

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY 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 PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/23/2011 13:27
 VOKAUxGScWHAHU.vL7zkVAFHfXm5K0
 k0j62046xjvcEDAV:8ApWvWLRdMVXZ
 tvym0BUgCx0qIJEJ

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

 TITLE

PI Encryption: 11/23/2011 13:27
 rLR0u66vQ9ASnQJe8RIzvxwbwGO:q0
 S2HJu0.uP9LnMCSuQcXsmhQ6AF:2fx
 IFoZ79Vwjd089z.G
 PART III - SETTLEMENT SUMMARY

 DATE

	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 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 OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 705 SOUTH GRAND AVENUE
 2 CITY: NASHVILLE STATE: IL

P.O. BOX: 1
 ZIP CODE: 62263- COUNTY: WASHINGTON 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			3
						V 6	XVIII 7	XIX 8	
3	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	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 OLTG	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

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

		IN-STATE	IN-STATE	OUT-OF	OUT-OF	MEDICAID	OTHER	
		PAID	ELIGIBLE	STATE	STATE			
		DAYS	DAYS	PAID	ELIGIBLE	HMO	MEDICAID	
		1	2	DAYS	DAYS	DAYS	DAYS	6
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							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.							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.							27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX	
		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
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	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 1	PROGRAM CODE 2	UNWEIGHTED FTES NONPROVIDER SITE 3	UNWEIGHTED FTES IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.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: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
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: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
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
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V XIX 1 2 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
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 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
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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.	1	2	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

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.	1	2	140
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IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

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

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

SEE 42 CFR §413.13)	PART A	PART B	
155 HOSPITAL	1	2	
156 SUBPROVIDER - IPF	N	N	155
157 SUBPROVIDER - IRF			156
158 SUBPROVIDER - (OTHER)			157
159 SNF			158
160 HHA			159
161 CMHC			160
			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	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE	
1	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)	1 N	2	1
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.	1 N	2	3 2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE
4	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.	1 Y	2 A	3 4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5
APPROVED EDUCATIONAL ACTIVITIES		Y/N		Y/N
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N		2 6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y/N 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
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		Y	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

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

CAPITAL RELATED COST

- 22 HAVE ASSETS BEEN RELIEFED 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 DEBRA 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

HOME OFFICE COSTS

- 36 WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? Y/N 1 DATE 2 36
- 37 IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. N 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

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
PERIOD FROM 05/01/2010 TO 04/30/2011

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

VERSION: 2011.10
11/23/2011 13:19

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

RHC III
COMPONENT NO: 14-3472

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

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

SOURCE OF FEDERAL FUNDS:

	GRANT AWARD	DATE	
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)	1	2	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

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

FACILITY HOURS OF OPERATIONS(1)

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

(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.

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

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

14.01 GRAND STREET RHC 14-347 14.01

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO Y/N V XVIII XIX 15
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)

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	INSURED PATIENTS	TOTAL		
		1	2	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 LENGTH 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)			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	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS
		1	2	3	4
GENERAL SERVICE COST CENTERS					
1	00100		337,907	337,907	1
2	00200		452,801	452,801	2
3	00300				3
4	00400	65,033	2,020,627	2,085,660	4
5	00500	946,231	802,323	1,748,554	74,717
6	00600	121,847	402,931	524,778	5
7	00700				6
8	00800		72,078	72,078	7
9	00900	208,853	32,906	241,759	8
10	01000	225,029	183,130	408,159	9
11	01100				-143,590
12	01200				143,590
13	01300	77,758	47	77,805	10
14	01400	54,308	144,775	199,083	11
15	01500	132,825	701,406	834,231	-128,703
16	01600	189,222	21,652	210,874	-683,621
17	01700				4,172
19	01900	198,501		198,501	12
20	02000				13
21	02100				14
22	02200				15
23	02300				16
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	737,443	36,331	773,774	-4,172
46	04600	514,443	28,203	542,646	30
ANCILLARY SERVICE COST CENTERS					
50	05000	233,905	83,314	317,219	46
51	05100				50
53	05300		89,670	89,670	51
54	05400	262,840	396,173	659,013	53
60	06000	322,253	510,076	832,329	48,539
62.30	06250				54
65	06500	34,214	62,695	96,909	60
66	06600	680,744	14,601	695,345	-28,268
67.01	06701	17,278	642	17,920	65
69	06900	8,181	12,392	20,573	66
71	07100				48,539
73	07300				67.01
76	03550		437,815	437,815	69
76.97	07697				156,971
76.98	07698				683,621
76.99	07699				71
OUTPATIENT SERVICE COST CENTERS					
88.01	08801				73
88.02	08802	1,443,542	214,891	1,658,433	76
91	09100	337,078	1,128,273	1,465,351	76.97
92	09200				76.98
OTHER REIMBURSABLE COST CENTERS					
99.10	09910				76.99
99.20	09920				99.10
99.30	09930				99.20
99.40	09940				99.30
SPECIAL PURPOSE COST CENTERS					
118		6,811,528	8,187,659	14,999,187	99.40
NONREIMBURSABLE COST CENTERS					
190	19000				118
190.02	19002				190
190.03	19003				190.02
190.04	19004	6,516	3,881	10,397	190.03
190.05	19005				190.04
192.01	19201				190.05
192.02	19202				192.01
200		6,818,044	8,191,540	15,009,584	192.02
TOTAL (SUM OF LINES 118-199)					
					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 CHRGD 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	----- INCREASE -----				
		COST CENTER	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			WKST A-7 REF.
			LINE #	SALARY	OTHER	
	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 -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
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

----- SUMMARY OF CAPITAL -----

DESCRIPTION	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

----- COMPUTATION OF RATIOS ----- ALLOCATION OF OTHER CAPITAL -----

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	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

----- SUMMARY OF CAPITAL -----

DESCRIPTION	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	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-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)		-825,892			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

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

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

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

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

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6					
7					
8					
9					
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 CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
 PERIOD FROM 05/01/2010 TO 04/30/2011

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

VERSION: 2011.10
 11/23/2011 13:19

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.	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			

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP	CAP	CAP	EMPLOYEE	SUBTOTAL	
	FOR COST					
	ALLOCATION	FIXTURES	EQUIPMENT			
	(FROM WKST	1	2	4	4A	
	A, COL.7)					
	0					
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	5
6	MAINTENANCE & REPAIRS	524,778	47,366	15,379	30,774	6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE	72,078	4,476	1,297		8
9	HOUSEKEEPING	241,759	2,050	119	52,749	9
10	DIETARY	264,569	8,399	2,132	36,840	10
11	CAFETERIA	115,112	4,125		19,994	11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION	77,805	652	176	19,639	13
14	CENTRAL SERVICES & SUPPLY	66,748	3,755	4,264	13,716	14
15	PHARMACY	150,610	4,595	14,833	33,547	15
16	MEDICAL RECORDS & LIBRARY	210,617	4,812	549	47,791	16
17	SOCIAL SERVICE	4,172	435		1,054	17
19	NONPHYSICIAN ANESTHETISTS	198,501			50,134	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	30
46	OTHER LONG TERM CARE	542,646	44,708	8,683	129,930	46
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	317,219	15,469	8,255	59,076	50
51	RECOVERY ROOM		1,225		1,225	51
53	ANESTHESIOLOGY	89,670		2,738		53
54	RADIOLOGY-DIAGNOSTIC	696,970	23,127	213,607	78,643	54
60	LABORATORY	799,545	9,970	12,832	81,390	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65	RESPIRATORY THERAPY	68,641	2,352	358	8,641	65
66	PHYSICAL THERAPY	695,345	9,748	2,789	171,932	66
67.01	CARDIAC REHAB	17,920	2,080	744	4,364	67.01
69	ELECTROCARDIOLOGY	8,942	287	721	2,066	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	156,971				71
73	DRUGS CHARGED TO PATIENTS	683,621				73
76	OP GERO PSYCH	437,815	8,088	257		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	88.02
91	EMERGENCY	1,187,403	16,013	5,498	85,134	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	118
NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		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	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	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 CHRGD 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 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	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 CHRGD 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 CHRGD 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	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS & FIXTURES	MOVABLE EQUIPMENT		BENEFITS	
	0	1	2	2A	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		5
6 MAINTENANCE & REPAIRS		47,366	15,379	62,745		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		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		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		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 CHRGD 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 & CANTEN		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 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	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 CHRGD 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 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	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 CHRGD 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 CHRGD 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	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	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 CHRGD 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-	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	TENANCE & REPAIRS SQUARE FEET	& LINEN SERVICE POUNDS OF LAUNDRY	KEEPING SQUARE FEET	MEALS SERVED	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 CHRGD 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 CHRGD 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 CHRGD 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	THERAPY	TOTAL	RCE	TOTAL
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS
	1	2	3	4	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 SPBEBCH 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 -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	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 CHRGD 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	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT	COST SERVICES	COST SVCES NOT	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	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 CHRGD 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	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	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
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (14-1308) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX-INPT IRF NF 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

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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 INSTRUC (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

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 + COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST	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

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

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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 INSTRUC
 (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

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 + COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST					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	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(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 CHRGD 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		
30 INPATIENT ROUTINE SERVICE COST CENTERS					30
ADULTS & PEDIATRICS					
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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

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

INPATIENT
 PART A
 PART B
 MM/DD/YYYY AMOUNT MM/DD/YYYY AMOUNT
 1 2 3 4

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	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.					
		NONE		NONE	3.01
					3.02
PROGRAM					3.03
TO					3.04
PROVIDER					3.05
					3.06
					3.07
					3.08
					3.09
	12/10/2010	46,678	12/10/2010	22,729	3.50
					3.51
PROVIDER					3.52
TO					3.53
PROGRAM					3.54
					3.55
					3.56
					3.57
					3.58
					3.59
					3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-46,678		-22,729	
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.					
		NONE		NONE	5.01
					5.02
PROGRAM					5.03
TO					5.04
PROVIDER					5.05
					5.06
					5.07
					5.08
					5.09
PROVIDER		NONE		NONE	5.50
TO					5.51
PROGRAM					5.52
					5.53
					5.54
					5.55
					5.56
					5.57
					5.58
					5.59
					5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT		81,035		147,266	6.01
					6.02
PROGRAM					6.02
TO					6.02
PROVIDER					6.02
PROVIDER					6.02
TO					6.02
PROGRAM					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 [] HOSPITAL
 APPLICABLE [] IPF
 BOX: [] IRF

[] SUB (OTHER)
 [] SNF
 [XX] SWING BED SNF (14-Z308)

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	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		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.		NONE		3.01
PROGRAM .01				3.02
TO .02				3.03
PROVIDER .03				3.04
TO .04				3.05
PROVIDER .05				3.06
TO .06				3.07
PROVIDER .07				3.08
TO .08				3.09
PROVIDER .09				3.50
12/10/2010 .50		9,812		NONE
PROVIDER .51				3.51
TO .52				3.52
PROVIDER .53				3.53
TO .54				3.54
PROVIDER .55				3.55
TO .56				3.56
PROVIDER .57				3.57
TO .58				3.58
PROVIDER .59				3.59
TO .99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-9,812		
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.		NONE		5.01
PROGRAM .01				5.02
TO .02				5.03
PROVIDER .03				5.04
TO .04				5.05
PROVIDER .05				5.06
TO .06				5.07
PROVIDER .07				5.08
TO .08				5.09
PROVIDER .09				5.50
12/10/2010 .50		NONE		NONE
PROVIDER .51				5.51
TO .52				5.52
PROVIDER .53				5.53
TO .54				5.54
PROVIDER .55				5.55
TO .56				5.56
PROVIDER .57				5.57
TO .58				5.58
PROVIDER .59				5.59
TO .99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT		21,391		6.01
PROGRAM .01				6.02
TO .02				6.02
PROVIDER .03				6.02
TO .04				6.02
PROVIDER .05				6.02
TO .06				6.02
PROVIDER .07				6.02
TO .08				6.02
PROVIDER .09				6.02
TO .10				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,618,047		7

8 NAME OF CONTRACTOR:

CONTRACTOR NUMBER:

DATE:

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
PERIOD FROM 05/01/2010 TO 04/30/2011

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

VERSION: 2011.10
11/23/2011 13:19

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14 172 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

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
 PERIOD FROM 05/01/2010 TO 04/30/2011

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

VERSION: 2011.10
 11/23/2011 13:19

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	PART B
		1	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 [XX] HOSPITAL (14-1308)
 APPLICABLE BOX: [] 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 HOSPITAL (14-1308) SNF PPS
 APPLICABLE TITLE XIX IPF NF TEFRA
 BOXES: IRF ICF/MR OTHER
 SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	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 ADJUSTMENTS)									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 ADJUSTMENTS)									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	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	394,806		394,806	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	403,693		403,693	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
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	1,838,345		1,838,345	18
19 ANCILLARY SERVICES	1,794,164	16,593,685	18,387,849	19
20 OUTPATIENT SERVICES		1,079,224	1,079,224	20
20.01 RHC				20.01
20.02 RHC II				20.02
21 RHC III	542	1,003,089	1,003,631	21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
27.01 OTHER (SPECIFY)				27.01
27.02 PHYSICIAN CHARGES	1,962	1,266,663	1,268,625	27.02
28 OUTPATIENT CLINIC		423,510	423,510	28
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	

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

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

RHC III
 COMPONENT NO: 14-3472

WORKSHEET M-1

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) COSTS UNDER AGREEMENT	1,443,542		1,443,542		1,443,542	-79,497	1,364,045	10
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) OTHER HEALTH CARE COSTS		65,455	65,455		65,455	-1,995	63,460	14
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 PROFESSIONAL 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) COSTS OTHER THAN RHC/FQHC SERVICES	1,443,542	198,065	1,641,607	-123,256	1,518,351	-81,802	1,436,549	22
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

RHC III
 COMPONENT NO: 14-3472

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	2.78	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	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

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

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)			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 ON OR AFTER
 JANUARY 1 JANUARY 1 (SEE INSTR.)
 1 2 3

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)	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 RECORDS)			33,946	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)				19
20	NET MEDICARE COST EXCLUDING 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

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,364,045	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	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 .01	36,676	6.01
	PROVIDER PROVIDER TO .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 ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
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 ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON 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 ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
		AMOUNT	%	AMOUNT	%	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 CHRGD 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 OPPTS.
(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 7,195,766
EXCLUDING SERVICES NOT SUBJECT TO OPPTS.
(WKST D, PART V, LINE 202, COLUMNS 2, 2.01,
& 2.02 LESS LINES 61, 66-68, 74, 94, 95 &
96)

3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)