

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: 01/24/2012 TIME: 07:58
 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: _____
 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 HAMILTON MEMORIAL HOSPITAL (14-1326) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2010 AND ENDING 06/30/2011, 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: 01/24/2012 07:58
 OkQ11lan2Y6g.whg41bmKWTMqs.jU0
 feVIL0vX7:xzdf5HXrisEFeI2jzq36
 .3X30wIroA0Q2v:1

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

TITLE _____

DATE _____

PI Encryption: 01/24/2012 07:58
 wFacOuxLzlc7rvv8RmuC2J103tWEG0
 l5Rk80W9jroXf3EDGSwCdT.YNY9Gkk
 Zfrc0v:PlZ0E3lr2

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		-79,598	149,890		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF		-10,174			5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC			-80,584		10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-89,772	69,306		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: 611 SOUTH MARSHALL P.O.BOX: 1
 2 CITY: MCLEANSBORO STATE: IL ZIP CODE: 62859 COUNTY: HAMILTON 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	14-1326	00014	1	05/01/2003	N	O	P	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF	14-2326	00014		05/01/2003	N	O	N	7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLT								11
12	HOSPITAL-BASED HHA	14-7167	00014		11/13/1978	N	P	N	12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	14-3477	00014		01/11/2006	N	O	N	15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2010			TO: 06/30/2011				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.	N	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

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

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	V 1	XVIII 2	XIX 3	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
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)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
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)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON- PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2		3	4	5
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
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.				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		
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.				Y		105	
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- SICAL Y	OCCUP- ATIONAL Y	RESPI- RATORY Y 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 N	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.	Y		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.		2,000,000	2,000,000 119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

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

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

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

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B.
 SEE 42 CFR §413.13)

		PART A	PART B	
155	HOSPITAL	1 Y	2 Y	155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	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.	Y/N 1 N	DATE 2	V/I 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.			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
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15

PS&R REPORT DATA		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	17	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	08/11/2011	Y	08/11/2011
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.	N		N	
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 RELIEF FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. | N | 22 |
| 23 | HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | N | 23 |
| 24 | WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | N | 24 |
| 25 | HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | N | 25 |
| 26 | WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | N | 26 |
| 27 | HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. | N | 27 |

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

	COMPONENT	WKST A LINE NO. 1	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS						TOTAL ALL PATIENTS 8		
			NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	TITLE V 5	TITLE XVIII 6	TITLE XIX 7			
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	25	9,125	65,328.00			2,173	167	2,722	1
2	HMO										2
3	HMO IPF										3
4	HMO IRF										4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF							598		598	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									68	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		25	9,125	65,328.00			2,771	167	3,388	7
8	INTENSIVE CARE UNIT	31									8
9	CORONARY CARE UNIT	32									9
10	BURN INTENSIVE CARE UNIT	33									10
11	SURGICAL INTENSIVE CARE UNIT	34									11
12	OTHER SPECIAL CARE (SPECIFY)	35									12
13	NURSERY	43									13
14	TOTAL (SEE INSTRUCTIONS)		25	9,125	65,328.00			2,771	167	3,388	14
15	CAH VISITS										15
16	SUBPROVIDER - IPF	40									16
17	SUBPROVIDER - IRF	41									17
18	SUBPROVIDER I	42									18
19	SKILLED NURSING FACILITY	44									19
20	NURSING FACILITY	45									20
21	OTHER LONG TERM CARE	46									21
22	HOME HEALTH AGENCY	101									22
23	ASC (DISTINCT PART)	115									23
24	HOSPICE (DISTINCT PART)	116									24
25	CMHC	99									25
26	RHC	88						1,029		3,754	26
27	TOTAL (SUM OF LINES 14-26)		25								27
28	OBSERVATION BED DAYS								111	660	28
29	AMBULANCE TRIPS										29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)										30
31	EMPLOYEE DISCOUNT DAYS-IRF										31
32	LABOR & DELIVERY DAYS (SEE INSTR.)										32
33	LTC NON-COVERED DAYS										33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

LINE	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---			----- DISCHARGES -----			TOTAL ALL PATIENTS	
			TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX		
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	9	10	11	12	13	14	15	1
2	HMO						691	87	968	2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)			113.09			691	87	968	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88		5.86						26
27	TOTAL (SUM OF LINES 14-26)			118.95						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

LINE	DESCRIPTION	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
1		1	2	3	4	5	6
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	5,289,221				1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A						4
4.01	PHYSICIANS-PART A - DIRECT TEACHING						4.01
5	PHYSICIAN-PART B						5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)						10
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)						11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A						13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS						14
15	HOME OFFICE: PHYSICIAN-PART A						15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						16
WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)						17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS						19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A						22
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS						26
27	ADMINISTRATIVE & GENERAL		738,973				27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		143,930				30
31	LAUNDRY & LINEN SERVICE		65,290				31
32	HOUSEKEEPING		158,308				32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY						34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA						36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		211,086				38
39	CENTRAL SERVICES AND SUPPLY						39
40	PHARMACY		163,307				40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		157,156				41
42	SOCIAL SERVICE		36,438				42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	5,289,221	5,289,221	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5,289,221	5,289,221	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)			4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)			5
6	TOTAL (SUM OF LINES 3 THRU 5)	5,289,221	5,289,221	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	1,674,488	1,674,488	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

		AMOUNT REPORTED
RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3	QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	3
4	PRIOR YEAR PENSION SERVICE COST	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5	401K/TSA PLAN ADMINISTRATION FEES	5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9	PRESCRIPTION DRUG PLAN	9
10	DENTAL, HEARING AND VISION PLAN	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15	WORKERS' COMPENSATION INSURANCE	15
16	RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES		
17	FICA-EMPLOYERS PORTION ONLY	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19	UNEMPLOYMENT INSURANCE	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER		
21	EXECUTIVE DEFERRED COMPENSATION	21
22	DAY CARE COSTS AND ALLOWANCES	22
23	TUITION REIMBURSEMENT	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24
PART B - OTHER THAN CORE RELATED COST		
25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
 PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT	
0		LABOR	COST	
		1	2	1
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	09/24/1984	2

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (COLS. 2 + 3)
	1	2	3	4
3	RUX			3
4	RUL			4
5	RVX			5
6	RVL			6
7	RHX			7
8	RHL			8
9	RMX			9
10	RML			10
11	RLX			11
12	RUC			12
13	RUB			13
14	RUA			14
15	RVC			15
16	RVB			16
17	RVA			17
18	RHC			18
19	RHB			19
20	RHA			20
21	RMC			21
22	RMB			22
23	RMA			23
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1			28
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1			34
35	HB2			35
36	HB1			36
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1			40
41	LC2			41
42	LC1			42
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1			48
49	CC2			49
50	CC1			50
51	CB2			51
52	CB1			52
53	CA2			53
54	CA1			54
55	SE3			55
56	SE2			56
57	SE1			57
58	SSC			58
59	SSB			59
60	SSA			60
61	IB2			61
62	IB1			62
63	IA1			63
64	IA2			64
65	BB2			65
66	BB1			66
67	BA2			67
68	BA1			68

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PE1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL			200

	CBSA AT BEGINNING OF COST REPORTING PERIOD 1	CBSA ON/AFTER OF THE COST REPORTING PERIOD (IF APPLICABLE) 2
SNF SERVICES		

201 ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY,
 IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN
 EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE). 201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING
 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207:
 ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY
 TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS
 INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

	EXPENSES 1	PERCENTAGE 2	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 3
202	STAFFING		202
203	RECRUITMENT		203
204	RETENTION OF EMPLOYEES		204
205	TRAINING		205
206	OTHER (SPECIFY)		206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)		207

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)			0.548598	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)					
2	NET REVENUE FROM MEDICAID			463,967	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?			Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?			N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID			596,834	5
6	MEDICAID CHARGES			3,763,012	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)			2,064,381	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)			1,003,580	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 11 MINUS LINE 9)				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 15 MINUS LINE 13)				16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)					
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE				17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)			1,003,580	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	290,704	8,369	299,073	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	159,480	4,591	164,071	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	4,295	424	4,719	22
23	COST OF CHARITY CARE	155,185	4,167	159,352	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)			1,643,234	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			250,896	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,392,338	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			763,834	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			923,186	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			1,926,766	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		939,168	939,168	952,436	1
2	00200		468,381	468,381	153,622	2
3	00300		35,393	35,393	-35,393	3
4	00400		1,285,537	1,285,537		4
5.01	00540		26,239	26,239		5.01
5.02	00550	68,169	13,367	81,536		5.02
5.03	00560	40,875	3,670	44,545		5.03
5.04	00570				129,268	5.04
5.05	00580	195,055	228,972	424,027	-129,268	5.05
5.06	00590	434,874	288,301	723,175	119,741	5.06
7	00700	143,930	547,075	691,005	-6,088	7
8	00800	65,290	25,900	91,190		8
9	00900	158,308	16,014	174,322		9
10	01000		67,890	67,890		10
11	01100					11
13	01300	211,086	4,399	215,485		13
14	01400		19,073	19,073	16,589	14
15	01500	163,307	358,671	521,978	-332,233	15
16	01600	157,156	36,304	193,460		16
17	01700	36,438	1,064	37,502		17
19	01900					19
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	974,435	92,699	1,067,134		30
ANCILLARY SERVICE COST CENTERS						
50	05000	111,379	193,033	304,412	-155,820	50
53	05300	238,884	29,301	268,185	-11,819	53
54	05400	291,338	272,972	564,310	-97,950	54
58	05800				89,550	58
60	06000	317,300	512,839	830,139	-1,200	60
65	06500	120,867	25,668	146,535	-3,323	65
65.50	06501		15,208	15,208		65.50
66	06600	314,208	185,631	499,839	-302	66
67	06700					67
68	06800					68
69	06900		3,627	3,627		69
71	07100				58,589	71
72	07200				44,329	72
73	07300				299,780	73
OUTPATIENT SERVICE COST CENTERS						
88	08800	515,978	64,605	580,583	-28,835	88
90	09000	42,194	50,619	92,813		90
91	09100	688,150	566,430	1,254,580	-5,817	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	11300		924,168	924,168	-924,168	113
117	06950					117
117.01	06951		106,087	106,087	-106,087	117.01
117.02	06952		25,601	25,601	-25,601	117.02
118		5,289,221	7,433,906	12,723,127		118
NONREIMBURSABLE COST CENTERS						
192	19200		118,339	118,339		192
194	07950		107,954	107,954		194
200		5,289,221	7,660,199	12,949,420		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	1,891,604	-31,224	1,860,380	1
2	00200	622,003	-4,860	617,143	2
3	00300				3
4	00400	1,285,537	-29,615	1,255,922	4
5.01	00540	26,239		26,239	5.01
5.02	00550	81,536		81,536	5.02
5.03	00560	44,545	-628	43,917	5.03
5.04	00570	129,268		129,268	5.04
5.05	00580	294,759		294,759	5.05
5.06	00590	842,916	-215,369	627,547	5.06
7	00700	684,917		684,917	7
8	00800	91,190		91,190	8
9	00900	174,322		174,322	9
10	01000	67,890	-590	67,300	10
11	01100				11
13	01300	215,485		215,485	13
14	01400	35,662		35,662	14
15	01500	189,745		189,745	15
16	01600	193,460	-4,210	189,250	16
17	01700	37,502		37,502	17
19	01900				19
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,067,134		1,067,134	30
ANCILLARY SERVICE COST CENTERS					
50	05000	148,592		148,592	50
53	05300	256,366		256,366	53
54	05400	466,360		466,360	54
58	05800	89,550		89,550	58
60	06000	828,939		828,939	60
65	06500	143,212		143,212	65
65.50	06501	15,208		15,208	65.50
66	06600	499,537	-32,244	467,293	66
67	06700				67
68	06800				68
69	06900	3,627		3,627	69
71	07100	58,589	-13,270	45,319	71
72	07200	44,329		44,329	72
73	07300	299,780	-19,303	280,477	73
OUTPATIENT SERVICE COST CENTERS					
88	08800	551,748	-162,717	389,031	88
90	09000	92,813		92,813	90
91	09100	1,248,763	-429,585	819,178	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113	11300				113
117	06950				117
117.01	06951				117.01
117.02	06952				117.02
118		12,723,127	-943,615	11,779,512	118
NONREIMBURSABLE COST CENTERS					
192	19200	118,339		118,339	192
194	07950	107,954	-100	107,854	194
200		12,949,420	-943,715	12,005,705	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		OTHER
			LINE #	SALARY	
	1	2	3	4	5
1 TO RECLASS INTEREST EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1		924,168 1
500 TOTAL RECLASSIFICATIONS					924,168 500
CODE LETTER - A					
1 TO RECLASS RENT EXPENSE	B	CAP REL COSTS-MVBLE EQUIP	2		146,497 1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
500 TOTAL RECLASSIFICATIONS					146,497 500
CODE LETTER - B					
1 TO RECLASS INSURANCE EXPENSE	C	OTHER ADMINISTRATIVE AND GENE	5.06		106,087 1
500 TOTAL RECLASSIFICATIONS					106,087 500
CODE LETTER - C					
1 TO RECLASS SALARIES & OTHER EXP	D	ADMITTING	5.04	64,953	64,315 1
500 TOTAL RECLASSIFICATIONS				64,953	64,315 500
CODE LETTER - D					
1 TO RECLASS SUPPLIES SOLD TO PATIENTS	E	MEDICAL SUPPLIES CHRGD TO PA	71		112,978 1
2					2
3					3
4					4
5					5
6					6
500 TOTAL RECLASSIFICATIONS					112,978 500
CODE LETTER - E					
1 TO RECLASS DRUGS TO PHARMACY	F	DRUGS CHARGED TO PATIENTS	73		281,483 1
500 TOTAL RECLASSIFICATIONS					281,483 500
CODE LETTER - F					
1 TO RECLASS SUPPLIES SOLD	G	CENTRAL SERVICES & SUPPLY	14		25,601 1
500 TOTAL RECLASSIFICATIONS					25,601 500
CODE LETTER - G					
1 TO RECLASS IV COSTS	H	DRUGS CHARGED TO PATIENTS	73		18,297 1
2					2
500 TOTAL RECLASSIFICATIONS					18,297 500
CODE LETTER - H					
1 TO RECLASS MALPRACTICE INSURANCE	I	OTHER ADMINISTRATIVE AND GENE	5.06		28,835 1
500 TOTAL RECLASSIFICATIONS					28,835 500
CODE LETTER - I					
1 TO RECLASS IMPL DEVICES	J	IMPL. DEV. CHARGED TO PATIENT	72		44,329 1
500 TOTAL RECLASSIFICATIONS					44,329 500
CODE LETTER - J					
1 RECLASS MRI COST	K	MAGNETIC RESONANCE IMAGING (M	58		89,550 1
500 TOTAL RECLASSIFICATIONS					89,550 500
CODE LETTER - K					
GRAND TOTAL (INCREASES)				64,953	1,842,140

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 TO RECLASS INTEREST EXPENSE	A	INTEREST EXPENSE	113		924,168	11 1
500 TOTAL RECLASSIFICATIONS					924,168	500
CODE LETTER - A						
1 TO RECLASS RENT EXPENSE	B	OTHER ADMINISTRATIVE AND GENE	5.06		15,181	10 1
2 OPERATING ROOM			50		70,952	2
3 RESPIRATORY THERAPY			65		1,878	3
4 PHYSICAL THERAPY			66		285	4
5 RADIOLOGY-DIAGNOSTIC			54		8,400	5
6 LABORATORY			60		1,200	6
7 PHARMACY			15		42,513	7
8 OPERATION OF PLANT			7		6,088	8
500 TOTAL RECLASSIFICATIONS					146,497	500
CODE LETTER - B						
1 TO RECLASS INSURANCE EXPENSE	C	INSURANCE AND MALPRACTICE	117.01		106,087	1
500 TOTAL RECLASSIFICATIONS					106,087	500
CODE LETTER - C						
1 TO RECLASS SALARIES & OTHER EXP	D	CASHIERING/ACCOUNTS RECEIVABL	5.05	64,953	64,315	1
500 TOTAL RECLASSIFICATIONS				64,953	64,315	500
CODE LETTER - D						
1 TO RECLASS SUPPLIES SOLD TO PATIENTS	E	EMERGENCY	91		5,817	1
2 ANESTHESIOLOGY			53		11,819	2
3 OPERATING ROOM			50		84,868	3
4 RESPIRATORY THERAPY			65		1,445	4
5 PHYSICAL THERAPY			66		17	5
6 CENTRAL SERVICES & SUPPLY			14		9,012	6
500 TOTAL RECLASSIFICATIONS					112,978	500
CODE LETTER - E						
1 TO RECLASS DRUGS TO PHARMACY	F	PHARMACY	15		281,483	1
500 TOTAL RECLASSIFICATIONS					281,483	500
CODE LETTER - F						
1 TO RECLASS SUPPLIES SOLD	G	SUPPLIES AND EXPENSE	117.02		25,601	1
500 TOTAL RECLASSIFICATIONS					25,601	500
CODE LETTER - G						
1 TO RECLASS IV COSTS	H	PHARMACY	15		8,237	1
2 MEDICAL SUPPLIES CHRGED TO PA			71		10,060	2
500 TOTAL RECLASSIFICATIONS					18,297	500
CODE LETTER - H						
1 TO RECLASS MALPRACTICE INSURANCE	I	RURAL HEALTH CLINIC (RHC)	88		28,835	1
500 TOTAL RECLASSIFICATIONS					28,835	500
CODE LETTER - I						
1 TO RECLASS IMPL DEVICES	J	MEDICAL SUPPLIES CHRGED TO PA	71		44,329	1
500 TOTAL RECLASSIFICATIONS					44,329	500
CODE LETTER - J						
1 RECLASS MRI COST	K	RADIOLOGY-DIAGNOSTIC	54		89,550	1
500 TOTAL RECLASSIFICATIONS					89,550	500
CODE LETTER - K						
GRAND TOTAL (DECREASES)				64,953	1,842,140	

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	71,258				1,498	69,760	1
2 LAND IMPROVEMENTS	607,155				15,783	591,372	2
3 BUILDINGS AND FIXTURES	20,112,778	3,320,905		3,320,905	1,984,999	21,448,684	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	5,482,906	536,944		536,944	465,029	5,554,821	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	26,274,097	3,857,849		3,857,849	2,467,309	27,664,637	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	26,274,097	3,857,849		3,857,849	2,467,309	27,664,637	10

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

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	910,900			28,268			939,168 1
2 CAP REL COSTS-MVBLE EQUIP	461,256			7,125			468,381 2
3 TOTAL (SUM OF LINES 1-2)	1,372,156			35,393			1,407,549 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	COMPUTATION OF RATIOS -----				ALLOCATION OF OTHER CAPITAL -----			
	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	22,040,056		22,040,056	0.798701	28,268		28,268 1	
2 CAP REL COSTS-MVBLE EQUIP	5,554,821		5,554,821	0.201299	7,125		7,125 2	
3 TOTAL (SUM OF LINES 1-2)	27,594,877		27,594,877	1.000000	35,393		35,393 3	

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	910,900			892,944	56,536		1,860,380 1
2 CAP REL COSTS-MVBLE EQUIP	456,396	146,497		14,250			617,143 2
3 TOTAL	1,367,296	146,497		892,944	70,786		2,477,523 3

ADJUSTMENTS TO EXPENSES

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8	
			COST CENTER	LINE NO.	WKST A-7	REF
	1	2	3	4	5	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-31,224	CAP REL COSTS-BLDG & FIXT	1	11	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-628	PURCHASING RECEIVING AND STORES	5.03		4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-6,686	OTHER ADMINISTRATIVE AND GENERA	5.06		8
9 PARKING LOT (CHAPTER 21)						9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST					
	A-8-2	-261,018				10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST					
	A-8-1					12
13 LAUNDRY AND LINEN SERVICE						13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-590	DIETARY	10		14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-13,270	MEDICAL SUPPLIES CHRGD TO PATI	71		16
17 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-19,303	DRUGS CHARGED TO PATIENTS	73		17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4,210	MEDICAL RECORDS & LIBRARY	16		18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						19
20 VENDING MACHINES	B	-2,304	OTHER ADMINISTRATIVE AND GENERA	5.06		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		PHYSICAL THERAPY	66		24
	A-8-3					
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		OCCUPATIONAL THERAPY	67		30
	A-8-3					
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST		SPEECH PATHOLOGY	68		31
	A-8-3					32
32 CAH HIT ADJ FOR DEPRECIATION AND COMMUNITY PROGRAM	B	-10,195	OTHER ADMINISTRATIVE AND GENERA	5.06		33
34						34
35 PORTION OF LOBBYING DUES	A	-4,290	OTHER ADMINISTRATIVE AND GENERA	5.06		35
36 WOMENS WELLNESS	B	-45,938	OTHER ADMINISTRATIVE AND GENERA	5.06		36
37 PHYSICIAN RECRUITMENT	A	-20,455	OTHER ADMINISTRATIVE AND GENERA	5.06		37
38 ADVERTISING	A	-49,548	OTHER ADMINISTRATIVE AND GENERA	5.06		38
39						39
40						40
41 VNA THERAPHY SERVICES	A	-32,244	PHYSICAL THERAPY	66		41
42 FUNDRAISING	A	-4,860	CAP REL COSTS-MVBLE EQUIP	2	9	42
43						43
44 NURSING CENTER SERVICES	B	-63,150	OTHER ADMINISTRATIVE AND GENERA	5.06		44
45						45
45.02 SURETY BOND	A	-100	NURSING CENTER	194		45.02
45.06 FUNDRAISING	A	-12,803	OTHER ADMINISTRATIVE AND GENERA	5.06		45.06
45.08 ER PHYSICIAN BENEFITS	A	-2,444	EMPLOYEE BENEFITS	4		45.08
45.09 NON RHC COST	A	-162,717	RURAL HEALTH CLINIC (RHC)	88		45.09
45.10 NON RHC BENEFITS	A	-19,433	EMPLOYEE BENEFITS	4		45.10
45.13 VNA SEVICES BENEFITS	A	-7,738	EMPLOYEE BENEFITS	4		45.13
45.14 ER PHYSICIAN COST	A	-168,567	EMERGENCY	91		45.14
46						46
47						47
48						48
49						49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-943,715				50

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (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-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	LINE	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
	1	2	3	4	5	6	7	8	9
2	91	EMERGENCY	492,487	261,018	231,469				
200		TOTAL	492,487	261,018	231,469				
		AGGREGATE							

PROVIDER CCN: 14-1326 HAMILTON MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10
 01/12/2012 15:32

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
			12	13	14	15	16	17	18
2	91	EMERGENCY							261,018
200		TOTAL							261,018
		AGGREGATE							

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

WORKSHEET A-8-3
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					247	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		1,903.75				9
10	AHSEA		68.79				10
11	STANDARD TRAVEL ALLOWANCE	34.40	34.40				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					130,959	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					130,959	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					130,959	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					130,959	23

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

WORKSHEET A-8-3
 PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	8,497	24
25	ASSISTANTS		25
26	SUBTOTAL	8,497	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	8,497	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	8,497	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					130,959	57
58					8,497	58
59						59
60						60
61						61
62						62
63					139,456	63
64					95,923	64
65						65

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

WORKSHEET A-8-3
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					249	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9			301.75			9
10			72.58			10
11	36.29	36.29				11
12						12
12.01						12.01
13						13
13.01						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS					14
15	THERAPISTS				21,901	15
16	ASSISTANTS					16
17	SUBTOTAL ALLOWANCE AMOUNT				21,901	17
18	AIDES					18
19	TRAINEES					19
20	TOTAL ALLOWANCE AMOUNT				21,901	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES				72.58	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES				56,612	22
23	TOTAL SALARY EQUIVALENCY				56,612	23

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

WORKSHEET A-8-3
 PARTS III & IV

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	9,036	24
25	ASSISTANTS		25
26	SUBTOTAL	9,036	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	9,036	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	9,036	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

STANDARD TRAVEL EXPENSE

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

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					56,612	57
58					9,036	58
59						59
60						60
61						61
62						62
63					65,648	63
64					18,105	64
65						65

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

WORKSHEET A-8-3
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					196	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		438.50				9
10	AHSEA		66.10				10
11	STANDARD TRAVEL ALLOWANCE	33.05	33.05				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					28,985	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					28,985	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					28,985	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					66.10	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					51,558	22
23	TOTAL SALARY EQUIVALENCY					51,558	23

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

WORKSHEET A-8-3
 PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	6,478	24
25	ASSISTANTS		25
26	SUBTOTAL	6,478	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	6,478	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	6,478	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					51,558	57
58					6,478	58
59						59
60						60
61						61
62						62
63					58,036	63
64					24,031	64
65						65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	NONPATIENT TELEPHONE S 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,860,380	1,860,380				1
2 CAP REL COSTS-MVBLE EQUIP	617,143		617,143			2
4 EMPLOYEE BENEFITS	1,255,922			1,255,922		4
5.01 NONPATIENT TELEPHONES	26,239	945	313		27,497	5.01
5.02 DATA PROCESSING	81,536			17,381		5.02
5.03 PURCHASING RECEIVING AND STORES	43,917	49,862	16,541	10,422	339	5.03
5.04 ADMITTING	129,268			16,561		5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	294,759	37,556	12,459	33,173		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	627,547	279,357	92,671	110,882	4,583	5.06
7 OPERATION OF PLANT	684,917	168,176	55,789	36,698	679	7
8 LAUNDRY & LINEN SERVICE	91,190	22,581	7,491	16,647	170	8
9 HOUSEKEEPING	174,322			40,364		9
10 DIETARY	67,300	3,756	1,246			10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	215,485	35,430	11,753	53,821	679	13
14 CENTRAL SERVICES & SUPPLY	35,662	6,472	2,147			14
15 PHARMACY	189,745	31,769	10,539	41,639	679	15
16 MEDICAL RECORDS & LIBRARY	189,250	35,218	11,683	40,071	1,188	16
17 SOCIAL SERVICE	37,502	4,535	1,504	9,291	679	17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,067,134	322,252	106,898	248,456	4,922	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	148,592	175,569	58,242	28,399	1,358	50
53 ANESTHESIOLOGY	256,366	898	298	60,909		53
54 RADIOLOGY-DIAGNOSTIC	466,360	112,244	37,235	74,284	1,697	54
58 MAGNETIC RESONANCE IMAGING (MRI)	89,550				170	58
60 LABORATORY	828,939	39,564	13,125	80,903	1,358	60
65 RESPIRATORY THERAPY	143,212	16,629	5,516	30,818	679	65
65.50 SLEEP LAB	15,208	6,637	2,202		509	65.50
66 PHYSICAL THERAPY	467,293	93,324	30,958	71,893	1,358	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	3,627					69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	45,319					71
72 IMPL. DEV. CHARGED TO PATIENT	44,329					72
73 DRUGS CHARGED TO PATIENTS	280,477					73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	389,031	192,434	63,836	90,072	2,885	88
90 CLINIC	92,813	18,258	6,057	10,758	679	90
91 EMERGENCY	819,178	108,606	36,028	132,480	2,207	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	11,779,512	1,762,072	584,531	1,255,922	26,818	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	118,339	98,308	32,612		679	192
194 NURSING CENTER	107,854					194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	12,005,705	1,860,380	617,143	1,255,922	27,497	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DATA PROCES- SSING	PURCHASING , RECEIVIN G AND STOR	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (COLS.0-4) 4A	
	5.02	5.03	5.04	5.05		
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING	98,917					5.02
5.03 PURCHASING RECEIVING AND STORES		121,081				5.03
5.04 ADMITTING			145,829			5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	80,246			458,193		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	18,671				1,134,807	5.06
7 OPERATION OF PLANT		1,096			951,288	7
8 LAUNDRY & LINEN SERVICE		5,029			139,541	8
9 HOUSEKEEPING		1,462			216,091	9
10 DIETARY		1,405			72,562	10
11 CAFETERIA		260				11
13 NURSING ADMINISTRATION		65			317,233	13
14 CENTRAL SERVICES & SUPPLY		1,853			46,134	14
15 PHARMACY		28,868			303,239	15
16 MEDICAL RECORDS & LIBRARY		2,004			279,414	16
17 SOCIAL SERVICE		149			53,660	17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		8,642	36,743	44,519	1,839,566	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		10,954	2,895	15,541	441,550	50
53 ANESTHESIOLOGY		2,170	968	5,427	327,036	53
54 RADIOLOGY-DIAGNOSTIC		2,165	16,522	84,676	795,183	54
58 MAGNETIC RESONANCE IMAGING (MRI)		295	2,095	10,302	102,412	58
60 LABORATORY		41,358	23,833	107,717	1,136,797	60
65 RESPIRATORY THERAPY		1,799	17,486	19,233	235,372	65
65.50 SLEEP LAB		122		1,759	26,437	65.50
66 PHYSICAL THERAPY		1,277	5,178	24,481	695,762	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		20	1,302	8,435	13,384	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,029	3,984	50,332	71
72 IMPL. DEV. CHARGED TO PATIENT					44,329	72
73 DRUGS CHARGED TO PATIENTS			34,474	54,414	369,365	73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		1,808	3,120	8,878	752,064	88
90 CLINIC		1,139		2,603	132,307	90
91 EMERGENCY		6,152	184	66,224	1,171,059	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	98,917	120,092	145,829	458,193	11,646,924	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES					249,938	192
194 NURSING CENTER		989			108,843	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	98,917	121,081	145,829	458,193	12,005,705	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	OTHER ADMI NISTRATIVE AND GENER 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	1,134,807					5.06
7 OPERATION OF PLANT	99,304	1,050,592				7
8 LAUNDRY & LINEN SERVICE	14,567	17,911	172,019			8
9 HOUSEKEEPING	22,558		4,233	242,882		9
10 DIETARY	7,575	2,979			83,116	10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	33,116	28,104		1,079		13
14 CENTRAL SERVICES & SUPPLY	4,816	5,134				14
15 PHARMACY	31,655	25,200				15
16 MEDICAL RECORDS & LIBRARY	29,168	27,935				16
17 SOCIAL SERVICE	5,602	3,597				17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	192,033	255,613	31,806	120,407	83,116	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	46,093	139,263	4,654	21,582		50
53 ANESTHESIOLOGY	34,139	712				53
54 RADIOLOGY-DIAGNOSTIC	83,008	89,033	3,844	16,186		54
58 MAGNETIC RESONANCE IMAGING (MRI)	10,691		524			58
60 LABORATORY	118,669	31,382		8,093		60
65 RESPIRATORY THERAPY	24,570	13,190				65
65.50 SLEEP LAB	2,760	5,265				65.50
66 PHYSICAL THERAPY	72,630	74,025	7,642	10,791		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	1,397					69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	5,254					71
72 IMPL. DEV. CHARGED TO PATIENT	4,627					72
73 DRUGS CHARGED TO PATIENTS	38,558					73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	78,507	152,641		32,372		88
90 CLINIC	13,811	14,483				90
91 EMERGENCY	122,246	86,147	5,896	32,372		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	1,097,354	972,614	58,599	242,882	83,116	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	26,091	77,978				192
194 NURSING CENTER	11,362		113,420			194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,134,807	1,050,592	172,019	242,882	83,116	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	379,532					13
14 CENTRAL SERVICES & SUPPLY		56,084				14
15 PHARMACY			360,094			15
16 MEDICAL RECORDS & LIBRARY				336,517		16
17 SOCIAL SERVICE					62,859	17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	278,593			157,785	20,318	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	18,290					50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC				61,408		54
58 MAGNETIC RESONANCE IMAGING (MRI)				8,370		58
60 LABORATORY				36,969		60
65 RESPIRATORY THERAPY						65
65.50 SLEEP LAB						65.50
66 PHYSICAL THERAPY					7,937	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		34,078				71
72 IMPL. DEV. CHARGED TO PATIENT		22,006				72
73 DRUGS CHARGED TO PATIENTS			359,758			73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			336	14,221	13,651	88
90 CLINIC						90
91 EMERGENCY	82,649			57,764	20,953	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	379,532	56,084	360,094	336,517	62,859	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 NURSING CENTER						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	379,532	56,084	360,094	336,517	62,859	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS		TOTAL 26
			25	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5.01 NONPATIENT TELEPHONES				5.01
5.02 DATA PROCESSING				5.02
5.03 PURCHASING RECEIVING AND STORES				5.03
5.04 ADMITTING				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL				5.06
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	2,979,237		2,979,237	30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	671,432		671,432	50
53 ANESTHESIOLOGY	361,887		361,887	53
54 RADIOLOGY-DIAGNOSTIC	1,048,662		1,048,662	54
58 MAGNETIC RESONANCE IMAGING (MRI)	121,997		121,997	58
60 LABORATORY	1,331,910		1,331,910	60
65 RESPIRATORY THERAPY	273,132		273,132	65
65.50 SLEEP LAB	34,462		34,462	65.50
66 PHYSICAL THERAPY	868,787		868,787	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	14,781		14,781	69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	89,664		89,664	71
72 IMPL. DEV. CHARGED TO PATIENT	70,962		70,962	72
73 DRUGS CHARGED TO PATIENTS	767,681		767,681	73
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	1,043,792		1,043,792	88
90 CLINIC	160,601		160,601	90
91 EMERGENCY	1,579,086		1,579,086	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
117 OTHER SPECIAL PURPOSE COST CENTERS				117
117.01 INSURANCE AND MALPRACTICE				117.01
117.02 SUPPLIES AND EXPENSE				117.02
118 SUBTOTALS (SUM OF LINES 1-117)	11,418,073		11,418,073	118
NONREIMBURSABLE COST CENTERS				
192 PHYSICIANS' PRIVATE OFFICES	354,007		354,007	192
194 NURSING CENTER	233,625		233,625	194
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	12,005,705		12,005,705	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	NONPATIENT TELEPHONE S 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES		945	313	1,258	1,258	5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES		49,862	16,541	66,403	16	5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE		37,556	12,459	50,015		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL		279,357	92,671	372,028	210	5.06
7 OPERATION OF PLANT		168,176	55,789	223,965	31	7
8 LAUNDRY & LINEN SERVICE		22,581	7,491	30,072	8	8
9 HOUSEKEEPING						9
10 DIETARY		3,756	1,246	5,002		10
11 CAFETERIA						11
13 NURSING ADMINISTRATION		35,430	11,753	47,183	31	13
14 CENTRAL SERVICES & SUPPLY		6,472	2,147	8,619		14
15 PHARMACY		31,769	10,539	42,308	31	15
16 MEDICAL RECORDS & LIBRARY		35,218	11,683	46,901	54	16
17 SOCIAL SERVICE		4,535	1,504	6,039	31	17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		322,252	106,898	429,150	225	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		175,569	58,242	233,811	62	50
53 ANESTHESIOLOGY		898	298	1,196		53
54 RADIOLOGY-DIAGNOSTIC		112,244	37,235	149,479	78	54
58 MAGNETIC RESONANCE IMAGING (MRI)					8	58
60 LABORATORY		39,564	13,125	52,689	62	60
65 RESPIRATORY THERAPY		16,629	5,516	22,145	31	65
65.50 SLEEP LAB		6,637	2,202	8,839	23	65.50
66 PHYSICAL THERAPY		93,324	30,958	124,282	62	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		192,434	63,836	256,270	132	88
90 CLINIC		18,258	6,057	24,315	31	90
91 EMERGENCY		108,606	36,028	144,634	101	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)		1,762,072	584,531	2,346,603	1,227	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		98,308	32,612	130,920	31	192
194 NURSING CENTER						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		1,860,380	617,143	2,477,523	1,258	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	PURCHASING , RECEIVING AND STORES 5.03	CASHIERING /ACCOUNTS RECEIVABLE 5.05	OTHER ADMINIS- TRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES	66,419					5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE		50,015				5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	601		372,839			5.06
7 OPERATION OF PLANT	2,759		32,626	259,381		7
8 LAUNDRY & LINEN SERVICE	802		4,786	4,422	40,090	8
9 HOUSEKEEPING	771		7,411		986	9
10 DIETARY	143		2,489	735		10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	36		10,880	6,939		13
14 CENTRAL SERVICES & SUPPLY	1,016		1,582	1,267		14
15 PHARMACY	15,836		10,400	6,222		15
16 MEDICAL RECORDS & LIBRARY	1,099		9,583	6,897		16
17 SOCIAL SERVICE	82		1,840	888		17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,741	4,860	63,092	63,108	7,413	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,009	1,696	15,144	34,383	1,085	50
53 ANESTHESIOLOGY	1,191	592	11,216	176		53
54 RADIOLOGY-DIAGNOSTIC	1,188	9,243	27,272	21,981	896	54
58 MAGNETIC RESONANCE IMAGING (MRI)	162	1,125	3,512		122	58
60 LABORATORY	22,683	11,758	38,989	7,748		60
65 RESPIRATORY THERAPY	987	2,099	8,073	3,256		65
65.50 SLEEP LAB	67	192	907	1,300		65.50
66 PHYSICAL THERAPY	701	2,672	23,863	18,276	1,781	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	11	921	459			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		435	1,726			71
72 IMPL. DEV. CHARGED TO PATIENT			1,520			72
73 DRUGS CHARGED TO PATIENTS		5,940	12,668			73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	992	969	25,794	37,686		88
90 CLINIC	625	284	4,538	3,576		90
91 EMERGENCY	3,375	7,229	40,164	21,269	1,374	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	65,877	50,015	360,534	240,129	13,657	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES			8,572	19,252		192
194 NURSING CENTER	542		3,733		26,433	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	66,419	50,015	372,839	259,381	40,090	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	HOUSE-	DIETARY	NURSING	CENTRAL	PHARMACY	
	KEEPING		ADMINIS-	SERVICES &		
	9	10	TRATION	SUPPLY	15	
			13	14		
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	9,168					9
10 DIETARY		8,369				10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	41		65,110			13
14 CENTRAL SERVICES & SUPPLY				12,484		14
15 PHARMACY					74,797	15
16 MEDICAL RECORDS & LIBRARY						16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,545	8,369	47,793			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	815		3,138			50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	611					54
58 MAGNETIC RESONANCE IMAGING (MRI)						58
60 LABORATORY	305					60
65 RESPIRATORY THERAPY						65
65.50 SLEEP LAB						65.50
66 PHYSICAL THERAPY	407					66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS				7,586		71
72 IMPL. DEV. CHARGED TO PATIENT				4,898		72
73 DRUGS CHARGED TO PATIENTS					74,727	73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,222				70	88
90 CLINIC						90
91 EMERGENCY	1,222		14,179			91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	9,168	8,369	65,110	12,484	74,797	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 NURSING CENTER						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	9,168	8,369	65,110	12,484	74,797	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORES					5.03
5.04 ADMITTING					5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL					5.06
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	64,534				16
17 SOCIAL SERVICE		8,880			17
19 NONPHYSICIAN ANESTHETISTS					19
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	30,259	2,870	666,425		666,425 30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM			296,143	296,143	50
53 ANESTHESIOLOGY			14,371	14,371	53
54 RADIOLOGY-DIAGNOSTIC	11,776		222,524	222,524	54
58 MAGNETIC RESONANCE IMAGING (MRI)	1,605		6,534	6,534	58
60 LABORATORY	7,090		141,324	141,324	60
65 RESPIRATORY THERAPY			36,591	36,591	65
65.50 SLEEP LAB			11,328	11,328	65.50
66 PHYSICAL THERAPY		1,121	173,165	173,165	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY			1,391	1,391	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			9,747	9,747	71
72 IMPL. DEV. CHARGED TO PATIENT			6,418	6,418	72
73 DRUGS CHARGED TO PATIENTS			93,335	93,335	73
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	2,727	1,928	327,790	327,790	88
90 CLINIC			33,369	33,369	90
91 EMERGENCY	11,077	2,961	247,585	247,585	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
117 OTHER SPECIAL PURPOSE COST CENTERS					117
117.01 INSURANCE AND MALPRACTICE					117.01
117.02 SUPPLIES AND EXPENSE					117.02
118 SUBTOTALS (SUM OF LINES 1-117)	64,534	8,880	2,288,040		2,288,040 118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES			158,775	158,775	192
194 NURSING CENTER			30,708	30,708	194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	64,534	8,880	2,477,523		2,477,523 202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS GROSS SALARIES 4	NONPATIENT TELEPHONE S #OF PHONES 5.01	DATA PROCESSING MACHINE TIME 5.02	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	78,762					1
2 CAP REL COSTS-MVBLE EQUIP		78,762				2
4 EMPLOYEE BENEFITS			4,925,693			4
5.01 NONPATIENT TELEPHONES	40	40		162		5.01
5.02 DATA PROCESSING			68,169		249	5.02
5.03 PURCHASING RECEIVING AND STORES	2,111	2,111	40,875	2		5.03
5.04 ADMITTING			64,953			5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	1,590	1,590	130,102		202	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	11,827	11,827	434,874	27	47	5.06
7 OPERATION OF PLANT	7,120	7,120	143,930	4		7
8 LAUNDRY & LINEN SERVICE	956	956	65,290	1		8
9 HOUSEKEEPING			158,308			9
10 DIETARY	159	159				10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	1,500	1,500	211,086	4		13
14 CENTRAL SERVICES & SUPPLY	274	274				14
15 PHARMACY	1,345	1,345	163,307	4		15
16 MEDICAL RECORDS & LIBRARY	1,491	1,491	157,156	7		16
17 SOCIAL SERVICE	192	192	36,438	4		17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	13,643	13,643	974,435	29		30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,433	7,433	111,379	8		50
53 ANESTHESIOLOGY	38	38	238,884			53
54 RADIOLOGY-DIAGNOSTIC	4,752	4,752	291,338	10		54
58 MAGNETIC RESONANCE IMAGING (MRI)				1		58
60 LABORATORY	1,675	1,675	317,300	8		60
65 RESPIRATORY THERAPY	704	704	120,867	4		65
65.50 SLEEP LAB	281	281		3		65.50
66 PHYSICAL THERAPY	3,951	3,951	281,964	8		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	8,147	8,147	353,261	17		88
90 CLINIC	773	773	42,194	4		90
91 EMERGENCY	4,598	4,598	519,583	13		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	74,600	74,600	4,925,693	158	249	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	4,162	4,162		4		192
194 NURSING CENTER						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,860,380	617,143	1,255,922	27,497	98,917	202
203 UNIT COST MULT-WS B PT I	23.620274	7.835543	0.254974	169.734568	397.257028	203
204 COST TO BE ALLOC PER B PT II				1,258		204
205 UNIT COST MULT-WS B PT II				7.765432		205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING , RECEIVING & AND STOR COSTS SUPPLIES 5.03	ADMITTING INPATIENT CHARGES 5.04	CASHIERING /ACCOUNTS RECEIVABLE GROSS CHARGES 5.05	RECON- CILIATION 5A.06	OTHER ADMI NISTRATIVE AND GENER ACCUM COST 5.06	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES	1,246,403					5.03
5.04 ADMITTING		6,564,825				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE			23,080,497			5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL				-1,134,807	10,870,898	5.06
7 OPERATION OF PLANT	11,281				951,288	7
8 LAUNDRY & LINEN SERVICE	51,769				139,541	8
9 HOUSEKEEPING	15,052				216,091	9
10 DIETARY	14,459				72,562	10
11 CAFETERIA	2,675					11
13 NURSING ADMINISTRATION	672				317,233	13
14 CENTRAL SERVICES & SUPPLY	19,073				46,134	14
15 PHARMACY	297,168				303,239	15
16 MEDICAL RECORDS & LIBRARY	20,626				279,414	16
17 SOCIAL SERVICE	1,534				53,660	17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	88,963	1,654,236	2,242,536		1,839,566	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	112,762	130,306	782,829		441,550	50
53 ANESTHESIOLOGY	22,343	43,565	273,392		327,036	53
54 RADIOLOGY-DIAGNOSTIC	22,288	743,781	4,265,343		795,183	54
58 MAGNETIC RESONANCE IMAGING (MRI)	3,039	94,288	518,936		102,412	58
60 LABORATORY	425,732	1,072,872	5,426,120		1,136,797	60
65 RESPIRATORY THERAPY	18,519	787,154	968,829		235,372	65
65.50 SLEEP LAB	1,258		88,600		26,437	65.50
66 PHYSICAL THERAPY	13,147	233,091	1,233,166		695,762	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	201	58,606	424,896		13,384	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		46,322	200,663		50,332	71
72 IMPL. DEV. CHARGED TO PATIENT					44,329	72
73 DRUGS CHARGED TO PATIENTS		1,551,899	2,740,979		369,365	73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	18,612	140,443	447,231		752,064	88
90 CLINIC	11,724		131,100		132,307	90
91 EMERGENCY	63,327	8,262	3,335,877		1,171,059	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	1,236,224	6,564,825	23,080,497	-1,134,807	10,512,117	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES					249,938	192
194 NURSING CENTER	10,179				108,843	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	121,081	145,829	458,193		1,134,807	202
203 UNIT COST MULT-WS B PT I	0.097144	0.022214	0.019852		0.104389	203
204 COST TO BE ALLOC PER B PT II	66,419		50,015		372,839	204
205 UNIT COST MULT-WS B PT II	0.053289		0.002167		0.034297	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	NURSING ADMINIS- TRATION HOURS OF SERVICE	
	SQUARE FEET	8	9	10	13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
7 OPERATION OF PLANT	56,074					7
8 LAUNDRY & LINEN SERVICE	956	264,519				8
9 HOUSEKEEPING		6,509	10,804			9
10 DIETARY	159			12,121		10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	1,500		48		89,229	13
14 CENTRAL SERVICES & SUPPLY	274					14
15 PHARMACY	1,345					15
16 MEDICAL RECORDS & LIBRARY	1,491					16
17 SOCIAL SERVICE	192					17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	13,643	48,909	5,356	12,121	65,498	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,433	7,156	960		4,300	50
53 ANESTHESIOLOGY	38					53
54 RADIOLOGY-DIAGNOSTIC	4,752	5,911	720			54
58 MAGNETIC RESONANCE IMAGING (MRI)		806				58
60 LABORATORY	1,675		360			60
65 RESPIRATORY THERAPY	704					65
65.50 SLEEP LAB	281					65.50
66 PHYSICAL THERAPY	3,951	11,752	480			66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	8,147		1,440			88
90 CLINIC	773					90
91 EMERGENCY	4,598	9,067	1,440		19,431	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	51,912	90,110	10,804	12,121	89,229	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	4,162					192
194 NURSING CENTER		174,409				194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,050,592	172,019	242,882	83,116	379,532	202
203 UNIT COST MULT-WS B PT I	18.735813	0.650309	22.480748	6.857190	4.253460	203
204 COST TO BE ALLOC PER B PT II	259,381	40,090	9,168	8,369	65,110	204
205 UNIT COST MULT-WS B PT II	4.625691	0.151558	0.848575	0.690455	0.729696	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY COSTED REQUISITIO 14	PHARMACY COSTED REQUISITIO 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORES					5.03
5.04 ADMITTING					5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL					5.06
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY	112,978				14
15 PHARMACY		305,571			15
16 MEDICAL RECORDS & LIBRARY			70,637		16
17 SOCIAL SERVICE				5,940	17
19 NONPHYSICIAN ANESTHETISTS					19
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS			33,120	1,920	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC			12,890		54
58 MAGNETIC RESONANCE IMAGING (MRI)			1,757		58
60 LABORATORY			7,760		60
65 RESPIRATORY THERAPY					65
65.50 SLEEP LAB					65.50
66 PHYSICAL THERAPY				750	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	68,649				71
72 IMPL. DEV. CHARGED TO PATIENT	44,329				72
73 DRUGS CHARGED TO PATIENTS		305,286			73
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)		285	2,985	1,290	88
90 CLINIC					90
91 EMERGENCY			12,125	1,980	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
117 OTHER SPECIAL PURPOSE COST CENTERS					117
117.01 INSURANCE AND MALPRACTICE					117.01
117.02 SUPPLIES AND EXPENSE					117.02
118 SUBTOTALS (SUM OF LINES 1-117)	112,978	305,571	70,637	5,940	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES					192
194 NURSING CENTER					194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	56,084	360,094	336,517	62,859	202
203 UNIT COST MULT-WS B PT I	0.496415	1.178430	4.764033	10.582323	203
204 COST TO BE ALLOC PER B PT II	12,484	74,797	64,534	8,880	204
205 UNIT COST MULT-WS B PT II	0.110499	0.244778	0.913601	1.494949	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	2,979,237		2,979,237		2,979,237	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	671,432		671,432		671,432	50
53 ANESTHESIOLOGY	361,887		361,887		361,887	53
54 RADIOLOGY-DIAGNOSTIC	1,048,662		1,048,662		1,048,662	54
58 MAGNETIC RESONANCE IMAGING	121,997		121,997		121,997	58
60 LABORATORY	1,331,910		1,331,910		1,331,910	60
65 RESPIRATORY THERAPY	273,132		273,132		273,132	65
65.50 SLEEP LAB	34,462		34,462		34,462	65.50
66 PHYSICAL THERAPY	868,787		868,787		868,787	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	14,781		14,781		14,781	69
71 MEDICAL SUPPLIES CHRGED TO	89,664		89,664		89,664	71
72 IMPL. DEV. CHARGED TO PATIE	70,962		70,962		70,962	72
73 DRUGS CHARGED TO PATIENTS	767,681		767,681		767,681	73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,043,792		1,043,792		1,043,792	88
90 CLINIC	160,601		160,601		160,601	90
91 EMERGENCY	1,579,086		1,579,086		1,579,086	91
92 OBSERVATION BEDS	492,637		492,637		492,637	92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
200 SUBTOTAL (SEE INSTRUCTIONS)	11,910,710		11,910,710		11,910,710	200
201 LESS OBSERVATION BEDS	492,637		492,637		492,637	201
202 TOTAL (SEE INSTRUCTIONS)	11,418,073		11,418,073		11,418,073	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			
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	1,654,236		1,654,236			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	58,326	444,516	502,842	1.335274	1.335274	1.335274 50
53 ANESTHESIOLOGY	42,497	225,587	268,084	1.349902	1.349902	1.349902 53
54 RADIOLOGY-DIAGNOSTIC	720,886	3,430,787	4,151,673	0.252588	0.252588	0.252588 54
58 MAGNETIC RESONANCE IMAGING	94,288	424,648	518,936	0.235091	0.235091	0.235091 58
60 LABORATORY	1,072,872	4,353,248	5,426,120	0.245463	0.245463	0.245463 60
65 RESPIRATORY THERAPY	344,412	109,862	454,274	0.601249	0.601249	0.601249 65
65.50 SLEEP LAB		88,600	88,600	0.388962	0.388962	0.388962 65.50
66 PHYSICAL THERAPY	233,091	1,000,075	1,233,166	0.704517	0.704517	0.704517 66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	65,606	359,290	424,896	0.034787	0.034787	0.034787 69
71 MEDICAL SUPPLIES CHRGD TO	591,351	489,856	1,081,207	0.082930	0.082930	0.082930 71
72 IMPL. DEV. CHARGED TO PATIE		44,329	44,329	1.600803	1.600803	1.600803 72
73 DRUGS CHARGED TO PATIENTS	1,551,899	1,189,080	2,740,979	0.280075	0.280075	0.280075 73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	140,443	306,788	447,231	2.333899	2.333899	2.333899 88
90 CLINIC		131,100	131,100	1.225027	1.225027	1.225027 90
91 EMERGENCY	1,918	2,013,196	2,015,114	0.783621	0.783621	0.783621 91
92 OBSERVATION BEDS		528,409	528,409	0.932302	0.932302	0.932302 92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST						117
117.01 INSURANCE AND MALPRACTICE						117.01
117.02 SUPPLIES AND EXPENSE						117.02
200 SUBTOTAL (SEE INSTRUCTIONS)	6,571,825	15,139,371	21,711,196			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	6,571,825	15,139,371	21,711,196			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1326) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES	COST REIMB. SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	1.335274		235,158			314,000		50
53 ANESTHESIOLOGY	1.349902		91,482			123,492		53
54 RADIOLOGY-DIAGNOSTIC	0.252588		1,191,290			300,906		54
58 MAGNETIC RESONANCE IMAGING (MRI)	0.235091		140,136			32,945		58
60 LABORATORY	0.245463		2,109,431			517,787		60
65 RESPIRATORY THERAPY	0.601249		67,274			40,448		65
65.50 SLEEP LAB	0.388962		28,200			10,969		65.50
66 PHYSICAL THERAPY	0.704517		467,787			329,564		66
67 OCCUPATIONAL THERAPY								67
68 SPEECH PATHOLOGY								68
69 ELECTROCARDIOLOGY	0.034787		230,539			8,020		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.082930		178,387			14,794		71
72 IMPL. DEV. CHARGED TO PATIENT	1.600803		42,195			67,546		72
73 DRUGS CHARGED TO PATIENTS	0.280075		503,541			141,029		73
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)	2.333899							88
90 CLINIC	1.225027		126,170			154,562		90
91 EMERGENCY	0.783621		808,599			633,635		91
92 OBSERVATION BEDS	0.932302		246,940			230,223		92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			6,467,129			2,919,920		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			6,467,129			2,919,920		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-Z326)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES		PROGRAM COSTS			
		PPS REIMBURSED SERVICES	COST REIMB. SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	COST SERVICES SUBJECT TO DED & COINS		
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	1.335274						50
53 ANESTHESIOLOGY	1.349902						53
54 RADIOLOGY-DIAGNOSTIC	0.252588						54
58 MAGNETIC RESONANCE IMAGING (MRI)	0.235091						58
60 LABORATORY	0.245463						60
65 RESPIRATORY THERAPY	0.601249						65
65.50 SLEEP LAB	0.388962						65.50
66 PHYSICAL THERAPY	0.704517						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.034787						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.082930						71
72 IMPL. DEV. CHARGED TO PATIENT	1.600803						72
73 DRUGS CHARGED TO PATIENTS	0.280075						73
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)	2.333899						88
90 CLINIC	1.225027						90
91 EMERGENCY	0.783621						91
92 OBSERVATION BEDS	0.932302						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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM
	(FROM WKST B, FT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)		CAP COST (COL.5 x COL.6)
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS							30
31 INTENSIVE CARE UNIT							31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY							43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)							200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-1326) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
58 MAGNETIC RESONANCE IMAGING (M					58
60 LABORATORY					60
65 RESPIRATORY THERAPY					65
65.50 SLEEP LAB					65.50
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PA					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)					200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					33
33 BURN INTENSIVE CARE UNIT					34
34 SURGICAL INTENSIVE CARE UNIT					35
35 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)					

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1326) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
65 RESPIRATORY THERAPY						65
65.50 SLEEP LAB						65.50
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1326) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
53 ANESTHESIOLOGY							53
54 RADIOLOGY-DIAGNOSTIC							54
58 MAGNETIC RESONANCE IMAGING (58
60 LABORATORY							60
65 RESPIRATORY THERAPY							65
65.50 SLEEP LAB							65.50
66 PHYSICAL THERAPY							66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY							69
71 MEDICAL SUPPLIES CHRGED TO P							71
72 IMPL. DEV. CHARGED TO PATIEN							72
73 DRUGS CHARGED TO PATIENTS							73
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
90 CLINIC							90
91 EMERGENCY							91
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)							200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1326) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		50
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	COST SERVICES SUBJECT TO DED & COINS 6	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1.335274		37,194		49,664	50
53 ANESTHESIOLOGY	1.349902		32,665		44,095	53
54 RADIOLOGY-DIAGNOSTIC	0.252588		821,174		207,419	54
58 MAGNETIC RESONANCE IMAGING (MRI)	0.235091		104,165		24,488	58
60 LABORATORY	0.245463		909,245		223,186	60
65 RESPIRATORY THERAPY	0.601249		10,703		6,435	65
65.50 SLEEP LAB	0.388962					65.50
66 PHYSICAL THERAPY	0.704517		133,963		94,379	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	0.034787		59,958		2,086	69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.082930		99,541		8,255	71
72 IMPL. DEV. CHARGED TO PATIENT	1.600803					72
73 DRUGS CHARGED TO PATIENTS	0.280075		335,204		93,882	73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	2.333899					88
90 CLINIC	1.225027					90
91 EMERGENCY	0.783621		639,573		501,183	91
92 OBSERVATION BEDS	0.932302		124,754		116,308	92
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)			3,308,139		1,371,380	200
201 LESS PBP CLINIC LAB SERVICES						201
202 NET CHARGES (LINE 200 - LINE 201)			3,308,139		1,371,380	202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1326) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,048	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,382	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,382	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	299	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)	299	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	34	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)	34	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	2,173	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	299	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)	299	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	123.51	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	126.51	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,979,237	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)	4,199	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	4,301	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	454,859	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,524,378	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,394,690	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,394,690	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.809992	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)	412.39	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,524,378	37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1326) [] 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) 746.42 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,621,971 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,621,971 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)				873,070 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)				2,495,041 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 COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE 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 223,180 64
 (TITLE XVIII ONLY)
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU 223,180 65
 (TITLE XVIII ONLY)
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 446,360 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 67
 (LINE 12 x LINE 19)
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 68
 (LINE 13 x LINE 20)
 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) 660 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 746.42 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 492,637 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	666,425	2,524,378	0.263996	492,637	130,054 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

CHECK	[]	TITLE V-INPT	[XX]	HOSPITAL (14-1326)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF	[]		[]	TEFRA
BOXES	[XX]	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)								4,048	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)								3,382	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)									3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)								3,382	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD								299	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)								299	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD								34	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)								34	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)								167	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								123.51	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD								126.51	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)								2,979,237	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)								4,199	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)								4,301	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)								454,859	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST								2,524,378	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT										
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)								1,394,690	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)									29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)								1,394,690	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)								1.809992	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)								412.39	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)									34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)									35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)									36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)								2,524,378	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1326) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] 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) 746.42 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 124,652 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) 124,652 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)					42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					106,526 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					231,178 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)					231,178 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 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)					660 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	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
	1	2	3	4	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 HOSPITAL (14-1326) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		1,185,035		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1.335274	27,804	37,126	50
53 ANESTHESIOLOGY	1.349902	23,346	31,515	53
54 RADIOLOGY-DIAGNOSTIC	0.252588	476,445	120,344	54
58 MAGNETIC RESONANCE IMAGING (MRI)	0.235091	66,620	15,662	58
60 LABORATORY	0.245463	745,494	182,991	60
65 RESPIRATORY THERAPY	0.601249	129,732	78,001	65
65.50 SLEEP LAB	0.388962			65.50
66 PHYSICAL THERAPY	0.704517	119,801	84,402	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.034787	48,415	1,684	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.082930	376,845	31,252	71
72 IMPL. DEV. CHARGED TO PATIENT	1.600803			72
73 DRUGS CHARGED TO PATIENTS	0.280075	1,035,418	289,995	73
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	2.333899			88
90 CLINIC	1.225027			90
91 EMERGENCY	0.783621	125	98	91
92 OBSERVATION BEDS	0.932302			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		3,050,045	873,070	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		3,050,045		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) S/B SNF(14-Z326) PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1.335274	2,240	2,991	50
53 ANESTHESIOLOGY	1.349902	966	1,304	53
54 RADIOLOGY-DIAGNOSTIC	0.252588	34,442	8,700	54
58 MAGNETIC RESONANCE IMAGING (MRI	0.235091	11,604	2,728	58
60 LABORATORY	0.245463	91,346	22,422	60
65 RESPIRATORY THERAPY	0.601249	37,869	22,769	65
65.50 SLEEP LAB	0.388962			65.50
66 PHYSICAL THERAPY	0.704517	83,302	58,688	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.034787	1,820	63	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.082930	91,995	7,629	71
72 IMPL. DEV. CHARGED TO PATIENT	1.600803			72
73 DRUGS CHARGED TO PATIENTS	0.280075	254,467	71,270	73
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	2.333899			88
90 CLINIC	1.225027			90
91 EMERGENCY	0.783621	125	98	91
92 OBSERVATION BEDS	0.932302			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		610,176	198,662	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		610,176		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1326) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		97,820		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1.335274	13,120	17,519	50
53 ANESTHESIOLOGY	1.349902	9,831	13,271	53
54 RADIOLOGY-DIAGNOSTIC	0.252588	57,210	14,451	54
58 MAGNETIC RESONANCE IMAGING (MRI)	0.235091	4,460	1,049	58
60 LABORATORY	0.245463	70,793	17,377	60
65 RESPIRATORY THERAPY	0.601249	12,849	7,725	65
65.50 SLEEP LAB	0.388962			65.50
66 PHYSICAL THERAPY	0.704517	2,458	1,732	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.034787	14,054	489	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.082930	80,405	6,668	71
72 IMPL. DEV. CHARGED TO PATIENT	1.600803			72
73 DRUGS CHARGED TO PATIENTS	0.280075	90,853	25,446	73
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	2.333899			88
90 CLINIC	1.225027			90
91 EMERGENCY	0.783621	1,020	799	91
92 OBSERVATION BEDS	0.932302			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		357,053	106,526	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		357,053		202

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[XX] HOSPITAL (14-1326) [] IPF [] IRF	[] SUB (OTHER) [] SNF [] SWING BED SNF	INPATIENT		PART B		
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			2,104,625		2,095,996	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.			NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	11/19/2010	59,052	11/19/2010	3,664	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 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)			59,052		3,664	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			2,163,677		2,099,660	4
TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99		NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM				149,890	6.01 6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			2,084,079		2,249,550	7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:		DATE:	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL	[] IPF	[] IRF	[] SUB (OTHER)	[] SNF	[XX] SWING BED SNF (14-Z326)	INPATIENT PART A	PART B	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
DESCRIPTION	1	2	3	4	5	6	7	8	9	10	11	12
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER										607,148		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.										NONE		NONE 2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.												
	.01	11/19/2010								39,820		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		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									39,820		3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)										646,968		4
TO BE COMPLETED BY CONTRACTOR												
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.												
	PROGRAM .01									NONE		NONE 5.01
	TO .02											5.02
	PROVIDER .03											5.03
	.04											5.04
	.05											5.05
	.06											5.06
	.07											5.07
	.08											5.08
	.09											5.09
	PROVIDER .50									NONE		NONE 5.50
	TO .51											5.51
	PROGRAM .52											5.52
	.53											5.53
	.54											5.54
	.55											5.55
	.56											5.56
	.57											5.57
	.58											5.58
	.59											5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99											5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT												
	PROGRAM TO .01											6.01
	PROVIDER TO .02									-10,174		6.02
	PROGRAM											
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)										636,794		7
8 NAME OF CONTRACTOR:						CONTRACTOR NUMBER:			DATE:			

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1326) [] 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	968	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,173	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	2,722	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	21,711,196	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	299,073	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-Z326)
 APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
 BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A 1	PART B 2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	450,824	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)	200,649	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	598	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)	651,473	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	651,473	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	651,473	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	14,679	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)	636,794	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)	636,794	19
20 INTERIM PAYMENTS	646,968	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	-10,174	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 (14-1326)
 APPLICABLE BOX: [] SUB (OTHER)

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

1	INPATIENT SERVICES	2,495,041	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	2,495,041	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 5 LESS LINE 6) (FOR CAH, SEE INSTRUCTIONS)	2,519,991	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	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)	2,519,991	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	485,990	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	2,034,001	22
23	COINSURANCE	825	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	2,033,176	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	50,903	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	50,903	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	48,358	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26 (LINE 26 HOSPITAL AND SUBPROVIDER ONLY))	2,084,079	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	2,084,079	30
31	INTERIM PAYMENTS	2,163,677	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	-79,598	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 (14-1326) 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	1
2	MEDICAL AND OTHER SERVICES	1,371,380 2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	1,371,380 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	1,371,380 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	3,665,192 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)	1,371,380 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 PLUS 29 MINUS 30)	1,371,380 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)	1,371,380 36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	1,371,380 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)	1,371,380 40
41	INTERIM PAYMENTS	1,371,380 41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	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	2,357,697			1
2 TEMPORARY INVESTMENTS	503,153			2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	3,149,398			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE				
7 NOTES & ACCOUNTS RECEIVABLE	-982,000			6
8 INVENTORY	375,802			7
9 PREPAID EXPENSES	300,458			8
10 OTHER CURRENT ASSETS	86,564			9
11 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	5,791,072			11
FIXED ASSETS				
12 LAND	69,760			12
13 LAND IMPROVEMENTS	591,372			13
14 ACCUMULATED DEPRECIATION	-242,432			14
15 BUILDINGS	21,448,684			15
16 ACCUMULATED DEPRECIATION	-4,504,613			16
17 LEASEHOLD IMPROVEMENTS				17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT				19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	5,554,822			23
24 ACCUMULATED DEPRECIATION	-4,138,046			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)	18,779,547			30
OTHER ASSETS				
31 INVESTMENTS				31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	1,455,232		100,600	34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	1,455,232		100,600	35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	26,025,851		100,600	36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	481,560			37
38 SALARIES, WAGES & FEES PAYABLE	451,933			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	305,000			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	832,861			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,071,354			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE				47
48 UNSECURED LOANS	17,320,000			48
49 OTHER LONG TERM LIABILITIES	2,561,000			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	19,881,000			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	21,952,354			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	4,073,497			52
53 SPECIFIC PURPOSE FUND BALANCE				53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED			100,600	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)	4,073,497		100,600	59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	26,025,851		100,600	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		3,571,331				101,044			1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		502,166							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		4,073,497				101,044			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)		4,073,497				101,044			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)					444				12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)						444			18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		4,073,497				100,600			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	1,394,690		1,394,690	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	105,730		105,730	6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY				8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	1,500,420		1,500,420	
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
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	1,500,420		1,500,420	17
18 ANCILLARY SERVICES	4,923,961	14,899,475	19,823,436	18
19 OUTPATIENT SERVICES		1,309,410	1,309,410	19
20 RHC	140,443	306,788	447,231	20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER	1,280		1,280	27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	6,566,104	16,515,673	23,081,777	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		12,949,420	29
30 BAD DEBTS	1,662,990		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		1,662,990	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)		14,612,410	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	23,081,777	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	9,805,813	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	13,275,964	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	14,612,410	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,336,446	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	442,790	6
7	INCOME FROM INVESTMENTS	33,044	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	628	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		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	13,269	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	19,303	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER)	452,930	24
24.01	OTHER (GAIN ON SWAP CONTRACT)	291,116	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	614,000	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,867,080	26
27	OTHER EXPENSES (LOSS ON SWAP CONTRACT)	530,634	27
27.01	OTHER EXPENSES (IMPAIRMENT LOSS ON NURSING HOME)	28,468	27.01
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	28,468	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	502,166	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-132) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT	1
2	CAPITAL DRG OTHER THAN OUTLIER	2
3	CAPITAL DRG OUTLIER PAYMENTS	3
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	4
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	5
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	6
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	7
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	8
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	9
10	SUM OF LINES 7 AND 8	10
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	11
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	12
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	13

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)	1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)	2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)	3
4	CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)	4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)	5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)	1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)	3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)	4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)	5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)	7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)	8
9	CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)	9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)	10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)	11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)	12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)	13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)	14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)	15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)	16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)	17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORE					5.03
5.04 ADMITTING					5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 OTHER ADMINISTRATIVE AND GENER					5.06
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
58 MAGNETIC RESONANCE IMAGING (MR					58
60 LABORATORY					60
65 RESPIRATORY THERAPY					65
65.50 SLEEP LAB					65.50
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGED TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
88 RURAL HEALTH CLINIC (RHC)					88
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
117 OTHER SPECIAL PURPOSE COST CEN					117
117.01 INSURANCE AND MALPRACTICE					117.01
117.02 SUPPLIES AND EXPENSE					117.02
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES					192
194 NURSING CENTER					194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

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

RHC I
 COMPONENT NO: 14-3477

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	254,932		254,932		254,932		254,932	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER								3
4 VISITING NURSE	49,464		49,464		49,464		49,464	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	304,396		304,396		304,396		304,396	10
PHYSICIAN SERVICES UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS								14
MEDICAL SUPPLIES								
15 MEDICAL SUPPLIES		285	285		285		285	15
TRANSPORTATION (HEALTH CARE STAFF)								
16 TRANSPORTATION (HEALTH CARE STAFF)								16
DEPRECIATION-MEDICAL EQUIPMENT								
17 DEPRECIATION-MEDICAL EQUIPMENT								17
PROFESSIONAL LIABILITY INSURANCE								
18 PROFESSIONAL LIABILITY INSURANCE								18
OTHER HEALTH CARE COSTS								
19 OTHER HEALTH CARE COSTS								19
ALLOWABLE GME COSTS								
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		285	285		285		285	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21) COSTS OTHER THAN RHC/FQHC SERVICES	304,396	285	304,681		304,681		304,681	22
PHARMACY								
23 PHARMACY								23
DENTAL								
24 DENTAL								24
OPTOMETRY								
25 OPTOMETRY								25
ALL OTHER NONREIMBURSABLE COSTS								
26 ALL OTHER NONREIMBURSABLE COSTS								26
NONALLOWABLE GME COSTS								
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27) FACILITY OVERHEAD								28
FACILITY COSTS								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS	48,865	35,485	84,350		84,350		84,350	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	48,865	35,485	84,350		84,350		84,350	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	353,261	35,770	389,031		389,031		389,031	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3477

WORKSHEET M-2

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	1.21	3,754	4,200	5,082	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	1.21	3,754		5,082	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.21	3,754		5,082	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)				304,681	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				304,681	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				84,350	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				654,761	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				739,111	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				739,111	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				739,111	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				1,043,792	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3477

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)	1,043,792	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	4,871	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,038,921	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	5,082	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,082	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	204.43	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)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	204.43	204.43	204.43 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	515	514	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	105,281	105,077	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)	105,281	105,077	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%)		76,127	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	84,225	76,127	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		9,918	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)			19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		160,352	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		3,738	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		164,090	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)		164,090	26
27	INTERIM PAYMENTS		244,674	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		-80,584	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 I
 COMPONENT NO: 14-3477

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	H1N1 VACCINE (SERVICES ON/AFTER 10/1/2009) 2.01	COMBINATION INFLUENZA & H1N1 IN SAME VISIT 2.02
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	304,396	304,396	304,396	304,396
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL	0.000003	0.000500		0.000500
HEALTH CARE STAFF TIME				
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	1	152		152
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	211	906		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	212	1,058		152
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	304,681	304,681	304,681	304,681
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	739,111	739,111	739,111	739,111
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL	0.000696	0.003472		0.000499
DIRECT COST (LINE 5 DIVIDED BY LINE 6)				
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	514	2,566		369
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR	726	3,624		521
ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)				
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	5	77		
(FROM YOUR RECORDS)				
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	145.20	47.06		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	5	64		
ADMINISTERED TO PROGRAM BENEFICIARIES				
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR	726	3,012		
THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)				
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR		4,871		
ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)				
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND		3,738		
THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)				

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

RHC I
 COMPONENT NO: 14-3477

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		203,275	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		3.01
	.02		3.02
	PROGRAM .03 11/19/2010	41,399	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
	.99	41,399	3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)			
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		244,674	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
	.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 (SEE INSTR.			
	PROGRAM TO .01		6.01
	PROVIDER TO .02	-80,584	6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		164,090	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	64.25		4.94				69.19 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	5.53		2.61				8.14 50
53 ANESTHESIOLOGY	8.71		3.67				12.38 53
54 RADIOLOGY-DIAGNOSTIC	11.48		1.38				12.86 54
58 MAGNETIC RESONANCE IMAGING (MRI)	12.84		0.86				13.70 58
60 LABORATORY	13.74		1.30				15.04 60
65 RESPIRATORY THERAPY	28.56		2.83				31.39 65
66 PHYSICAL THERAPY	9.71		0.20				9.91 66
69 ELECTROCARDIOLOGY	11.39		3.31				14.70 69
71 MEDICAL SUPPLIES CHRGED TO PATI	34.85		7.44				42.29 71
73 DRUGS CHARGED TO PATIENTS	37.78		3.31				41.09 73
91 EMERGENCY	0.01		0.05				0.06 91
200 TOTAL CHARGES	15.21		1.78				16.99 200

***** 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	0.45						0.45 50
53 ANESTHESIOLOGY	0.36						0.36 53
54 RADIOLOGY-DIAGNOSTIC	0.83						0.83 54
58 MAGNETIC RESONANCE IMAGING (MRI)	2.24						2.24 58
60 LABORATORY	1.68						1.68 60
65 RESPIRATORY THERAPY	8.34						8.34 65
66 PHYSICAL THERAPY	6.76						6.76 66
69 ELECTROCARDIOLOGY	0.43						0.43 69
71 MEDICAL SUPPLIES CHRGED TO PATI	8.51						8.51 71
73 DRUGS CHARGED TO PATIENTS	9.28						9.28 73
91 EMERGENCY	0.01						0.01 91
200 TOTAL CHARGES	3.04						3.04 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,860,380	15.50	-1,860,380	-28.09		1
2	CAP REL COSTS-MVBLE EQUIP	617,143	5.14	-617,143	-9.32		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	1,255,922	10.46	-1,255,922	-18.97		4
5.01	NONPATIENT TELEPHONES	26,239	0.22	-26,239	-0.40		5.01
5.02	DATA PROCESSING	81,536	0.68	-81,536	-1.23		5.02
5.03	PURCHASING RECEIVING AND STORES	43,917	0.37	-43,917	-0.66		5.03
5.04	ADMITTING	129,268	1.08	-129,268	-1.95		5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	294,759	2.46	-294,759	-4.45		5.05
5.06	OTHER ADMINISTRATIVE AND GENERA	627,547	5.23	-627,547	-9.48		5.06
7	OPERATION OF PLANT	684,917	5.70	-684,917	-10.34		7
8	LAUNDRY & LINEN SERVICE	91,190	0.76	-91,190	-1.38		8
9	HOUSEKEEPING	174,322	1.45	-174,322	-2.63		9
10	DIETARY	67,300	0.56	-67,300	-1.02		10
11	CAFETERIA						11
13	NURSING ADMINISTRATION	215,485	1.79	-215,485	-3.25		13
14	CENTRAL SERVICES & SUPPLY	35,662	0.30	-35,662	-0.54		14
15	PHARMACY	189,745	1.58	-189,745	-2.87		15
16	MEDICAL RECORDS & LIBRARY	189,250	1.58	-189,250	-2.86		16
17	SOCIAL SERVICE	37,502	0.31	-37,502	-0.57		17
19	NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,067,134	8.89	1,912,103	28.87	2,979,237	24.82
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	148,592	1.24	522,840	7.90	671,432	5.59
53	ANESTHESIOLOGY	256,366	2.14	105,521	1.59	361,887	3.01
54	RADIOLOGY-DIAGNOSTIC	466,360	3.88	582,302	8.79	1,048,662	8.73
58	MAGNETIC RESONANCE IMAGING (MRI)	89,550	0.75	32,447	0.49	121,997	1.02
60	LABORATORY	828,939	6.90	502,971	7.60	1,331,910	11.09
65	RESPIRATORY THERAPY	143,212	1.19	129,920	1.96	273,132	2.28
65.50	SLEEP LAB	15,208	0.13	19,254	0.29	34,462	0.29
66	PHYSICAL THERAPY	467,293	3.89	401,494	6.06	868,787	7.24
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	3,627	0.03	11,154	0.17	14,781	0.12
71	MEDICAL SUPPLIES CHRGD TO PATI	45,319	0.38	44,345	0.67	89,664	0.75
72	IMPL. DEV. CHARGED TO PATIENT	44,329	0.37	26,633	0.40	70,962	0.59
73	DRUGS CHARGED TO PATIENTS	280,477	2.34	487,204	7.36	767,681	6.39
88	RURAL HEALTH CLINIC (RHC)	389,031	3.24	654,761	9.89	1,043,792	8.69
90	CLINIC	92,813	0.77	67,788	1.02	160,601	1.34
91	EMERGENCY	819,178	6.82	759,908	11.48	1,579,086	13.15
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
117	OTHER SPECIAL PURPOSE COST CENT						117
117.01	INSURANCE AND MALPRACTICE						117.01
117.02	SUPPLIES AND EXPENSE						117.02
NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	118,339	0.99	235,668	3.56	354,007	2.95
194	NURSING CENTER	107,854	0.90	125,771	1.90	233,625	1.95
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	12,005,705	100.00			12,005,705	100.00

**** 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 COLUMN 1
LESS LINES 61, 66-68, 74, 94, 95 & 96)
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES
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)

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

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

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

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

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