

DR. JOHN WARNER HOSPITAL

CLINTON, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED APRIL 30, 2011

November 22, 2011

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

**Re: Provider: Dr. John Warner Hospital**  
**Provider Numbers: 14-1303, 14-2303, 14-3404**  
**Period ended: 4-30-11**  
**Protested amount claimed on submitted cost report.**

Dear Sir or Madam:

The cost report for Dr. John Warner Hospital, for the year ended April 30, 2011, claims additional amounts due the provider for an expense paid by the provider, but currently not classified as a reimbursable cost by National Government Services, Inc. The expenses in question relate to the CRNA pass through cost in the amount of \$146,100, which we have included as adjustments to line 40 (Anesthesiology) on worksheet A-8. We feel as though the expense should be, and is, allowed as a reimbursable cost under Medicare Guidelines.

The calculation of the additional amounts due the provider was calculated by removing the adjustments on worksheet A-8. The protested amounts claimed for the period ended April 30, 2011 are as follows:

Worksheet E, part B, line 36	\$ 41,980
Worksheet E-2, line 22	(303)
Worksheet E-3, part II, line 34	(2,604)
Worksheet M-3, line 27	<u>(1,441)</u>
Total	<u>\$ 37,632</u>

Sincerely,

Earl Sheehy, CEO  
Dr. John Warner Hospital  
422 West White Street  
Clinton, Illinois 61727  
(217) 935-9571

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

WORKSHEET S  
 PARTS I, II & III

PART I - COST REPORT STATUS

- PROVIDER USE ONLY 1.  ELECTRONICALLY FILED COST REPORT DATE: 11/23/2011 TIME: 13:51  
 2.  MANUALLY SUBMITTED COST REPORT  
 3.  IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT  
 4.  MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.
- CONTRACTOR USE ONLY 5.  COST REPORT STATUS 6. DATE RECEIVED: \_\_\_\_\_ 10. NPR DATE: 11/23/2011  
 1 - AS SUBMITTED 7. CONTRACTOR NO: \_\_\_\_\_ 11. CONTRACTOR'S VENDOR CODE: \_\_\_\_\_  
 2 - SETTLED WITHOUT AUDIT 8.  INITIAL REPORT FOR THIS PROVIDER CCN 12.  IF LINE 5, COLUMN 1 IS 4: ENTER  
 3 - SETTLED WITH AUDIT 9.  FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.  
 4 - REOPENED  
 5 - AMENDED

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY DR JOHN WARNER HOSPITAL (14-1303) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 05/01/2010 AND ENDING 04/30/2011, AND 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 IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/23/2011 13:51  
 klP4xfafhAVbaU2L4h0lR8lND4Gzg0  
 ZT4Wq0yyn.XUVkZnvZuh6QRtbnlLaa  
 941:0Wzh7K05LEIi

(SIGNED)

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PI Encryption: 11/23/2011 13:51  
 hk6AUob.hr7avAuHeqmsolNcJi5Xe0  
 Gacub02:EF8p33dFPM4VUASOYX2pys  
 UPA98tZra20DkTHm

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		106,135	-173,861		101,345	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		13,435				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			190,050			10
11 HEALTH CLINIC - FOHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		119,570	16,189		101,345	200

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 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 422 WEST WHITE STREET P.O. BOX: 1  
 2 CITY: CLINTON STATE: IL ZIP CODE: 61727 COUNTY: DEWITT 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			3
						V	XVIII	XIX	
3	HOSPITAL	14-1303	00014	1	03/01/2000	N	O	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF	14-2303	00014		03/01/2000	N	O	N	7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED CLTC								11
12	HOSPITAL-BASED HHA								12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	14-3404	00014		07/03/1995	N	O	N	15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 05/01/2010			TO: 04/30/2011				20
21	TYPE OF CONTROL								21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2) (PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.								1	2
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.								2	N 23

		IN-STATE		OUT-OF-STATE		MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
		MEDICAID PAID DAYS	MEDICAID ELIGIBLE DAYS	MEDICAID PAID DAYS	MEDICAID ELIGIBLE DAYS			
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	1	2	3	4	5	6	24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		V	XVIII	XIX	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS  
 THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER  
 JULY 1, 2009 AND BEFORE JUNE 30, 2010.

	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2  
 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY  
 CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-  
 PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY  
 CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5  
 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE  
 INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS  
 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010

66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/(COL.3+COL.4))
1	2	3	4	5
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
<b>INPATIENT REHABILITATION FACILITY PPS</b>				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID 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. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
<b>LONG TERM CARE HOSPITAL PPS</b>				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
<b>TEFRA PROVIDERS</b>				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
<b>TITLE V AND XIX INPATIENT SERVICES</b>				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
<b>RURAL PROVIDERS</b>				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 106
107	COLUMN 1: 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 IN COLUMN 1. 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, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			N N 107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			Y 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	Y Y Y N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

			1	2	
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.		N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.		2		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.	1,000,000		3,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.		N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.		Y		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.			N	125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				134

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.		Y		140
-----	--	--	---	--	-----

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B.

SEE 42 CFR §413.13)		PART A	PART B
155	HOSPITAL	1	2
156	SUBPROVIDER - IPF	N	N
157	SUBPROVIDER - IRF		
158	SUBPROVIDER - (OTHER)		
159	SNF		
160	HHA		
161	CMHC		

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		165	
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.				168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.				169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE	
1		1	2	
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1
		Y/N	DATE	V/I
2		1	2	3
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE
4		1	2	3
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N	
6		1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
PS&R REPORT DATA		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	06/03/2011	Y	06/03/2011
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		Y	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COST

- 22 HAVE ASSETS BEEN RELIEVED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. N 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 27

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 28
- 29 DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. Y 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. N 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. N 31

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. N 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. Y 34
- 35 IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 35

HOME OFFICE COSTS

- |    |  | Y/N | DATE |
|----|--|-----|------|
|    |  | 1   | 2    |
| 36 | WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?   | N   |      |
| 37 | IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  |     |      |
| 38 | IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. | N   |      |
| 39 | IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.   |     |      |
| 40 | IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  |     |      |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I

LINE	COMPONENT	WKST A LINE NO. 1	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS			TOTAL ALL PATIENTS 8
						TITLE V 5	TITLE XVIII 6	TITLE XIX 7	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	23	8,395	22,390.00		690	50	950
2	HMO								2
3	HMO IPF								3
4	HMO IRF								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						52		52
6	HOSPITAL ADULTS & PEDS. SWING BED NF								10
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		23	8,395	22,390.00		742	50	1,012
8	INTENSIVE CARE UNIT	31							8
9	CORONARY CARE UNIT	32							9
10	BURN INTENSIVE CARE UNIT	33							10
11	SURGICAL INTENSIVE CARE UNIT	34							11
12	OTHER SPECIAL CARE (SPECIFY)	35							12
13	NURSERY	43							13
14	TOTAL (SEE INSTRUCTIONS)		23	8,395	22,390.00		742	50	1,012
15	CAH VISITS								15
16	SUBPROVIDER - IPF	40							16
17	SUBPROVIDER - IRF	41							17
18	SUBPROVIDER I	42							18
19	SKILLED NURSING FACILITY	44							19
20	NURSING FACILITY	45							20
21	OTHER LONG TERM CARE	46							21
22	HOME HEALTH AGENCY	101							22
23	ASC (DISTINCT PART)	115							23
24	HOSPICE (DISTINCT PART)	116							24
25	CMHC	99							25
26	RHC	88							13,305
27	TOTAL (SUM OF LINES 14-26)		23						27
28	OBSERVATION BED DAYS							26	221
29	AMBULANCE TRIPS								29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								30
31	EMPLOYEE DISCOUNT DAYS-IRF								31
32	LABOR & DELIVERY DAYS (SEE INSTR.)								32
33	LTC NON-COVERED DAYS								33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I  
 (CONTINUED)

LINE	COMPONENT	WKST A LINE NO. 1	--- FULL TIME EQUIVALENTS ---			DISCHARGES			TOTAL ALL PATIENTS 15
			TOTAL INTERNS & RESIDENTS 9	ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					200	24	305
2	HMO								2
3	HMO IPF								3
4	HMO IRF								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)								7
8	INTENSIVE CARE UNIT	31							8
9	CORONARY CARE UNIT	32							9
10	BURN INTENSIVE CARE UNIT	33							10
11	SURGICAL INTENSIVE CARE UNIT	34							11
12	OTHER SPECIAL CARE (SPECIFY)	35							12
13	NURSERY	43							13
14	TOTAL (SEE INSTRUCTIONS)			134.02			200	24	305
15	CAH VISITS								15
16	SUBPROVIDER - IPF	40							16
17	SUBPROVIDER - IRF	41							17
18	SUBPROVIDER I	42							18
19	SKILLED NURSING FACILITY	44							19
20	NURSING FACILITY	45							20
21	OTHER LONG TERM CARE	46							21
22	HOME HEALTH AGENCY	101							22
23	ASC (DISTINCT PART)	115							23
24	HOSPICE (DISTINCT PART)	116							24
25	CMHC	99							25
26	RHC	88		23.10					26
27	TOTAL (SUM OF LINES 14-26)			157.12					27
28	OBSERVATION BED DAYS								28
29	AMBULANCE TRIPS								29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								30
31	EMPLOYEE DISCOUNT DAYS-IRF								31
32	LABOR & DELIVERY DAYS (SEE INSTR.)								32
33	LTCH NON-COVERED DAYS								33



HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)		0.650220	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)				
2	NET REVENUE FROM MEDICAID		1,692,517	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID			5
6	MEDICAID CHARGES		4,787,661	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)		3,113,033	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 2 PLUS LINE 5 MINUS LINE 7)		-1,420,516	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)				
9	NET REVENUE FROM STAND-ALONE SCHIP			9
10	STAND-ALONE SCHIP CHARGES			10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)			11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 9 MINUS LINE 11)			12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)				
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)			13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)			14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)			15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 13 MINUS LINE 15)			16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)				
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS			18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)		-1,420,516	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	225,307	63,894	289,201
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES	146,499	41,545	188,044
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	38,270	21,991	60,261
23	COST OF CHARITY CARE	108,229	19,554	127,783
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM			N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)			25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			3,090,046
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			283,943
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			2,806,103
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,824,584
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,952,367
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			531,851

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSIFI-	
		1	2	(COL. 1 + COL. 2)	CATIONS	
				3	4	
GENERAL SERVICE COST CENTERS						
1	00100		294,434	294,434	104,165	1
2	00200		510,855	510,855	13,079	2
3	00300					3
4	00400		2,231,190	2,231,190		4
5	00500	1,029,059	942,429	1,971,488	483,882	5
6	00600					6
7	00700	164,733	363,137	527,870	10,153	7
8	00800	7,669	89,309	96,978		8
9	00900	104,198	43,433	147,631		9
10	01000	186,890	173,762	360,652	-24,525	10
11	01100				24,525	11
12	01200					12
13	01300	119,979	5,960	125,939	8,846	13
14	01400	14,274	143,836	158,110	-143,530	14
15	01500	248,061	374,135	622,196	-292,769	15
16	01600	133,450	135,535	268,985		16
17	01700	34,307	2,144	36,451		17
19	01900				71,800	19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	834,817	337,158	1,171,975	-410	30
ANCILLARY SERVICE COST CENTERS						
50	05000	343,089	68,523	411,612	342	50
53	05300		224,416	224,416	-71,800	53
54	05400	286,294	702,963	989,257		54
60	06000	385,801	596,220	982,021	2,881	60
62	06200				2,520	62
62.30	06250					62.30
64	06400				8,642	64
65	06500	159,062	70,009	229,071	-25,642	65
66	06600	32,855	359,890	392,745	-22,506	66
67	06700					67
68	06800					68
69	06900	49,908	27,373	77,281		69
71	07100				171,163	71
72	07200		77,149	77,149		72
73	07300				293,519	73
76	03950	50,961	4,824	55,785		76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	2,105,179	377,875	2,483,054	-544,531	88
90	09000				1,348	90
90.01	09001	901	1,604	2,505		90.01
91	09100	452,192	1,518,787	1,970,979	-14,747	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	699,510	93,793	793,303		95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
113	11300		78,633	78,633	-78,633	113
118		7,443,189	9,849,376	17,292,565	-22,228	118
NONREIMBURSABLE COST CENTERS						
192	19200	55,326	2,802	58,128		192
192.01	19201	2,635	10,574	13,209		192.01
192.02	19202					192.02
192.03	19203				22,228	192.03
192.04	19204					192.04
200		7,501,150	9,862,752	17,363,902		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	398,599	-17,889	380,710	1
2	00200	CAP REL COSTS-MVBLE EQUIP	523,934		523,934	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	2,231,190		2,231,190	4
5	00500	ADMINISTRATIVE & GENERAL	2,455,370	-52,531	2,402,839	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	538,023		538,023	7
8	00800	LAUNDRY & LINEN SERVICE	96,978		96,978	8
9	00900	HOUSEKEEPING	147,631		147,631	9
10	01000	DIETARY	336,127	-265,371	70,756	10
11	01100	CAFETERIA	24,525	-18,832	5,693	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	134,785		134,785	13
14	01400	CENTRAL SERVICES & SUPPLY	14,580		14,580	14
15	01500	PHARMACY	329,427		329,427	15
16	01600	MEDICAL RECORDS & LIBRARY	268,985	-5,355	263,630	16
17	01700	SOCIAL SERVICE	36,451		36,451	17
19	01900	NONPHYSICIAN ANESTHETISTS	71,800		71,800	19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,171,565		1,171,565	30
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	411,954		411,954	50
53	05300	ANESTHESIOLOGY	152,616	-146,100	6,516	53
54	05400	RADIOLOGY-DIAGNOSTIC	989,257		989,257	54
60	06000	LABORATORY	984,902	-3,056	981,846	60
62	06200	WHOLE BLOOD & PKD RED BLOOD CELLS	2,520		2,520	62
62.30	06250	BLOOD CLOTTING FACTORS ADMIN COSTS				62.30
64	06400	INTRAVENOUS THERAPY	8,642		8,642	64
65	06500	RESPIRATORY THERAPY	203,429	-80	203,349	65
66	06600	PHYSICAL THERAPY	370,239	-5,549	364,690	66
67	06700	OCCUPATIONAL THERAPY				67
68	06800	SPEECH PATHOLOGY				68
69	06900	ELECTROCARDIOLOGY	77,281	-32,499	44,782	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	171,163	-1,629	169,534	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	77,149		77,149	72
73	07300	DRUGS CHARGED TO PATIENTS	293,519	-697	292,822	73
76	03950	CARDIAC REHAB	55,785		55,785	76
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC (RHC)	1,938,523	-155,511	1,783,012	88
90	09000	CLINIC	1,348		1,348	90
90.01	09001	PROVIDER BASED CLINIC	2,505		2,505	90.01
91	09100	EMERGENCY	1,956,232	-910,299	1,045,933	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
95	09500	AMBULANCE SERVICES	793,303		793,303	95
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	17,270,337	-1,615,398	15,654,939	118
NONREIMBURSABLE COST CENTERS						
192	19200	PHYSICIANS' PRIVATE OFFICES	58,128		58,128	192
192.01	19201	LIFELINE	13,209		13,209	192.01
192.02	19202	HOME MEDICAL EQUIPMENT				192.02
192.03	19203	COMMUNITY BENEFIT	22,228		22,228	192.03
192.04	19204	RENTAL PROPERTIES				192.04
200		TOTAL (SUM OF LINES 118-199)	17,363,902	-1,615,398	15,748,504	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER	
		COST CENTER	LINE #			
	1	2	3	4	5	
1 TO RECLASS CAFETERIA COSTS FROM DIET	A	CAFETERIA	11	12,709	11,816	1
2 TO RECLASS DRUGS SOLD TO PATIENTS	B	DRUGS CHARGED TO PATIENTS	73		293,519	2
3 TO RECLASS INTEREST EXPENSE	C	CAP REL COSTS-BLDG & FIXT	1		78,633	3
4 TO RECLASS SUPPLIES CHARGED TO PTS	D	MEDICAL SUPPLIES CHRGED TO PA	71		143,530	4
5 TO RECLASS ER PHYSICIAN CONTRACTED	E	ADMINISTRATIVE & GENERAL	5		16,159	5
6 TO RECLASS PROPERTY INS EXP	F	OTHER CAPITAL RELATED COSTS	3		38,611	6
7 TO RECLASS RHC ADMIN EXPENSES	G	ADMINISTRATIVE & GENERAL	5		131,077	7
8 TO RECLASS OXYGEN SUPPLIES	H	MEDICAL SUPPLIES CHRGED TO PA	71		27,633	8
9 TO RECLASS NURSING COST	I	INTRAVENOUS THERAPY	64	8,642		9
10 TO RECLASS NURSING COST	J	WHOLE BLOOD & PCKD RED BLOOD	62	2,520		10
11 TO RECLASS NURSING COST	K	CLINIC	90	1,348		11
12 TO RECLASS GRANT EXPENSES	L					12
13	L	OPERATION OF PLANT	7		5,475	13
14	L	NURSING ADMINISTRATION	13		8,846	14
15	L	PHARMACY	15		750	15
16	L	ADULTS & PEDIATRICS	30		7,554	16
17	L	OPERATING ROOM	50		342	17
18	L	RESPIRATORY THERAPY	65		425	18
19 TO RECLASS RESTRICTED DONATIONS	M					19
20	M	ADULTS & PEDIATRICS	30		5,958	20
21	M	LABORATORY	60		2,881	21
22	M	RESPIRATORY THERAPY	65		1,566	22
23	M	PHYSICAL THERAPY	66		4,400	23
24	M	RURAL HEALTH CLINIC (RHC)	88		305	24
25 TO RECLASS PHYSICIAN HOSP ADMIN TIM	N	ADMINISTRATIVE & GENERAL	5	413,759		25
26 TO RECLASS ATHLETIC TRAINER EXPENSE	O	COMMUNITY BENEFIT	192.03		22,228	26
27 TO RECLASS PT UTILITIES TO PLANT	Q	OPERATION OF PLANT	7		4,678	27
28 TO RECLASS CRNA EXPENSE AFTER 12/31	R	NONPHYSICIAN ANESTHETISTS	19		71,800	28
29 TO RECLASS NURSING COST	S	EMERGENCY	91	1,412		29
500 TOTAL RECLASSIFICATIONS (SUM OF COLS. 4 & 5 MUST EQUAL SUM OF COLS. 8 & 9)				440,390	878,186	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
	1	6	7	8	9	10
1 TO RECLASS CAFETERIA COSTS FROM DIET	A	DIETARY	10	12,709	11,816	1
2 TO RECLASS DRUGS SOLD TO PATIENTS	B	PHARMACY	15		293,519	2
3 TO RECLASS INTEREST EXPENSE	C	INTEREST EXPENSE	113		78,633	11 3
4 TO RECLASS SUPPLIES CHARGED TO PTS	D	CENTRAL SERVICES & SUPPLY	14		143,530	4
5 TO RECLASS ER PHYSICIAN CONTRACTED	E	EMERGENCY	91		16,159	5
6 TO RECLSS PROPERTY INS EXP	F	ADMINISTRATIVE & GENERAL	5		38,611	12 6
7 TO RECLASS RHC ADMIN EXPENSES	G	RURAL HEALTH CLINIC (RHC)	88		131,077	7
8 TO RECLASS OXYGEN SUPPLIES	H	RESPIRATORY THERAPY	65		27,633	8
9 TO RECLASS NURSING COST	I	ADULTS & PEDIATRICS	30	8,642		9
10 TO RECLASS NURSING COST	J	ADULTS & PEDIATRICS	30	2,520		10
11 TO RECLASS NURSING COST	K	ADULTS & PEDIATRICS	30	1,348		11
12 TO RECLASS GRANT EXPENSES	L	ADMINISTRATIVE & GENERAL	5		23,392	12
13	L					13
14	L					14
15	L					15
16	L					16
17	L					17
18	L					18
19 TO RECLASS RESCTRICTED DONATIONS	M	ADMINISTRATIVE & GENERAL	5		15,110	19
20	M					20
21	M					21
22	M					22
23	M					23
24	M					24
25 TO RECLASS PHYSICIAN HOSP ADMIN TIM	N	RURAL HEALTH CLINIC (RHC)	88	413,759		25
26 TO RECLASS ATHLETIC TRAINER EXPENSE	O	PHYSICAL THERAPY	66		22,228	26
27 TO RECLASS PT UTILITIES TO PLANT	Q	PHYSICAL THERAPY	66		4,678	27
28 TO RECLASS CRNA EXPENSE AFTER 12/31	R	ANESTHESIOLOGY	53		71,800	28
29 TO RECLASS NURSING COST	S	ADULTS & PEDIATRICS	30	1,412		29
500 TOTAL RECLASSIFICATIONS (SUM OF COLS. 4 & 5 MUST EQUAL SUM OF COLS. 8 & 9)				440,390	878,186	500

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND RETIREMENTS	BALANCE	DEPRECIATED ASSETS
	1	2	3	4	5	6	7
1 LAND	300,187	9,891		9,891		310,078	1
2 LAND IMPROVEMENTS							2
3 BUILDINGS AND FIXTURES	8,933,193	421,707		421,707	62,360	9,292,540	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT	180,620	25,947		25,947	14,262	192,305	5
6 MOVABLE EQUIPMENT	4,668,779	462,671		462,671	272,677	4,858,773	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	14,082,779	920,216		920,216	349,299	14,653,696	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	14,082,779	920,216		920,216	349,299	14,653,696	10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (SEE INSTR.)	TAXES (SEE INSTR.)	OTHER	TOTAL(1)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	12	13	14	15
1 CAP REL COSTS-BLDG & FIXT	294,434						294,434 1
2 CAP REL COSTS-MVBLE EQUIP	510,855						510,855 2
3 TOTAL (SUM OF LINES 1-2)	805,289						805,289 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2)	RATIO (SEE INSTR.)	INSURANCE	TAXES	OTHER	TOTAL
							CAPITAL- RELATED COSTS	(SUM OF COLS. 5-7)
	1	2	3	4	5	6	7	8
1 CAP REL COSTS-BLDG & FIXT	9,484,845		9,484,845	0.661259	25,532			25,532 1
2 CAP REL COSTS-MVBLE EQUIP	4,858,773		4,858,773	0.338741	13,079			13,079 2
3 TOTAL (SUM OF LINES 1-2)	14,343,618		14,343,618	1.000000	38,611			38,611 3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (SEE INSTR.)	TAXES (SEE INSTR.)	OTHER	TOTAL(2)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	12	13	14	15
1 CAP REL COSTS-BLDG & FIXT	294,434			60,744	25,532		380,710 1
2 CAP REL COSTS-MVBLE EQUIP	510,855				13,079		523,934 2
3 TOTAL	805,289			60,744	38,611		904,644 3

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	
			COST CENTER	LINE NO.	REF	5	
	1	2	3	4		5	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-17,889	CAP REL COSTS-BLDG & FIXT	1	11	1	
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2	
3 INVESTMENT INCOME-OTHER (CHAPTER 2)						3	
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4	
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5	
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6	
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7	
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)						8	
9 PARKING LOT (CHAPTER 21)						9	
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,091,561					10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)							11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	48,524					12
13 LAUNDRY AND LINEN SERVICE							13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-18,832	CAFETERIA	11			14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS							15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-1,629	MEDICAL SUPPLIES CHRGD TO PATI	71			16
17 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-697	DRUGS CHARGED TO PATIENTS	73			17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-5,355	MEDICAL RECORDS & LIBRARY	16			18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)							19
20 VENDING MACHINES							20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)							21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT							22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3						23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66			24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114			25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1			26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2			27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19			28
29 PHYSICIANS' ASSISTANT							29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67			30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68			31
32 CAH HIT ADJ FOR DEPRECIATION AND							32
33 OTHER INCOME	B	-5,913	ADMINISTRATIVE & GENERAL	5			33
34 OUTSIDE DIETARY SERVICES	B	-265,371	DIETARY	10			34
35 RESTING METABOLIC	B	-80	RESPIRATORY THERAPY	65			35
36 FITNESS MGMT	B	-5,549	PHYSICAL THERAPY	66			36
37 OUTSIDE LAB SERVICES	B	-3,056	LABORATORY	60			37
38 OTHER REVENUE - RHC	B	-6,748	RURAL HEALTH CLINIC (RHC)	88			38
39 CONTRIBUTIONS	A	-1,492	ADMINISTRATIVE & GENERAL	5			39
40 LOBBYING EXPENSE	A	-6,600	ADMINISTRATIVE & GENERAL	5			40
41 ADVERTISING EXPENSE	A	-63,223	ADMINISTRATIVE & GENERAL	5			41
42 MARKETING OTHER EXPENSE	A	-23,827	ADMINISTRATIVE & GENERAL	5			42
43 CRNA EXPENSE	A	-146,100	ANESTHESIOLOGY	53			43
44							44
45							45
46							46
47							47
48							48
49							49
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,615,398					50
TRANSFER TO WKST A, COL. 6, LINE 200)							

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 (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	5	ADMINISTRATIVE & GENERAL	ADMINISTRATION & GENERAL	48,524	48,524	1
2						2
3						3
4						4
5		TOTALS (SUM OF LINES 1-4)		48,524	48,524	5
		TRANSFER COL. 6, LINE 5 TO				
		WKST A-8, COL. 2, LINE 12.				

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
6	2	3	4	5	6
B			CITY OF CLINTON		CITY GOVERNMENT

(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 CCN: 14-1303 DR JOHN WARNER HOSPITAL  
 PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 11/23/2011 13:28

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	60 LABORATORY	3,228		3,228				
2	69 ELECTROCARDIOLOGY AGGREGATE	32,499	32,499					
3	91 EMERGENCY AGGREGATE	1,276,890	910,299	366,591				
4	88 RURAL HEALTH CLINIC (RHC AGGREGATE	1,487,454	148,763	1,338,691				
200	TOTAL	2,800,071	1,091,561	1,708,510				

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL  
 PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 11/23/2011 13:28

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
LINE NO.	11	12	13	14	15	16	17	18
1	60 LABORATORY							
2	69 ELECTROCARDIOLOGY							32,499
3	91 EMERGENCY							910,299
4	88 RURAL HEALTH CLINIC (RHC							148,763
200	TOTAL							1,091,561

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

WORKSHEET A-8-3  
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					1	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					15	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					1	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					4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					0.49	8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		1.00				9
10	AHSEA		72.49	54.37			10
11	STANDARD TRAVEL ALLOWANCE	36.25	36.25	27.19			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					72	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					72	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					72	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					72.00	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					1,080	22
23	TOTAL SALARY EQUIVALENCY					1,080	23

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL  
PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
11/23/2011 13:28

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

WORKSHEET A-8-3  
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	36	24
25	ASSISTANTS		25
26	SUBTOTAL	36	26
27	STANDARD TRAVEL EXPENSE	5	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	41	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	41	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 CCN: 14-1303 DR JOHN WARNER HOSPITAL  
 PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 11/23/2011 13:28

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

WORKSHEET A-8-3  
 PARTS V,VI & VII

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

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						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					1,080	57
58					41	58
59						59
60						60
61						61
62						62
63					1,121	63
64					24	64
65						65

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL  
 PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 11/23/2011 13:28

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

WORKSHEET A-8-3  
 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				227	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE				237	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				4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
		1	2	3	4	5
9	TOTAL HOURS WORKED		2,667.75	1,890.75		
10	AHSEA		76.32	57.24		
11	STANDARD TRAVEL ALLOWANCE	38.16	38.16	28.62		
12	NO OF TRAVEL HRS (PROV SITE)					
12.01	NO OF TRAVEL HRS (OFFSITE)					
13	MILES DRIVEN (PROV SITE)					
13.01	MILES DRIVEN (OFFSITE)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS					14
15	THERAPISTS				203,603	15
16	ASSISTANTS				108,227	16
17	SUBTOTAL ALLOWANCE AMOUNT				311,830	17
18	AIDES					18
19	TRAINEES					19
20	TOTAL ALLOWANCE AMOUNT				311,830	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					22
23	TOTAL SALARY EQUIVALENCY				311,830	23

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL  
PERIOD FROM 05/01/2010 TO 04/30/2011

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-8-3  
PARTS III & IV

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

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

24	STANDARD TRAVEL ALLOWANCE		
	THERAPISTS	8,662	24
25	ASSISTANTS	6,783	25
26	SUBTOTAL	15,445	26
27	STANDARD TRAVEL EXPENSE	2,250	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	17,695	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	17,695	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

STANDARD TRAVEL EXPENSE

36	THERAPISTS		36
37	ASSISTANTS		37
38	SUBTOTAL		38
39	STANDARD TRAVEL EXPENSE		39

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

40	THERAPISTS		40
41	ASSISTANTS		41
42	SUBTOTAL		42
43	OPTIONAL TRAVEL EXPENSE		43

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

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

WORKSHEET A-8-3  
 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						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					311,830	57
58					17,695	58
59						59
60						60
61						61
62						62
63					329,525	63
64					198,177	64
65						65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP	CAP	CAP	EMPLOYEE	SUBTOTAL	
	FOR COST					
	ALLOCATION	FIXTURES	EQUIPMENT		4A	
	(FROM WKST	1	2	4		
	A, COL.7)					
	0					
GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	380,710	380,710			1
2	CAP REL COSTS-MVBLE EQUIP	523,934		523,934		2
4	EMPLOYEE BENEFITS	2,231,190	2,352		2,233,542	4
5	ADMINISTRATIVE & GENERAL	2,402,839	45,641	116,229	429,613	5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT	538,023	68,655	9,444	49,051	7
8	LAUNDRY & LINEN SERVICE	96,978	4,641		2,284	8
9	HOUSEKEEPING	147,631	2,160		31,026	9
10	DIETARY	70,756	12,140	1,778	51,864	10
11	CAFETERIA	5,693			3,784	11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION	134,785	1,693		35,725	13
14	CENTRAL SERVICES & SUPPLY	14,580	7,915	529	4,250	14
15	PHARMACY	329,427	6,751	3,689	73,863	15
16	MEDICAL RECORDS & LIBRARY	263,630	8,742	7,873	39,736	16
17	SOCIAL SERVICE	36,451			10,215	17
19	NONPHYSICIAN ANESTHETISTS	71,800				19
20	NURSING SCHOOL					20
21	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,171,565	47,953	33,377	244,850	30
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	411,954	27,003	44,696	102,158	50
53	ANESTHESIOLOGY	6,516	1,007	15,496		53
54	RADIOLOGY-DIAGNOSTIC	989,257	25,585	169,998	85,247	54
60	LABORATORY	981,846	5,941	41,927	114,876	60
62	WHOLE BLOOD & PCKD RED BLOOD CELLS	2,520			750	62
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
64	INTRAVENOUS THERAPY	8,642			2,573	64
65	RESPIRATORY THERAPY	203,349	1,384	9,407	47,362	65
66	PHYSICAL THERAPY	364,690	2,329	323	9,783	66
67	OCCUPATIONAL THERAPY					67
68	SPEECH PATHOLOGY					68
69	ELECTROCARDIOLOGY	44,782	1,384	668	14,861	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	169,534				71
72	IMPL. DEV. CHARGED TO PATIENT	77,149				72
73	DRUGS CHARGED TO PATIENTS	292,822				73
76	CARDIAC REHAB	55,785	1,609		15,174	76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	1,783,012	45,821	16,181	503,638	88
90	CLINIC	1,348			401	90
90.01	PROVIDER BASED CLINIC	2,505	574		268	90.01
91	EMERGENCY	1,045,933	15,808	20,512	134,645	91
92	OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	793,303	15,122	31,338	208,286	95
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE					113
118	SUBTOTALS (SUM OF LINES 1-117)	15,654,939	352,210	523,465	2,216,283	118
NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	58,128	25,130	469	16,474	192
192.01	LIFELINE	13,209			785	192.01
192.02	HOME MEDICAL EQUIPMENT					192.02
192.03	COMMUNITY BENEFIT	22,228				192.03
192.04	RENTAL PROPERTIES		3,370			192.04
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	15,748,504	380,710	523,934	2,233,542	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION		ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	2,994,322					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	156,164	821,337				7
8	LAUNDRY & LINEN SERVICE	24,394	14,436	142,733			8
9	HOUSEKEEPING	42,451	6,719		229,987		9
10	DIETARY	32,055	37,761		10,853	217,207	10
11	CAFETERIA	2,225					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	40,428	5,267		1,514		13
14	CENTRAL SERVICES & SUPPLY	6,403	24,620		7,076		14
15	PHARMACY	97,132	20,998		6,035		15
16	MEDICAL RECORDS & LIBRARY	75,123	27,192		7,815		16
17	SOCIAL SERVICE	10,956					17
19	NONPHYSICIAN ANESTHETISTS	16,857					19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	351,629	149,153	46,116	42,870	204,178	30
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	137,532	83,990	17,846	24,140	9,994	50
53	ANESTHESIOLOGY	5,404	3,132		900		53
54	RADIOLOGY-DIAGNOSTIC	298,181	79,581	15,331	22,873		54
60	LABORATORY	268,718	18,478		5,311		60
62	WHOLE BLOOD & PCKD RED BLOOD CELLS	768					62
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
64	INTRAVENOUS THERAPY	2,633					64
65	RESPIRATORY THERAPY	61,393	4,304	3,927	1,237		65
66	PHYSICAL THERAPY	88,538	7,244	4,235	2,082		66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	14,484	4,304		1,237		69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	39,802					71
72	IMPL. DEV. CHARGED TO PATIENT	18,112					72
73	DRUGS CHARGED TO PATIENTS	68,746					73
76	CARDIAC REHAB	17,037	5,004	3	1,438		76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)	551,394	142,521	5,411	40,963		88
90	CLINIC	411					90
90.01	PROVIDER BASED CLINIC	786	1,785		513		90.01
91	EMERGENCY	285,694	49,169	38,221	14,132	3,035	91
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	246,053	47,035	10,870	13,519		95
99.10	CORP						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	2,961,503	732,693	141,960	204,508	217,207	118
NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	23,524	78,163	773	22,466		192
192.01	LIFELINE	3,285					192.01
192.02	HOME MEDICAL EQUIPMENT						192.02
192.03	COMMUNITY BENEFIT	5,219					192.03
192.04	RENTAL PROPERTIES	791	10,481		3,013		192.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	2,994,322	821,337	142,733	229,987	217,207	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	11,702					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	188	219,600				13
14 CENTRAL SERVICES & SUPPLY	73		65,446			14
15 PHARMACY	279		2,024	540,198		15
16 MEDICAL RECORDS & LIBRARY	405		45		430,561	16
17 SOCIAL SERVICE	46	1,276				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,541	42,372	2,628		84,867	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,310	36,037	2,088		2,263	50
53 ANESTHESIOLOGY			67		566	53
54 RADIOLOGY-DIAGNOSTIC	705		6,910		102,124	54
60 LABORATORY	952		20,774		77,512	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS						62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY	742		436		1,132	65
66 PHYSICAL THERAPY	119		772		283	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	76		124			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			14,997			71
72 IMPL. DEV. CHARGED TO PATIENT			8,061			72
73 DRUGS CHARGED TO PATIENTS				540,198		73
76 CARDIAC REHAB	79	2,172	57			76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	2,269	62,413	1,861		5,375	88
90 CLINIC			88			90
90.01 PROVIDER BASED CLINIC	3		84			90.01
91 EMERGENCY	920	25,314	2,459		145,689	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,819	50,016	1,971		566	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	11,526	219,600	65,446	540,198	420,377	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	167				10,184	192
192.01 LIFELINE	9					192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES						192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	11,702	219,600	65,446	540,198	430,561	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	17	19		24	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	58,944				17
19 NONPHYSICIAN ANESTHETISTS		88,657			19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
30 INPATIENT ROUTINE SERV COST CENTERS	56,972		2,480,071		30
ADULTS & PEDIATRICS					
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM			901,011		50
53 ANESTHESIOLOGY		88,657	121,745		53
54 RADIOLOGY-DIAGNOSTIC			1,795,792		54
60 LABORATORY			1,536,335		60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS			4,038		62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
64 INTRAVENOUS THERAPY			13,848		64
65 RESPIRATORY THERAPY			334,673		65
66 PHYSICAL THERAPY			480,398		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY			81,920		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			224,333		71
72 IMPL. DEV. CHARGED TO PATIENT			103,322		72
73 DRUGS CHARGED TO PATIENTS			901,766		73
76 CARDIAC REHAB			98,358		76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)			3,160,859		88
90 CLINIC			2,248		90
90.01 PROVIDER BASED CLINIC			6,518		90.01
91 EMERGENCY	1,972		1,783,503		91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES			1,419,898		95
99.10 CORP					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	58,944	88,657	15,450,636		118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES			235,478		192
192.01 LIFELINE			17,288		192.01
192.02 HOME MEDICAL EQUIPMENT					192.02
192.03 COMMUNITY BENEFIT			27,447		192.03
192.04 RENTAL PROPERTIES			17,655		192.04
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	58,944	88,657	15,748,504		202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS 0	BLDGS & FIXTURES 1	MOVABLE EQUIPMENT 2		BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		2,352		2,352	2,352	4
5 ADMINISTRATIVE & GENERAL		45,641	116,229	161,870	453	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		68,655	9,444	78,099	52	7
8 LAUNDRY & LINEN SERVICE		4,641		4,641	2	8
9 HOUSEKEEPING		2,160		2,160	33	9
10 DIETARY		12,140	1,778	13,918	55	10
11 CAFETERIA					4	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		1,693		1,693	38	13
14 CENTRAL SERVICES & SUPPLY		7,915	529	8,444	4	14
15 PHARMACY		6,751	3,689	10,440	78	15
16 MEDICAL RECORDS & LIBRARY		8,742	7,873	16,615	42	16
17 SOCIAL SERVICE					11	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INFAPIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		47,953	33,377	81,330	258	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		27,003	44,696	71,699	108	50
53 ANESTHESIOLOGY		1,007	15,496	16,503		53
54 RADIOLOGY-DIAGNOSTIC		25,585	169,998	195,583	90	54
60 LABORATORY		5,941	41,927	47,868	121	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS					1	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
64 INTRAVENOUS THERAPY					3	64
65 RESPIRATORY THERAPY		1,384	9,407	10,791	50	65
66 PHYSICAL THERAPY		2,329	323	2,652	10	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		1,384	668	2,052	16	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB		1,609		1,609	16	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		45,821	16,181	62,002	527	88
90 CLINIC						90
90.01 PROVIDER BASED CLINIC		574		574		90.01
91 EMERGENCY		15,808	20,512	36,320	142	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		15,122	31,338	46,460	220	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		352,210	523,465	875,675	2,334	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		25,130	469	25,599	17	192
192.01 LIFELINE					1	192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES		3,370		3,370		192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		380,710	523,934	904,644	2,352	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	162,323					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	8,466	86,617				7
8 LAUNDRY & LINEN SERVICE	1,322	1,522	7,487			8
9 HOUSEKEEPING	2,301	709		5,203		9
10 DIETARY	1,738	3,982		246	19,939	10
11 CAFETERIA	121					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,192	555		34		13
14 CENTRAL SERVICES & SUPPLY	347	2,596		160		14
15 PHARMACY	5,266	2,214		137		15
16 MEDICAL RECORDS & LIBRARY	4,072	2,868		177		16
17 SOCIAL SERVICE	594					17
19 NONPHYSICIAN ANESTHETISTS	914					19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	19,062	15,732	2,419	969	18,743	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,456	8,857	936	546	917	50
53 ANESTHESIOLOGY	293	330		20		53
54 RADIOLOGY-DIAGNOSTIC	16,164	8,392	804	517		54
60 LABORATORY	14,567	1,949		120		60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	42					62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
64 INTRAVENOUS THERAPY	143					64
65 RESPIRATORY THERAPY	3,328	454	206	28		65
66 PHYSICAL THERAPY	4,800	764	222	47		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	785	454		28		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	2,158					71
72 IMPL. DEV. CHARGED TO PATIENT	982					72
73 DRUGS CHARGED TO PATIENTS	3,727					73
76 CARDIAC REHAB	924	528		33		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	29,889	15,030	284	927		88
90 CLINIC	22					90
90.01 PROVIDER BASED CLINIC	43	188		12		90.01
91 EMERGENCY	15,487	5,185	2,005	320	279	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	13,339	4,960	570	306		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	160,544	77,269	7,446	4,627	19,939	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	1,275	8,243	41	508		192
192.01 LIFELINE	178					192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT	283					192.03
192.04 RENTAL PROPERTIES	43	1,105		68		192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	162,323	86,617	7,487	5,203	19,939	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	125					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2	4,514				13
14 CENTRAL SERVICES & SUPPLY	1		11,552			14
15 PHARMACY	3		357	18,495		15
16 MEDICAL RECORDS & LIBRARY	4		8		23,786	16
17 SOCIAL SERVICE		26				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	16	871	464		4,688	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	14	741	369		125	50
53 ANESTHESIOLOGY			12		31	53
54 RADIOLOGY-DIAGNOSTIC	8		1,220		5,642	54
60 LABORATORY	10		3,665		4,282	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS						62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY	8		77		63	65
66 PHYSICAL THERAPY	1		136		16	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	1		22			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			2,647			71
72 IMPL. DEV. CHARGED TO PATIENT			1,423			72
73 DRUGS CHARGED TO PATIENTS				18,495		73
76 CARDIAC REHAB	1	45	10			76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	25	1,283	329		297	88
90 CLINIC			16			90
90.01 PROVIDER BASED CLINIC			15			90.01
91 EMERGENCY	10	520	434		8,048	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	19	1,028	348		31	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	123	4,514	11,552	18,495	23,223	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	2				563	192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES						192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	125	4,514	11,552	18,495	23,786	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	17	19		24	
GENERAL SERVICE COST CENTERS					
1					1
2					2
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	631				17
19		914			19
20					20
21					21
22					22
23					23
30	610		145,162		145,162 30
ANCILLARY SERVICE COST CENTERS					
50			91,768		91,768 50
53			17,189		17,189 53
54			228,420		228,420 54
60			72,582		72,582 60
62			43		43 62
62.30					62.30
64			146		146 64
65			15,005		15,005 65
66			8,648		8,648 66
67					67
68					68
69			3,358		3,358 69
71			4,805		4,805 71
72			2,405		2,405 72
73			22,222		22,222 73
76			3,166		3,166 76
76.97					76.97
76.98					76.98
76.99					76.99
OUTPATIENT SERVICE COST CENTERS					
88			110,593		110,593 88
90			38		38 90
90.01			832		832 90.01
91	21		68,771		68,771 91
92					92
OTHER REIMBURSABLE COST CENTERS					
95			67,281		67,281 95
99.10					99.10
99.20					99.20
99.30					99.30
99.40					99.40
SPECIAL PURPOSE COST CENTERS					
113					113
118	631		862,434		862,434 118
NONREIMBURSABLE COST CENTERS					
192			36,248		36,248 192
192.01			179		179 192.01
192.02					192.02
192.03			283		283 192.03
192.04			4,586		4,586 192.04
200		914	914		914 200
201					201
202	631	914	904,644		904,644 202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	67,674					1
2 CAP REL COSTS-MVBLE EQUIP		517,395				2
4 EMPLOYEE BENEFITS	418		7,501,150			4
5 ADMINISTRATIVE & GENERAL	8,113	114,778	1,442,818	-2,994,322	12,754,182	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	12,204	9,326	164,733		665,173	7
8 LAUNDRY & LINEN SERVICE	825		7,669		103,903	8
9 HOUSEKEEPING	384		104,198		180,817	9
10 DIETARY	2,158	1,756	174,181		136,538	10
11 CAFETERIA			12,709		9,477	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	301		119,979		172,203	13
14 CENTRAL SERVICES & SUPPLY	1,407	522	14,274		27,274	14
15 PHARMACY	1,200	3,643	248,061		413,730	15
16 MEDICAL RECORDS & LIBRARY	1,554	7,775	133,450		319,981	16
17 SOCIAL SERVICE			34,307		46,666	17
19 NONPHYSICIAN ANESTHETISTS					71,800	19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	8,524	32,960	822,307		1,497,745	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,800	44,138	343,089		585,811	50
53 ANESTHESIOLOGY	179	15,303			23,019	53
54 RADIOLOGY-DIAGNOSTIC	4,548	167,876	286,294		1,270,087	54
60 LABORATORY	1,056	41,404	385,801		1,144,590	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS			2,520		3,270	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
64 INTRAVENOUS THERAPY			8,642		11,215	64
65 RESPIRATORY THERAPY	246	9,290	159,062		261,502	65
66 PHYSICAL THERAPY	414	319	32,855		377,125	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	246	660	49,908		61,695	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					169,534	71
72 IMPL. DEV. CHARGED TO PATIENT					77,149	72
73 DRUGS CHARGED TO PATIENTS					292,822	73
76 CARDIAC REHAB	286		50,961		72,568	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	8,145	15,979	1,691,420		2,348,652	88
90 CLINIC			1,348		1,749	90
90.01 PROVIDER BASED CLINIC	102		901		3,347	90.01
91 EMERGENCY	2,810	20,256	452,192		1,216,898	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	2,688	30,947	699,510		1,048,049	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
118 SUBTOTALS (SUM OF LINES 1-117)	62,608	516,932	7,443,189	-2,994,322	12,614,389	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	4,467	463	55,326		100,201	192
192.01 LIFELINE			2,635		13,994	192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT					22,228	192.03
192.04 RENTAL PROPERTIES	599				3,370	192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL  
 PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 11/23/2011 13:28

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	380,710	523,934	2,233,542		2,994,322	202
203 UNIT COST MULT-WS B PT I	5.625646	1.012638	0.297760		0.234772	203
204 COST TO BE ALLOC PER B PT II			2,352		162,323	204
205 UNIT COST MULT-WS B PT II			0.000314		0.012727	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	SERVICE	SQUARE	MEALS	PAID	
	FEET	POUNDS OF	FEET	SERVED	HOURS	
	7	LAUNDRY	9	10	11	
		8				
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5						5
6						6
7	46,939					7
8	825	50,963				8
9	384		45,730			9
10	2,158		2,158	4,151		10
11					269,138	11
12						12
13	301		301		4,313	13
14	1,407		1,407		1,677	14
15	1,200		1,200		6,417	15
16	1,554		1,554		9,320	16
17					1,067	17
19						19
20						20
21						21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	8,524	16,466	8,524	3,902	35,435	30
ANCILLARY SERVICE COST CENTERS						
50	4,800	6,372	4,800	191	30,137	50
53	179		179			53
54	4,548	5,474	4,548		16,216	54
60	1,056		1,056		21,895	60
62						62
62.30						62.30
64						64
65	246	1,402	246		17,059	65
66	414	1,512	414		2,747	66
67						67
68						68
69	246		246		1,751	69
71						71
72						72
73						73
76	286	1	286		1,816	76
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
88	8,145	1,932	8,145		52,193	88
90						90
90.01	102		102		63	90.01
91	2,810	13,647	2,810	58	21,170	91
92						92
OTHER REIMBURSABLE COST CENTERS						
95	2,688	3,881	2,688		41,827	95
99.10						99.10
99.20						99.20
99.30						99.30
99.40						99.40
118	41,873	50,687	40,664	4,151	265,103	118
NONREIMBURSABLE COST CENTERS						
192	4,467	276	4,467		3,837	192
192.01					198	192.01
192.02						192.02
192.03						192.03
192.04	599		599			192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL  
 PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 11/23/2011 13:28

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET 7	POUNDS OF LAUNDRY 8	SQUARE FEET 9	MEALS SERVED 10	PAID HOURS 11	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	821,337	142,733	229,987	217,207	11,702	202
203 UNIT COST MULT-WS B PT I	17.497965	2.800718	5.029237	52.326427	0.043480	203
204 COST TO BE ALLOC PER B PT II	86,617	7,487	5,203	19,939	125	204
205 UNIT COST MULT-WS B PT II	1.845310	0.146911	0.113777	4.803421	0.000464	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	183,647					13
14 CENTRAL SERVICES & SUPPLY		626,346				14
15 PHARMACY		19,366	568,907			15
16 MEDICAL RECORDS & LIBRARY		429		1,522		16
17 SOCIAL SERVICE	1,067				269	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	35,435	25,152		300	260	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	30,137	19,983		8		50
53 ANESTHESIOLOGY		639		2		53
54 RADIOLOGY-DIAGNOSTIC		66,132		361		54
60 LABORATORY		198,816		274		60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS						62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY		4,170		4		65
66 PHYSICAL THERAPY		7,384		1		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		1,191				69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		143,530				71
72 IMPL. DEV. CHARGED TO PATIENT		77,149				72
73 DRUGS CHARGED TO PATIENTS			568,907			73
76 CARDIAC REHAB	1,816	550				76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	52,195	17,813		19		88
90 CLINIC		844				90
90.01 PROVIDER BASED CLINIC		805				90.01
91 EMERGENCY	21,170	23,530		515	9	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	41,827	18,863		2		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	183,647	626,346	568,907	1,486	269	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES				36		192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES						192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL  
 PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 11/23/2011 13:28

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY  COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE  TIME SPENT 17	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	219,600	65,446	540,198	430,561	58,944	202
203	UNIT COST MULT-WS B PT I	1.195772	0.104489	0.949537	282.891590	219.122677	203
204	COST TO BE ALLOC PER B PT II	4,514	11,552	18,495	23,786	631	204
205	UNIT COST MULT-WS B PT II	0.024580	0.018443	0.032510	15.628121	2.345725	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NONPHYSIC. ANESTHET.	ASSIGNED TIME	
		19	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS	100		19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
30 INPATIENT ROUTINE SERV COST CENTERS			
ADULTS & PEDIATRICS			30
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
53 ANESTHESIOLOGY	100		53
54 RADIOLOGY-DIAGNOSTIC			54
60 LABORATORY			60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS			62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS			62.30
64 INTRAVENOUS THERAPY			64
65 RESPIRATORY THERAPY			65
66 PHYSICAL THERAPY			66
67 OCCUPATIONAL THERAPY			67
68 SPEECH PATHOLOGY			68
69 ELECTROCARDIOLOGY			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			71
72 IMPL. DEV. CHARGED TO PATIENT			72
73 DRUGS CHARGED TO PATIENTS			73
76 CARDIAC REHAB			76
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
88 RURAL HEALTH CLINIC (RHC)			88
90 CLINIC			90
90.01 PROVIDER BASED CLINIC			90.01
91 EMERGENCY			91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
95 AMBULANCE SERVICES			95
99.10 CORF			99.10
99.20 OUTPATIENT PHYSICAL THERAPY			99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40 OUTPATIENT SPEECH PATHOLOGY			99.40
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	100		118
NONREIMBURSABLE COST CENTERS			
192 PHYSICIANS' PRIVATE OFFICES			192
192.01 LIFELINE			192.01
192.02 HOME MEDICAL EQUIPMENT			192.02
192.03 COMMUNITY BENEFIT			192.03
192.04 RENTAL PROPERTIES			192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL  
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VERSION: 2011.10  
11/23/2011 13:28

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NONPHYSIC. ANESTHET.	ASSIGNED TIME	
200	CROSS FOOT ADJUSTMENTS		19	200
201	NEGATIVE COST CENTER			201
202	COST TO BE ALLOC PER B PT I	88,657		202
203	UNIT COST MULT-WS B PT I	886.570000		203
204	COST TO BE ALLOC PER B PT II	914		204
205	UNIT COST MULT-WS B PT II	9.140000		205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
30 INPATIENT ROUTINE SERV COST CENTERS					
ADULTS & PEDIATRICS	2,480,071		2,480,071		30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	901,011		901,011		50
53 ANESTHESIOLOGY	121,745		121,745		53
54 RADIOLOGY-DIAGNOSTIC	1,795,792		1,795,792		54
60 LABORATORY	1,536,335		1,536,335		60
62 WHOLE BLOOD & PCKD RED BLOO	4,038		4,038		62
62.30 BLOOD CLOTTING FACTORS ADMI					62.30
64 INTRAVENOUS THERAPY	13,848		13,848		64
65 RESPIRATORY THERAPY	334,673		334,673		65
66 PHYSICAL THERAPY	480,398		480,398		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	81,920		81,920		69
71 MEDICAL SUPPLIES CHRGED TO	224,333		224,333		71
72 IMPL. DEV. CHARGED TO PATIE	103,322		103,322		72
73 DRUGS CHARGED TO PATIENTS	901,766		901,766		73
76 CARDIAC REHAB	98,358		98,358		76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	3,160,859		3,160,859		88
90 CLINIC	2,248		2,248		90
90.01 PROVIDER BASED CLINIC	6,518		6,518		90.01
91 EMERGENCY	1,783,503		1,783,503		91
92 OBSERVATION BEDS	447,945		447,945		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	1,419,898		1,419,898		95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THE					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
113 INTEREST EXPENSE					113
200 SUBTOTAL (SEE INSTRUCTIONS)	15,898,581		15,898,581		200
201 LESS OBSERVATION BEDS	447,945		447,945		201
202 TOTAL (SEE INSTRUCTIONS)	15,450,636		15,450,636		202

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 (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	819,548		819,548			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	90,972	1,317,697	1,408,669	0.639619		50
53 ANESTHESIOLOGY	41,996	515,902	557,898	0.218221		53
54 RADIOLOGY-DIAGNOSTIC	400,046	5,175,168	5,575,214	0.322103		54
60 LABORATORY	463,772	3,794,168	4,257,940	0.360816		60
62 WHOLE BLOOD & PCKD RED BLOO		30,711	30,711	0.131484		62
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
64 INTRAVENOUS THERAPY	345	157,122	157,467	0.087942		64
65 RESPIRATORY THERAPY	181,975	308,744	490,719	0.682005		65
66 PHYSICAL THERAPY	16,618	1,404,305	1,420,923	0.338089		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
OUTPATIENT SERVICE COST CENTERS						
69 ELECTROCARDIOLOGY	52,801	376,704	429,505	0.190731		69
71 MEDICAL SUPPLIES CHRGD TO	271,445	384,598	656,043	0.341949		71
72 IMPL. DEV. CHARGED TO PATIE	5,315	137,386	142,701	0.724045		72
73 DRUGS CHARGED TO PATIENTS	873,873	1,663,179	2,537,052	0.355439		73
76 CARDIAC REHAB		93,676	93,676	1.049981		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
88 RURAL HEALTH CLINIC (RHC)	144,920	1,852,504	1,997,424	1.582468		88
90 CLINIC		7,352	7,352	0.305767		90
90.01 PROVIDER BASED CLINIC		59,400	59,400	0.109731		90.01
91 EMERGENCY	53,132	2,408,677	2,461,809	0.724468		91
92 OBSERVATION BEDS	8,591	181,415	190,006	2.357531		92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	25,816	1,131,199	1,157,015	1.227208		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	3,451,165	20,999,907	24,451,072			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		20,999,907	24,451,072			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1303) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS			
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES DED & COINS 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7		
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.639619		424,275			271,374			50
53 ANESTHESIOLOGY	0.218221		124,175			27,098			53
54 RADIOLOGY-DIAGNOSTIC	0.322103		1,915,416			616,961			54
60 LABORATORY	0.360816		1,721,719			621,224			60
62 WHOLE BLOOD & PCKD RED BLOOD CE	0.131484		27,496			3,615			62
62.30 BLOOD CLOTTING FACTORS ADMIN CO									62.30
64 INTRAVENOUS THERAPY	0.087942		69,702			6,130			64
65 RESPIRATORY THERAPY	0.682005		129,816			88,535			65
66 PHYSICAL THERAPY	0.338089		349,499			118,162			66
67 OCCUPATIONAL THERAPY									67
68 SPEECH PATHOLOGY									68
69 ELECTROCARDIOLOGY	0.190731		189,891			36,218			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.341949		127,853			43,719			71
72 IMPL. DEV. CHARGED TO PATIENT	0.724045		2,534			1,835			72
73 DRUGS CHARGED TO PATIENTS	0.355439		719,338			255,681			73
76 CARDIAC REHAB	1.049981		72,444			76,065			76
76.97 CARDIAC REHABILITATION									76.97
76.98 HYPERBARIC OXYGEN THERAPY									76.98
76.99 LITHOTRIPSY									76.99
OUTPATIENT SERVICE COST CENTERS									
88 RURAL HEALTH CLINIC (RHC)	1.582468								88
90 CLINIC	0.305767		1,059			324			90
90.01 PROVIDER BASED CLINIC	0.109731		46,809			5,136			90.01
91 EMERGENCY	0.724468		798,114			578,208			91
92 OBSERVATION BEDS	2.357531		98,863			233,073			92
OTHER REIMBURSABLE COST CENTERS									
95 AMBULANCE SERVICES	1.227208								95
200 SUBTOTAL (SEE INSTRUCTIONS)			6,819,003			2,983,358			200
201 LESS PBP CLINIC LAB SERVICES									201
202 NET CHARGES (LINE 200 - LINE 201)			6,819,003			2,983,358			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B-SNF (14-Z303)  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO		COST REIMB.	COST REIMB.	COST	COST		
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT	SERVICES	SVCES NOT
	FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO	
	PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS	
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.639619							50
53 ANESTHESIOLOGY	0.218221							53
54 RADIOLOGY-DIAGNOSTIC	0.322103							54
60 LABORATORY	0.360816							60
62 WHOLE BLOOD & PCKD RED BLOOD CE	0.131484							62
62.30 BLOOD CLOTTING FACTORS ADMIN CO								62.30
64 INTRAVENOUS THERAPY	0.087942							64
65 RESPIRATORY THERAPY	0.682005							65
66 PHYSICAL THERAPY	0.338089							66
67 OCCUPATIONAL THERAPY								67
68 SPEECH PATHOLOGY								68
69 ELECTROCARDIOLOGY	0.190731							69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.341949							71
72 IMPL. DEV. CHARGED TO PATIENT	0.724045							72
73 DRUGS CHARGED TO PATIENTS	0.355439							73
76 CARDIAC REHAB	1.049981							76
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)	1.582468							88
90 CLINIC	0.305767							90
90.01 PROVIDER BASED CLINIC	0.109731							90.01
91 EMERGENCY	0.724468							91
92 OBSERVATION BEDS	2.357531							92
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	1.227208							95
200 SUBTOTAL (SEE INSTRUCTIONS)								200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1303) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	1,233	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,171	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,171	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	31	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	21	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	10	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	690	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 (SEE INSTRUCTIONS)	31	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	21	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
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	117.54	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,480,071	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	1,175	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	106,574	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,373,497	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	819,548	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	819,548	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	2,896,105	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	699.87	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,373,497	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1303) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 2,026.90 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,398,561 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,398,561 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 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
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					563,807	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,962,368	49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59  
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60  
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 61  
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62  
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST  
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 62,834 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 42,565 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 105,399 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 221 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 2,026.90 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 447,945 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	145,162	2,373,497	0.061160	447,945	27,396	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1303) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	1,233	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,171	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,171	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	31	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	21	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	10	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	50	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 (SEE INSTRUCTIONS)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
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	117.54	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,480,071	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	1,175	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	106,574	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,373,497	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	819,548	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	819,548	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	2,896,105	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	699.87	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,373,497	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1303) [ ] SUB (OTHER) [ ] FPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 2,026.90 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 101,345 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 101,345 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 + COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 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
48 PROGRAM INPATIENT ANCLLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					101,345 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCLLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59  
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60  
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE B 61  
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62  
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST  
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 221 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST	ROUTINE COST (FROM LINE 27)	COL. 1 + COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
		1	2	3	4	5
90 CAPITAL-RELATED COST						90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-1303) [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
30 INPATIENT ROUTINE SERVICE COST CENTERS		550,309		30
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.639619	20,871	13,349	50
53 ANESTHESIOLOGY	0.218221	7,817	1,706	53
54 RADIOLOGY-DIAGNOSTIC	0.322103	230,537	74,257	54
60 LABORATORY	0.360816	315,875	113,973	60
62 WHOLE BLOOD & PCKD RED BLOOD CE	0.131484			62
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
64 INTRAVENOUS THERAPY	0.087942			64
65 RESPIRATORY THERAPY	0.682005	136,123	92,837	65
66 PHYSICAL THERAPY	0.338089	10,753	3,635	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.190731	34,104	6,505	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.341949	170,820	58,412	71
72 IMPL. DEV. CHARGED TO PATIENT	0.724045	7	5	72
73 DRUGS CHARGED TO PATIENTS	0.355439	543,426	193,155	73
76 CARDIAC REHAB	1.049981			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	1.582468			88
90 CLINIC	0.305767			90
90.01 PROVIDER BASED CLINIC	0.109731			90.01
91 EMERGENCY	0.724468	797	577	91
92 OBSERVATION BEDS	2.357531	2,289	5,396	92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,473,419	563,807	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,473,419		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B SNF(14-Z303) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.639619			50
53 ANESTHESIOLOGY	0.218221			53
54 RADIOLOGY-DIAGNOSTIC	0.322103	969	312	54
60 LABORATORY	0.360816	7,072	2,552	60
62 WHOLE BLOOD & PCKD RED BLOOD CE	0.131484			62
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
64 INTRAVENOUS THERAPY	0.087942			64
65 RESPIRATORY THERAPY	0.682005	6,110	4,167	65
66 PHYSICAL THERAPY	0.338089	3,728	1,260	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.190731	674	129	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.341949	7,801	2,668	71
72 IMPL. DEV. CHARGED TO PATIENT	0.724045			72
73 DRUGS CHARGED TO PATIENTS	0.355439	60,468	21,493	73
76 CARDIAC REHAB	1.049981			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	1.582468			88
90 CLINIC	0.305767			90
90.01 PROVIDER BASED CLINIC	0.109731			90.01
91 EMERGENCY	0.724468			91
92 OBSERVATION BEDS	2.357531			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		86,822	32,581	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		86,822		202



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [XX] HOSPITAL (14-1303) [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOX: [ ] IRF [ ] SWING BED SNF

INPATIENT  
 PART A

PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,750,783		2,388,603	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		NONE		NONE	3.01
TO .02					3.02
PROVIDER .03					3.03
TO .04					3.04
PROVIDER .05					3.05
TO .06					3.06
PROVIDER .07					3.07
TO .08					3.08
PROVIDER .09					3.09
TO .50		NONE		NONE	3.50
PROVIDER .51					3.51
TO .52					3.52
PROVIDER .53					3.53
TO .54					3.54
PROVIDER .55					3.55
TO .56					3.56
PROVIDER .57					3.57
TO .58					3.58
PROVIDER .59					3.59
TO .99					3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		1,750,783		2,388,603	4

TO BE COMPLETED BY CONTRACTOR

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		NONE		NONE	5.01
TO .02					5.02
PROVIDER .03					5.03
TO .04					5.04
PROVIDER .05					5.05
TO .06					5.06
PROVIDER .07					5.07
TO .08					5.08
PROVIDER .09					5.09
TO .50		NONE		NONE	5.50
PROVIDER .51					5.51
TO .52					5.52
PROVIDER .53					5.53
TO .54					5.54
PROVIDER .55					5.55
TO .56					5.56
PROVIDER .57					5.57
TO .58					5.58
PROVIDER .59					5.59
TO .99					5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT					
PROGRAM .01		106,135			6.01
TO .02					
PROVIDER .01					
TO .02					
PROVIDER .02				-173,861	6.02
TO .01					
PROGRAM .01					
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,856,918		2,214,742	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		DATE:	



PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL  
PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
11/23/2011 13:28

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL (14-1303) [ ] CAH  
APPLICABLE BOX

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	305	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	690	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	950	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	24,451,072	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	289,201	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET B-2

CHECK [ ] TITLE V [XX] SWING BED - SNF (14-Z303)  
 APPLICABLE [XX] TITLE XVIII [ ] SWING BED - NF  
 BOXES [ ] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	106,453	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	32,907	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	52	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	139,360	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	139,360	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	139,360	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	3,113	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	136,247	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	136,247	19
20 INTERIM PAYMENTS	122,812	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	13,435	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	-303	23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART V

CHECK  HOSPITAL (14-1303)  
 APPLICABLE BOX:  SUB (OTHER)

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)

1	INPATIENT SERVICES	1,962,368	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,962,368	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 5 LESS LINE 6) (FOR CAH, SEE INSTRUCTIONS)	1,981,992	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES	1,473,419	8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6, 17 AND 18)	1,981,992	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	140,978	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	1,841,014	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,841,014	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	15,904	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	15,904	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	14,862	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26 (LINE 26 HOSPITAL AND SUBPROVIDER ONLY))	1,856,918	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,856,918	30
31	INTERIM PAYMENTS	1,750,783	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	106,135	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	-2,604	34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

CHECK  TITLE V  HOSPITAL (14-1303)  SNF  PPS  
 APPLICABLE  TITLE XIX  IPF  NF  TEFRA  
 BOXES:  IRF  ICF/MR  OTHER  
 SUB (OTHER)

PART VII - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	101,345 1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	101,345 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	101,345 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 7 (SEE INSTRUCTIONS))	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 7 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LINE 7)	101,345 21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22-26)	27
28	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)	28
29	TITLE V OR XIX PPS, LESSER OF LINES 27 OR 28, NON-PPS ENTER AMOUNT FROM LINE 27	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19-21 MINUS 29)	101,345 31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	101,345 36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	101,345 38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	101,345 40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	101,345 42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

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	306,261			1
2	TEMPORARY INVESTMENTS	880,304			2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	4,554,507			4
5	OTHER RECEIVABLES	236,000			5
6	ALLOWANCE FOR UNCOLLECTIBLE				
	NOTES & ACCOUNTS RECEIVABLE	-2,205,587			6
7	INVENTORY	403,909			7
8	PREPAID EXPENSES	262,597			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	4,437,991			11
FIXED ASSETS					
12	LAND	310,078			12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	9,475,969			15
16	ACCUMULATED DEPRECIATION	-6,140,746			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	5,051,076			23
24	ACCUMULATED DEPRECIATION	-3,319,657			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	5,376,720			30
OTHER ASSETS					
31	INVESTMENTS	1,476,231			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	298,784			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	1,775,015			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	11,589,726			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	668,018			37
38	SALARIES, WAGES & FEES PAYABLE	791,296			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	215,000			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	161,242			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,835,556			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	1,300,000			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	1,300,000			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	3,135,556			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	8,454,170			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	8,454,170			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	11,589,726			60

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		8,781,617							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		-374,310							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		8,407,307							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 CAPITAL GRANTS		48,437							5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		48,437							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		8,455,744							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 UNREALIZED LOSS		1,574							13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		1,574							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		8,454,170							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	817,980		817,980	2
3 SUBPROVIDER IPF				3
4 SUBPROVIDER IRF				5
5 SWING BED - SNF				6
6 SWING BED - NF				7
7 SKILLED NURSING FACILITY				8
8 NURSING FACILITY				9
9 OTHER LONG TERM CARE				10
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	817,980		817,980	
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	817,980		817,980	17
19 ANCILLARY SERVICES	2,544,070		2,544,070	18
20 OUTPATIENT SERVICES		20,618,222	20,618,222	19
21 RHC	144,920	1,878,995	2,023,915	20
22 FQHC				21
23 HOME HEALTH AGENCY				22
24 AMBULANCE	25,816	1,131,199	1,157,015	23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	3,532,786	23,628,416	27,161,202	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		17,363,902	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38 INTEREST EXPENSE	-78,633		38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)	-78,633		42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		17,285,269	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	27,161,202	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	10,906,723	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	16,254,479	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	17,285,269	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,030,790	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	23,994	6
7	INCOME FROM INVESTMENTS	37,004	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	18,832	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	500	15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	1,629	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	697	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	10,599	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	1,477	21
22	RENTAL OF HOSPITAL SPACE	19,620	22
23	GOVERNMENTAL APPROPRIATIONS	253,071	23
24	OTHER (OTHER DIETARY REVENUE)	265,371	24
24.01	OTHER (GRANT REVENUE)	54,303	24.01
24.02	OTHER (FITNESS CENTER)	5,549	24.02
24.03	OTHER (GAIN (LOSS) SALE/DISPOSE ASSET)	3,040	24.03
24.04	OTHER (LIFELINE)	13,765	24.04
24.05	OTHER (MISC OTHER)	25,662	24.05
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	735,113	25
26	TOTAL (LINE 5 PLUS LINE 25)	-295,677	26
27	OTHER EXPENSES (INTEREST EXPENSE)	78,633	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	78,633	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-374,310	29

RHC I  
 COMPONENT NO: 14-3404

WORKSHEET M-1

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

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1	1,487,671		1,487,671	-413,759	1,073,912	-148,763	925,149	1
2								2
3	66,787		66,787		66,787		66,787	3
4								4
5	238,758		238,758	-9,850	228,908		228,908	5
6								6
7								7
8								8
9	311,962		311,962		311,962		311,962	9
10	2,105,178		2,105,178	-423,609	1,681,569	-148,763	1,532,806	10
COSTS UNDER AGREEMENT								
11		6,978	6,978		6,978		6,978	11
12								12
13								13
14		6,978	6,978		6,978		6,978	14
OTHER HEALTH CARE COSTS								
15		50,316	50,316		50,316		50,316	15
16		5,414	5,414		5,414		5,414	16
17								17
18		131,077	131,077	-131,077				18
19		88,502	88,502		88,502		88,502	19
20								20
21		275,309	275,309	-131,077	144,232		144,232	21
22	2,105,178	282,287	2,387,465	-554,686	1,832,779	-148,763	1,684,016	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26				9,850	9,850		9,850	26
27								27
28				9,850	9,850		9,850	28
FACILITY OVERHEAD								
29								29
30		95,589	95,589	305	95,894	-6,748	89,146	30
31		95,589	95,589	305	95,894	-6,748	89,146	31
32	2,105,178	377,876	2,483,054	-544,531	1,938,523	-155,511	1,783,012	32

RHC I  
 COMPONENT NO: 14-3404

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	2.57	12,216	4,200	10,794	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	0.40	1,033	2,100	840	3
4	SUBTOTAL (SUM OF LINES 1-3)	2.97	13,249		11,634	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2.97	13,249			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		56			9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				1,684,016	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)				9,850	11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				1,693,866	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				0.994185	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				89,146	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				1,377,847	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				1,466,993	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				1,466,993	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				1,458,462	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				3,142,478	20

RHC I  
 COMPONENT NO: 14-3404

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	3,142,478	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	13,355	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	3,129,123	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	13,249	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)	56	5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	13,305	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	235.18	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)	155.00	155.00	8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	235.18	235.18	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	2,391	1,195	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	562,315	281,040	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)			14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)			15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	562,315	281,040	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)			16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)			16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)			16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		180,872	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	449,852	180,872	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		54,950	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)			19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		630,724	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		3,298	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		634,022	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		22,369	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		22,034	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		656,391	26
27	INTERIM PAYMENTS		466,341	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		190,050	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		-1,441	30

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

RHC I  
 COMPONENT NO: 14-3404

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,532,806	1,532,806	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000070	0.001500	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	107	2,299	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	648	4,084	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	755	6,383	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,684,016	1,684,016	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,466,993	1,466,993	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.000448	0.003790	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	657	5,560	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,412	11,943	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	16	352	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	88.25	33.93	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	7	79	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	618	2,680	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		13,355	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		3,298	16

