

MEDICARE COST ANALYSIS
MARSHALL BROWNING HOSPITAL
DUQUOIN, ILLINOIS
YEAR ENDED JUNE 30, 2010

Wisconsin Physicians Services
Medicare Part A
PO Box 1604
Omaha, NE 68101

Dear Sir or Madam

The cost report of Marshall Browning Hospital for the year ended June 30, 2010 includes three Level 2000 Errors.

The 2070S error reads if S-2, Col, Line 45 = 'Y', Providers should insure that proper documentation has been submitted to their fiscal intermediary in accordance with CMS Pub 15-I, Section 2313

The 2070S refers to a change in housekeeping statistical basis which approval has granted by WPS. See letter from WPS dated April 9, 2010 and included as an attachment to the CMS 339.

The remaining two errors are each a 2027 error which reads that Wkst C, Part I, Col 11 should not be more than 100% or less than .1%. The error is listed two separate times once each for:

Line 37.00 - Operating Room
Line 63.50 RHC

Marshall Browning Hospital is a rural Illinois Critical Access Hospital. In order to provide the needed services in line 37.00 and 63.50 to the rural area the Hospital incurs cost in excess of the amount it is able to bill for patient volume.

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

WORKSHEET S
 PARTS I & II

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

PART I - CERTIFICATION

CHECK XX ELECTRONICALLY FILED COST REPORT DATE: 11/10/2010
 APPLICABLE BOX ___ MANUALLY SUBMITTED COST REPORT TIME: 13:36

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY MARSHALL BROWNING HOSPITAL (14-1331) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2009 AND ENDING 06/30/2010, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/10/2010 13:36
 1Y5bn0AzulEIK:s5OgwnI9IJIjFqkH0
 jmcDo0gJgHhc0J.Vm06camQzBpLJ08
 wReS0VJFOG0R6Xdt

(SIGNED)

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

PI Encryption: 11/10/2010 13:36
 jFUKNx5Q3lvazoawtqN5x42rH.Ltq0
 1e5Gm03Ey.nHB1kLmHFXIAEQJJrsm
 pMtB7wglCY0j4w8P

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	2	3	4	1
2	SUBPROVIDER I	237548	67521		2
3	SWING BED - SNF	248369			3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY				5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	OUTPATIENT REHABILITATION PROVIDER				8
9	RURAL HEALTH CLINIC I		107770		9
100	TOTAL	485917	175291		100

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 900 NORTH WASHINGTON STREET P.O.BOX: 1
 1.01 CITY: DUQUOIN STATE: IL ZIP CODE: 62832 COUNTY: PERRY 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 XVIII XIX				
				4	5	6		
2	HOSPITAL	MARSHALL BROWNING HOSPITAL	14-1331	01/01/2004	N	O	P	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	MARSHALL BROWNING SWING BED	14-2331	01/01/2004	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA							9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC	MARSHALL BROWNING PHYSICIAN CLINIC	14-8504	05/01/2009	N	O	N	14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16
17	COST REPORTING PERIOD (MM/DD/YYYY)		FROM: 07/01/2009	TO: 06/30/2010				17
18	TYPE OF CONTROL		1	2				18

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL			1				19
20	SUBPROVIDER I							20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.							21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 'Y' OR 'N' FOR NO.							21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.							21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy) (SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.			2		Y	99914	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 100 OR FEWER BEDS UNDER MIPPA 147? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS). IS THIS AN SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS).			NO		NO		21.07
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS? ENTER IN COLUMN 1, 1 IF IT IS BASED ON DATE OF ADMISSION, 2 IF IT IS BASED ON CENSUS DAYS, OR 3 IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE LAST COST REPORTING PERIOD? ENTER IN COLUMN 2, 'Y' FOR YES AND 'N' FOR NO.							21.08
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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO		25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO		25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO		25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO		25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO		25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:			26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.			26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:			26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	01/01/2004	27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st			28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.			28.02
	A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)			
28.03	STAFFING	0.00	NO	28.03
28.04	RECRUITMENT	0.00	NO	28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO	28.05
28.06	TRAINING	0.00	NO	28.06
28.07	OTHER (SPECIFY)		NO	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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

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

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

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

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 THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COL. 2 THE HOME OFFICE CHAIN NUMBER. (SEE INST.) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE ON LINES 40.01-40.03.	NO				40
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40.01	NAME:	FI/CONTRACTOR'S NAME:	FI/CONTRACTOR'S NUMBER:			40.01
40.02	STREET:		P.O.BOX:			40.02
40.03	CITY:		STATE:	ZIP CODE:		40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		YES			41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?		YES			42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?		YES			42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?		YES			42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?		NO			43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?		NO			44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.		YES	04/09/2010		45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		YES			45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		NO			45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		NO			45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.					46

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

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
	1	2	3	4	5	
47	HOSPITAL	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N	N	N	49
50	HOME HEALTH AGENCY	N	N	N	N	50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?	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: AND/OR SELF INSURANCE:					54
54.01	PREMIUMS: 231406 PAID LOSSES: AND/OR SELF INSURANCE:					54.01
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

		DATE	Y/N	LIMIT	Y/N	FEE\$	
		0	1	2	3	4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		NO				58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (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
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	09/14/2010			63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	-----I/P DAYS / O/P VISITS / TRIPS-----			OBS. BEDS ADMITTED 5.01	
				TITLE V 3	TITLE XVIII 4	LTCH NONCOVERED DAYS 4.01		TITLE XIX 5
1 HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	25	9125	45288.00		1408		201	1
2 HMO								2
3 HOSPITAL ADULTS & PEDS - SWING BED SNF					967			3
4 HOSPITAL ADULTS & PEDS - SWING BED NF								4
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	25	9125	45288.00		2375		201	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	25	9125	45288.00		2375		201	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					1130			24
25 TOTAL	25							25
26 OBSERVATION BED DAYS							16	1 26
27 AMBULANCE TRIPS								27
28 EMPLOYEE DISCOUNT DAYS								28
29 LABOR & DELIVERY DAYS								29

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	-----I/P DAYS / O/P VISITS / TRIPS-----		---INTERNS & RES FTES---			--FULL TIME EQUIV--			
	OBS. BEDS NOT ADMITTED	TOTAL ALL PATIENTS	OBS. BEDS ADMITTED	OBS. BEDS NOT ADMITTED	TOTAL	LESS I&R REPL NON- PHYS ANES	NET	EMPLOYEES ON PAYROLL	NONPAID WORKERS
	5.02	6	6.01	6.02	7	8	9	10	11
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		1887							1
2 HMO XIX									2
3 HOSPITAL ADULTS & PEDS - SWING BED SNF		967							3
4 HOSPITAL ADULTS & PEDS - SWING BED NF		74							4
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		2928							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		2928						136.06	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		2188						6.64	24
25 TOTAL								142.70	25
26 OBSERVATION BED DAYS	15	158	11	147					26
27 AMBULANCE TRIPS									27
28 EMPLOYEE DISCOUNT DAYS									28
29 LABOR & DELIVERY DAYS									29

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	-----DISCHARGES-----				TOTAL ALL PATIENTS
	TITLE V 12	TITLE XVIII 13	TITLE XIX 14		
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		348	65	506	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		348	65	506	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.	ADJUSTED	PAID HOURS	AVERAGE	DATA	WORKSHEET S-3
		REPORTED	OF SALARIES	SALARIES	RELATED	HOURLY WAGE	SOURCE	PART II
		1	A-6	(COL.1 +	TO SALARY	(COL.3 /		
			2	COL.2)	IN COL.3	COL.4)		
1	SALARIES							
1	TOTAL SALARIES	6567894						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	579182	52952					8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS							11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)						CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS						CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)						CMS 339	19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS							21
22	ADMINISTRATIVE & GENERAL	944977						22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS	158654						23
24	OPERATION OF PLANT							24
25	LAUNDRY & LINEN SERVICE	25348						25
26	HOUSEKEEPING	253339						26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	232181	-150918					27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA		150918					28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	427632						30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY	193994						32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	193969						33
34	SOCIAL SERVICE	42891						34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART III

PART III - HOSPITAL WAGE INDEX SUMMARY		AMOUNT	RECLASS.	ADJUSTED	PAID HOURS	AVERAGE		
		REPORTED	OF SALARIES	SALARIES	RELATED	HOURLY WAGE		
		1	FROM WKST.	(COL.1 +	TO SALARY	(COL.3 /		
			A-6	COL.2)	IN COL.3	COL.4)		
			2					
1	NET SALARIES	6567894		6567894				1
2	EXCLUDED AREA SALARIES	579182	52952	632134				2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5988712	-52952	5935760				3
4	SUBTOTAL OTHER WAGES & REL COSTS							4
5	SUBTOTAL WAGE-RELATED COSTS							5
6	TOTAL (SUM OF LINES 3 THRU 5)	5988712	-52952	5935760				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	2472985		2472985				13

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
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	AAA					45
45.01	ES3					45.01
45.02	ES2					45.02
45.03	ES1					45.03
45.04	HE2					45.04
45.05	HE1					45.05
45.06	HD2					45.06
45.07	HD1					45.07
45.08	HC2					45.08
45.09	HC1					45.09
45.10	HB2					45.10
45.11	HB1					45.11
45.12	LE2					45.12
45.13	LE1					45.13
45.14	LD2					45.14
45.15	LD1					45.15
45.16	LC2					45.16
45.17	LC1					45.17
45.18	LB2					45.18
45.19	LB1					45.19
45.20	CE2					45.20
45.21	CE1					45.21
45.22	CD2					45.22
45.23	CD1					45.23
46	TOTAL					46

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

RHC I
 COMPONENT NO: 14-8504

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 900 N. WASHINGTON 1
 1.01 CITY: DU QUOIN STATE: IL ZIP CODE: 62832 COUNTY: PERRY 1.01
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT PHYSICIAN NAME BILLING NO. 9

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

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

FACILITY HOURS OF OPERATIONS (1)

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

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

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? NO 13

14 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? NO 14

IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.
 LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.
 15 PROVIDER NAME: PROVIDER NUMBER: - V XVIII XIX 15

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. NO 16

17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. NO 17

IF YES, SEE INSTRUCTIONS.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSI- FICATIONS	RECLASS. TRIAL BALANCE	ADJUST- MENTS	NET EXP FOR ALLOCATION	
		1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS									
3	0300 NEW CAP REL COSTS-BLDG & FIXT		723803	723803	-197464	526339	296	526635	3
3.01	0301 2008 BLDG & FIXT				526008	526008		526008	3.01
3.02	0302 RHC BLDG & FIXT				25691	25691		25691	3.02
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		517151	517151	-7590	509561	-810	508751	4
4.01	0401 2008 MVBLE EQUIP				91997	91997		91997	4.01
4.02	0402 RHC MVBLE EQUIP				1139	1139		1139	4.02
5	0500 EMPLOYEE BENEFITS		1700118	1700118		1700118	266945	1967063	5
6	0600 ADMINISTRATIVE & GENERAL	944977	2197083	3142060		3142060	-1459615	1682445	6
7	0700 MAINTENANCE & REPAIRS	158654	127048	285702		285702	-141	285561	7
8	0800 OPERATION OF PLANT		318471	318471		318471	1296	319767	8
9	0900 LAUNDRY & LINEN SERVICE	25348	43425	68773		68773		68773	9
10	1000 HOUSEKEEPING	253339	29796	283135		283135		283135	10
11	1100 DIETARY	232181	125527	357708	-232511	125197	-711	124486	11
12	1200 CAFETERIA				232511	232511	-44659	187852	12
14	1400 NURSING ADMINISTRATION	427632	9999	437631		437631	-2150	435481	14
16	1600 PHARMACY	193994	564883	758877		758877	-66659	692218	16
17	1700 MEDICAL RECORDS & LIBRARY	193969	19626	213595		213595	-1449	212146	17
18	1800 SOCIAL SERVICE	42891	190	43081		43081	-289	42792	18
20	2000 NONPHYSICIAN ANESTHETISTS								20
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	766583	28749	795332		795332	-4936	790396	25
ANCILLARY SERVICE COST CENTERS									
37	3700 OPERATING ROOM	231873	41514	273387		273387	942	274329	37
40	4000 ANESTHESIOLOGY	182238	18700	200938		200938		200938	40
41	4100 RADIOLOGY-DIAGNOSTIC	375054	450170	825224		825224	-2767	822457	41
44	4400 LABORATORY	398010	248630	646640		646640	4596	651236	44
49	4900 RESPIRATORY THERAPY	222868	53605	276473		276473	1832	278305	49
50	5000 PHYSICAL THERAPY	515324	47114	562438		562438	2835	565273	50
51	5100 OCCUPATIONAL THERAPY								51
52	5200 SPEECH PATHOLOGY								52
53	5300 ELECTROCARDIOLOGY	18559	16441	35000		35000	-15200	19800	53
55	5500 MEDICAL SUPPLIES CHARGED TO PAT		672290	672290		672290		672290	55
56	5600 DRUGS CHARGED TO PATIENTS								56
56.01	5601 CARDIAC REHABILITATION	25259	8519	33778		33778	-6000	27778	56.01
OUTPATIENT SERVICE COST CENTERS									
61	6100 EMERGENCY	354872	868203	1223075		1223075	-538669	684406	61
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 RHC	425087	78291	503378	-60026	443352	900	444252	63.50
63.60	6320 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS									
71	7100 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS									
88	8800 INTEREST EXPENSE		680017	680017	-404741	275276	-275276		88
90	9000 OTHER CAPITAL RELATED COSTS		35040	35040	-35040				90
95	SUBTOTALS	5988712	9624403	15613115	-60026	15553089	-2139689	13413400	95
NONREIMBURSABLE COST CENTERS									
96	9600 GIFT, FLOWER, COFFEE SHOP & CAN								96
98	9800 PHYSICIANS' PRIVATE OFFICES	512984	250684	763668	60026	823694	-99358	724336	98
98.02	9802 INDEPENDENT LIVING	66198	105614	171812		171812	238	172050	98.02
98.03	9803 MEALS ON WHEELS								98.03
101	TOTAL	6567894	9980701	16548595		16548595	-2238809	14309786	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----			
		COST CENTER	LINE #	SALARY	OTHER
1	1	2	3	4	5
1 TO RECLASS CAFETERIA COSTS	A	CAFETERIA	12	150918	81593 1
2 TO RECLASS INTEREST EXP	C	NEW CAP REL COSTS-MVBLE EQUIP	4		66271 2
3	C	NEW CAP REL COSTS-BLDG & FIXT	3		169869 3
4	C	2008 BLDG & FIXT	3.01		155113 4
5	C	2008 MVBLE EQUIP	4.01		13488 5
6 TO RECLASS BOND AMORITZATION	D	2008 BLDG & FIXT	3.01		3485 6
7	D	NEW CAP REL COSTS-MVBLE EQUIP	4		490 7
8	D	2008 MVBLE EQUIP	4.01		303 8
9 TO RECLASS DEPRECIATION EXPENSE	E	2008 BLDG & FIXT	3.01		360831 9
10	E	2008 MVBLE EQUIP	4.01		77604 10
11 TO RECLASS DEPRECIATION EXPENSE	F	RHC BLDG & FIXT	3.02		25691 11
12	F	RHC MVBLE EQUIP	4.02		1139 12
13 TO RECLASS RHC EXP PHYS. CLINIC	G	PHYSICIANS' PRIVATE OFFICES	98	52952	7074 13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36 TOTAL RECLASSIFICATIONS				203870	962951 36

RECLASSIFICATIONS

WORKSHEET A-6
 PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF. 10
				LINE #	SALARY	OTHER	
		1	6	7	8	9	
1	TO RECLASS CAFETERIA COSTS	A	DIETARY	11	150918	81593	1
2	TO RECLASS INTEREST EXP	C	INTEREST EXPENSE	88		404741	11 2
3		C					11 3
4		C					11 4
5		C					11 5
6	TO RECLASS BOND AMORITZATION	D	NEW CAP REL COSTS-BLDG & FIXT	3		4278	9 6
7		D					9 7
8		D					9 8
9	TO RECLASS DEPRECIATION EXPENSE	E	NEW CAP REL COSTS-BLDG & FIXT	3		360831	9 9
10		E	NEW CAP REL COSTS-MVBLE EQUIP	4		77604	9 10
11	TO RECLASS DEPRECIATION EXPENSE	F	NEW CAP REL COSTS-BLDG & FIXT	3		25691	9 11
12		F	NEW CAP REL COSTS-MVBLE EQUIP	4		1139	9 12
13	TO RECLASS RHC EXP PHYS. CLINIC	G	RHC	63.50	52952	7074	13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				203870	962951	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	3116					3116		1
2 LAND IMPROVEMENTS	792452	310316		310316	21850	1080918		2
3 BUILDINGS AND FIXTURES	7967601	1773682		1773682	1169926	8571357		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	6281145	28849		28849		6309994		5
6 MOVABLE EQUIPMENT	4621110	99221		99221		4720331		6
7 SUBTOTAL	19665424	2212068		2212068	1191776	20685716		7
8 RECONCILING ITEMS								8
9 TOTAL	19665424	2212068		2212068	1191776	20685716		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	1	2	3	4	5	6	7	8
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT	22181051		22181051	.669715			23467	23467 3
3.01 2008 BLDG & FIXT	6218783		6218783	.187764			6579	6579 3.01
3.02 RHC BLDG & FIXT				.000000				3.02
4 NEW CAP REL COSTS-MVBLE EQUIP	4151131		4151131	.125335			4392	4392 4
4.01 2008 MVBLE EQUIP	569200		569200	.017186			602	602 4.01
4.02 RHC MVBLE EQUIP				.000000				4.02
5 TOTAL	33120165		33120165	1.000000			35040	35040 5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	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	333003		170165			23467	526635 3
3.01 2008 BLDG & FIXT	364316		155113			6579	526008 3.01
3.02 RHC BLDG & FIXT	25691						25691 3.02
4 NEW CAP REL COSTS-MVBLE EQUIP	438898		65461			4392	508751 4
4.01 2008 MVBLE EQUIP	77907		13488			602	91997 4.01
4.02 RHC MVBLE EQUIP	1139						1139 4.02
5 TOTAL	1240954		404227			35040	1680221 5

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	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	723803						723803 3
3.01 2008 BLDG & FIXT							3.01
3.02 RHC BLDG & FIXT							3.02
4 NEW CAP REL COSTS-MVBLE EQUIP	517151						517151 4
4.01 2008 MVBLE EQUIP							4.01
4.02 RHC MVBLE EQUIP							4.02
5 TOTAL	1240954						1240954 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES	B	-121	NEW CAP REL COSTS-BLDG & FIXT	3	11 3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT	B	-810	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					7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)					9
10 TELEVISION AND RADIO SERVICE					10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2	-556546			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	-44659	CAFETERIA	12	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-65496	PHARMACY	16	19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-955	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
	A-8-4				
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		PHYSICAL THERAPY	50	26
	A-8-4				
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST		HOME HEALTH AGENCY	71	27
	A-8-3				
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		OCCUPATIONAL THERAPY	51	35
	WKST A-8-4				
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		SPEECH PATHOLOGY	52	36
	WKST A-8-4				
37 MISCELLABEOUS INCOME	B	-58283	ADMINISTRATIVE & GENERAL	6	37
38 BAD DEBTS	A	-1356087	ADMINISTRATIVE & GENERAL	6	38
39 AHA DUES USED FOR LOBBYING	A	-6776	ADMINISTRATIVE & GENERAL	6	39
40 IHA DUES USED FOR LOBBYING	A	-1901	ADMINISTRATIVE & GENERAL	6	40
41 MARKETING	A	-36718	ADMINISTRATIVE & GENERAL	6	41
42 FAS 106 BENEFIT ACCRUAL REDUCTION	A	266945	EMPLOYEE BENEFITS	5	42
43 DR. HALL SHARED EXPENSES	A	-98459	PHYSICIANS' PRIVATE OFFICES	98	43
44 DEPRECIATION	A	417	NEW CAP REL COSTS-BLDG & FIXT	3	11 44
45 DEPRECIATION	A	150	ADMINISTRATIVE & GENERAL	6	45
46 DEPRECIATION	A	-141	MAINTENANCE & REPAIRS	7	46
47 DEPRECIATION	A	1296	OPERATION OF PLANT	8	47
48 DEPRECIATION	A	-711	DIETARY	11	48
49 DEPRECIATION	A	-2150	NURSING ADMINISTRATION	14	49
49.01 DEPRECIATION	A	-1163	PHARMACY	16	49.01
49.02 DEPRECIATION	A	-494	MEDICAL RECORDS & LIBRARY	17	49.02
49.03 DEPRECIATION	A	-289	SOCIAL SERVICE	18	49.03
49.04 DEPRECIATION	A	-4936	ADULTS & PEDIATRICS	25	49.04
49.05 DEPRECIATION	A	942	OPERATING ROOM	37	49.05
49.06 DEPRECIATION	A	-2767	RADIOLOGY-DIAGNOSTIC	41	49.06
49.07 DEPRECIATION	A	4596	LABORATORY	44	49.07
49.08 DEPRECIATION	A	1832	RESPIRATORY THERAPY	49	49.08
49.09 DEPRECIATION	A	2835	PHYSICAL THERAPY	50	49.09
49.10 DEPRECIATION	A	-3323	EMERGENCY	61	49.10
49.11 DEPRECIATION	A	900	RHC	63.50	49.11
49.12 DEPRECIATION	A	-899	PHYSICIANS' PRIVATE OFFICES	98	49.12
49.13 DEPRECIATION	A	238	INDEPENDENT LIVING	98.02	49.13
49.14 SWAP UNALLOWABLE INTEREST	A	-275276	INTEREST EXPENSE	88	49.14
50 TOTAL		-2238809			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.

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----						
SYMBOL (1)	NAME	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. 14-1331 MARSHALL BROWNING HOSPITAL
 PERIOD FROM 07/01/2009 TO 06/30/2010

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

VERSION: 2010.09
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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
1	2		3	4	5	6	7	8	9
1	53 ELECTROCARDIOLOGY	AGGREGATE	15200	15200					
2	56.01 CARDIAC REHABILITATION	AGGREGATE	6000	6000					
3	61 EMERGENCY	AGGREGATE	853822	535346	318476				
101	TOTAL		875022	556546	318476				

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
10	11	12	13	14	15	16	17	18
1 53	ELECTROCARDIOLOGY		AGGREGATE					15200
2 56.01	CARDIAC REHABILITATION		AGGREGATE					6000
3 61	EMERGENCY		AGGREGATE					535346
101	TOTAL							556546

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)					50	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					750	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					31	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		43.45	170.00			9
10	AHSEA		66.46	49.85			10
11	STANDARD TRAVEL ALLOWANCE	33.23	33.23	24.93			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					2888	15
16	ASSISTANTS					8475	16
17	SUBTOTAL ALLOWANCE AMOUNT					11363	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					11363	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					53.23	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					39923	22
23	TOTAL SALARY EQUIVALENCY					39923	23

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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

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

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	1030	24
25	ASSISTANTS		25
26	SUBTOTAL	1030	26
27	STANDARD TRAVEL EXPENSE	155	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	1185	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	1185	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

PROVIDER NO. 14-1331 MARSHALL BROWNING HOSPITAL
 PERIOD FROM 07/01/2009 TO 06/30/2010

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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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 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				
	COMPUTATION AT THE AHSEA				
56	OVERTIME ALLOWANCE				56
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT					
57	SALARY EQUIVALENCY AMOUNT				39923
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE				1185
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES				59
60	OVERTIME ALLOWANCE				60
61	EQUIPMENT COST				61
62	SUPPLIES				62
63	TOTAL ALLOWANCE				41108
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES				9483
65	EXCESS OVER LIMITATION				65

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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 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	9483	66
67	TOTAL COST	9483	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

PROVIDER NO. 14-1331 MARSHALL BROWNING HOSPITAL
 PERIOD FROM 07/01/2009 TO 06/30/2010

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

VERSION: 2010.09
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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 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					88	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINERS	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		379.25				9
10	AHSEA		70.13				10
11	STANDARD TRAVEL ALLOWANCE	35.07	35.07				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					26597	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					26597	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					26597	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					70.13	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					54701	22
23	TOTAL SALARY EQUIVALENCY					54701	23

PROVIDER NO. 14-1331 MARSHALL BROWNING HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

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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 [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	3086	24
25	ASSISTANTS		25
26	SUBTOTAL	3086	26
27	STANDARD TRAVEL EXPENSE	440	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	3526	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	3526	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

PROVIDER NO. 14-1331 MARSHALL BROWNING HOSPITAL
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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 V, VI & VII

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT					54701	57
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE					3526	58
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES						59
60 OVERTIME ALLOWANCE						60
61 EQUIPMENT COST						61
62 SUPPLIES						62
63 TOTAL ALLOWANCE					58227	63
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES					20859	64
65 EXCESS OVER LIMITATION						65

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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	20859	66
67	TOTAL COST	20859	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

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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 I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					10	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					150	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					2	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		4.25				9
10	AHSEA		63.86				10
11	STANDARD TRAVEL ALLOWANCE	31.93	31.93				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					271	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					271	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					271	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					63.76	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					9564	22
23	TOTAL SALARY EQUIVALENCY					9564	23

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

WORKSHEET A-8-4
 PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	64	24
25	ASSISTANTS		25
26	SUBTOTAL	64	26
27	STANDARD TRAVEL EXPENSE	10	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	74	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	74	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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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					9564	57
58					74	58
59						59
60						60
61						61
62						62
63					9638	63
64					234	64
65						65

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PERIOD FROM 07/01/2009 TO 06/30/2010

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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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 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	234	66
67	TOTAL COST	234	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	OLD CAP BLDGS + FIXTURES 3.01	NEW CAP REL COSTS- BLDG & FIX 3.02	NEW CAP MOVABLE EQUIPMENT 4	NEW CAP MOVABLE EQUIPMENT 4.01	NEW CAP MVBLE EQUI 4.02	EMPLOYEE BENEFITS 5
GENERAL SERVICE COST CENTERS								
3 NEW CAP REL COSTS-BLDG & FIXT	526635	526635						3
3.01 2008 BLDG & FIXT	526008		526008					3.01
3.02 RHC BLDG & FIXT	25691			25691				3.02
4 NEW CAP REL COSTS-MVBLE EQUIP	508751				508751			4
4.01 2008 MVBLE EQUIP	91997					91997		4.01
4.02 RHC MVBLE EQUIP	1139						1139	4.02
5 EMPLOYEE BENEFITS	1967063							1967063
6 ADMINISTRATIVE & GENERAL	1682445	141485	14073		197324	837		283017
7 MAINTENANCE & REPAIRS	285561				1878			47516
8 OPERATION OF PLANT	319767	45389	4958					
9 LAUNDRY & LINEN SERVICE	68773	17820			386			7592
10 HOUSEKEEPING	283135	10163			347			75874
11 DIETARY	124486	21350			379			24338
12 CAFETERIA	187852	6342			707			45199
14 NURSING ADMINISTRATION	435481	5177			1459			128075
16 PHARMACY	692218		28874		279	2756		58101
17 MEDICAL RECORDS & LIBRARY	212146	11186			7472	395		58093
18 SOCIAL SERVICE	42792	1098						12846
20 NONPHYSICIAN ANESTHETISTS								
23 I&R SERVICES-OTHER PRGM COSTS A								
24 PARAMED ED PRGM-(SPECIFY)								
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	790396		295427		10055	21828		229589
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	274329		134528		525	64227		69445
40 ANESTHESIOLOGY	200938				3072			54580
41 RADIOLOGY-DIAGNOSTIC	822457	10760			228789			112328
44 LABORATORY	651236	3205	48148		11593	1954		119203
49 RESPIRATORY THERAPY	278305	17352			12168			66748
50 PHYSICAL THERAPY	565273	28566			11581			154338
51 OCCUPATIONAL THERAPY								
52 SPEECH PATHOLOGY								
53 ELECTROCARDIOLOGY	19800	508						5558
55 MEDICAL SUPPLIES CHARGED TO PAT	672290							
56 DRUGS CHARGED TO PATIENTS								
56.01 CARDIAC REHABILITATION	27778	3625						7565
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY	684406	19432				14322		106283
62 OBSERVATION BEDS (NON-DISTINCT								
63.50 RHC	444252			25691			1139	111453
63.60 FQHC								
OTHER REIMBURSABLE COST CENTERS								
71 HOME HEALTH AGENCY								
SPECIAL PURPOSE COST CENTERS								
95 SUBTOTALS	13413400	343458	526008	25691	502336	91997	1139	1777741
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN		5536						
98 PHYSICIANS' PRIVATE OFFICES	724336	36534			5531			169496
98.02 INDEPENDENT LIVING	172050	141107			884			19826
98.03 MEALS ON WHEELS								
101 CROSS FOOT ADJUSTMENTS								
102 NEGATIVE COST CENTER								
103 TOTAL	14309786	526635	526008	25691	508751	91997	1139	1967063

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL	ADMINIS-	MAIN-	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA
		TRATIVE & GENERAL	TENANCE & REPAIRS	OF PLANT	& LINEN SERVICE	KEEPING		
	5A	6	7	8	9	10	11	12
GENERAL SERVICE COST CENTERS								
3 NEW CAP REL COSTS-BLDG & FIXT								3
3.01 2008 BLDG & FIXT								3.01
3.02 RHC BLDG & FIXT								3.02
4 NEW CAP REL COSTS-MVBLE EQUIP								4
4.01 2008 MVBLE EQUIP								4.01
4.02 RHC MVBLE EQUIP								4.02
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL	2319181	2319181						6
7 MAINTENANCE & REPAIRS	334955	64786	399741					7
8 OPERATION OF PLANT	370114	71586		441700				8
9 LAUNDRY & LINEN SERVICE	94571	18292	5722	23151	141736			9
10 HOUSEKEEPING	369519	71471	7357	13204	3415	464966		10
11 DIETARY	170553	32988	9810	27737	2872	21948	265908	11
12 CAFETERIA	240100	46439	18802	8239	5356	40807		359743
14 NURSING ADMINISTRATION	570192	110285		6725				29734
16 PHARMACY	782228	151296	7357	10458		7032		9911
17 MEDICAL RECORDS & LIBRARY	289292	55954	6540	14533		7032		24962
18 SOCIAL SERVICE	56736	10974		1426				2937
20 NONPHYSICIAN ANESTHETISTS								
23 I&R SERVICES-OTHER PRGM COSTS A								
24 PARAMED ED PRGM-(SPECIFY)								
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	1347295	260584	113628	106996	59457	190078	252095	75986
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	543054	105036	12262	48723	16145	36012		15785
40 ANESTHESIOLOGY	258590	50016						3304
41 RADIOLOGY-DIAGNOSTIC	1174334	227136	16349	13979	6831	30472		27531
44 LABORATORY	835339	161569	29429	21602	1242	20137		34139
49 RESPIRATORY THERAPY	374573	72449	49048	22544	7219	18859		19088
50 PHYSICAL THERAPY	759758	146950	38421	37112	19677	18113		34139
51 OCCUPATIONAL THERAPY								
52 SPEECH PATHOLOGY								
53 ELECTROCARDIOLOGY	25866	5003		660				
55 MEDICAL SUPPLIES CHARGED TO PAT	672290	130032						
56 DRUGS CHARGED TO PATIENTS								
56.01 CARDIAC REHABILITATION	38968	7537		4709				
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY	824443	159461	16349	25246	15020	32603		25696
62 OBSERVATION BEDS (NON-DISTINCT)								
63.50 RHC	582535	112672				2344		23126
63.60 FQHC								
OTHER REIMBURSABLE COST CENTERS								
71 HOME HEALTH AGENCY								
SPECIAL PURPOSE COST CENTERS								
95 SUBTOTALS	13034486	2072516	331074	387044	137234	425437	252095	326338
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN	5536	1071		7192				
98 PHYSICIANS' PRIVATE OFFICES	935897	181018	37603	47464	4502	39529		24595
98.02 INDEPENDENT LIVING	333867	64576	31064					8810
98.03 MEALS ON WHEELS							13813	
101 CROSS FOOT ADJUSTMENTS								
102 NEGATIVE COST CENTER								
103 TOTAL	14309786	2319181	399741	441700	141736	464966	265908	359743

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 14	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27	
GENERAL SERVICE COST CENTERS								
3 NEW CAP REL COSTS-BLDG & FIXT								3
3.01 2008 BLDG & FIXT								3.01
3.02 RHC BLDG & FIXT								3.02
4 NEW CAP REL COSTS-MVBLE EQUIP								4
4.01 2008 MVBLE EQUIP								4.01
4.02 RHC MVBLE EQUIP								4.02
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
14 NURSING ADMINISTRATION	716936							14
16 PHARMACY		968282						16
17 MEDICAL RECORDS & LIBRARY			398313					17
18 SOCIAL SERVICE				72073				18
20 NONPHYSICIAN ANESTHETISTS								20
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
25 INPATIENT ROUTINE SERV COST CENTERS								
ADULTS & PEDIATRICS	464169		106762	72073	3049123		3049123	25
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	95667		20562		893246		893246	37
40 ANESTHESIOLOGY					311910		311910	40
41 RADIOLOGY-DIAGNOSTIC			61824		1558456		1558456	41
44 LABORATORY			37040		1140497		1140497	44
49 RESPIRATORY THERAPY			9124		572904		572904	49
50 PHYSICAL THERAPY			10349		1064519		1064519	50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY					31529		31529	53
55 MEDICAL SUPPLIES CHARGED TO PAT					802322		802322	55
56 DRUGS CHARGED TO PATIENTS		968282			968282		968282	56
56.01 CARDIAC REHABILITATION					51214		51214	56.01
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY	157100		86335		1342253		1342253	61
62 OBSERVATION BEDS (NON-DISTINCT)								62
63.50 RHC					720677		720677	63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
71 HOME HEALTH AGENCY								71
71 SPECIAL PURPOSE COST CENTERS								
95 SUBTOTALS	716936	968282	331996	72073	12506932		12506932	95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN					13799		13799	96
98 PHYSICIANS' PRIVATE OFFICES			66317		1336925		1336925	98
98.02 INDEPENDENT LIVING					438317		438317	98.02
98.03 MEALS ON WHEELS					13813		13813	98.03
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	716936	968282	398313	72073	14309786		14309786	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	OLD CAP BLDGS + FIXTURES 3.01	NEW CAP REL COSTS- BLDG & FIX 3.02	NEW CAP MOVABLE EQUIPMENT 4	NEW CAP MOVABLE EQUIPMENT 4.01	NEW CAP MVBLE EQUI 4.02	CAP REL COST TO BE ALLOC 4A
GENERAL SERVICE COST CENTERS								
3 NEW CAP REL COSTS-BLDG & FIXT								3
3.01 2008 BLDG & FIXT								3.01
3.02 RHC BLDG & FIXT								3.02
4 NEW CAP REL COSTS-MVBLE EQUIP								4
4.01 2008 MVBLE EQUIP								4.01
4.02 RHC MVBLE EQUIP								4.02
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL		141485	14073		197324	837		353719
7 MAINTENANCE & REPAIRS					1878			1878
8 OPERATION OF PLANT		45389	4958					50347
9 LAUNDRY & LINEN SERVICE		17820			386			18206
10 HOUSEKEEPING		10163			347			10510
11 DIETARY		21350			379			21729
12 CAFETERIA		6342			707			7049
14 NURSING ADMINISTRATION		5177			1459			6636
16 PHARMACY			28874		279	2756		31909
17 MEDICAL RECORDS & LIBRARY		11186			7472	395		19053
18 SOCIAL SERVICE		1098						1098
20 NONPHYSICIAN ANESTHETISTS								
23 I&R SERVICES-OTHER PRGM COSTS A								
24 PARAMED ED PRGM-(SPECIFY)								
25 INPATIENT ROUTINE SERV COST CENTERS								
ADULTS & PEDIATRICS			295427		10055	21828		327310
25 ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM			134528		525	64227		199280
40 ANESTHESIOLOGY					3072			3072
41 RADIOLOGY-DIAGNOSTIC		10760			228789			239549
44 LABORATORY		3205	48148		11593	1954		64900
49 RESPIRATORY THERAPY		17352			12168			29520
50 PHYSICAL THERAPY		28566			11581			40147
51 OCCUPATIONAL THERAPY								
52 SPEECH PATHOLOGY								
53 ELECTROCARDIOLOGY		508						508
55 MEDICAL SUPPLIES CHARGED TO PAT								
56 DRUGS CHARGED TO PATIENTS								
56.01 CARDIAC REHABILITATION		3625						3625
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY		19432				14322		33754
62 OBSERVATION BEDS (NON-DISTINCT								
63.50 RHC				25691			1139	26830
63.60 FQHC								
OTHER REIMBURSABLE COST CENTERS								
71 HOME HEALTH AGENCY								
SPECIAL PURPOSE COST CENTERS								
95 SUBTOTALS		343458	526008	25691	502336	91997	1139	1490629
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN		5536						5536
98 PHYSICIANS' PRIVATE OFFICES		36534			5531			42065
98.02 INDEPENDENT LIVING		141107			884			141991
98.03 MEALS ON WHEELS								
101 CROSS FOOT ADJUSTMENTS								
102 NEGATIVE COST CENTER								
103 TOTAL		526635	526008	25691	508751	91997	1139	1680221

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 6	MAIN- TENANCE & REPAIRS 7	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINIS- TRATION 14	
GENERAL SERVICE COST CENTERS									
3 NEW CAP REL COSTS-BLDG & FIXT									3
3.01 2008 BLDG & FIXT									3.01
3.02 RHC BLDG & FIXT									3.02
4 NEW CAP REL COSTS-MVBLE EQUIP									4
4.01 2008 MVBLE EQUIP									4.01
4.02 RHC MVBLE EQUIP									4.02
5 EMPLOYEE BENEFITS									5
6 ADMINISTRATIVE & GENERAL	353719								6
7 MAINTENANCE & REPAIRS	9881	11759							7
8 OPERATION OF PLANT	10918		61265						8
9 LAUNDRY & LINEN SERVICE	2790	168	3211	24375					9
10 HOUSEKEEPING	10901	216	1831	587	24045				10
11 DIETARY	5031	289	3847	494	1135	32525			11
12 CAFETERIA	7083	553	1143	921	2110		18859		12
14 NURSING ADMINISTRATION	16821		933				1559	25949	14
16 PHARMACY	23076	216	1450		364		520		16
17 MEDICAL RECORDS & LIBRARY	8534	192	2016		364		1309		17
18 SOCIAL SERVICE	1674		198				154		18
20 NONPHYSICIAN ANESTHETISTS									20
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	39740	3343	14840	10225	9830	30835	3983	16800	25
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	16020	361	6758	2777	1862		827	3463	37
40 ANESTHESIOLOGY	7628						173		40
41 RADIOLOGY-DIAGNOSTIC	34643	481	1939	1175	1576		1443		41
44 LABORATORY	24643	866	2996	214	1041		1790		44
49 RESPIRATORY THERAPY	11050	1443	3127	1241	975		1001		49
50 PHYSICAL THERAPY	22413	1130	5148	3384	937		1790		50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY	763		92						53
55 MEDICAL SUPPLIES CHARGED TO PAT	19833								55
56 DRUGS CHARGED TO PATIENTS									56
56.01 CARDIAC REHABILITATION	1150		653						56.01
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY	24321	481	3502	2583	1686		1347	5686	61
62 OBSERVATION BEDS (NON-DISTINCT)									62
63.50 RHC	17185				121		1212		63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
95 SUBTOTALS	316098	9739	53684	23601	22001	30835	17108	25949	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN	163		998						96
98 PHYSICIANS' PRIVATE OFFICES	27609	1106	6583	774	2044		1289		98
98.02 INDEPENDENT LIVING	9849	914					462		98.02
98.03 MEALS ON WHEELS						1690			98.03
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	353719	11759	61265	24375	24045	32525	18859	25949	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	16	17	18	25	26	27
GENERAL SERVICE COST CENTERS						
3 NEW CAP REL COSTS-BLDG & FIXT						3
3.01 2008 BLDG & FIXT						3.01
3.02 RHC BLDG & FIXT						3.02
4 NEW CAP REL COSTS-MVBLE EQUIP						4
4.01 2008 MVBLE EQUIP						4.01
4.02 RHC MVBLE EQUIP						4.02
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
14 NURSING ADMINISTRATION						14
16 PHARMACY	57535					16
17 MEDICAL RECORDS & LIBRARY		31468				17
18 SOCIAL SERVICE			3124			18
20 NONPHYSICIAN ANESTHETISTS						20
23 I&R SERVICES-OTHER PRGM COSTS A						23
24 PARAMED ED PRGM-(SPECIFY)						24
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS		8434	3124	468464		468464
25 ANCILLARY SERVICE COST CENTERS						25
37 OPERATING ROOM		1625		232973		232973
40 ANESTHESIOLOGY				10873		10873
41 RADIOLOGY-DIAGNOSTIC		4884		285690		285690
44 LABORATORY		2926		99376		99376
49 RESPIRATORY THERAPY		721		49078		49078
50 PHYSICAL THERAPY		818		75767		75767
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY				1363		1363
55 MEDICAL SUPPLIES CHARGED TO PAT				19833		19833
56 DRUGS CHARGED TO PATIENTS	57535			57535		57535
56.01 CARDIAC REHABILITATION				5428		5428
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY		6821		80181		80181
62 OBSERVATION BEDS (NON-DISTINCT						62
63.50 RHC				45348		45348
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
71 HOME HEALTH AGENCY						71
SPECIAL PURPOSE COST CENTERS						
95 SUBTOTALS	57535	26229	3124	1431909		1431909
NONREIMBURSABLE COST CENTERS						
96 GIFT, FLOWER, COFFEE SHOP & CAN				6697		6697
98 PHYSICIANS' PRIVATE OFFICES		5239		86709		86709
98.02 INDEPENDENT LIVING				153216		153216
98.03 MEALS ON WHEELS				1690		1690
101 CROSS FOOT ADJUSTMENTS						101
102 NEGATIVE COST CENTER						102
103 TOTAL	57535	31468	3124	1680221		1680221

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET	OLD CAP BLDGS + FIXTURES SQUARE FEET	NEW CAP REL COSTS- BLDG & FIX SQUARE FEET	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE	NEW CAP MOVABLE EQUIP DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	
	3	3.01	3.02	4	4.01	4.02		5	
GENERAL SERVICE COST CENTERS									
3 NEW CAP REL COSTS-BLDG & FIXT	77726								3
3.01 2008 BLDG & FIXT		21642							3.01
3.02 RHC BLDG & FIXT			4575						3.02
4 NEW CAP REL COSTS-MVBLE EQUIP				438408					4
4.01 2008 MVBLE EQUIP					77604				4.01
4.02 RHC MVBLE EQUIP						1139			4.02
5 EMPLOYEE BENEFITS								6567894	5
6 ADMINISTRATIVE & GENERAL	20882	579		170041	706			944977	6
7 MAINTENANCE & REPAIRS				1618				158654	7
8 OPERATION OF PLANT	6699	204							8
9 LAUNDRY & LINEN SERVICE	2630			333				25348	9
10 HOUSEKEEPING	1500			299				253339	10
11 DIETARY	3151			327				81263	11
12 CAFETERIA	936			609				150918	12
14 NURSING ADMINISTRATION	764			1257				427632	14
16 PHARMACY		1188		240	2325			193994	16
17 MEDICAL RECORDS & LIBRARY	1651			6439	333			193969	17
18 SOCIAL SERVICE	162							42891	18
20 NONPHYSICIAN ANESTHETISTS									20
23 I&R SERVICES-OTHER PRGM COSTS									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS		12155		8665	18413			766583	25
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM		5535		452	54179			231873	37
40 ANESTHESIOLOGY				2647				182238	40
41 RADIOLOGY-DIAGNOSTIC	1588			197155				375054	41
44 LABORATORY	473	1981		9990	1648			398010	44
49 RESPIRATORY THERAPY	2561			10486				222868	49
50 PHYSICAL THERAPY	4216			9980				515324	50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY	75							18559	53
55 MEDICAL SUPPLIES CHARGED TO P									55
56 DRUGS CHARGED TO PATIENTS									56
56.01 CARDIAC REHABILITATION	535							25259	56.01
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY	2868			12342				354872	61
62 OBSERVATION BEDS (NON-DISTINC									62
63.50 RHC			4575			1139		372135	63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
95 SUBTOTALS	50691	21642	4575	432880	77604	1139		5935760	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & C	817								96
98 PHYSICIANS' PRIVATE OFFICES	5392			4766				565936	98
98.02 INDEPENDENT LIVING	20826			762				66198	98.02
98.03 MEALS ON WHEELS									98.03
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 COST TO BE ALLOC PER B PT I	526635	526008	25691	508751	91997	1139		1967063	103
104 UNIT COST MULT-WS B PT I		24.304963		1.160451		1.000000			104
104 UNIT COST MULT-WS B PT I	6.775532		5.615519		1.185467			.299497	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

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	RECON- CILIATION 6A	ADMINIS- TRATIVE & GENERAL ACCUM COST 6	MAIN- TENANCE & REPAIRS TIME SPENT 7	OPERATION OF PLANT SQUARE FEET 8	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	HOUSE- KEEPING TIME SPENT 10	DIETARY MEALS SERVED 11	CAFETERIA MEALS SERVED 12
GENERAL SERVICE COST CENTERS								
3 NEW CAP REL COSTS-BLDG & FIXT								3
3.01 2008 BLDG & FIXT								3.01
3.02 RHC BLDG & FIXT								3.02
4 NEW CAP REL COSTS-MVBLE EQUIP								4
4.01 2008 MVBLE EQUIP								4.01
4.02 RHC MVBLE EQUIP								4.02
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL	-2319181	11990605						6
7 MAINTENANCE & REPAIRS		334955	489					7
8 OPERATION OF PLANT		370114		50178				8
9 LAUNDRY & LINEN SERVICE		94571	7	2630	3652			9
10 HOUSEKEEPING		369519	9	1500	88	4364		10
11 DIETARY		170553	12	3151	74	206	12320	11
12 CAFETERIA		240100	23	936	138	383		980 12
14 NURSING ADMINISTRATION		570192		764				81 14
16 PHARMACY		782228	9	1188		66		27 16
17 MEDICAL RECORDS & LIBRARY		289292	8	1651		66		68 17
18 SOCIAL SERVICE		56736		162				8 18
20 NONPHYSICIAN ANESTHETISTS								20
23 I&R SERVICES-OTHER PRGM COSTS								23
24 PARAMED ED PRGM-(SPECIFY)								24
25 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS		1347295	139	12155	1532	1784	11680	207 25
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		543054	15	5535	416	338		43 37
40 ANESTHESIOLOGY		258590						9 40
41 RADIOLOGY-DIAGNOSTIC		1174334	20	1588	176	286		75 41
44 LABORATORY		835339	36	2454	32	189		93 44
49 RESPIRATORY THERAPY		374573	60	2561	186	177		52 49
50 PHYSICAL THERAPY		759758	47	4216	507	170		93 50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY		25866		75				53
55 MEDICAL SUPPLIES CHARGED TO P		672290						55
56 DRUGS CHARGED TO PATIENTS								56
56.01 CARDIAC REHABILITATION		38968		535				56.01
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY		824443	20	2868	387	306		70 61
62 OBSERVATION BEDS (NON-DISTINC								62
63.50 RHC		582535				22		63 63.50
63.60 PQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
95 SUBTOTALS	-2319181	10715305	405	43969	3536	3993	11680	889 95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & C		5536		817				96
98 PHYSICIANS' PRIVATE OFFICES		935897	46	5392	116	371		67 98
98.02 INDEPENDENT LIVING		333867	38					24 98.02
98.03 MEALS ON WHEELS							640	98.03
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I		2319181	399741	441700	141736	464966	265908	359743 103
104 UNIT COST MULT-WS B PT I			817.466258		38.810515		21.583442	104
104 UNIT COST MULT-WS B PT I		.193417		8.802663		106.545830		367.084694 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		353719	11759	61265	24375	24045	32525	18859 107
108 UNIT COST MULT-WS B PT III			24.047035		6.674425		2.640016	108
108 UNIT COST MULT-WS B PT III		.029500		1.220953		5.509853		19.243878 108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING	PHARMACY	MEDICAL	SOCIAL	
	ADMINIS- TRATION HOURS SUPE R VISED	COSTED REQUIS.	RECORDS & LIBRARY TIME SPENT	SERVICE TIME SPENT	
	14	16	17	18	
GENERAL SERVICE COST CENTERS					
3 NEW CAP REL COSTS-BLDG & FIXT					3
3.01 2008 BLDG & FIXT					3.01
3.02 RHC BLDG & FIXT					3.02
4 NEW CAP REL COSTS-MVBLE EQUIP					4
4.01 2008 MVBLE EQUIP					4.01
4.02 RHC MVBLE EQUIP					4.02
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
14 NURSING ADMINISTRATION	66345				14
16 PHARMACY		100			16
17 MEDICAL RECORDS & LIBRARY			2925		17
18 SOCIAL SERVICE				315	18
20 NONPHYSICIAN ANESTHETISTS					20
23 I&R SERVICES-OTHER PRGM COSTS					23
24 PARAMED ED PRGM-(SPECIFY)					24
INPATIENT ROUTINE SERV COST CENTERS					
25 ADULTS & PEDIATRICS	42954		784	315	25
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM	8853		151		37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC			454		41
44 LABORATORY			272		44
49 RESPIRATORY THERAPY			67		49
50 PHYSICAL THERAPY			76		50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
53 ELECTROCARDIOLOGY					53
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS		100			56
56.01 CARDIAC REHABILITATION					56.01
OUTPATIENT SERVICE COST CENTERS					
61 EMERGENCY	14538		634		61
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
71 HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS					
95 SUBTOTALS	66345	100	2438	315	95
NONREIMBURSABLE COST CENTERS					
96 GIFT, FLOWER, COFFEE SHOP & C					96
98 PHYSICIANS' PRIVATE OFFICES			487		98
98.02 INDEPENDENT LIVING					98.02
98.03 MEALS ON WHEELS					98.03
101 CROSS FOOT ADJUSTMENTS					101
102 NEGATIVE COST CENTER					102
103 COST TO BE ALLOC PER B PT I	716936	968282	398313	72073	103
104 UNIT COST MULT-WS B PT I	10.806180		136.175385		104
104 UNIT COST MULT-WS B PT I		9682.820000		228.803175	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	25949	57535	31468	3124	107
108 UNIT COST MULT-WS B PT III	.391122		10.758291		108
108 UNIT COST MULT-WS B PT III		575.350000		9.917460	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	3049123		3049123		3049123	25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	893246		893246		893246	37
40 ANESTHESIOLOGY	311910		311910		311910	40
41 RADIOLOGY-DIAGNOSTIC	1558456		1558456		1558456	41
44 LABORATORY	1140497		1140497		1140497	44
49 RESPIRATORY THERAPY	572904		572904		572904	49
50 PHYSICAL THERAPY	1064519		1064519		1064519	50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	31529		31529		31529	53
55 MEDICAL SUPPLIES CHARGED TO	802322		802322		802322	55
56 DRUGS CHARGED TO PATIENTS	968282		968282		968282	56
56.01 CARDIAC REHABILITATION	51214		51214		51214	56.01
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	1342253		1342253		1342253	61
62 OBSERVATION BEDS (NON-DISTI	159488		159488		159488	62
63.50 RHC	720677		720677		720677	63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	12666420		12666420		12666420	101
102 LESS OBSERVATION BEDS	159488		159488		159488	102
103 TOTAL	12506932		12506932		12506932	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	1117050		1117050			25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	171335	695407	866742	1.030579	1.030579	37
40 ANESTHESIOLOGY	120396	373888	494284	.631034	.631034	40
41 RADIOLOGY-DIAGNOSTIC	628483	4751874	5380357	.289657	.289657	41
44 LABORATORY	1412704	4509504	5922208	.192580	.192580	44
49 RESPIRATORY THERAPY	434378	343356	777734	.736632	.736632	49
50 PHYSICAL THERAPY	264255	1720233	1984488	.536420	.536420	50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	292600	317321	609921	.051694	.051694	53
55 MEDICAL SUPPLIES CHARGED TO	1428718	708212	2136930	.375455	.375455	55
56 DRUGS CHARGED TO PATIENTS	929698	485486	1415184	.684209	.684209	56
56.01 CARDIAC REHABILITATION		56723	56723	.902879	.902879	56.01
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	77526	1704210	1781736	.753340	.753340	61
62 OBSERVATION BEDS (NON-DISTI	14462	204213	218675	.729338	.729338	62
63.50 RHC		408619	408619	1.763689	1.763689	63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	6891605	16279046	23170651			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	6891605	16279046	23170651			103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1331) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	1.030579	1.030579	1.030579			37
40 ANESTHESIOLOGY	.631034	.631034	.631034			40
41 RADIOLOGY-DIAGNOSTIC	.289657	.289657	.289657			41
44 LABORATORY	.192580	.192580	.192580			44
49 RESPIRATORY THERAPY	.736632	.736632	.736632			49
50 PHYSICAL THERAPY	.536420	.536420	.536420			50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	.051694	.051694	.051694			53
55 MEDICAL SUPPLIES CHARGED TO PAT	.375455	.375455	.375455			55
56 DRUGS CHARGED TO PATIENTS	.684209	.684209	.684209			56
56.01 CARDIAC REHABILITATION	.902879	.902879	.902879			56.01
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	.753340	.753340	.753340			61
62 OBSERVATION BEDS (NON-DISTINCT)	.729338	.729338	.729338			62
63.50 RHC	1.763689	1.763689	1.763689			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						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	1	.684209	1
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)	2		2
2.01 VACCINE CHARGES - HEPATITIS B	2.01		2.01
3 VACCINE COSTS (OTHER THAN HEPATITIS B)	3		3
3.01 VACCINE COSTS - HEPATITIS B	3.01		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1331) [] 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 SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT 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	292703							37
40 ANESTHESIOLOGY	141732							40
41 RADIOLOGY-DIAGNOSTIC	2120699							41
44 LABORATORY	2285266							44
49 RESPIRATORY THERAPY	65580							49
50 PHYSICAL THERAPY	612271							50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY	117523							53
55 MEDICAL SUPPLIES CHARGED TO PA	401240							55
56 DRUGS CHARGED TO PATIENTS	354132							56
56.01 CARDIAC REHABILITATION	30654							56.01
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY	521809							61
62 OBSERVATION BEDS (NON-DISTINCT	57701							62
63.50 RHC								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	7001310							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	7001310							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1331) [] 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)	PPS SERVICES (COLUMNS 1.01x5.01)	ALL OTHER (COLUMNS 1.01x5.02)	PPS SERVICES (COLUMNS 1.01x5.03)	PPS SERVICES (COLUMNS 1.01x5.04)	I/P PART B CHARGES (SEE INSTRU.)	I/P PART B COST (COLUMNS 1.02x10)
	9	9.01	9.02	9.03	9.04	10	11
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	301654						37
40 ANESTHESIOLOGY	89438						40
41 RADIOLOGY-DIAGNOSTIC	614275						41
44 LABORATORY	440097						44
49 RESPIRATORY THERAPY	48308						49
50 PHYSICAL THERAPY	328434						50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY	6075						53
55 MEDICAL SUPPLIES CHARGED TO PAT	150648						55
56 DRUGS CHARGED TO PATIENTS	242300						56
56.01 CARDIAC REHABILITATION	27677						56.01
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	393100						61
62 OBSERVATION BEDS (NON-DISTINCT)	42084						62
63.50 RHC							63.50
63.60 FOHC							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	2684090						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	2684090						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	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	
	1	2	3	4	5	6	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS				468464	151312	317152	25
26 INTENSIVE CARE UNIT							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				468464		317152	101

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL			
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST	
	7	8	9	10	11	12	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS	2045	201			155.09	31173	25
26 INTENSIVE CARE UNIT							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	2045	201				31173	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-1331) [] 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 CAPITAL RELATED COST	NEW CAPITAL RELATED COST	TOTAL CHARGES	INPATIENT PROGRAM CHARGES	----	OLD CAPITAL RATIO OF COST TO CHARGES	----	NEW CAPITAL RATIO OF COST TO CHARGES	----
	1	2	3	4	5	6	7	8	
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM		232973	866742	37627			.268792	10114	37
40 ANESTHESIOLOGY		10873	494284	24892			.021997	548	40
41 RADIOLOGY-DIAGNOSTIC		285690	5380357	105738			.053099	5615	41
44 LABORATORY		99376	5922208	183287			.016780	3076	44
49 RESPIRATORY THERAPY		49078	777734	43894			.063104	2770	49
50 PHYSICAL THERAPY		75767	1984488	4214			.038180	161	50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY		1363	609921	8497			.002235	19	53
55 MEDICAL SUPPLIES CHARGED TO P		19833	2136930	150961			.009281	1401	55
56 DRUGS CHARGED TO PATIENTS		57535	1415184	96474			.040655	3922	56
56.01 CARDIAC REHABILITATION		5428	56723				.095693		56.01
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY		80181	1781736	30097			.045002	1354	61
62 OBSERVATION BEDS (NON-DISTINC			218675						62
63.50 RHC			408619						63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
101 TOTAL		918097	21644982	685681				28980	101

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	TOTAL	PER	INPATIENT	INPATIENT
		ANESTHETIST	EDUCATION	ADJUSTMENT	TOTAL	PATIENT	DIEM	PROGRAM	PROGRAM
		COST	COST	AMOUNT	COSTS	DAYS		DAYS	PASS THRU
		1	2	3	4	5	6	7	8
	INPAT ROUTINE SERV COST CTRS								
25	ADULTS & PEDIATRICS					2045		201	25
26	INTENSIVE CARE UNIT								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					2045		201	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-1331)	[]	SUB IV	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	SUB I	[]	SNF	[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	SUB II	[]	NP	[]	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
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY							53
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
56.01 CARDIAC REHABILITATION							56.01
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							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 (14-1331) [] 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		866742			37627		37
40 ANESTHESIOLOGY		494284			24892		40
41 RADIOLOGY-DIAGNOSTIC		5380357			105738		41
44 LABORATORY		5922208			183287		44
49 RESPIRATORY THERAPY		777734			43894		49
50 PHYSICAL THERAPY		1984488			4214		50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY		609921			8497		53
55 MEDICAL SUPPLIES CHARGED TO P		2136930			150961		55
56 DRUGS CHARGED TO PATIENTS		1415184			96474		56
56.01 CARDIAC REHABILITATION		56723					56.01
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY		1781736			30097		61
62 OBSERVATION BEDS (NON-DISTINC		218675					62
63.50 RHC		408619					63.50
63.60 PQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		21644982			685681		101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-1331)	<input type="checkbox"/>	SUB IV	<input type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	SUB I	<input type="checkbox"/>	SNF	<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	SUB II	<input type="checkbox"/>	NF	<input type="checkbox"/>	OTHER
			<input type="checkbox"/>	SUB III	<input type="checkbox"/>	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
ANCILLARY SERVICE COST CENTERS	8.01	8.02	9	9.01	9.02
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
53 ELECTROCARDIOLOGY					53
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
56.01 CARDIAC REHABILITATION					56.01
OUTPATIENT SERVICE COST CENTERS					
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
101 TOTAL					101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1331) [] SNF
 APPLICABLE [] TITLE XVIII-PT B [] SUB I [] NP
 BOXES [XX] 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	PART I	PART II	OUTPATIENT	OUTPATIENT	OTHER
	COL. 8	COL. 9	COL. 9	AMBULATORY	RADIOLOGY	OUTPATIENT
	1	1.01	1.02	2	3	4
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	1.030579	1.030579	1.030579			37
40 ANESTHESIOLOGY	.631034	.631034	.631034			40
41 RADIOLOGY-DIAGNOSTIC	.289657	.289657	.289657			41
44 LABORATORY	.192580	.192580	.192580			44
49 RESPIRATORY THERAPY	.736632	.736632	.736632			49
50 PHYSICAL THERAPY	.536420	.536420	.536420			50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	.051694	.051694	.051694			53
55 MEDICAL SUPPLIES CHARGED TO PAT	.375455	.375455	.375455			55
56 DRUGS CHARGED TO PATIENTS	.684209	.684209	.684209			56
56.01 CARDIAC REHABILITATION	.902879	.902879	.902879			56.01
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	.753340	.753340	.753340			61
62 OBSERVATION BEDS (NON-DISTINCT)	.729338	.729338	.729338			62
63.50 RHC	1.763689	1.763689	1.763689			63.50
63.60 FOHC						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						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	1	.684209	1
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)	2		2
2.01 VACCINE CHARGES - HEPATITIS B	2.01		2.01
3 VACCINE COSTS (OTHER THAN HEPATITIS B)	3		3
3.01 VACCINE COSTS - HEPATITIS B	3.01		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1331) [] SNF
 APPLICABLE [] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [XX] 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 (SEE	ALL OTHER (SEE	PPS SER- VICES (SEE	PPS SER- VICES (SEE	OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
	INSTRU.)	INSTRU.)	INSTRU.)	INSTRU.)	INSTRU.)	6	7	8	
	5	5.01	5.02	5.03	5.04				
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	118529							37	
40 ANESTHESIOLOGY	72898							40	
41 RADIOLOGY-DIAGNOSTIC	898391							41	
44 LABORATORY	624567							44	
49 RESPIRATORY THERAPY	83865							49	
50 PHYSICAL THERAPY	188418							50	
51 OCCUPATIONAL THERAPY								51	
52 SPEECH PATHOLOGY								52	
53 ELECTROCARDIOLOGY	57355							53	
55 MEDICAL SUPPLIES CHARGED TO PA	223067							55	
56 DRUGS CHARGED TO PATIENTS	69551							56	
56.01 CARDIAC REHABILITATION								56.01	
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY	678292							61	
62 OBSERVATION BEDS (NON-DISTINCT								62	
63.50 RHC	26674							63.50	
63.60 FOHC								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	3041607							101	
102 CRNA CHARGES								102	
103 PBP CLINIC LAB								103	
104 NET CHARGES	3041607							104	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1331) [] SNF
 APPLICABLE [] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [XX] 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	122153						37
40 ANESTHESIOLOGY	46001						40
41 RADIOLOGY-DIAGNOSTIC	260225						41
44 LABORATORY	120279						44
49 RESPIRATORY THERAPY	61778						49
50 PHYSICAL THERAPY	101071						50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY	2965						53
55 MEDICAL SUPPLIES CHARGED TO PAT	83752						55
56 DRUGS CHARGED TO PATIENTS	47587						56
56.01 CARDIAC REHABILITATION							56.01
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	510984						61
62 OBSERVATION BEDS (NON-DISTINCT)							62
63.50 RHC	47045						63.50
63.60 FOHC							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	1403840						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	1403840						104

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

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

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1331)	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)	3086						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	2045						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2045						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	484						5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	483						6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	37						7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	37						8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1408						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	484						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	483						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) (14-1331)	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	116.26						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	119.75						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3049123						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	4302						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	4431						25
26 TOTAL SWING-BED COST	984852						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2064271						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1117050						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1117050						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.847967						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	546.23						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	2064271						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) (14-1331)	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	1009.43					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1421277					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1421277					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						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						47
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-1331)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	1268584					48
49 TOTAL PROGRAM INPATIENT COSTS	2689861					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) (14-1331)	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	488564					60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	487555					61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	976119					62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

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

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

SNF

	1	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST		66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		67
68 PROGRAM ROUTINE SERVICE COST		68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS		71
72 PER DIEM CAPITAL RELATED COSTS		72
73 PROGRAM CAPITAL RELATED COSTS		73
74 INPATIENT ROUTINE SERVICE COST		74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT		76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78 INPATIENT ROUTINE SERVICE COST LIMITATION		78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS		79
80 PROGRAM INPATIENT ANCILLARY SERVICES		80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS		82

PROVIDER NO. 14-1331 MARSHALL BROWNING HOSPITAL
PERIOD FROM 07/01/2009 TO 06/30/2010

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

VERSION: 2010.09
11/10/2010 13:32

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-1331)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	158	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1009.42	84
85 OBSERVATION BED COST	159488	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) (14-1331)	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)	3086					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	2045					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)						3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2045					4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	484					5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	483					6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	37					7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	37					8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	201					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) (14-1331)	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	116.26						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	119.75						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3049123						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	4302						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	4431						25
26 TOTAL SWING-BED COST	984852						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2064271						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1117050						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1117050						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.847967						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	546.23						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	2064271						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) (14-1331)	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	1009.43					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	202895					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	202895					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
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (PPS) (14-1331)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	300804					48
49 TOTAL PROGRAM INPATIENT COSTS	503699					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	31173					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	28980					51
52 TOTAL PROGRAM EXCLUDABLE COST	60153					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	443546					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) (14-1331)	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

66	SNF/NF/ICF/MR ROUTINE SERVICE COST	1	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 SUB I SUB II SUB III SUB IV
 (PPS)
 (14-1331)
 1 1 1 1 1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	158	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1009.42	84
85 OBSERVATION BED COST	159488	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

	HOSPITAL ROUTINE COST (FROM LINE 27)	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST (FROM LINE 85)	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4
	1	2	3	4
86 OLD CAPITAL-RELATED COST	2064271		159488	86
87 NEW CAPITAL-RELATED COST	2064271		159488	87
88 NON PHYSICIAN ANESTHETIST	2064271		159488	88
89 MEDICAL EDUCATION	2064271		159488	89

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[] TITLE V [XX] HOSPITAL (14-1331) [] SNF [] PPS
 [XX] TITLE XVIII-PT A [] SUB I [] NF [] TEFRA
 [] TITLE XIX [] SUB II [] S/B-SNF [XX] OTHER
 [] SUB III [] S/B-NF
 [] SUB IV [] 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		835758		25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	1.030579	81119	83600	37
40 ANESTHESIOLOGY	.631034	55880	35262	40
41 RADIOLOGY-DIAGNOSTIC	.289657	375837	108864	41
44 LABORATORY	.192580	844174	162571	44
49 RESPIRATORY THERAPY	.736632	235197	173254	49
50 PHYSICAL THERAPY	.536420	65490	35130	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	.051694	188078	9723	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.375455	764487	287030	55
56 DRUGS CHARGED TO PATIENTS	.684209	501328	343013	56
56.01 CARDIAC REHABILITATION	.902879			56.01
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.753340	40004	30137	61
62 OBSERVATION BEDS (NON-DISTINCT	.729338			62
OTHER REIMBURSABLE COST CENTERS				
63.50 RHC	1.763689			63.50
63.60 FQHC				63.60
101 TOTAL		3151594	1268584	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		3151594		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-Z331)	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	1.030579	1184	1220	37
40 ANESTHESIOLOGY	.631034			40
41 RADIOLOGY-DIAGNOSTIC	.289657	24055	6968	41
44 LABORATORY	.192580	217215	41831	44
49 RESPIRATORY THERAPY	.736632	104649	77088	49
50 PHYSICAL THERAPY	.536420	174565	93640	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	.051694	32164	1663	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.375455	353578	132753	55
56 DRUGS CHARGED TO PATIENTS	.684209	220137	150620	56
56.01 CARDIAC REHABILITATION	.902879			56.01
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.753340			61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.729338			62
63.50 RHC	1.763689			63.50
63.60 FQHC				63.60
101 TOTAL		1127547	505783	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		1127547		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[] TITLE V [XX] HOSPITAL (14-1331) [] SNF [XX] PPS
 [] TITLE XVIII-PT A [] SUB I [] NF [] TEFRA
 [XX] TITLE XIX [] SUB II [] S/B-SNF [] OTHER
 [] SUB III [] S/B-NF
 [] SUB IV [] 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		153735		25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	1.030579	37627	38778	37
40 ANESTHESIOLOGY	.631034	24892	15708	40
41 RADIOLOGY-DIAGNOSTIC	.289657	105738	30628	41
44 LABORATORY	.192580	183287	35297	44
49 RESPIRATORY THERAPY	.736632	43894	32334	49
50 PHYSICAL THERAPY	.536420	4214	2260	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	.051694	8497	439	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.375455	150961	56679	55
56 DRUGS CHARGED TO PATIENTS	.684209	96474	66008	56
56.01 CARDIAC REHABILITATION	.902879			56.01
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.753340	30097	22673	61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.729338			62
63.50 RHC	1.763689			63.50
63.60 FQHC				63.60
101 TOTAL		685681	300804	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		685681		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				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				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
OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19						
3.21						3.21
3.22						3.22
3.23						3.23
[SUM OF LINES] [PLUS E-3, PT.VI]						
[3.21-3.23] [LINE 23]						
3.24						3.24
DISPROPORTIONATE SHARE ADJUSTMENT						
4						4
PART A PATIENT DAYS						
4.01						4.01
4.02						4.02
4.03						4.03
4.04						4.04
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD						
BENEFICIARY DISCHARGES						
5						5
TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING						
DISCHARGES FOR DRGs 302, 316 AND 317						
5.01						5.01
TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302,						
316 AND 317						
5.02						5.02
DIVIDE LINE 5.01 BY LINE 5						
5.03						5.03
TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs						
302, 316 AND 317						
5.04						5.04
RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK						
5.05						5.05
AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS						
5.06						5.06
TOTAL ADDITIONAL PAYMENT						
6						6
SUBTOTAL						
7						7
HOSPITAL SPECIFIC PAYMENTS						
7.01						7.01
HOSPITAL SPECIFIC PAYMENTS (1996 HSR)						
8						8
TOTAL PAYMENT FOR INPATIENT OPERATING COSTS						
9						9
PAYMENT FOR INPATIENT PROGRAM CAPITAL						
10						10
EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL						
11						11
DIRECT GRADUATE MEDICAL EDUCATION PAYMENT						
11.01						11.01
NURSING AND ALLIED HEALTH MANAGED CARE						
11.02						11.02
ADD-ON PAYMENT FOR NEW TECHNOLOGIES						
12						12
NET ORGAN ACQUISITION COST						
13						13
COST OF TEACHING PHYSICIANS						
14						14
ROUTINE SERVICE OTHER PASS THROUGH COSTS						
15						15
ANCILLARY SERVICE OTHER PASS THROUGH COSTS						
16						16
TOTAL						
17						17
PRIMARY PAYER PAYMENTS						
18						18
TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES						
19						19
DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES						
20						20
COINSURANCE BILLED TO PROGRAM BENEFICIARIES						
21						21
REIMBURSABLE BAD DEBTS						
21.01						21.01
REDUCED PROGRAM REIMBURSABLE BAD DEBTS						
21.02						21.02
REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES						
22						22
SUBTOTAL						

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
24						24
25						25
26						26
27						27
28						28
28.01						28.01
29						29
30						30
50						50
51						51
52						52
53						53
54						54
55						55
56						56

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1331) 1	HOSPITAL (14-1331) 1.01	HOSPITAL (14-1331) 1.02	
1				1
1.01	2684090			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
2				2
3				3
4				4
5	2684090			5
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
6				6
7				7
8				8
9				9
10				10
CUSTOMARY CHARGES				
11				11
12				12
13				13
14				14
15				15
16				16
17	2710931			17
17.01				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1331)	HOSPITAL (14-1331)	HOSPITAL (14-1331)
	1	1.01	1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES			18
18.01 COINSURANCE	981840		18.01
19 SUBTOTAL	1729091		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	1729091		23
24 PRIMARY PAYER PAYMENTS			24
25 SUBTOTAL	1729091		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	202256		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	202256		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	202256		27.02
28 SUBTOTAL	1931347		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	1931347		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	1863826		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	67521		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONILIATION AMOUNT (SEE INSTRUCT			51
52 THE RATE USED TO CALCULATE THE TIME VALUE			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 HOSPITAL (14-1331)

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		2246098		1863826	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM					
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .01				3.01
REVISION OF THE INTERIM RATE FOR THE COST	TO .02				3.02
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .03	NONE		NONE	3.03
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .04				3.04
	PROVIDER .05				3.05
	PROGRAM .50				3.50
	PROVIDER .51				3.51
	TO .52	NONE		NONE	3.52
	PROGRAM .53				3.53
	PROGRAM .54				3.54
SUBTOTAL	.99				3.99
4 TOTAL INTERIM PAYMENTS		2246098		1863826	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				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	237548		67521	6.01
	PROVIDER TO .02				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		2483646		1931347	7

NAME OF INTERMEDIARY: _____
 SIGNATURE OF AUTHORIZED PERSON: _____

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 SWING BED SKILLED NURSING FACILITY (14-2331)

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		1224347		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		NONE 2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM				
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT				
REVISION OF THE INTERIM RATE FOR THE COST				
REPORTING PERIOD. ALSO SHOW DATE OF EACH				
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				
PROGRAM .01	01/27/2010	17100		3.01
TO .02				3.02
PROVIDER .03			NONE	3.03
PROVIDER .04				3.04
TO .05				3.05
PROVIDER .50				3.50
TO .51				3.51
PROVIDER .52		NONE		NONE 3.52
PROGRAM .53				3.53
PROGRAM .54				3.54
SUBTOTAL .99		17100		3.99
4 TOTAL INTERIM PAYMENTS		1241447		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		248369		6.01
PROVIDER TO .02				6.02
PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		1489816		7
NAME OF INTERMEDIARY: _____			INTERMEDIARY NUMBER: _____	
SIGNATURE OF AUTHORIZED PERSON: _____			DATE (MO/DAY/YR): _____	

CALCULATION OF REIMBURSEMENT SETTLEMENT
 SWING BEDS

SUPPLEMENTAL
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

	TITLE V	--- TITLE XVIII ---		--- TITLE XIX ---		
	S/B NF	S/B SNF	S/B SNF	S/B SNF	S/B NF	
		PART A	PART B	(14-Z331)	(14-Z331)	
	1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF	985880				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF					2
3	ANCILLARY SERVICES	510841				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					4
5	PROGRAM DAYS	967				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY					7
8	SUBTOTAL	1496721				8
9	PRIMARY PAYER PAYMENTS					9
10	SUBTOTAL	1496721				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)					11
12	SUBTOTAL	1496721				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	6905				13
14	80% OF PART B COSTS					14
15	SUBTOTAL	1489816				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	1489816				18
19	SEQUESTRATION ADJUSTMENT					19
20	INTERIM PAYMENTS	1241447				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					20.01
21	BALANCE DUE PROVIDER/PROGRAM	248369				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1331)	SUB I	SUB II	SUB III	SUB IV	SNF I
1	INPATIENT SERVICES	2689861				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	2689861				4
5	PRIMARY PAYER PAYMENTS					5
6	TOTAL COST	2716760				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 (14-1331)	SUB I	SUB II	SUB III	SUB IV	SNF I
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
25.01						25.01
25.02						25.02
26						26
27						27
28						28
29						29
30						30
31						31
32						32
32.01						32.01
33						33
34						34

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	NF I		
	HOSPITAL (14-1331) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I
1	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1
2	INPATIENT HOSPITAL/SNF/NF SERVICES					1
3	MEDICAL AND OTHER SERVICES	1403840				2
4	INTERNS AND RESIDENTS					3
5	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O					4
6	COST OF TEACHING PHYSICIANS					5
7	SUBTOTAL	1403840				6
8	INPATIENT PRIMARY PAYER PAYMENTS					7
9	OUTPATIENT PRIMARY PAYER PAYMENTS					8
10	SUBTOTAL	1403840				9
11	COMPUTATION OF LESSER OF COST OR CHARGES					
12	ROUTINE SERVICE CHARGES					10
13	ANCILLARY SERVICE CHARGES	3727288				11
14	INTERNS AND RESIDENTS SERVICE CHARGES					12
15	ORGAN ACQUISITION CHARGES, NET OF REVENUE					13
16	TEACHING PHYSICIANS					14
17	INCENTIVE FROM TARGET AMOUNT COMPUTATION					15
18	TOTAL REASONABLE CHARGES					16
19	CUSTOMARY CHARGES					
20	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE					17
21	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM					18
22	A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN					
23	ACCORDANCE WITH 42 CFR 413.13(E)					
24	RATIO OF LINE 17 TO LINE 18					19
25	TOTAL CUSTOMARY CHARGES					20
26	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST					21
27	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES					22
28	COST OF COVERED SERVICES	1403840				23
29	PROSPECTIVE PAYMENT AMOUNT					
30	OTHER THAN OUTLIER PAYMENTS					24
31	OUTLIER PAYMENTS					25
32	PROGRAM CAPITAL PAYMENTS					26
33	CAPITAL EXCEPTION PAYMENTS					27
34	ROUTINE SERVICE OTHER PASS THROUGH COSTS					28
35	ANCILLARY SERVICE OTHER PASS THROUGH COSTS					29
36	SUBTOTAL	1403840				30
37	CUSTOMARY CHARGES (TITLE XIX PPS COVERED					31
38	LESSER OF LINES 30 OR 31					32
39	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		NF I
	HOSPITAL (14-1331) (PPS)	SUB I	SUB II	SUB III	SUB IV
	1	1	1	1	1
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
34	EXCESS OF REASONABLE COST				34
35	SUBTOTAL				35
36	COINSURANCE				36
37	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	179423			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	2765721			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-353608			6
7 INVENTORY	324660			7
8 PREPAID EXPENSES	183943			8
9 OTHER CURRENT ASSETS	790169			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS	3890308			11
FIXED ASSETS				
12 LAND	3114			12
12.01 ACCUMULATED DEPRECIATION				12.01
13 LAND IMPROVEMENTS	1080919			13
13.01 ACCUMULATED DEPRECIATION	-456649			13.01
14 BUILDINGS	8571357			14
14.01 ACCUMULATED DEPRECIATION	-3003610			14.01
15 LEASEHOLD IMPROVEMENTS				15
15.01 ACCUMULATED AMORTIZATION				15.01
16 FIXED EQUIPMENT	6309993			16
16.01 ACCUMULATED DEPRECIATION	-2672304			16.01
17 AUTOMOBILES AND TRUCKS				17
17.01 ACCUMULATED DEPRECIATION				17.01
18 MAJOR MOVABLE EQUIPMENT	4707346			18
18.01 ACCUMULATED DEPRECIATION	-3499504			18.01
19 MINOR EQUIPMENT DEPRECIABLE				19
19.01 ACCUMULATED DEPRECIATION				19.01
20 MINOR EQUIPMENT-NONDEPRECIABLE				20
21 TOTAL FIXED ASSETS	11040662			21
OTHER ASSETS				
22 INVESTMENTS	5754423			22
23 DEPOSITS ON LEASES				23
24 DUE FROM OWNERS/OFFICERS				24
25 OTHER ASSETS	184138			25
26 TOTAL OTHER ASSETS	5938561			26
27 TOTAL ASSETS	20869531			27
LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	519500			28
29 SALARIES, WAGES & FEES PAYABLE	898657			29
30 PAYROLL TAXES PAYABLE				30
31 NOTES & LOANS PAYABLE (SHORT TERM)	564151			31
32 DEFERRED INCOME				32
33 ACCELERATED PAYMENTS				33
34 DUE TO OTHER FUNDS				34
35 OTHER CURRENT LIABILITIES	64570			35
36 TOTAL CURRENT LIABILITIES	2046878			36
LONG-TERM LIABILITIES				
37 MORTGAGE PAYABLE				37
38 NOTES PAYABLE	9770629			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	1826546			41
42 TOTAL LONG TERM LIABILITIES	11597175			42
43 TOTAL LIABILITIES	13644053			43
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	7225478			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	7225478			51
52 TOTAL LIABILITIES AND FUND BALANCES	20869531			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	7409976			1
2 NET INCOME (LOSS)	-184498			2
3 TOTAL	7225478			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5 RESTRICTED CONTRIBUTIONS				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	7225478			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13 RELEASED FROM RESTRICTION				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	7225478			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	1117050		1117050	1
2 SUBPROVIDER I				2
4 SWING BED - SNF	275088		275088	4
5 SWING BED - NF				5
6 SKILLED NURSING FACILITY				6
7 NURSING FACILITY				7
8 OTHER LONG TERM CARE				8
9 TOTAL GENERAL INPATIENT CARE SERVICES	1392138		1392138	9
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10 INTENSIVE CARE UNIT				10
11 CORONARY CARE UNIT				11
12 BURN INTENSIVE CARE UNIT				12
13 SURGICAL INTENSIVE CARE UNIT				13
14 OTHER SPECIAL CARE (SPECIFY)				14
15 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
16 TOTAL INPATIENT ROUTINE CARE SERVICES	1392138		1392138	16
17 ANCILLARY SERVICES	5697119	14051431	19748550	17
18 OUTPATIENT SERVICES	270155	5189295	5459450	18
18.50 RHC				18.50
18.60 PQHC				18.60
19 HOME HEALTH AGENCY				19
20 AMBULANCE				20
21 CORF				21
22 ASC				22
23 HOSPICE				23
24				24
25 TOTAL PATIENT REVENUES	7359412	19240726	26600138	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		16548595	26
27 ADD (SPECIFY)			27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS			33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		16548595	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	26600138	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	11122419	2
3	NET PATIENT REVENUES	15477719	3
4	LESS - TOTAL OPERATING EXPENSES	16548595	4
5	NET INCOME FROM SERVICE TO PATIENTS	-1070876	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	45102	6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	44659	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	302964	15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	65496	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	955	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	GAIN ON INVESTMENTS - NET	238672	24
24.01	OTHER INCOME	188530	24.01
24.02	OTHER GAINS		24.02
25	TOTAL OTHER INCOME	886378	25
26	TOTAL	-184498	26
27	LOSS ON INVESTMENTS - NET		27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-184498	31

CALCULATION OF CAPITAL PAYMENT - TITLE XIX - COST METHOD

WORKSHEET L

	HOSPITAL (14-1331)	HOSPITAL (14-1331)	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 I-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	4A	25	26	27
GENERAL SERVICE COST CENTERS					
3 NEW CAP REL COSTS-BLDG & FIXT					3
3.01 2008 BLDG & FIXT					3.01
3.02 RHC BLDG & FIXT					3.02
4 NEW CAP REL COSTS-MVBLE EQUIP					4
4.01 2008 MVBLE EQUIP					4.01
4.02 RHC MVBLE EQUIP					4.02
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
14 NURSING ADMINISTRATION					14
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY					17
18 SOCIAL SERVICE					18
20 NONPHYSICIAN ANESTHETISTS					20
23 I&R SERVICES-OTHER PRGM COSTS					23
24 PARAMED ED PRGM-(SPECIFY)					24
25 INPATIENT ROUTINE SERV COST CENTERS					25
ADULTS & PEDIATRICS					25
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
53 ELECTROCARDIOLOGY					53
55 MEDICAL SUPPLIES CHARGED TO PA					55
56 DRUGS CHARGED TO PATIENTS					56
56.01 CARDIAC REHABILITATION					56.01
OUTPATIENT SERVICE COST CENTERS					
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINCT					62
63.50 RHC					63.50
63.60 PQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
71 HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS					
95 SUBTOTALS					95
NONREIMBURSABLE COST CENTERS					
96 GIFT, FLOWER, COFFEE SHOP & CA					96
98 PHYSICIANS' PRIVATE OFFICES					98
98.02 INDEPENDENT LIVING					98.02
98.03 MEALS ON WHEELS					98.03
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

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

RHC I
 COMPONENT NO: 14-8504

WORKSHEET M-1

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1	244958		244958	-30328	214630		214630	1
2								2
3	24031		24031		24031		24031	3
4								4
5	52253		52253	-7453	44800		44800	5
6								6
7								7
8								8
9								9
10	321242		321242	-37781	283461		283461	10
COSTS UNDER AGREEMENT								
11								11
12								12
13								13
14								14
OTHER HEALTH CARE COSTS								
15		7804	7804	-1791	6013		6013	15
16		3280	3280	-37	3243		3243	16
17						900	900	17
18		26339	26339		26339		26339	18
19		2597	2597	-1474	1123		1123	19
20								20
21		40020	40020	-3302	36718	900	37618	21
22	321242	40020	361262	-41083	320179	900	321079	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26								26
27								27
28								28
FACILITY OVERHEAD								
29		3569	3569	-197	3372		3372	29
30	103845	34702	138547	-18746	119801		119801	30
31	103845	38271	142116	-18943	123173		123173	31
32	425087	78291	503378	-60026	443352	900	444252	32

RHC I
 COMPONENT NO: 14-8504

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1 PHYSICIANS	0.64	1756	4200	2688		1
2 PHYSICIAN ASSISTANTS			2100			2
3 NURSE PRACTITIONERS	0.26	432	2100	546		3
4 SUBTOTAL	0.90	2188		3234	3234	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	0.90	2188			3234	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					321079	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					321079	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD					123173	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					276425	15
16 TOTAL OVERHEAD					399598	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					399598	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					399598	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					720677	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-8504

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	720677	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	1109	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	719568	3
4	TOTAL VISITS	3234	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	3234	6
7	ADJUSTED COST PER VISIT	222.50	7

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

8	PER VISIT PAYMENT LIMIT			8
9	RATE FOR PROGRAM COVERED VISITS	222.50	222.50	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	565	565	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	125713	125713	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES			14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST			15
16	TOTAL PROGRAM COST			251426 16
16.01	PRIMARY PAYOR PAYMENTS			16.01
17	LESS: BENEFICIARY DEDUCTIBLE			13447 17
18	NET PROGRAM COST EXCLUDING VACCINES			237979 18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			190383 19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			838 20
21	TOTAL REIMBURSABLE PROGRAM COST			191221 21
22	REIMBURSABLE BAD DEBTS			22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			22.01
23	OTHER ADJUSTMENTS			23
24	NET REIMBURSABLE AMOUNT			191221 24
25	INTERIM PAYMENTS			83451 25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE COMPONENT/PROGRAM			107770 26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			27

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

RHC I
 COMPONENT NO: 14-8504

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	H1N1 VACCINE (SERVICES ON/AFTER 10/1/2009) 2.01	COMBINATION INFLUENZA & H1N1 IN SAME VISIT 2.02	
1 HEALTH CARE STAFF COSTS	283461	283461	283461	283461	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		0.000200			2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST		57			3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	184	253			4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	184	310			5
6 TOTAL DIRECT COST OF THE FACILITY	321079	321079	321079	321079	6
7 TOTAL OVERHEAD	399598	399598	399598	399598	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.000573	0.000965			8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	229	386			9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	413	696			10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	5	36			11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	82.60	19.33			12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	5	22			13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	413	425			14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		1109			15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		838			16

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

RHC I
 COMPONENT NO: 14-8504

WORKSHEET M-5

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		83451	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	PROGRAM .01		3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .02		3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .03	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		3.50
	PROVIDER .51		3.51
	TO .52	NONE	3.52
	PROGRAM .53		3.53
	.54		3.54
SUBTOTAL	.99		3.99
4 TOTAL INTERIM PAYMENTS		83451	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01		5.01
	TO .02	NONE	5.02
	PROVIDER .03		5.03
	PROVIDER .50		5.50
	TO .51	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	107770	6.01
	PROVIDER TO .02		6.02
PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY		191221	7
NAME OF INTERMEDIARY:	INTERMEDIARY NUMBER:		
SIGNATURE OF AUTHORIZED PERSON:	DATE (MO/DAY/YR):		

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD	
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	PARTY UTIL 7	
UTILIZATION PERCENTAGES BASED ON DAYS								
25 ADULTS & PEDIATRICS	68.85		9.83				78.68	25
UTILIZATION PERCENTAGES BASED ON CHARGES								
37 OPERATING ROOM	9.36	33.77	4.34	13.68			61.15	37
40 ANESTHESIOLOGY	11.31	28.67	5.04	14.75			59.77	40
41 RADIOLOGY-DIAGNOSTIC	6.99	39.42	1.97	16.70			65.08	41
44 LABORATORY	14.25	38.59	3.09	10.55			66.48	44
49 RESPIRATORY THERAPY	30.24	8.43	5.64	10.78			55.09	49
50 PHYSICAL THERAPY	3.30	30.85	0.21	9.49			43.85	50
53 ELECTROCARDIOLOGY	30.84	19.27	1.39	9.40			60.90	53
55 MEDICAL SUPPLIES CHARGED TO PAT	35.78	18.78	7.06	10.44			72.06	55
56 DRUGS CHARGED TO PATIENTS	35.42	25.02	6.82	4.91			72.17	56
56.01 CARDIAC REHABILITATION		54.04					54.04	56.01
61 EMERGENCY	2.25	29.29	1.69	38.07			71.30	61
62 OBSERVATION BEDS (NON-DISTINCT		26.39					26.39	62
63.50 RHC				6.53			6.53	63.50
101 TOTAL CHARGES	13.60	30.22	2.96	13.13			59.91	101

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
3	NEW CAP REL COSTS-BLDG & FIXT	526635	3.68	-526635	-6.60		3
3.01	2008 BLDG & FIXT	526008	3.68	-526008	-6.59		3.01
3.02	RHC BLDG & FIXT	25691	.18	-25691	-.32		3.02
4	NEW CAP REL COSTS-MVBLE EQUIP	508751	3.56	-508751	-6.37		4
4.01	2008 MVBLE EQUIP	91997	.64	-91997	-1.15		4.01
4.02	RHC MVBLE EQUIP	1139	.01	-1139	-.01		4.02
5	EMPLOYEE BENEFITS	1967063	13.75	-1967063	-24.64		5
6	ADMINISTRATIVE & GENERAL	1682445	11.76	-1682445	-21.08		6
7	MAINTENANCE & REPAIRS	285561	2.00	-285561	-3.58		7
8	OPERATION OF PLANT	319767	2.23	-319767	-4.01		8
9	LAUNDRY & LINEN SERVICE	68773	.48	-68773	-.86		9
10	HOUSEKEEPING	283135	1.98	-283135	-3.55		10
11	DIETARY	124486	.87	-124486	-1.56		11
12	CAFETERIA	187852	1.31	-187852	-2.35		12
14	NURSING ADMINISTRATION	435481	3.04	-435481	-5.46		14
16	PHARMACY	692218	4.84	-692218	-8.67		16
17	MEDICAL RECORDS & LIBRARY	212146	1.48	-212146	-2.66		17
18	SOCIAL SERVICE	42792	.30	-42792	-.54		18
20	NONPHYSICIAN ANESTHETISTS						20
23	I&R SERVICES-OTHER PRGM COSTS A						23
24	PARAMED ED PRGM-(SPECIFY)						24
INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	790396	5.52	2258727	28.30	3049123	21.31
ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	274329	1.92	618917	7.75	893246	6.24
40	ANESTHESIOLOGY	200938	1.40	110972	1.39	311910	2.18
41	RADIOLOGY-DIAGNOSTIC	822457	5.75	735999	9.22	1558456	10.89
44	LABORATORY	651236	4.55	489261	6.13	1140497	7.97
49	RESPIRATORY THERAPY	278305	1.94	294599	3.69	572904	4.00
50	PHYSICAL THERAPY	565273	3.95	499246	6.25	1064519	7.44
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY	19800	.14	11729	.15	31529	.22
55	MEDICAL SUPPLIES CHARGED TO PAT	672290	4.70	130032	1.63	802322	5.61
56	DRUGS CHARGED TO PATIENTS			968282	12.13	968282	6.77
56.01	CARDIAC REHABILITATION	27778	.19	23436	.29	51214	.36
61	EMERGENCY	684406	4.78	657847	8.24	1342253	9.38
62	OBSERVATION BEDS (NON-DISTINCT						62
63.50	RHC	444252	3.10	276425	3.46	720677	5.04
63.60	PQHC						63.60
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
71	HOME HEALTH AGENCY						71
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
96	GIFT, FLOWER, COFFEE SHOP & CAN			13799	.17	13799	.10

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
98 PHYSICIANS' PRIVATE OFFICES	724336	5.06	612589	7.67	1336925	9.34	98
98.02 INDEPENDENT LIVING	172050	1.20	266267	3.34	438317	3.06	98.02
98.03 MEALS ON WHEELS			13813	.17	13813	.10	98.03
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 TOTAL	14309786	100.00	0	.00	14309786	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 OPFS. (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)	2355656
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPFS. (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)	6389039
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.369

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES				CLINIC NAME	REPORTING PERIOD	ATTACHMENT #1
				Marshall Browning Physician Clinic	14-8504 FROM: 7/1/09 TO: 6/30/10	
COST CENTER (OMIT CENTERS)	COMPENSATION	OTHER	TOTAL COL. 1&2	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE COL. 3&4	ADJUSTMENTS INCREASES (DECREASES) COL. 5&6
1	1	2	3	4	5	7
1 SUPPLEMENTAL COSTS						
2 Pharmacy						
3 Patient Transport (off)	None					
4 Medical Case Management						
5 Health Education						
6 Nutrition Counseling						
7 Others (specify)						
8						
9						
10						
11						
12 Supplemental Subtotal (sum of lines 2 through 11)						
13 DENTAL						
14 NON-ALLOWABLE COST CENTERS						
15 HMHK Case Management						
16 WIC (Women, Infants, & Children)						
17 Fundraising & Public Relations						
18 Social Services						
19 Unlicensed Social Workers						
20 Others (specify)						
21						
22						
23						
24						
25 Non-Allowable Subtotal (sum of lines 15 - 24)						
26 Totals for schedule C (sum of lines 12, 13, & 25)						

NOTE: This schedule allows for supplemental reimbursement of some costs which are not allowable under the Medicare program.

RURAL HEALTH CENTER DENTAL STATISTICS		CLINIC NAME	REPORTING PERIOD	FROM	TO	ATTACHMENT #2		
COST CENTER (OMIT CENTS)		COMPENSATION	OTHER	COL. 1&2	RECLASSI- FICATIONS	RE-CLASSIFIED TRIAL BALANCE (COL. 3&4)	ADJUSTMENTS INCREASES (DECREASES)	NET EXPENSES (COL. 5&6)
		1	2	3	4	5	6	7
1	RHC DENTAL STAFF COST							
2	Dentists							
3	Dental Hygienist	N/A						
4								
5								
6	TOTAL - Dentists(Sum of lines 1 through 5)							
7	Other - Dental Staff							
8								
9								
10								
11	SUBTOTAL - Other Dental Staff(Sum of lines 7-10)							
12	TOTAL - Dental Staff (Sum of lines 6 and 11)							
13	Dental Services Under Agreement							
14								
15	TOTAL DENTAL COST(Sum of lines 12 through 14)							

7/1/09
6/30/10

14-8504

Marshall Browning
Physician Clinic

DENTAL SERVICES PERSONNEL		DENTAL SERVICES PERSONNEL, EQUIVALENTS, HOURS ON SITE, AND ENCOUNTERS		
DENTAL SERVICES PERSONNEL	FULL TIME PERSONNEL EQUIVALENTS (FTEs)	HEALTH SERVICES HOURS	ENCOUNTERS	
			ON-SITE	OFF-SITE
TOTAL	TOTAL	TOTAL	TOTAL	TOTAL
16 RHC DENTAL STAFF				
17 Dentists	1	2	3	4
18 Dental Hygienist				
19				
20				
21 TOTAL - Dentists(Sum of lines 17 through 20)				
22 Other - Dental Staff				
23				
24				
25				
26 SUBTOTAL - Other Dental Staff(Sum of lines 22 through 25)				
27 TOTAL - Dental Staff(Sum of lines 21 and 26)				
28 Dental Services Under Agreement				
29				
30 TOTAL DENTAL(Sum of lines 27 through 29)				

100

N/A

NOTE: Total dental cost from line 15, column 7, must agree with Attachment #1, line 13