HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT WORKSHEET S
CERTIFICATION AND SETTLEMENT SUMMARY PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY
1. [X] ELECTRONICALLY FILED COST REPORT DATE: 11/23/2011 TIME: 13:27_____
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
1 - AS SUBMITTED
2 - SETTLED WITHOUT AUDIT
3 - SETTLED WITH AUDIT
4 - REOPENED
5 - AMENDED
6. DATE RECEIVED: _____
7. CONTRACTOR NO: _____
8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN
9. [ ] FINAL REPORT FOR THIS PROVIDER CCN
10. NPR DATE: 11/23/2011
11. CONTRACTOR'S VENDOR CODE: ___
12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED - 0-9.

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 WASHINGTON COUNTY HOSPITAL (14-1308) (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 PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/23/2011 13:27
V0KAUxGScWHAHU.vL7zkVaFHfXM5K0
k0j62046xjvcEDAv:8ApWvWLrDMVXZ
tvym0BUgCx0qIJEJ

PI Encryption: 11/23/2011 13:27
rLR0u66vQ9ASnQJe8RIzvxbwtGO:q0
S2HJu0.uP9LnMCSuQcXsmhQ6AF:2fx
IFoZ79Vwjd089z:G

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		81,035	147,266		4,263	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		21,391				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
10.01	HEALTH CLINIC - RHC II						10.01
10.02	HEALTH CLINIC - RHC III			36,676			10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		102,426	183,942		4,263	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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 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: 705 SOUTH GRAND AVENUE — P.O.BOX: — 1
2 CITY: NASHVILLE — STATE: IL — ZIP CODE: 62263- — COUNTY: WASHINGTON — 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	WASHINGTON COUNTY HOSPITAL	14-1308	99914	1	12/01/2000	N	O	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	WASHINGTON COUNTY SWING BED	14-Z308	99914		08/18/2000	N	O	O	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC	WASHINGTON COUNTY EXTENDED CA	-							11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	OKAWVILLE RHC	14-3470	99914		08/01/2005	N	O	N	15.01
15.02	HOSPITAL-BASED HEALTH CLINIC - RHC III	GRAND STREET RHC	14-3472	99914		08/01/2005	N	O	N	15.02
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	11		21

INPATIENT PPS INFORMATION

		1	2	
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 FACILTY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	N	N	22
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.	3	N	23

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS 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.							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 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

		V	XVIII	XIX	
	PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL	1	2	3	
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

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

		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
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

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	

INPATIENT PSYCHIATRIC FACILITY PPS

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: — 71
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.

INPATIENT REHABILITATION FACILITY PPS

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: — 76
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.

LONG TERM CARE HOSPITAL PPS

80 IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO. — N — 80

TEFRA PROVIDERS

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

		V	XIX	
TITLE V AND XIX INPATIENT SERVICES		1	2	
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

		1	2	
RURAL PROVIDERS				
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.	Y		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

		PHY-SICAL	OCCUP-ATIONAL	SPEECH	RESPI-RATORY	
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.	N	N	N	N	109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2 PART I (CONT)

		1	2	
	MISCELLANEOUS COST REPORTING INFORMATION			
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.	1		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.	N		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			
		1	2	
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.	N		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 1	PART B 2	
155	HOSPITAL	N	N	155
156	SUBPROVIDER - IPF			156
157	SUBPROVIDER - IRF			157
158	SUBPROVIDER - (OTHER)			158
159	SNF			159
160	HHA			160
161	CMHC			161

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 0	COUNTY 1	STATE 2	ZIP CODE 3	CBSA 4	FTE/CAMPUS 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

		Y/N	DATE	
	PROVIDER ORGANIZATION AND OPERATION	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	
		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

		Y/N	TYPE	DATE	
	FINANCIAL DATA AND REPORTS	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

		Y/N	Y/N	
	APPROVED EDUCATIONAL ACTIVITIES	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

		Y/N	
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

BED COMPLEMENT

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	
	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	07/12/2011	Y	07/12/2011	16
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		17
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		18
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		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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 RELIFED 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.	N	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

		Y/N	DATE	
	HOME OFFICE COSTS	1	2	
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	N		36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			37
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		38
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.			39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			40

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	22	8,030	14,990.00		462	6	534	1
2	HMO									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						1,602		1,602	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								82	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		22	8,030	14,990.00		2,064	6	2,218	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)		22	8,030	14,990.00		2,064	6	2,218	14
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	28	10,220					9,913	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								26
26.01	RHC II	88.01								26.01
26.02	RHC III	88.02					2,445		8,817	26.02
27	TOTAL (SUM OF LINES 14-26)		50							27
28	OBSERVATION BED DAYS							4	42	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 AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	---------- DISCHARGES ---------- TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					140	4	172	1
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)			113.39			140	4	172	14
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		17.54						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								26
26.01	RHC II	88.01								26.01
26.02	RHC III	88.02		13.87						26.02
27	TOTAL (SUM OF LINES 14-26)			144.80						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

RHC III

WORKSHEET S-8

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

COMPONENT NO: 14-3472

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 705 SOUTH GRAND AVE
2 CITY: NASHVILLE STATE: IL ZIP CODE: 62263 COUNTY: WASHINGTON
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN

SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 2	
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)			4
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)			5
6 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)			6
7 APPALACHIAN REGIONAL COMMISSION			7
8 LOOK-ALIKES			8
9 OTHER			9

	1	2	
10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N		10

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
11	CLINIC			0730	1900	0730	1900	0730	1900	0730	1900	0730	1900	0800	1400	11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

	1	2	
12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N		12
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.	Y	2	13

14 PROVIDER NAME: OKAWVILLE RHC CCN NUMBER: 14-347 14

14.01 GRAND STREET RHC 14-347 14.01

	Y/N	V	XVIII	XIX	
15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)	N				15

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)	0.646366	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	1,127,729	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	2,342,855	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	1,514,342	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 2 PLUS LINE 5 MINUS LINE 7)	-386,613	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)	-386,613	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	89,393	56,621	146,014	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES	57,781	36,598	94,378	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	9,629	29,934	39,563	22
23	COST OF CHARITY CARE	48,152	6,664	54,815	23
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 LENGHTH OF STAY LIMIT (SEE INSTRUCTIONS)				25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			1,797,858	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			135,052	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,662,806	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,074,781	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,129,596	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			742,984	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI-CATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		337,907	337,907		1
2	00200	CAP REL COSTS-MVBLE EQUIP		452,801	452,801		2
3	00300	OTHER CAPITAL RELATED COSTS					3
4	00400	EMPLOYEE BENEFITS	65,033	2,020,627	2,085,660		4
5	00500	ADMINISTRATIVE & GENERAL	946,231	802,323	1,748,554	74,717	5
6	00600	MAINTENANCE & REPAIRS	121,847	402,931	524,778		6
7	00700	OPERATION OF PLANT					7
8	00800	LAUNDRY & LINEN SERVICE		72,078	72,078		8
9	00900	HOUSEKEEPING	208,853	32,906	241,759		9
10	01000	DIETARY	225,029	183,130	408,159	-143,590	10
11	01100	CAFETERIA				143,590	11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	77,758	47	77,805		13
14	01400	CENTRAL SERVICES & SUPPLY	54,308	144,775	199,083	-128,703	14
15	01500	PHARMACY	132,825	701,406	834,231	-683,621	15
16	01600	MEDICAL RECORDS & LIBRARY	189,222	21,652	210,874		16
17	01700	SOCIAL SERVICE				4,172	17
19	01900	NONPHYSICIAN ANESTHETISTS	198,501		198,501		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	737,443	36,331	773,774	-4,172	30
46	04600	OTHER LONG TERM CARE	514,443	28,203	542,646		46
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	233,905	83,314	317,219		50
51	05100	RECOVERY ROOM					51
53	05300	ANESTHESIOLOGY		89,670	89,670		53
54	05400	RADIOLOGY-DIAGNOSTIC	262,840	396,173	659,013	48,539	54
60	06000	LABORATORY	322,253	510,076	832,329		60
62.30	06250	BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65	06500	RESPIRATORY THERAPY	34,214	62,695	96,909	-28,268	65
66	06600	PHYSICAL THERAPY	680,744	14,601	695,345		66
67.01	06701	CARDIAC REHAB	17,278	642	17,920		67.01
69	06900	ELECTROCARDIOLOGY	8,181	12,392	20,573		69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS				156,971	71
73	07300	DRUGS CHARGED TO PATIENTS				683,621	73
76	03550	OP GERO PSYCH		437,815	437,815		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					
88.01	08801	RURAL HEALTH CLINIC 2					88.01
88.02	08802	RURAL HEALTH CLINIC 3	1,443,542	214,891	1,658,433	-123,256	88.02
91	09100	EMERGENCY	337,078	1,128,273	1,465,351		91
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
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					
118		SUBTOTALS (SUM OF LINES 1-117)	6,811,528	8,187,659	14,999,187		118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
190.02	19002	UNUSED SPACE					190.02
190.03	19003	NON-REIMBURSEABLE HOME HEALTH					190.03
190.04	19004	OUTPATIENT CLINIC	6,516	3,881	10,397		190.04
190.05	19005	NON-REIMBURSEABLE OUTPATIENT MEALS					190.05
192.01	19201	PHYSICIANS' CLINIC					192.01
192.02	19202	WASHINGTON COUNTY HEALTH CENTER					192.02
200		TOTAL (SUM OF LINES 118-199)	6,818,044	8,191,540	15,009,584		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	337,907		337,907	1
2	00200	CAP REL COSTS-MVBLE EQUIP	452,801		452,801	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	2,085,660	-380,993	1,704,667	4
5	00500	ADMINISTRATIVE & GENERAL	1,823,271	4,053	1,827,324	5
6	00600	MAINTENANCE & REPAIRS	524,778		524,778	6
7	00700	OPERATION OF PLANT				7
8	00800	LAUNDRY & LINEN SERVICE	72,078		72,078	8
9	00900	HOUSEKEEPING	241,759		241,759	9
10	01000	DIETARY	264,569		264,569	10
11	01100	CAFETERIA	143,590	-28,478	115,112	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	77,805		77,805	13
14	01400	CENTRAL SERVICES & SUPPLY	70,380	-3,632	66,748	14
15	01500	PHARMACY	150,610		150,610	15
16	01600	MEDICAL RECORDS & LIBRARY	210,874	-257	210,617	16
17	01700	SOCIAL SERVICE	4,172		4,172	17
19	01900	NONPHYSICIAN ANESTHETISTS	198,501		198,501	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	769,602		769,602	30
46	04600	OTHER LONG TERM CARE	542,646		542,646	46
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	317,219		317,219	50
51	05100	RECOVERY ROOM				51
53	05300	ANESTHESIOLOGY	89,670		89,670	53
54	05400	RADIOLOGY-DIAGNOSTIC	707,552	-10,582	696,970	54
60	06000	LABORATORY	832,329	-32,784	799,545	60
62.30	06250	BLOOD CLOTTING FACTORS ADMIN COSTS				62.30
65	06500	RESPIRATORY THERAPY	68,641		68,641	65
66	06600	PHYSICAL THERAPY	695,345		695,345	66
67.01	06701	CARDIAC REHAB	17,920		17,920	67.01
69	06900	ELECTROCARDIOLOGY	20,573	-11,631	8,942	69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	156,971		156,971	71
73	07300	DRUGS CHARGED TO PATIENTS	683,621		683,621	73
76	03550	OP GERO PSYCH	437,815		437,815	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				
88.01	08801	RURAL HEALTH CLINIC 2				88.01
88.02	08802	RURAL HEALTH CLINIC 3	1,535,177	-83,640	1,451,537	88.02
91	09100	EMERGENCY	1,465,351	-277,948	1,187,403	91
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
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				
118		SUBTOTALS (SUM OF LINES 1-117)	14,999,187	-825,892	14,173,295	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
190.02	19002	UNUSED SPACE				190.02
190.03	19003	NON-REIMBURSEABLE HOME HEALTH				190.03
190.04	19004	OUTPATIENT CLINIC	10,397		10,397	190.04
190.05	19005	NON-REIMBURSEABLE OUTPATIENT MEALS				190.05
192.01	19201	PHYSICIANS' CLINIC				192.01
192.02	19202	WASHINGTON COUNTY HEALTH CENTER				192.02
200		TOTAL (SUM OF LINES 118-199)	15,009,584	-825,892	14,183,692	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASSIFY DRUG COSTS	A	DRUGS CHARGED TO PATIENTS	73		683,621	1
2	RECLASSIFY MEDICAL SUPPLY COSTS	B	MEDICAL SUPPLIES CHRGED TO PA	71		128,703	2
3	RECLASSIFY CAFETERIA COSTS	C	CAFETERIA	11	79,165	64,425	3
4	RECLASSIFY PROF LIABILITY INSURANCE	D	ADMINISTRATIVE & GENERAL	5		123,256	4
5	RECLASSIFY SOCIAL SERVICES COSTS	E	SOCIAL SERVICE	17	4,172		5
6	RECLASSIFY X-RAY DIRECTOR'S SALARY	F	RADIOLOGY-DIAGNOSTIC	54	48,539		6
7	RECLASS OXYGEN SUPPLIES	G	MEDICAL SUPPLIES CHRGED TO PA	71		28,268	7
500	TOTAL RECLASSIFICATIONS (SUM OF COLS. 4 & 5 MUST EQUAL SUM OF COLS. 8 & 9)				131,876	1,028,273	500

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	RECLASSIFY DRUG COSTS	A	PHARMACY	15		683,621	1
2	RECLASSIFY MEDICAL SUPPLY COSTS	B	CENTRAL SERVICES & SUPPLY	14		128,703	2
3	RECLASSIFY CAFETERIA COSTS	C	DIETARY	10	79,165	64,425	3
4	RECLASSIFY PROF LIABILITY INSURANCE	D	RURAL HEALTH CLINIC 3	88.02		123,256	4
5	RECLASSIFY SOCIAL SERVICES COSTS	E	ADULTS & PEDIATRICS	30	4,172		5
6	RECLASSIFY X-RAY DIRECTOR'S SALARY	F	ADMINISTRATIVE & GENERAL	5	48,539		6
7	RECLASS OXYGEN SUPPLIES	G	RESPIRATORY THERAPY	65		28,268	7
500	TOTAL RECLASSIFICATIONS (SUM OF COLS. 4 & 5 MUST EQUAL SUM OF COLS. 8 & 9)				131,876	1,028,273	500

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	62,855					62,855		1
2	LAND IMPROVEMENTS	372,843					372,843		2
3	BUILDINGS AND FIXTURES	9,050,027					9,050,027		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	6,170,761	69,247		69,247		6,240,008		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	15,656,486	69,247		69,247		15,725,733		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	15,656,486	69,247		69,247		15,725,733		10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	337,907						337,907	1
2	CAP REL COSTS-MVBLE EQUIP	452,801						452,801	2
3	TOTAL (SUM OF LINES 1-2)	790,708						790,708	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	ALLOCATION OF OTHER CAPITAL INSURANCE 5	TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT	9,485,725		9,485,725	0.603198					1
2	CAP REL COSTS-MVBLE EQUIP	6,240,008		6,240,008	0.396802					2
3	TOTAL (SUM OF LINES 1-2)	15,725,733		15,725,733	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	337,907						337,907	1
2	CAP REL COSTS-MVBLE EQUIP	452,801						452,801	2
3	TOTAL	790,708						790,708	3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)	B	-9,273	ADMINISTRATIVE & GENERAL	5	3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-3,632	CENTRAL SERVICES & SUPPLY	14	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)	A	-6,843	ADMINISTRATIVE & GENERAL	5	7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9	PARKING LOT (CHAPTER 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-314,201			10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-23	RADIOLOGY-DIAGNOSTIC	54	11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-28,478	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-257	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				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				30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33	MISCELLANEOUS REVENUE	B	-923	ADMINISTRATIVE & GENERAL	5	33
34	LAB FEES	B	-18,721	LABORATORY	60	34
35	EDUCATION FEES	B	-1,049	ADMINISTRATIVE & GENERAL	5	35
36	NONALLOWABLE PUBLIC RELATIONS	A	-12,820	ADMINISTRATIVE & GENERAL	5	36
37	HEALTHLINK ADMIN FEES	A	49,302	ADMINISTRATIVE & GENERAL	5	37
38	LOBBYING PORTION OF DUES	A	-14,341	ADMINISTRATIVE & GENERAL	5	38
39	NON-RHC SERVICES	A	-83,640	RURAL HEALTH CLINIC 3	88.02	39
40	NON-RHC BENEFITS	A	-23,849	EMPLOYEE BENEFITS	4	40
41	EMPLOYEE SELF INSURANCE COST	A	-357,144	EMPLOYEE BENEFITS	4	41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-825,892			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS — WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJUSTMENTS (COL. 4-5)	WKST A-7 REF	LINE NO.
1							1
2							2
3							3
4							4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.						5
	1	2	3	4	5	6	7	

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

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

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

			RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6						6
7						7
8						8
9						9
10						10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERATION INCL FRINGES	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
	1	2		3	4	5	6	7	8	9
1	54	RADIOLOGY-DIAGNOSTIC	RADIOLOGY	1,700	1,700					
2	54	RADIOLOGY-DIAGNOSTIC	ULTRASOUND	7,384	7,384					
3	60	LABORATORY	LABORATORY	14,063	14,063					
4	69	ELECTROCARDIOLOGY	EKG	11,631	11,631					
5	91	EMERGENCY	EMERGENCY	1,093,887	277,948	815,939				
6	54	RADIOLOGY-DIAGNOSTIC	MAMMOGRAPHY	1,475	1,475					
200		TOTAL		1,130,140	314,201	815,939				

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18
1	54	RADIOLOGY-DIAGNOSTIC	RADIOLOGY							1,700
2	54	RADIOLOGY-DIAGNOSTIC	ULTRASOUND							7,384
3	60	LABORATORY	LABORATORY							14,063
4	69	ELECTROCARDIOLOGY	EKG							11,631
5	91	EMERGENCY	EMERGENCY							277,948
6	54	RADIOLOGY-DIAGNOSTIC	MAMMOGRAPHY							1,475
200		TOTAL								314,201

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	337,907	337,907				1
2	CAP REL COSTS-MVBLE EQUIP	452,801		452,801			2
4	EMPLOYEE BENEFITS	1,704,667	652	254	1,705,573		4
5	ADMINISTRATIVE & GENERAL	1,827,324	78,745	134,222	226,726	2,267,017	5
6	MAINTENANCE & REPAIRS	524,778	47,366	15,379	30,774	618,297	6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	72,078	4,476	1,297		77,851	8
9	HOUSEKEEPING	241,759	2,050	119	52,749	296,677	9
10	DIETARY	264,569	8,399	2,132	36,840	311,940	10
11	CAFETERIA	115,112	4,125		19,994	139,231	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	77,805	652	176	19,639	98,272	13
14	CENTRAL SERVICES & SUPPLY	66,748	3,755	4,264	13,716	88,483	14
15	PHARMACY	150,610	4,595	14,833	33,547	203,585	15
16	MEDICAL RECORDS & LIBRARY	210,617	4,812	549	47,791	263,769	16
17	SOCIAL SERVICE	4,172	435		1,054	5,661	17
19	NONPHYSICIAN ANESTHETISTS	198,501			50,134	248,635	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	769,602	25,178	19,294	185,199	999,273	30
46	OTHER LONG TERM CARE	542,646	44,708	8,683	129,930	725,967	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	317,219	15,469	8,255	59,076	400,019	50
51	RECOVERY ROOM		1,225			1,225	51
53	ANESTHESIOLOGY	89,670		2,738		92,408	53
54	RADIOLOGY-DIAGNOSTIC	696,970	23,127	213,607	78,643	1,012,347	54
60	LABORATORY	799,545	9,970	12,832	81,390	903,737	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY	68,641	2,352	358	8,641	79,992	65
66	PHYSICAL THERAPY	695,345	9,748	2,789	171,932	879,814	66
67.01	CARDIAC REHAB	17,920	2,080	744	4,364	25,108	67.01
69	ELECTROCARDIOLOGY	8,942	287	721	2,066	12,016	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	156,971				156,971	71
73	DRUGS CHARGED TO PATIENTS	683,621				683,621	73
76	OP GERO PSYCH	437,815	8,088	257		446,160	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3	1,451,537	11,912	1,189	364,588	1,829,226	88.02
91	EMERGENCY	1,187,403	16,013	5,498	85,134	1,294,048	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)	14,173,295	330,219	450,190	1,703,927	14,161,350	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,206			1,206	190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC	10,397	6,482	2,611	1,646	21,136	190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	14,183,692	337,907	452,801	1,705,573	14,183,692	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL 5	MAIN-TENANCE & REPAIRS 6	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	2,267,017					5
6	MAINTENANCE & REPAIRS	117,624	735,921				6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	14,810	15,601	108,262			8
9	HOUSEKEEPING	56,440	7,146		360,263		9
10	DIETARY	59,343	29,274		14,788	415,345	10
11	CAFETERIA	26,487	14,379		7,264		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	18,695	2,273		1,148		13
14	CENTRAL SERVICES & SUPPLY	16,833	13,087		6,611		14
15	PHARMACY	38,730	16,015		8,090		15
16	MEDICAL RECORDS & LIBRARY	50,179	16,772		8,473		16
17	SOCIAL SERVICE	1,077	1,515		765		17
19	NONPHYSICIAN ANESTHETISTS	47,300					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	190,101	87,754	19,032	44,329	83,599	30
46	OTHER LONG TERM CARE	138,107	155,826	58,777	78,716	311,411	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	76,099	53,916	4,913	27,236		50
51	RECOVERY ROOM	233	4,271		2,157		51
53	ANESTHESIOLOGY	17,580					53
54	RADIOLOGY-DIAGNOSTIC	192,588	80,608	4,885	40,719		54
60	LABORATORY	171,926	34,750	3	17,554		60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY	15,218	8,197		4,141		65
66	PHYSICAL THERAPY	167,375	33,975	12,037	17,163		66
67.01	CARDIAC REHAB	4,777	7,250		3,662		67.01
69	ELECTROCARDIOLOGY	2,286	999		505		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	29,862					71
73	DRUGS CHARGED TO PATIENTS	130,051					73
76	OP GERO PSYCH	84,877	28,189	270	14,240		76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3	347,991	41,518	1,148	20,973		88.02
91	EMERGENCY	246,178	55,811	7,049	28,193		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)	2,262,767	709,126	108,114	346,727	395,010	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	229	4,202		2,123		190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC	4,021	22,593	148	11,413		190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS					20,335	190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	2,267,017	735,921	108,262	360,263	415,345	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11	13	14	15	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	187,361					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		120,388				13
14	CENTRAL SERVICES & SUPPLY	3,406		128,420			14
15	PHARMACY	3,348		1,728	271,496		15
16	MEDICAL RECORDS & LIBRARY	11,441		303		350,937	16
17	SOCIAL SERVICE	191					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	33,481	45,713	30,447	171	14,635	30
46	OTHER LONG TERM CARE	33,558	43,870	20,862		16,659	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	8,131	10,508	18,759	8	21,782	50
51	RECOVERY ROOM					835	51
53	ANESTHESIOLOGY	1,913		904	38	1,815	53
54	RADIOLOGY-DIAGNOSTIC	11,996		10,365	239	83,186	54
60	LABORATORY	14,751		9,891	34	73,307	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY	1,913	2,469	1,942		5,418	65
66	PHYSICAL THERAPY	22,748		2,012	247	34,463	66
67.01	CARDIAC REHAB	765		540		1,130	67.01
69	ELECTROCARDIOLOGY	344	449	456		3,455	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS					13,082	71
73	DRUGS CHARGED TO PATIENTS				270,622	38,218	73
76	OP GERO PSYCH			410		10,859	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3	25,733		4,217	2	16,157	88.02
91	EMERGENCY	13,259	17,379	25,436	135	15,936	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)	186,978	120,388	128,272	271,496	350,937	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC	383		148			190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	187,361	120,388	128,420	271,496	350,937	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	25	26	
	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	9,209					17
19	NONPHYSICIAN ANESTHETISTS		295,935				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	8,288		1,556,823		1,556,823	30
46	OTHER LONG TERM CARE	921		1,584,674		1,584,674	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM			621,371		621,371	50
51	RECOVERY ROOM			8,721		8,721	51
53	ANESTHESIOLOGY		295,935	410,593		410,593	53
54	RADIOLOGY-DIAGNOSTIC			1,436,933		1,436,933	54
60	LABORATORY			1,225,953		1,225,953	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY			119,290		119,290	65
66	PHYSICAL THERAPY			1,169,834		1,169,834	66
67.01	CARDIAC REHAB			43,232		43,232	67.01
69	ELECTROCARDIOLOGY			20,510		20,510	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			199,915		199,915	71
73	DRUGS CHARGED TO PATIENTS			1,122,512		1,122,512	73
76	OP GERO PSYCH			585,005		585,005	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3			2,286,965		2,286,965	88.02
91	EMERGENCY			1,703,424		1,703,424	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)	9,209	295,935	14,095,755		14,095,755	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			7,760		7,760	190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC			59,842		59,842	190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS			20,335		20,335	190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	9,209	295,935	14,183,692		14,183,692	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS		652	254	906	906	4
5	ADMINISTRATIVE & GENERAL		78,745	134,222	212,967	120	5
6	MAINTENANCE & REPAIRS		47,366	15,379	62,745	16	6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE		4,476	1,297	5,773		8
9	HOUSEKEEPING		2,050	119	2,169	28	9
10	DIETARY		8,399	2,132	10,531	20	10
11	CAFETERIA		4,125		4,125	11	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		652	176	828	10	13
14	CENTRAL SERVICES & SUPPLY		3,755	4,264	8,019	7	14
15	PHARMACY		4,595	14,833	19,428	18	15
16	MEDICAL RECORDS & LIBRARY		4,812	549	5,361	25	16
17	SOCIAL SERVICE		435		435	1	17
19	NONPHYSICIAN ANESTHETISTS					27	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		25,178	19,294	44,472	98	30
46	OTHER LONG TERM CARE		44,708	8,683	53,391	69	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		15,469	8,255	23,724	31	50
51	RECOVERY ROOM		1,225		1,225		51
53	ANESTHESIOLOGY			2,738	2,738		53
54	RADIOLOGY-DIAGNOSTIC		23,127	213,607	236,734	42	54
60	LABORATORY		9,970	12,832	22,802	43	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY		2,352	358	2,710	5	65
66	PHYSICAL THERAPY		9,748	2,789	12,537	91	66
67.01	CARDIAC REHAB		2,080	744	2,824	2	67.01
69	ELECTROCARDIOLOGY		287	721	1,008	1	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
76	OP GERO PSYCH		8,088	257	8,345		76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3		11,912	1,189	13,101	195	88.02
91	EMERGENCY		16,013	5,498	21,511	45	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)		330,219	450,190	780,409	905	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,206		1,206		190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC		6,482	2,611	9,093	1	190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		337,907	452,801	790,708	906	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	6	8	9	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	213,087					5
6	MAINTENANCE & REPAIRS	11,056	73,817				6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	1,392	1,565	8,730			8
9	HOUSEKEEPING	5,305	717		8,219		9
10	DIETARY	5,578	2,936		337	19,402	10
11	CAFETERIA	2,490	1,442		166		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,757	228		26		13
14	CENTRAL SERVICES & SUPPLY	1,582	1,313		151		14
15	PHARMACY	3,640	1,606		185		15
16	MEDICAL RECORDS & LIBRARY	4,716	1,682		193		16
17	SOCIAL SERVICE	101	152		17		17
19	NONPHYSICIAN ANESTHETISTS	4,446					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	17,868	8,802	1,535	1,011	3,905	30
46	OTHER LONG TERM CARE	12,981	15,633	4,739	1,798	14,547	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	7,153	5,408	396	621		50
51	RECOVERY ROOM	22	428		49		51
53	ANESTHESIOLOGY	1,652					53
54	RADIOLOGY-DIAGNOSTIC	18,102	8,085	394	929		54
60	LABORATORY	16,160	3,486		400		60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY	1,430	822		94		65
66	PHYSICAL THERAPY	15,732	3,408	971	392		66
67.01	CARDIAC REHAB	449	727		84		67.01
69	ELECTROCARDIOLOGY	215	100		12		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	2,807					71
73	DRUGS CHARGED TO PATIENTS	12,224					73
76	OP GERO PSYCH	7,978	2,828	22	325		76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3	32,712	4,164	93	478		88.02
91	EMERGENCY	23,139	5,598	568	643		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)	212,687	71,130	8,718	7,911	18,452	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22	421		48		190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC	378	2,266	12	260		190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS					950	190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	213,087	73,817	8,730	8,219	19,402	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11	13	14	15	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	8,234					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		2,849				13
14	CENTRAL SERVICES & SUPPLY	150		11,222			14
15	PHARMACY	147		151	25,175		15
16	MEDICAL RECORDS & LIBRARY	503		27		12,507	16
17	SOCIAL SERVICE	8					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	1,471	1,082	2,660	16	522	30
46	OTHER LONG TERM CARE	1,475	1,038	1,823		594	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	357	249	1,639	1	777	50
51	RECOVERY ROOM					30	51
53	ANESTHESIOLOGY	84		79	4	65	53
54	RADIOLOGY-DIAGNOSTIC	527		906	22	2,960	54
60	LABORATORY	648		864	3	2,614	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY	84	58	170		193	65
66	PHYSICAL THERAPY	1,000		176	23	1,229	66
67.01	CARDIAC REHAB	34		47		40	67.01
69	ELECTROCARDIOLOGY	15	11	40		123	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS					466	71
73	DRUGS CHARGED TO PATIENTS				25,093	1,363	73
76	OP GERO PSYCH			36		387	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3	1,131		368		576	88.02
91	EMERGENCY	583	411	2,223	13	568	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)	8,217	2,849	11,209	25,175	12,507	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC	17		13			190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	8,234	2,849	11,222	25,175	12,507	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	25	26	
	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	714					17
19	NONPHYSICIAN ANESTHETISTS		4,473				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	643		84,085		84,085	30
46	OTHER LONG TERM CARE	71		108,159		108,159	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM			40,356		40,356	50
51	RECOVERY ROOM			1,754		1,754	51
53	ANESTHESIOLOGY			4,622		4,622	53
54	RADIOLOGY-DIAGNOSTIC			268,701		268,701	54
60	LABORATORY			47,020		47,020	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY			5,566		5,566	65
66	PHYSICAL THERAPY			35,559		35,559	66
67.01	CARDIAC REHAB			4,207		4,207	67.01
69	ELECTROCARDIOLOGY			1,525		1,525	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			3,273		3,273	71
73	DRUGS CHARGED TO PATIENTS			38,680		38,680	73
76	OP GERO PSYCH			19,921		19,921	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3			52,818		52,818	88.02
91	EMERGENCY			55,302		55,302	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)	714		771,548		771,548	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			1,697		1,697	190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC			12,040		12,040	190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS			950		950	190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS		4,473	4,473		4,473	200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	714	4,473	790,708		790,708	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	68,393					1
2	CAP REL COSTS-MVBLE EQUIP		398,704				2
4	EMPLOYEE BENEFITS	132	224	6,753,011			4
5	ADMINISTRATIVE & GENERAL	15,938	118,186	897,692	-2,267,017	11,916,675	5
6	MAINTENANCE & REPAIRS	9,587	13,542	121,847		618,297	6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	906	1,142			77,851	8
9	HOUSEKEEPING	415	105	208,853		296,677	9
10	DIETARY	1,700	1,877	145,864		311,940	10
11	CAFETERIA	835		79,165		139,231	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	132	155	77,758		98,272	13
14	CENTRAL SERVICES & SUPPLY	760	3,755	54,308		88,483	14
15	PHARMACY	930	13,061	132,825		203,585	15
16	MEDICAL RECORDS & LIBRARY	974	483	189,222		263,769	16
17	SOCIAL SERVICE	88		4,172		5,661	17
19	NONPHYSICIAN ANESTHETISTS			198,501		248,635	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	5,096	16,989	733,271		999,273	30
46	OTHER LONG TERM CARE	9,049	7,646	514,443		725,967	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,131	7,269	233,905		400,019	50
51	RECOVERY ROOM	248				1,225	51
53	ANESTHESIOLOGY		2,411			92,408	53
54	RADIOLOGY-DIAGNOSTIC	4,681	188,086	311,379		1,012,347	54
60	LABORATORY	2,018	11,299	322,253		903,737	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY	476	315	34,214		79,992	65
66	PHYSICAL THERAPY	1,973	2,456	680,744		879,814	66
67.01	CARDIAC REHAB	421	655	17,278		25,108	67.01
69	ELECTROCARDIOLOGY	58	635	8,181		12,016	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS					156,971	71
73	DRUGS CHARGED TO PATIENTS					683,621	73
76	OP GERO PSYCH	1,637	226			446,160	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3	2,411	1,047	1,443,542		1,829,226	88.02
91	EMERGENCY	3,241	4,841	337,078		1,294,048	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)	66,837	396,405	6,746,495	-2,267,017	11,894,333	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	244				1,206	190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC	1,312	2,299	6,516		21,136	190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	337,907	452,801	1,705,573		2,267,017	202
203	UNIT COST MULT-WS B PT I	4.940666	1.135682	0.252565		0.190239	203
204	COST TO BE ALLOC PER B PT II			906		213,087	204
205	UNIT COST MULT-WS B PT II			0.000134		0.017881	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	MAIN-TENANCE & REPAIRS SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	
		6	8	9	10	11	
	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	42,736					6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	906	34,420				8
9	HOUSEKEEPING	415		41,415			9
10	DIETARY	1,700		1,700	45,937		10
11	CAFETERIA	835		835		9,793	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	132		132			13
14	CENTRAL SERVICES & SUPPLY	760		760		178	14
15	PHARMACY	930		930		175	15
16	MEDICAL RECORDS & LIBRARY	974		974		598	16
17	SOCIAL SERVICE	88		88		10	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	5,096	6,051	5,096	9,246	1,750	30
46	OTHER LONG TERM CARE	9,049	18,687	9,049	34,442	1,754	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,131	1,562	3,131		425	50
51	RECOVERY ROOM	248		248			51
53	ANESTHESIOLOGY					100	53
54	RADIOLOGY-DIAGNOSTIC	4,681	1,553	4,681		627	54
60	LABORATORY	2,018	1	2,018		771	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY	476		476		100	65
66	PHYSICAL THERAPY	1,973	3,827	1,973		1,189	66
67.01	CARDIAC REHAB	421		421		40	67.01
69	ELECTROCARDIOLOGY	58		58		18	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
76	OP GERO PSYCH	1,637	86	1,637			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3	2,411	365	2,411		1,345	88.02
91	EMERGENCY	3,241	2,241	3,241		693	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)	41,180	34,373	39,859	43,688	9,773	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	244		244			190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC	1,312	47	1,312		20	190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS				2,249		190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	735,921	108,262	360,263	415,345	187,361	202
203	UNIT COST MULT-WS B PT I	17.220166	3.145322	8.698853	9.041622	19.132135	203
204	COST TO BE ALLOC PER B PT II	73,817	8,730	8,219	19,402	8,234	204
205	UNIT COST MULT-WS B PT II	1.727279	0.253632	0.198455	0.422361	0.840805	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 GROSS CHARGES 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	100,754					13
14	CENTRAL SERVICES & SUPPLY		94,377				14
15	PHARMACY		1,270	685,833			15
16	MEDICAL RECORDS & LIBRARY		223		21,798,844		16
17	SOCIAL SERVICE					100	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	38,258	22,376	433	909,062	90	30
46	OTHER LONG TERM CARE	36,715	15,332		1,034,807	10	46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	8,794	13,786	20	1,352,987		50
51	RECOVERY ROOM				51,874		51
53	ANESTHESIOLOGY		664	97	112,760		53
54	RADIOLOGY-DIAGNOSTIC		7,617	605	5,167,184		54
60	LABORATORY		7,269	85	4,553,515		60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY	2,066	1,427		336,570		65
66	PHYSICAL THERAPY		1,479	625	2,140,693		66
67.01	CARDIAC REHAB		397		70,179		67.01
69	ELECTROCARDIOLOGY	376	335		214,581		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS				812,624		71
73	DRUGS CHARGED TO PATIENTS			683,621	2,373,959		73
76	OP GERO PSYCH		301		674,545		76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3		3,099	5	1,003,631		88.02
91	EMERGENCY	14,545	18,693	342	989,873		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
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)	100,754	94,268	685,833	21,798,844	100	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.02	UNUSED SPACE						190.02
190.03	NON-REIMBURSEABLE HOME HEALTH						190.03
190.04	OUTPATIENT CLINIC		109				190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01	PHYSICIANS' CLINIC						192.01
192.02	WASHINGTON COUNTY HEALTH CENTER						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	120,388	128,420	271,496	350,937	9,209	202
203	UNIT COST MULT-WS B PT I	1.194871	1.360713	0.395863	0.016099	92.090000	203
204	COST TO BE ALLOC PER B PT II	2,849	11,222	25,175	12,507	714	204
205	UNIT COST MULT-WS B PT II	0.028277	0.118906	0.036707	0.000574	7.140000	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
	INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS		30
46	OTHER LONG TERM CARE		46
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM		50
51	RECOVERY ROOM		51
53	ANESTHESIOLOGY	100	53
54	RADIOLOGY-DIAGNOSTIC		54
60	LABORATORY		60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS		62.30
65	RESPIRATORY THERAPY		65
66	PHYSICAL THERAPY		66
67.01	CARDIAC REHAB		67.01
69	ELECTROCARDIOLOGY		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		71
73	DRUGS CHARGED TO PATIENTS		73
76	OP GERO PSYCH		76
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
88.01	RURAL HEALTH CLINIC 2		88.01
88.02	RURAL HEALTH CLINIC 3		88.02
91	EMERGENCY		91
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
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		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
190.02	UNUSED SPACE		190.02
190.03	NON-REIMBURSEABLE HOME HEALTH		190.03
190.04	OUTPATIENT CLINIC		190.04
190.05	NON-REIMBURSEABLE OUTPATIENT MEALS		190.05
192.01	PHYSICIANS' CLINIC		192.01
192.02	WASHINGTON COUNTY HEALTH CENTER		192.02
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	295,935	202
203	UNIT COST MULT-WS B PT I	2,959.350000	203
204	COST TO BE ALLOC PER B PT II	4,473	204
205	UNIT COST MULT-WS B PT II	44.730000	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	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,556,823		1,556,823			30
46	OTHER LONG TERM CARE	1,584,674		1,584,674			46
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	621,371		621,371			50
51	RECOVERY ROOM	8,721		8,721			51
53	ANESTHESIOLOGY	410,593		410,593			53
54	RADIOLOGY-DIAGNOSTIC	1,436,933		1,436,933			54
60	LABORATORY	1,225,953		1,225,953			60
62.30	BLOOD CLOTTING FACTORS ADMI						62.30
65	RESPIRATORY THERAPY	119,290		119,290			65
66	PHYSICAL THERAPY	1,169,834		1,169,834			66
67.01	CARDIAC REHAB	43,232		43,232			67.01
69	ELECTROCARDIOLOGY	20,510		20,510			69
71	MEDICAL SUPPLIES CHRGED TO	199,915		199,915			71
73	DRUGS CHARGED TO PATIENTS	1,122,512		1,122,512			73
76	OP GERO PSYCH	585,005		585,005			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88.01	RURAL HEALTH CLINIC 2						88.01
88.02	RURAL HEALTH CLINIC 3	2,286,965		2,286,965			88.02
91	EMERGENCY	1,703,424		1,703,424			91
92	OBSERVATION BEDS	29,837		29,837			92
	OTHER REIMBURSABLE COST CENTERS						
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
200	SUBTOTAL (SEE INSTRUCTIONS)	14,125,592		14,125,592			200
201	LESS OBSERVATION BEDS	29,837		29,837			201
202	TOTAL (SEE INSTRUCTIONS)	14,095,755		14,095,755			202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	CHARGES TOTAL (COLS. 6 + 7) 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	871,666		871,666				30
46	OTHER LONG TERM CARE	1,034,807		1,034,807				46
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,080	1,341,907	1,352,987	0.459259			50
51	RECOVERY ROOM	1,065	50,809	51,874	0.168119			51
53	ANESTHESIOLOGY	4,422	108,338	112,760	3.641300			53
54	RADIOLOGY-DIAGNOSTIC	130,553	5,036,631	5,167,184	0.278088			54
60	LABORATORY	306,377	4,247,138	4,553,515	0.269232			60
62.30	BLOOD CLOTTING FACTORS ADMI							62.30
65	RESPIRATORY THERAPY	86,050	153,569	239,619	0.497832			65
66	PHYSICAL THERAPY	431,953	1,708,740	2,140,693	0.546474			66
67.01	CARDIAC REHAB		70,179	70,179	0.616025			67.01
	OUTPATIENT SERVICE COST CENTERS							
69	ELECTROCARDIOLOGY	13,548	256,033	269,581	0.076081			69
71	MEDICAL SUPPLIES CHRGED TO	113,166	796,409	909,575	0.219789			71
73	DRUGS CHARGED TO PATIENTS	700,988	1,672,971	2,373,959	0.472844			73
76	OP GERO PSYCH		674,545	674,545	0.867259			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
88.01	RURAL HEALTH CLINIC 2							88.01
88.02	RURAL HEALTH CLINIC 3	542	1,003,089	1,003,631	2.278691			88.02
91	EMERGENCY		989,873	989,873	1.720851			91
92	OBSERVATION BEDS		37,396	37,396	0.797866			92
	OTHER REIMBURSABLE COST CENTERS							
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
200	SUBTOTAL (SEE INSTRUCTIONS)	3,706,217	18,147,627	21,853,844				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		18,147,627	21,853,844				202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
PART V

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1308)	[ ]	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	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.459259		602,046			276,495		50
51	RECOVERY ROOM	0.168119							51
53	ANESTHESIOLOGY	3.641300		45,786			166,721		53
54	RADIOLOGY-DIAGNOSTIC	0.278088		1,531,849			425,989		54
60	LABORATORY	0.269232		2,124,245			571,915		60
62.30	BLOOD CLOTTING FACTORS ADMIN CO								62.30
65	RESPIRATORY THERAPY	0.497832		60,288			30,013		65
66	PHYSICAL THERAPY	0.546474		650,308			355,376		66
67.01	CARDIAC REHAB	0.616025		41,071			25,301		67.01
69	ELECTROCARDIOLOGY	0.076081		251,451			19,131		69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.219789		410,611			90,248		71
73	DRUGS CHARGED TO PATIENTS	0.472844		1,145,037			541,424		73
76	OP GERO PSYCH	0.867259		674,544			585,004		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88.01	RURAL HEALTH CLINIC 2								88.01
88.02	RURAL HEALTH CLINIC 3	2.278691							88.02
91	EMERGENCY	1.720851		326,140			561,238		91
92	OBSERVATION BEDS	0.797866		23,769			18,964		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)			7,887,145			3,667,819		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			7,887,145			3,667,819		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-Z308)
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	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.459259							50
51	RECOVERY ROOM	0.168119							51
53	ANESTHESIOLOGY	3.641300							53
54	RADIOLOGY-DIAGNOSTIC	0.278088							54
60	LABORATORY	0.269232							60
62.30	BLOOD CLOTTING FACTORS ADMIN CO								62.30
65	RESPIRATORY THERAPY	0.497832							65
66	PHYSICAL THERAPY	0.546474							66
67.01	CARDIAC REHAB	0.616025							67.01
69	ELECTROCARDIOLOGY	0.076081							69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.219789							71
73	DRUGS CHARGED TO PATIENTS	0.472844							73
76	OP GERO PSYCH	0.867259							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88.01	RURAL HEALTH CLINIC 2								88.01
88.02	RURAL HEALTH CLINIC 3	2.278691							88.02
91	EMERGENCY	1.720851							91
92	OBSERVATION BEDS	0.797866							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1308)	[ ]	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)	2,260	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	576	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	576	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	987	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)	615	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	80	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)	2	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	462	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)	987	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)	615	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	116.26	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	116.26	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,556,823	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)	9,301	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	233	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,147,627	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	409,196	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	871,666	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	871,666	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.469441	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)	1,513.31	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)	409,196	37

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1 PART II

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1308)	[ ]	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)	710.42 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	328,214 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)	328,214 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)					206,394	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					534,608	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)					701,185	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)					436,908	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					1,138,093	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)	42 87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	710.41 88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	29,837 89

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	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)	
90	CAPITAL-RELATED COST	84,085	409,196	0.205488	29,837	6,131	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1 PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1308)	[ ]	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)	2,260	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	576	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	576	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	987	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)	615	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	80	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)	2	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	6	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	116.26	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	116.26	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,556,823	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)	9,301	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	233	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,147,627	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	409,196	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	871,666	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	871,666	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.469441	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)	1,513.31	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)	409,196	37

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1 PART II

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1308)	[ ]	SUB (OTHER)	[ ] PPS
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)	710.42	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	4,263	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)	4,263	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)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					4,263	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)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (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)	42	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 (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)	
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 (14-1308)	[ ]	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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		340,664		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.459259	8,653	3,974	50
51	RECOVERY ROOM	0.168119			51
53	ANESTHESIOLOGY	3.641300	2,456	8,943	53
54	RADIOLOGY-DIAGNOSTIC	0.278088	77,572	21,572	54
60	LABORATORY	0.269232	140,733	37,890	60
62.30	BLOOD CLOTTING FACTORS ADMIN CO				62.30
65	RESPIRATORY THERAPY	0.497832	24,965	12,428	65
66	PHYSICAL THERAPY	0.546474	29,639	16,197	66
67.01	CARDIAC REHAB	0.616025			67.01
69	ELECTROCARDIOLOGY	0.076081	10,401	791	69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.219789	39,174	8,610	71
73	DRUGS CHARGED TO PATIENTS	0.472844	203,004	95,989	73
76	OP GERO PSYCH	0.867259			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88.01	RURAL HEALTH CLINIC 2				88.01
88.02	RURAL HEALTH CLINIC 3	2.278691			88.02
91	EMERGENCY	1.720851			91
92	OBSERVATION BEDS	0.797866			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		536,597	206,394	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		536,597		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B SNF(14-Z308)	[ ]	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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.459259	1,232	566	50
51	RECOVERY ROOM	0.168119			51
53	ANESTHESIOLOGY	3.641300			53
54	RADIOLOGY-DIAGNOSTIC	0.278088	27,512	7,651	54
60	LABORATORY	0.269232	140,357	37,789	60
62.30	BLOOD CLOTTING FACTORS ADMIN CO				62.30
65	RESPIRATORY THERAPY	0.497832	43,515	21,663	65
66	PHYSICAL THERAPY	0.546474	390,793	213,558	66
67.01	CARDIAC REHAB	0.616025			67.01
69	ELECTROCARDIOLOGY	0.076081	3,138	239	69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.219789	66,049	14,517	71
73	DRUGS CHARGED TO PATIENTS	0.472844	449,139	212,373	73
76	OP GERO PSYCH	0.867259			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88.01	RURAL HEALTH CLINIC 2				88.01
88.02	RURAL HEALTH CLINIC 3	2.278691			88.02
91	EMERGENCY	1.720851			91
92	OBSERVATION BEDS	0.797866			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		1,121,735	508,356	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		1,121,735		202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-1308) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,667,819	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	3,667,819	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	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)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	3,704,497	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	25,246	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,172,443	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	2,506,808	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	2,506,808	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,506,808	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	123,877	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	123,877	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	123,877	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	2,630,685	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	2,630,685	40
41	INTERIM PAYMENTS	2,483,419	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	147,266	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
PART I

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-1308) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				402,985		2,506,148	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE		NONE	3.01
		.02					3.02
	PROGRAM TO PROVIDER	.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50	12/10/2010	46,678	12/10/2010	22,729	3.50
		.51					3.51
	PROVIDER TO PROGRAM	.52					3.52
		.53					3.53
		.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		-46,678		-22,729	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				356,307		2,483,419	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 TO PROVIDER	.01		NONE		NONE	5.01
		.02					5.02
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER TO PROGRAM	.50		NONE		NONE	5.50
		.51					5.51
		.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01		81,035		147,266	6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				437,342		2,630,685	7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED WORKSHEET E-1 PART I

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [XX] SWING BED SNF (14-Z308)

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,606,468			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					3.01
			.02					3.02
		PROGRAM	.03					3.03
		TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.50	12/10/2010	9,812		NONE	3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		-9,812			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				1,596,656			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					5.01
		TO	.02					5.02
		PROVIDER	.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER	.50		NONE		NONE	5.50
		TO	.51					5.51
		PROGRAM	.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01		21,391			6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				1,618,047			7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT WORKSHEET E-1
PART II

CHECK APPLICABLE BOX [XX] HOSPITAL (14-1308) [ ] CAH

	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	172	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	462	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	534	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	21,853,844	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	146,014	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 E-2

CHECK	[ ]	TITLE V	[XX]	SWING BED - SNF (14-Z308)
APPLICABLE	[XX]	TITLE XVIII	[ ]	SWING BED - NF
BOXES	[ ]	TITLE XIX		

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	1,149,474		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)	513,440		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			4
5	PROGRAM DAYS	1,602		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)	1,662,914		8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	1,662,914		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)			11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	1,662,914		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	44,867		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)	1,618,047		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)	1,618,047		19
20	INTERIM PAYMENTS	1,596,656		20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	21,391		22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART V

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-1308) [ ] SUB (OTHER)

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

1	INPATIENT SERVICES	534,608	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	534,608	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 5 LESS LINE 6) (FOR CAH, SEE INSTRUCTIONS)	539,954	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES	536,597	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)	539,954	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	111,828	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	428,126	22
23	COINSURANCE	1,959	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	426,167	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	11,175	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	11,175	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	11,175	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26 (LINE 26 HOSPITAL AND SUBPROVIDER ONLY))	437,342	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	437,342	30
31	INTERIM PAYMENTS	356,307	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	81,035	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART VII

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1308)	[ ]	SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
BOXES:			[ ]	IRF	[ ]	ICF/MR	[XX]	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	4,263	1
2	MEDICAL AND OTHER SERVICES		2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	4,263	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	4,263	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)	4,263	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)	4,263	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)	4,263	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)	4,263	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)	4,263	40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	4,263	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	30,599				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3,390,410				4
5	OTHER RECEIVABLES	58,107				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,516,286				6
7	INVENTORY	275,063				7
8	PREPAID EXPENSES	166,901				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	2,404,794				11
	FIXED ASSETS					
12	LAND	62,855				12
13	LAND IMPROVEMENTS	372,843				13
14	ACCUMULATED DEPRECIATION	-339,128				14
15	BUILDINGS	9,050,027				15
16	ACCUMULATED DEPRECIATION	-6,025,531				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	7,068,850				23
24	ACCUMULATED DEPRECIATION	-5,456,650				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)	4,733,266				30
	OTHER ASSETS					
31	INVESTMENTS	805,500				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	131,280				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	936,780				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	8,074,840				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	464,143				37
38	SALARIES, WAGES & FEES PAYABLE	925,717				38
39	PAYROLL TAXES PAYABLE	66,569				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	247,821				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES					44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,704,250				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	2,123,172				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	2,123,172				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	3,827,422				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	4,247,418				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)	4,247,418				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	8,074,840				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1 2	3 4	5 6	7 8	
1	FUND BALANCES AT BEGINNING OF PERIOD	5,178,968				1
2	NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)	-931,550				2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	4,247,418				3
4	ADDITIONS (CREDIT ADJUST-MENTS)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)					10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	4,247,418				11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	4,247,418				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES — WORKSHEET G-2 PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	394,806		394,806	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	403,693		403,693	5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE	1,039,846		1,039,846	9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	1,838,345		1,838,345	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	1,838,345		1,838,345	17
18	ANCILLARY SERVICES	1,794,164	16,593,685	18,387,849	18
19	OUTPATIENT SERVICES		1,079,224	1,079,224	19
20	RHC				20
20.01	RHC II				20.01
20.02	RHC III	542	1,003,089	1,003,631	20.02
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
27.01	PHYSICIAN CHARGES	1,962	1,266,663	1,268,625	27.01
27.02	OUTPATIENT CLINIC		423,510	423,510	27.02
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	3,635,013	20,366,171	24,001,184	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		15,009,584	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34	DEDUCT (SPECIFY)			34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		15,009,584	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	24,001,184	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	10,384,915	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	13,616,269	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	15,009,584	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,393,315	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	19,360	6
7	INCOME FROM INVESTMENTS	26,571	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	3,632	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	28,478	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	2,319	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	257	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS	319,963	23
24	OTHER (RENTAL INCOME)	7,402	24
24.01	OTHER (GRANT INCOME)	30,868	24.01
24.02	OTHER (OTHER OPERATING REVENUE)	22,915	24.02
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	461,765	25
26	TOTAL (LINE 5 PLUS LINE 25)	-931,550	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-931,550	29

RHC III

WORKSHEET M-1

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

COMPONENT NO: 14-3472

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	PHYSICIAN	1,443,542		1,443,542		1,443,542	-79,497	1,364,045	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE								5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS								9
10	SUBTOTAL (SUM OF LINES 1-9)	1,443,542		1,443,542		1,443,542	-79,497	1,364,045	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT		63,360	63,360		63,360		63,360	11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT		2,095	2,095		2,095	-1,995	100	13
14	SUBTOTAL (SUM OF LINES 11-13)		65,455	65,455		65,455	-1,995	63,460	14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		7,029	7,029		7,029	-310	6,719	15
16	TRANSPORTATION (HEALTH CARE STAFF)		2,325	2,325		2,325		2,325	16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		123,256	123,256	-123,256				18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		132,610	132,610	-123,256	9,354	-310	9,044	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,443,542	198,065	1,641,607	-123,256	1,518,351	-81,802	1,436,549	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY		5	5		5		5	23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		5	5		5		5	28
	FACILITY OVERHEAD								
29	FACILITY COSTS		3,051	3,051		3,051	-1,838	1,213	29
30	ADMINISTRATIVE COSTS		13,770	13,770		13,770		13,770	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		16,821	16,821		16,821	-1,838	14,983	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,443,542	214,891	1,658,433	-123,256	1,535,177	-83,640	1,451,537	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC III
COMPONENT NO: 14-3472

WORKSHEET M-2

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	2.78	6,892	4,200	11,676		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	0.63	1,925	2,100	1,323		3
4	SUBTOTAL (SUM OF LINES 1-3)	3.41	8,817		12,999	12,999	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	3.41	8,817			12,999	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						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)	1,436,549	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)	5	11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	1,436,554	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	0.999997	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)	14,983	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	835,428	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	850,411	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	850,411	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	850,408	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	2,286,957	20

RHC III WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3472

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	2,286,957	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	13,264	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	2,273,693	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	12,999	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	12,999	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	174.91	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)	76.84	77.76		8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	174.91	174.91	174.91	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	2,445			10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	427,655			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)	427,655			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%)		-27,157		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	342,124	-27,157		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		33,946		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)				19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		314,967		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		5,093		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		320,060		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)				23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		320,060		26
27	INTERIM PAYMENTS		283,384		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		36,676		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC III
COMPONENT NO: 14-3472

WORKSHEET M-4

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,364,045	1,364,045	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000352	0.002679	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	480	3,654	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	711	3,487	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,191	7,141	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,436,549	1,436,549	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	850,411	850,411	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.000829	0.004971	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	705	4,227	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,896	11,368	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	15	114	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	126.40	99.72	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	4	46	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	506	4,587	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)		13,264	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)		5,093	16

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

RHC III COMPONENT NO: 14-3472

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				283,384	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE	3.01
			.02			3.02
		PROGRAM	.03			3.03
		TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50		NONE	3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				283,384	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE	5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER	.50		NONE	5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99			5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO PROVIDER	.01		36,676	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				320,060	7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

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

	COST CENTERS	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE XIX INPATIENT 3	TITLE XIX OUTPATIENT 4	TITLE V INPATIENT 5	TITLE V OUTPATIENT 6	TOTAL PARTY 7	THIRD UTIL
UTILIZATION PERCENTAGES BASED ON DAYS									
30	ADULTS & PEDIATRICS	80.21		1.04				81.25	30
UTILIZATION PERCENTAGES BASED ON CHARGES									
50	OPERATING ROOM	0.64						0.64	50
53	ANESTHESIOLOGY	2.18						2.18	53
54	RADIOLOGY-DIAGNOSTIC	1.50						1.50	54
60	LABORATORY	3.09						3.09	60
65	RESPIRATORY THERAPY	10.42						10.42	65
66	PHYSICAL THERAPY	1.38						1.38	66
69	ELECTROCARDIOLOGY	3.86						3.86	69
71	MEDICAL SUPPLIES CHRGED TO PATI	4.31						4.31	71
73	DRUGS CHARGED TO PATIENTS	8.55						8.55	73
200	TOTAL CHARGES	2.69						2.69	200

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

SWING-BED SNF / NF

	COST CENTERS	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE XIX INPATIENT 3	TITLE XIX OUTPATIENT 4	TITLE V INPATIENT 5	TITLE V OUTPATIENT 6	TOTAL THIRD PARTY 7	UTIL
UTILIZATION PERCENTAGES BASED ON CHARGES									
50	OPERATING ROOM	0.09						0.09	50
54	RADIOLOGY-DIAGNOSTIC	0.53						0.53	54
60	LABORATORY	3.08						3.08	60
65	RESPIRATORY THERAPY	18.16						18.16	65
66	PHYSICAL THERAPY	18.26						18.26	66
69	ELECTROCARDIOLOGY	1.16						1.16	69
71	MEDICAL SUPPLIES CHRGED TO PATI	7.26						7.26	71
73	DRUGS CHARGED TO PATIENTS	18.92						18.92	73
200	TOTAL CHARGES	5.62						5.62	200

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	337,907	2.38	-337,907	-5.41			1
2	CAP REL COSTS-MVBLE EQUIP	452,801	3.19	-452,801	-7.25			2
3	OTHER CAPITAL RELATED COSTS							3
4	EMPLOYEE BENEFITS	1,704,667	12.02	-1,704,667	-27.28			4
5	ADMINISTRATIVE & GENERAL	1,827,324	12.88	-1,827,324	-29.24			5
6	MAINTENANCE & REPAIRS	524,778	3.70	-524,778	-8.40			6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	72,078	0.51	-72,078	-1.15			8
9	HOUSEKEEPING	241,759	1.70	-241,759	-3.87			9
10	DIETARY	264,569	1.87	-264,569	-4.23			10
11	CAFETERIA	115,112	0.81	-115,112	-1.84			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	77,805	0.55	-77,805	-1.24			13
14	CENTRAL SERVICES & SUPPLY	66,748	0.47	-66,748	-1.07			14
15	PHARMACY	150,610	1.06	-150,610	-2.41			15
16	MEDICAL RECORDS & LIBRARY	210,617	1.48	-210,617	-3.37			16
17	SOCIAL SERVICE	4,172	0.03	-4,172	-0.07			17
19	NONPHYSICIAN ANESTHETISTS	198,501	1.40	-198,501	-3.18			19
20	NURSING SCHOOL							20
21	I&R SRVCES-SALARY & FRINGES APP							21
22	I&R SRVCES-OTHER PRGM COSTS APP							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	769,602	5.43	787,221	12.60	1,556,823	10.98	30
46	OTHER LONG TERM CARE	542,646	3.83	1,042,028	16.67	1,584,674	11.17	46
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	317,219	2.24	304,152	4.87	621,371	4.38	50
51	RECOVERY ROOM			8,721	0.14	8,721	0.06	51
53	ANESTHESIOLOGY	89,670	0.63	320,923	5.14	410,593	2.89	53
54	RADIOLOGY-DIAGNOSTIC	696,970	4.91	739,963	11.84	1,436,933	10.13	54
60	LABORATORY	799,545	5.64	426,408	6.82	1,225,953	8.64	60
62.30	BLOOD CLOTTING FACTORS ADMIN CO							62.30
65	RESPIRATORY THERAPY	68,641	0.48	50,649	0.81	119,290	0.84	65
66	PHYSICAL THERAPY	695,345	4.90	474,489	7.59	1,169,834	8.25	66
67.01	CARDIAC REHAB	17,920	0.13	25,312	0.41	43,232	0.30	67.01
69	ELECTROCARDIOLOGY	8,942	0.06	11,568	0.19	20,510	0.14	69
71	MEDICAL SUPPLIES CHRGED TO PATI	156,971	1.11	42,944	0.69	199,915	1.41	71
73	DRUGS CHARGED TO PATIENTS	683,621	4.82	438,891	7.02	1,122,512	7.91	73
76	OP GERO PSYCH	437,815	3.09	147,190	2.36	585,005	4.12	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
88.01	RURAL HEALTH CLINIC 2							88.01
88.02	RURAL HEALTH CLINIC 3	1,451,537	10.23	835,428	13.37	2,286,965	16.12	88.02
91	EMERGENCY	1,187,403	8.37	516,021	8.26	1,703,424	12.01	91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
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							
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CAN			7,760	0.12	7,760	0.05	190
190.02	UNUSED SPACE							190.02
190.03	NON-REIMBURSEABLE HOME HEALTH							190.03
190.04	OUTPATIENT CLINIC	10,397	0.07	49,445	0.79	59,842	0.42	190.04
190.05	NON-REIMBURSEABLE OUTPATIENT ME			20,335	0.33	20,335	0.14	190.05
192.01	PHYSICIANS' CLINIC							192.01
192.02	WASHINGTON COUNTY HEALTH CENTER							192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	14,183,692	100.00			14,183,692	100.00	202

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, COLUMNS 2, 2.01, & 2.02 x 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	
2.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	7,195,766
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	