREGATE OF THE PROGRAM LIMITATION

COST PER VISIT COMPUTATION		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	AVERAGE	
PATIENT SERVICES		WKST H-5, PART I, COL 29, LINE	COSTS	ANCILLARY COSTS	COSTS	VISITS	COST PER VISIT	
		2	1	2	3	4	5	
1	SKILLED NURSING CARE	2	870390		870390	5565	156.40	1
2	PHYSICAL THERAPY	3	133629		133629	1105	120.93	2
3	OCCUPATIONAL THERAPY	4	4495		4495	20	224.75	3
4	SPEECH PATHOLOGY	5	14443		14443	123	117.42	4
5	MEDICAL SOCIAL SERV	6	57393		57393	134	428.31	5
6	HOME HEALTH AIDE SERV	7	132938		132938	962	138.19	6
7	TOTAL		1213288		1213288	7909		7
LIMITATION COST COMPUTATION			MSA				PROGRAM	
PATIENT SERVICES			NO.				COST	
			1	2	3	4	LIMITS	
8	SKILLED NURSING CARE							8
9	PHYSICAL THERAPY							9
10	OCCUPATIONAL THERAPY							10
11	SPEECH PATHOLOGY							11
12	MEDICAL SOCIAL SERV							12
13	HOME HEALTH AIDE SERV							13
14	TOTAL							14
SUPPLIES AND DRUGS COST COMPUTATIONS		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	RATIO	
OTHER PATIENT SERVICES		WKST H-5, PART I, COL 29, LINE	COSTS	ANCILLARY COSTS	COSTS	CHARGES		
		8	1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	23922		23922	38389	.623147	15
16	COST OF DRUGS	9				875		16
16.20	COST OF ADMINISTERING VACCINES	9.20						16.20
PER BENEFICIARY COST LIMITATION:						MSA	AMOUNT	
						NO.		
						1	2	
17	PROGRAM UNDUPLICATED CENSUS FROM WORKSHEET S-4							17
18	PER BENEFICIARY COST LIMITATION							18
19	PER BENEFICIARY COST LIMITATION							19



APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7166

WORKSHEET H-6  
 PARTS II & III

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

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

	FROM WKST C, PART I, COL 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES	HHA SHARED ANCILLARY COSTS	TRANSFER TO PART I	
	1	2	3	4	5	
1	PHYSICAL THERAPY 50	.411506			COL 2, LINE 2	1
2	OCCUPATIONAL THERAPY 51				COL 2, LINE 3	2
3	SPEECH PATHOLOGY 52	.978933			COL 2, LINE 4	3
4	MEDICAL SUPPLIES CHARGED TO PA 55	.525709			COL 2, LINE 15	4
5	DRUGS CHARGED TO PATIENTS 56	.598653			COL 2, LINE 16	5

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE  
 PROGRAM VISITS PROGRAM COST PROGRAM

	FROM PART I COL. 5	COST PER VISIT	PRIOR TO 1/1/98	FROM 1/1/98 THRU 12/31/98	PRIOR TO 1/1/98	FROM 1/1/98 THRU 12/31/98	VISITS ON OR AFTER 1/1/99	
	1	2	3	4	5	6	7	
1	PHYSICAL THERAPY	120.93	2.01	3	3.01	4	5	1
2	OCCUPATIONAL THERAPY	224.75						2
3	SPEECH PATHOLOGY	117.42						3
4	TOTAL							4

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 14-7166

WORKSHEET H-7  
 PARTS I & II

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

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

DESCRIPTION	PART A 1	----- PART B -----		
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
1 REASONABLE COST OF PROGRAM SERVICES				1
2 REASONABLE COST OF SERVICES				2
3 TOTAL CHARGES	421667		478227	3
CUSTOMARY CHARGES				
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				4
5 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(B)				5
6 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				6
7 TOTAL CUSTOMARY CHARGES				7
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST				8
9 EXCESS OF TOTAL REASONABLE COST OVER TOTAL CUSTOMARY CHARGES				9
10 PRIMARY PAYOR PAYMENTS				10

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10.01 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	475650	566071	10.01
10.02 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.02
10.03 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	10700	20920	10.03
10.04 TOTAL PPS REIMBURSEMENT - PEP EPISODES	3677	3575	10.04
10.05 TOTAL PPS REIMBURSEMENT - SCIC WITHIN A PEP EPISODES			10.05
10.06 TOTAL PPS REIMBURSEMENT - SCIC EPISODES			10.06
10.07 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.07
10.08 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			10.08
10.09 TOTAL PPS OUTLIER REIMBURSEMENT - SCIC WITHIN A PEP EPISODES			10.09
10.10 TOTAL PPS OUTLIER REIMBURSEMENT - SCIC EPISODES			10.10
10.11 TOTAL OTHER PAYMENTS			10.11
10.12 DME PAYMENTS			10.12
10.13 OXYGEN PAYMENTS			10.13
10.14 PROSTHETIC AND ORTHOTIC PAYMENTS			10.14
11 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCL COINSURANCE)			11
12 SUBTOTAL	490027	590566	12
13 EXCESS REASONABLE COST			13
14 SUBTOTAL	490027	590566	14
15 COINSURANCE BILLED TO PROGRAM PATIENTS			15
16 NET COST	490027	590566	16
17 REIMBURSABLE BAD DEBTS			17
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			17.01
18 TOTAL COSTS - CURRENT COST REPORTING PERIOD	490027	590566	18
19 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			19
20 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR OR DECREASE IN PROGRAM UTILIZATION			20
21 OTHER ADJUSTMENTS (SPECIFY):			21
22 SUBTOTAL	490027	590566	22
23 SEQUESTRATION ADJUSTMENT			23
24 SUBTOTAL	490027	590566	24
25 TOTAL INTERIM PAYMENTS	490028	590566	25
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26 BALANCE DUE PROVIDER/PROGRAM	-1		26
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			27

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S  
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7166

WORKSHEET H-8

DESCRIPTION	PART A		PART B		
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		490028		590566	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					3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .01				3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .02				3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .03	NONE		NONE	3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROVIDER .04				3.05
	TO .05				3.50
	PROGRAM .50				3.51
	PROVIDER .51				3.52
	TO .52	NONE		NONE	3.53
	PROGRAM .53				3.54
	.54				
SUBTOTAL	.99				3.99
4 TOTAL INTERIM PAYMENTS		490028		590566	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY-	PROGRAM .01				5.01
MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH	TO .02	NONE		NONE	5.02
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	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	PROGRAM TO				
(BALANCE DUE) BASED ON THE COST	PROVIDER .01				6.01
REPORT.	PROVIDER TO .02	-1			6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		490027		590566	7

NAME OF INTERMEDIARY: \_\_\_\_\_  
 SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

INTERMEDIARY NUMBER: \_\_\_\_\_  
 DATE (MO/DAY/YR): \_\_\_\_\_

CALCULATION OF CAPITAL PAYMENT - TITLE XIX - COST METHOD

WORKSHEET L

	HOSPITAL (14-1306)	HOSPITAL (14-1306)	SUB I	SUB II	SUB III
	1	1.01			
PART I - FULLY PROSPECTIVE METHOD					
1					1
2					2
3					3
3.01					3.01
4					4
4.01					4.01
4.02					4.02
4.03					4.03
5					5
5.01					5.01
5.02					5.02
5.03					5.03
5.04					5.04
6					6
PART II - HOLD HARMLESS METHOD					
1					1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
PART III - PAYMENT UNDER REASONABLE COST					
1					1
2					2
3					3
4					4
5					5
PART IV - COMPUTATION OF EXCEPTION PAYMENTS					
1					1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL 4A	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
3.01	NEW CAPITAL - BUILDING 1				3.01
3.02	NEW CAPITAL - BUILDING 2				3.02
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
19	OTHER GENERAL SERVICE COST CENT				19
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				25
26	INTENSIVE CARE UNIT				26
ANCILLARY SERVICE COST CENTERS					
37	OPERATING ROOM				37
38	RECOVERY ROOM				38
40	ANESTHESIOLOGY				40
41	RADIOLOGY-DIAGNOSTIC				41
44	LABORATORY				44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
48	INTRAVENOUS THERAPY				48
49	RESPIRATORY THERAPY				49
50	PHYSICAL THERAPY				50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
55	MEDICAL SUPPLIES CHARGED TO PAT				55
56	DRUGS CHARGED TO PATIENTS				56
59	CARDIOLOGY				59
OUTPATIENT SERVICE COST CENTERS					
60	CLINIC				60
61	EMERGENCY				61
62	OBSERVATION BEDS (NON-DISTINCT				62
63.50	RURAL HEALTH CLINIC				63.50
63.60	FQHC				63.60
OTHER REIMBURSABLE 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
95	SUBTOTALS				95
NONREIMBURSABLE COST CENTERS					
96	GIFT, FLOWER, COFFEE SHOP & CAN				96
98	PHYSICIANS' PRIVATE OFFICES				98
00	RENTAL PROPERTY				00
00.01	MEDICAL OFFICE BUILDINGS				00.01
101	CROSS FOOT ADJUSTMENTS				101
102	NEGATIVE COST CENTER				102
103	TOTAL				103
104	TOTAL STATISTICAL BASIS				104
105	UNIT COST MULTIPLIER				105
105	UNIT COST MULTIPLIER				105

\*\*\*\*\* REPORT 97 \*\*\*\*\* UTILIZATION STATISTICS \*\*\*\*\*

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
25 ADULTS & PEDIATRICS	62.62		5.16				67.78 25
26 INTENSIVE CARE UNIT	84.91		3.66				88.57 26
UTILIZATION PERCENTAGES BASED ON CHARGES							
37 OPERATING ROOM	8.90	45.13					54.03 37
38 RECOVERY ROOM	9.93	36.79					46.72 38
40 ANESTHESIOLOGY	11.12	37.06					48.18 40
41 RADIOLOGY-DIAGNOSTIC	5.39	37.99					43.38 41
44 LABORATORY	9.18	38.89					48.07 44
48 INTRAVENOUS THERAPY	41.85	20.42					62.27 48
49 RESPIRATORY THERAPY	21.74	33.13					54.87 49
50 PHYSICAL THERAPY	1.73	33.68					35.41 50
52 SPEECH PATHOLOGY	20.41	55.97					76.38 52
55 MEDICAL SUPPLIES CHARGED TO PAT	26.73	32.49					59.22 55
56 DRUGS CHARGED TO PATIENTS	15.06	60.33					75.39 56
59 CARDIOLOGY	5.00	77.51					82.51 59
60 CLINIC		58.03					58.03 60
61 EMERGENCY		35.83					35.83 61
62 OBSERVATION BEDS (NON-DISTINCT)		66.13					66.13 62
101 TOTAL CHARGES	9.22	38.17					47.39 101

COST CENTER	---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
	AMOUNT	%	AMOUNT	%	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	11710	.09	-11710	-.25			3
3.01 NEW CAPITAL - BUILDING 1	17806	.14	-17806	-.37			3.01
3.02 NEW CAPITAL - BUILDING 2	84672	.67	-84672	-1.78			3.02
4 NEW CAP REL COSTS-MVBLE EQUIP	442291	3.50	-442291	-9.31			4
5 EMPLOYEE BENEFITS	1307175	10.35	-1307175	-27.50			5
6 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	1506537	11.93	-1506537	-31.70			6
7 OPERATION OF PLANT	576589	4.57	-576589	-12.13			7
8 LAUNDRY & LINEN SERVICE	26341	.21	-26341	-.55			8
9 HOUSEKEEPING	172517	1.37	-172517	-3.63			9
10 DIETARY	74841	.59	-74841	-1.57			10
11 CAFETERIA	114213	.90	-114213	-2.40			11
12 MAINTENANCE OF PERSONNEL							12
13 NURSING ADMINISTRATION	202676	1.61	-202676	-4.26			13
14 CENTRAL SERVICES & SUPPLY							14
15 PHARMACY							15
16 MEDICAL RECORDS & LIBRARY	162024	1.28	-162024	-3.41			16
17 SOCIAL SERVICE	53208	.42	-53208	-1.12			17
18 OTHER GENERAL SERVICE COST CENT							18
19 NONPHYSICIAN ANESTHETISTS							19
20 NURSING SCHOOL							20
21 I&R SERVICES-SALARY & FRINGES A							21
22 I&R SERVICES-OTHER PRGM COSTS A							22
23 PARAMED ED PRGM-(SPECIFY)							23
24 INPATIENT ROUTINE SERV COST CENTERS							24
25 ADULTS & PEDIATRICS	699354	5.54	1100854	23.16	1800208	14.26	25
26 INTENSIVE CARE UNIT	310166	2.46	325887	6.86	636053	5.04	26
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	257107	2.04	300826	6.33	557933	4.42	37
38 RECOVERY ROOM	40148	.32	58359	1.23	98507	.78	38
40 ANESTHESIOLOGY	128580	1.02	28236	.59	156816	1.24	40
41 RADIOLOGY-DIAGNOSTIC	924620	7.32	518279	10.91	1442899	11.43	41
44 LABORATORY	1019507	8.07	456537	9.61	1476044	11.69	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
48 INTRAVENOUS THERAPY	10520	.08	4744	.10	15264	.12	48
49 RESPIRATORY THERAPY	251170	1.99	151700	3.19	402870	3.19	49
50 PHYSICAL THERAPY	403019	3.19	166783	3.51	569802	4.51	50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY	8140	.06	1386	.03	9526	.08	52
55 MEDICAL SUPPLIES CHARGED TO PAT	323201	2.56	135007	2.84	458208	3.63	55
56 DRUGS CHARGED TO PATIENTS	1073076	8.50	268226	5.64	1341302	10.62	56
59 CARDIOLOGY	52687	.42	91538	1.93	144225	1.14	59
60 CLINIC	24642	.20	67535	1.42	92177	.73	60
61 EMERGENCY	1000883	7.93	421961	8.88	1422844	11.27	61

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
62 OBSERVATION BEDS (NON-DISTINCT							62
63.50 RURAL HEALTH CLINIC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
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	823035	6.52	414175	8.71	1237210	9.80	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							
96 GIFT, FLOWER, COFFEE SHOP & CAN			6663	.14	6663	.05	96
98 PHYSICIANS' PRIVATE OFFICES	469124	3.72	225294	4.74	694418	5.50	98
100 RENTAL PROPERTY	-114				-114		100
100.01 MEDICAL OFFICE BUILDINGS	55599	.44	8610	.18	64209	.51	100.01
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 TOTAL	12627064	100.00	0	.00	12627064	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 OPPTS. (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)	3416599
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (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)	7693264
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.444