

August 11, 2011

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

Re: Provider: Hardin County General Hospital
Provider Numbers: 14-1328, 14-Z328, 14-3479
Period ended: 03/31/2011
Protested amounts claimed on submitted cost report.

Dear Sir or Madam:

The cost report for Hardin County General Hospital, for the year ended March 31, 2011, claims additional amounts due the provider for an expense paid by the provider, but currently not classified as a reimbursable cost by National Government Services, Inc. The expenses in question relate to the Illinois State Medicaid Provider Tax Assessment in the amount of \$150,680 which we have included as adjustments to line 6 (A&G) on worksheet A-8. We feel as though the tax should be, and is, allowed as a reimbursable cost under Medicare Guidelines and should remain on line 6 (A&G) for inclusion in the B-1 allocation process.

The calculation of the additional amounts due the provider was calculated by removing the adjustments on worksheet A-8. The expense was then allowed to be allocated by the B-1 accumulated cost statistic to the various Hospital departments. The protested amounts claimed for the period ended March 31, 2011, are as follows:

Worksheet E, part B, line 36	\$ 23,511
Worksheet E-2, line 22	14,257
Worksheet E-3, part II, line 34	37,535
Worksheet M-3, line 27	<u>6,290</u>
Total	\$ 81,593

Sincerely,

Roby Williams
Administrator
Hardin County General Hospital
6 Ferrell Road
Rosiclare, IL 62982
(217) 285-6634

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

WORKSHEET S
 PARTS I & II

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

PART I - CERTIFICATION

CHECK XX ELECTRONICALLY FILED COST REPORT DATE: 08/10/2011
 APPLICABLE BOX MANUALLY SUBMITTED COST REPORT TIME: 10:06

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 HARDIN COUNTY GENERAL HOSPITAL (14-1328) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 04/01/2010 AND ENDING 03/31/2011, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 08/10/2011 10:06
 LJPKQXoZDrWwvr:q83QJdBoA62oVm0
 Lu9lJ0.J4ite9H4Ncs6sW8lhngChPm
 apzw02X4b70Y66.Q

(SIGNED)

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

PI Encryption: 08/10/2011 10:06
 9SADgxpRachs3ZCAT9IoZXNG83rt60
 k3Hn600YTUGLxHy7NbHtT.KOB56YWe
 Qs576DUXIO0YyqhW

 DATE

PART II - SETTLEMENT SUMMARY

TITLE V	TITLE XVIII		TITLE XIX	
	PART A	PART B		
1 HOSPITAL	2 98919	3 6737	4 260405	1
2 SUBPROVIDER I				2
3 SWING BED - SNF	-12515			3
4 SWING BED - NF				4
5 SKILLED NURSING FACILITY				5
6 NURSING FACILITY				6
7 HOME HEALTH AGENCY				7
8 OUTPATIENT REHABILITATION PROVIDER				8
9 RURAL HEALTH CLINIC I		65385		9
100 TOTAL	86404	72122	260405	100

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

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

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

WORKSHEET S
 PARTS I & II

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

PART I - CERTIFICATION

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 APPLICABLE BOX _____ MANUALLY SUBMITTED COST REPORT TIME: _____

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(SIGNED)

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	98919	6737	260405	1
2	SUBPROVIDER I				2
3	SWING BED - SNF	-12515			3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY				5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	OUTPATIENT REHABILITATION PROVIDER				8
9	RURAL HEALTH CLINIC I		65385		9
100	TOTAL	86404	72122	260405	100

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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: FERRELL ROAD
 1.01 CITY: ROSICLARE

STATE: IL

P.O. BOX: 2467

ZIP CODE: 62982

COUNTY: HARDIN

1
 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N) V XVIII XIX				
				4	5	6		
2	HOSPITAL	HARDIN COUNTY GENERAL HOSPITAL	14-1328	07/09/2003	N	O	O	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	HARDIN COUNTY SWING BED	14-2328	07/09/2003	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTG							8
9	HOSPITAL-BASED HHA							9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC	HARDIN COUNTY RHC	14-3479	04/03/2006	N	O	N	14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16
17	COST REPORTING PERIOD (MM/DD/YYYY)		FROM: 04/01/2010	TO: 03/31/2011				17
18	TYPE OF CONTROL		1	2				18
19	TYPE OF HOSPITAL/SUBPROVIDER							19
20	HOSPITAL							20
20	SUBPROVIDER I							20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.							21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 'Y' OR 'N' FOR NO.					NO		21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.							21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy) (SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.		2				99914	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.							21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.							21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION (OR APPLICABLE EXTENSION) OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105, MIPPA 147, ACA 3121, OR MMEA 108? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES OR 'N' FOR NO.				NO			21.06
21.07	DOES THIS HOSPITAL QUALIFY AS AN SCH WITH 100 OR FEWER BEDS UNDER MIPPA 147? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS). IS THIS AN SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121 OR MMEA SECTION 108? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS).				NO	NO		21.07
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS? ENTER IN COLUMN 1, 1 IF IT IS BASED ON DATE OF ADMISSION, 2 IF IT IS BASED ON CENSUS DAYS, OR 3 IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE LAST COST REPORTING PERIOD? ENTER IN COLUMN 2, 'Y' FOR YES AND 'N' FOR NO.						NO	21.08
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?					NO		22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW					NO		23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.							23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.							24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER, ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.							24.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO		25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO		25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO		25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO		25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO		25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.06
25.07	HAS YOUR FACILITY'S TRAINED RESIDENTS IN NON-PROVIDER SETTING DURING THE COST REPORTING PERIOD? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1.	NO		25.07
25.08	IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE WEIGHTED NUMBER OF NON-PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE UNWEIGHTED NUMBER OF NON-PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. USE LINES 25.09 THROUGH 25.59 AS NECESSARY TO IDENTIFY THE PROGRAM NAME IN COLUMN 1, THE PROGRAM CODE IN COLUMN 2, AND THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS BY SPECIALTY IN COLUMN 3 FOR EACH PRIMARY CARE SPECIALTY PROGRAM IN WHICH RESIDENTS ARE TRAINED.	0.00		25.08
			PROGRAM CODE(2)	RESIDENT FTEs(3)
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:			26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.			26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:			26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	07/09/2003	27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st			28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.			28.02

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

28.03	STAFFING	0.00	NO		28.03
28.04	RECRUITMENT	0.00	NO		28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO		28.05
28.06	TRAINING	0.00	NO		28.06
28.07	OTHER (SPECIFY)		NO		28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?		NO		29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.		YES		30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.		NO		30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?		NO		30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)		NO		30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.		NO		30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).		NO		31
MISCELLANEOUS COST REPORTING INFORMATION					
32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.		NO		32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.		NO		33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?		NO		34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?		NO		35
PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL					
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	V	XVIII	XIX	
		1	2	3	
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?				37.01
TITLE XIX INPATIENT HOSPITAL SERVICES					
38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES			38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO			38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO			38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO			38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO			38.04

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COL. 2 THE HOME OFFICE CHAIN NUMBER. (SEE INST.) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE ON LINES 40.01-40.03. NO 40

40.01 NAME: FI/CONTRACTOR'S NAME: FI/CONTRACTOR'S NUMBER: 40.01
 40.02 STREET: P.O.BOX: 40.02
 40.03 CITY: STATE: ZIP CODE: 40.03

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? YES 41
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? YES 42
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? YES 42.01
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? YES 42.02
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS? NO 43
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY? NO 44
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2. NO 45

45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS? 45.01
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? 45.02
 45.03 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? 45.03
 46 IF YOU ARE PARTICIPATING IN THE NHCQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE. 46

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

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

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? NO 52

52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV. NO 52.01

53 IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 53

53.01 MDH PERIOD: BEGINNING: ENDING: 53.01

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: 54

PREMIUMS: 66800 PAID LOSSES: AND/OR SELF INSURANCE:

54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. NO 54.01

55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO. NO 55

56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. DATE Y/N LIMIT Y/N FEES
 0 1 2 3 4
 / / NO 0.00 NO 56

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? NO 57

58 ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. NO 58

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS) 58.01

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS) NO 59

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)	NO						60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)							60.01
MULTICAMPUS								
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.	NO						61
	COUNTY: 1	STATE: 2	ZIP CODE 3	CBSA 4	FTE/ CAMPUS 5			
SETTLEMENT DATA								
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)	NO						63
MISCELLANEOUS DATA								
64	DOES THIS HOSPITAL HAVE DIRECT ASSIGNMENT OF COST FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO.	NO						64

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	-----I/P DAYS / O/P VISITS / TRIPS-----					OBS. BEDS ADMITTED 5.01
				TITLE V 3	TITLE XVIII 4	NONCOVERED DAYS 4.01	TITLE XIX 5		
1 HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	25	9125	49440.00		1592		284		1
2 HMO									2
3 HOSPITAL ADULTS & PEDS - SWING BED SNF					693				3
4 HOSPITAL ADULTS & PEDS - SWING BED NF									4
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	25	9125	49440.00		2285		284		5
6 INTENSIVE CARE UNIT									6
7 CORONARY CARE UNIT									7
8 BURN INTENSIVE CARE UNIT									8
9 SURGICAL INTENSIVE CARE UNIT									9
10 OTHER SPECIAL CARE (SPECIFY)									10
11 NURSERY									11
12 TOTAL HOSPITAL	25	9125	49440.00		2285		284		12
13 RPCH VISITS									13
14 SUBPROVIDER I									14
15 SKILLED NURSING FACILITY									15
16 NURSING FACILITY									16
17 OTHER LONG TERM CARE									17
18 HOME HEALTH AGENCY									18
20 ASC (DISTINCT PART)									20
21 HOSPICE (DISTINCT PART)									21
23 O/P REHAB PROVIDER									23
24 RHC I					4161				24
25 TOTAL	25								25
26 OBSERVATION BED DAYS							128		26
27 AMBULANCE TRIPS									27
28 EMPLOYEE DISCOUNT DAYS									28
29 LABOR & DELIVERY DAYS									29

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	-----I/P DAYS / O/P		VISITS / TRIPS-----		---INTERNS & RES FTES----			--FULL TIME EQUIV--	
	OBS.	TOTAL ALL	OBS.	OBS.	TOTAL	LESS I&R	NET	EMPLOYEES	NONPAID
	BEDS NOT	PATIENTS	BEDS	BEDS NOT		REPL NON-		ON PAYROLL	WORKERS
	ADMITTED		ADMITTED	ADMITTED		PHYS ANES			
	5.02	6	6.01	6.02	7	8	9	10	11
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		2060							1
2 HMO XIX									2
3 HOSPITAL ADULTS & PEDS - SWING BED SNF		693							3
4 HOSPITAL ADULTS & PEDS - SWING BED NF		56							4
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		2809							5
6 INTENSIVE CARE UNIT									6
7 CORONARY CARE UNIT									7
8 BURN INTENSIVE CARE UNIT									8
9 SURGICAL INTENSIVE CARE UNIT									9
10 OTHER SPECIAL CARE (SPECIFY)									10
11 NURSERY									11
12 TOTAL HOSPITAL		2809						121.25	12
13 RPCH VISITS									13
14 SUBPROVIDER I									14
15 SKILLED NURSING FACILITY									15
16 NURSING FACILITY									16
17 OTHER LONG TERM CARE									17
18 HOME HEALTH AGENCY									18
20 ASC (DISTINCT PART)									20
21 HOSPICE (DISTINCT PART)									21
23 O/P REHAB PROVIDER									23
24 RHC I		11544						16.49	24
25 TOTAL								137.74	25
26 OBSERVATION BED DAYS		355							26
27 AMBULANCE TRIPS									27
28 EMPLOYEE DISCOUNT DAYS									28
29 LABOR & DELIVERY DAYS									29

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	-----DISCHARGES-----				TOTAL ALL PATIENTS	
	TITLE	TITLE	TITLE			
	V 12	XVIII 13	XIX 14	15		
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		404	83	546		1
2 HMO XIX						2
3 HOSPITAL ADULTS & PEDS - SWING BED SNF						3
4 HOSPITAL ADULTS & PEDS - SWING BED NF						4
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS						5
6 INTENSIVE CARE UNIT						6
7 CORONARY CARE UNIT						7
8 BURN INTENSIVE CARE UNIT						8
9 SURGICAL INTENSIVE CARE UNIT						9
10 OTHER SPECIAL CARE (SPECIFY)						10
11 NURSERY						11
12 TOTAL HOSPITAL		404	83	546		12
13 RPCH VISITS						13
14 SUBPROVIDER I						14
15 SKILLED NURSING FACILITY						15
16 NURSING FACILITY						16
17 OTHER LONG TERM CARE						17
18 HOME HEALTH AGENCY						18
20 ASC (DISTINCT PART)						20
21 HOSPICE (DISTINCT PART)						21
23 O/P REHAB PROVIDER						23
24 RHC I						24
25 TOTAL						25
26 OBSERVATION BED DAYS						26
27 AMBULANCE TRIPS						27
28 EMPLOYEE DISCOUNT DAYS						28

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II

PART II - WAGE DATA	AMOUNT REPORTED	RECLASS.	ADJUSTED	PAID HOURS	AVERAGE	DATA SOURCE	
		OF SALARIES FROM WKST. A-6	SALARIES (COL.1 + COL.2)	RELATED TO SALARY IN COL.3	HOURLY WAGE (COL.3 / COL.4)		
	1	2	3	4	5	6	
1 SALARIES							1
2 TOTAL SALARIES	5432621						2
3 NON-PHYSICIAN ANESTHETIST PART A							3
4 NON-PHYSICIAN ANESTHETIST PART B							4
5 PHYSICIAN - PART A							5
6.01 TEACHING PHYSICIAN SALARIES							6.01
7 PHYSICIAN - PART B							7
8.01 NON-PHYSICIAN - PART B							8.01
9 INTERNS & RESIDENTS (IN APPR PGM)							9
10.01 CONTRACT SERVICES, I&R							10.01
11 HOME OFFICE PERSONNEL							11
12 SNF							12
13.01 EXCLUDED AREA SALARIES							13.01
14 OTHER WAGES & RELATED COSTS							14
15 CONTRACT LABOR							15
16.01 PHARMACY SERVICES UNDER CONTRACT							16.01
17 LABORATORY SERVICES UNDER CONTRACT							17
18.03 MANAGEMENT AND ADMINISTRATIVE SERVICES							18.03
19 CONTRACT LABOR: PHYSICIAN PART A							19
20.01 TEACHING PHYSICIAN UNDER CONTRACT							20.01
21 HOME OFFICE SALARIES & WAGE REL COSTS							21
22 HOME OFFICE: PHYSICIAN PART A							22
23.01 TEACHING PHYSICIAN SALARIES							23.01
24 WAGE-RELATED COSTS							24
25 WAGE RELATED COSTS (CORE)						CMS 339	25
26 WAGE RELATED COSTS (OTHER)						CMS 339	26
27 EXCLUDED AREAS						CMS 339	27
28 NON-PHYSICIAN ANESTHETIST PART A						CMS 339	28
29 NON-PHYSICIAN ANESTHETIST PART B						CMS 339	29
30 PHYSICIAN PART A						CMS 339	30
31.01 PART A TEACHING PHYSICIANS						CMS 339	31.01
32 PHYSICIAN PART B						CMS 339	32
33.01 WAGE RELATED COSTS (RHC/FQHC)						CMS 339	33.01
34 INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	34
35 OVERHEAD COSTS - DIRECT SALARIES							35
36 EMPLOYEE BENEFITS							36
37 ADMINISTRATIVE & GENERAL	697333						37
38.01 ADMINISTRATIVE & GENERAL UNDER CONTACT							38.01
39 MAINTENANCE & REPAIRS							39
40 OPERATION OF PLANT	172359	-644					40
41 LAUNDRY & LINEN SERVICE	54255						41
42 HOUSEKEEPING	93277	-9402					42
43.01 HOUSEKEEPING UNDER CONTRACT							43.01
44 DIETARY	103147	-50542					44
45.01 DIETARY UNDER CONTRACT							45.01
46 CAFETERIA		50542					46
47 MAINTENANCE OF PERSONNEL							47
48 NURSING ADMINISTRATION		72498					48
49 CENTRAL SERVICES AND SUPPLY	28192	-21144					49
50 PHARMACY	182526						50
51 MEDICAL RECORDS & MEDICAL RECORDS LIBR	237931	-18062					51
52 SOCIAL SERVICE	49061						52
53 OTHER GENERAL SERVICE							53

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART III

PART III - HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED	RECLASS.	ADJUSTED	PAID HOURS	AVERAGE	
		OF SALARIES FROM WKST. A-6	SALARIES (COL.1 + COL.2)	RELATED TO SALARY IN COL.3	HOURLY WAGE (COL.3 / COL.4)	
	1	2	3	4	5	
1 NET SALARIES	5432621		5432621			1
2 EXCLUDED AREA SALARIES						2
3 SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5432621		5432621			3
4 SUBTOTAL OTHER WAGES & REL COSTS						4
5 SUBTOTAL WAGE-RELATED COSTS						5
6 TOTAL (SUM OF LINES 3 THRU 5)	5432621		5432621			6
7 NET SALARIES						7
8 EXCLUDED AREA SALARIES						8
9 SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10 SUBTOTAL OTHER WAGES & REL COSTS						10
11 SUBTOTAL WAGE-RELATED COSTS						11
12 TOTAL (SUM OF LINES 9 THRU 11)						12
13 TOTAL OVERHEAD COSTS	1618081	23246	1641327			13

NHCMQ DEMONSTRATION STATISTICAL DATA
 STATISTICAL DATA

WORKSHEET S-7

GROUP	M3PI REVENUE CODE	SERVICES		SERVICES		TOTAL
		PRIOR TO JANUARY 1	DAYS	ON OR AFTER JANUARY 1	DAYS	
1	2	RATE	3.01	RATE	4.01	5
1	RVC/RUC					1
2	RVB/RUB					2
3	RVA/RUA					3
3.01	RUX					3.01
3.02	RUL					3.02
4	RHD/RVC					4
5	RHC/RVB					5
6	RHE/RVA					6
6.01	RVX					6.01
6.02	RVL					6.02
7	RHA/RHC					7
8	RMC/RHB					8
9	RMB/RHA					9
9.01	RHX					9.01
9.02	RHL					9.02
10	RMA/RMC					10
11	RLB/RMB					11
12	RLA/RMA					12
12.01	RMX					12.01
12.02	RML					12.02
13	SE3/RLB					13
14	SE2/RLA					14
15	SE1/SE3					15
16	SSC/SE2					16
17	SSB/SE1					17
18	SSA/SSC					18
19	CD2/SSB					19
20	CD1/SSA					20
21	CC2					21
22	CC1					22
23	CB2					23
24	CB1					24
25	CA2					25
26	CA1					26
27	IB2					27
28	IB1					28
29	IA2					29
30	IA1					30
31	BB2					31
32	BB1					32
33	BA2					33
34	BA1					34
35	PE2					35
36	PE1					36
37	PD2					37
38	PD1					38
39	PC2					39
40	PC1					40
41	PB2					41
42	PB1					42
43	PA2					43
44	PA1					44
45	AAA					45
45.01	ES3					45.01
45.02	ES2					45.02
45.03	ES1					45.03
45.04	HE2					45.04
45.05	HE1					45.05
45.06	HD2					45.06
45.07	HD1					45.07
45.08	HC2					45.08
45.09	HC1					45.09
45.10	HB2					45.10
45.11	HB1					45.11
45.12	LE2					45.12
45.13	LE1					45.13
45.14	LD2					45.14
45.15	LD1					45.15
45.16	LC2					45.16
45.17	LC1					45.17
45.18	LB2					45.18
45.19	LB1					45.19
45.20	CE2					45.20
45.21	CE1					45.21
45.22	CD2					45.22
45.23	CD1					45.23
46	TOTAL					46

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

RHC I
 COMPONENT NO: 14-3479

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 6 FERRELL ROAD 1
 1.01 CITY: ROSICLARE STATE: IL ZIP CODE: 62982 COUNTY: HARDIN 1.01
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:

GRANT AWARD
 1

DATE
 2

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

PHYSICIAN INFORMATION:

PHYSICIAN NAME

BILLING NO.

9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT 9

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

PHYSICIAN NAME

HOURS

10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO

IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2

(ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)

11

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12 CLINIC			900	1700	900	1700	900	1700	900	1700	900	1700		

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

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

14 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? NO 14
 IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.

LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.

15 PROVIDER NAME: PROVIDER NUMBER: - 15

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

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSI-	RECLASS.	ADJUST-	NET EXP	
		1	2	3	FICATIONS	TRIAL	MENTS	FOR	
					4	BALANCE	6	ALLOCATION	
						5		7	
GENERAL SERVICE COST CENTERS									
3	0300		31098	31098	44758	75856		75856	3
4	0400		175454	175454	6562	182016		182016	4
5	0500				66566	66566		66566	5
6	0600	697333	2024460	2721793	-63738	2658055	-1063540	1594515	6
8	0800	172359	225015	397374	-764	396610	-24	396586	8
9	0900	54255	15159	69414		69414		69414	9
10	1000	93277	34087	127364	-11076	116288		116288	10
11	1100	103147	130948	234095	-99959	134136		134136	11
12	1200				98916	98916	-27238	71678	12
14	1400				85548	85548		85548	14
15	1500	28192	7147	35339	-27120	8219		8219	15
16	1600	182526	122619	305145	-48087	257058	-9111	247947	16
17	1700	237931	64174	302105	-20976	281129	-5369	275760	17
18	1800	49061	13027	62088		62088		62088	18
INPATIENT ROUTINE SERV COST CENTERS									
25	2500	1209180	506920	1716100	-288238	1427862	-87444	1340418	25
ANCILLARY SERVICE COST CENTERS									
41	4100	371406	252022	623428	-2592	620836		620836	41
44	4400	367239	671019	1038258	-6225	1032033	-111438	920595	44
49	4900	171269	68589	239858	-27924	211934	-29665	182269	49
50	5000	81209	85281	166490	-116	166374		166374	50
51	5100								51
52	5200								52
53	5300	9866	932	10798	16003	26801		26801	53
55	5500				131053	131053		131053	55
56	5600				291463	291463		291463	56
OUTPATIENT SERVICE COST CENTERS									
61	6100	744467	189163	933630	20898	954528	-261554	692974	61
62	6200								62
63.50	6310	859904	190803	1050707	-89138	961569		961569	63.50
OTHER REIMBURSABLE COST CENTERS									
71	7100								71
SPECIAL PURPOSE COST CENTERS									
88	8800		75814	75814	-75814				88
95		5432621	4883731	10316352		10316352	-1595383	8720969	95
NONREIMBURSABLE COST CENTERS									
96	9600								96
96.01	9601		12892	12892		12892		12892	96.01
101		5432621	4896623	10329244		10329244	-1595383	8733861	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----				
		COST CENTER	LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 TO RECLASS SUPPLY COST FROM CS	A	MEDICAL SUPPLIES CHARGED TO P	55	21144	5976	1
2 TO RECLASS DON COST	B	NURSING ADMINISTRATION	14	72498	13050	2
3 TO RECLASS COST TO CLINC	C	RURAL HEALTH CLINIC	63.50	28108	4708	3
	C					4
	C					5
6 TO RECLASS SUPPLY COST	D	MEDICAL SUPPLIES CHARGED TO P	55		103933	6
	D					7
	D					8
	D					9
	D					10
	D					11
	D					12
13 TO RECLASS INSURANCE EXPENSE	E	NEW CAP REL COSTS-BLDG & FIXT	3		2188	13
	E	NEW CAP REL COSTS-MVBLE EQUIP	4		6562	14
	E	EMPLOYEE BENEFITS	5		66566	15
16 TO RECLASS INTEREST	F	NEW CAP REL COSTS-BLDG & FIXT	3		42570	16
	F	ADMINISTRATIVE & GENERAL	6		11578	17
	F	RADIOLOGY-DIAGNOSTIC	41		6716	18
	F	ADULTS & PEDIATRICS	25		11126	19
	F	RURAL HEALTH CLINIC	63.50		3824	20
21 TO RECLASS CAFE COST	G	CAFETERIA	12	50542	48374	21
22 TO RECLASS CARDIAC MONITORING COST	H	ELECTROCARDIOLOGY	53	13350	2653	22
	H					23
24 TO RECLASS DRUG COST	I	DRUGS CHARGED TO PATIENTS	56		291463	24
	I					25
	I					26
	I					27
	I					28
	I					29
	I					30
31 TO RECLASS CLINIC COST	J	EMERGENCY	61	109372	16406	31
	J					32
	J					33
	J					34
	J					35
36 TOTAL RECLASSIFICATIONS				295014	637693	36

RECLASSIFICATIONS

WORKSHEET A-6
 PAGE 1

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 TO RECLASS SUPPLY COST FROM CS	A	CENTRAL SERVICES & SUPPLY	15	21144	5976	1
2 TO RECLASS DON COST	B	ADULTS & PEDIATRICS	25	72498	13050	2
3 TO RECLASS COST TO CLINC	C	OPERATION OF PLANT	8	644	120	3
4	C	HOUSEKEEPING	10	9402	1674	4
5	C	MEDICAL RECORDS & LIBRARY	17	18062	2914	5
6 TO RECLASS SUPPLY COST	D	ADULTS & PEDIATRICS	25		42137	6
7	D	EMERGENCY	61		19113	7
8	D	RADIOLOGY-DIAGNOSTIC	41		9303	8
9	D	LABORATORY	44		6225	9
10	D	RESPIRATORY THERAPY	49		27121	10
11	D	PHYSICAL THERAPY	50		34	11
12	D					12
13 TO RECLASS INSURANCE EXPENSE	E					12 13
14	E					12 14
15	E	ADMINISTRATIVE & GENERAL	6		75316	15
16 TO RECLASS INTEREST	F					11 16
17	F					17
18	F					18
19	F					19
20	F	INTEREST EXPENSE	88		75814	20
21 TO RECLASS CAFE COST	G	DIETARY	11	50542	48374	21
22 TO RECLASS CARDIAC MONITORING COS	H					22
23	H	ADULTS & PEDIATRICS	25	13350	2653	23
24 TO RECLASS DRUG COST	I	ADULTS & PEDIATRICS	25		155676	24
25	I	EMERGENCY	61		85767	25
26	I	PHARMACY	16		48087	26
27	I	RESPIRATORY THERAPY	49		803	27
28	I	PHYSICAL THERAPY	50		82	28
29	I	DIETARY	11		1043	29
30	I	RADIOLOGY-DIAGNOSTIC	41		5	30
31 TO RECLASS CLINIC COST	J	RURAL HEALTH CLINIC	63.50	109372	16406	31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				295014	637693	36

ANALYSIS OF CHANGES DURING COST REPORTING
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL								7
8 RECONCILING ITEMS								8
9 TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	17000					17000		1
2 LAND IMPROVEMENTS	100979					100979		2
3 BUILDINGS AND FIXTURES	1380939	47445		47445	491	1427893		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	2521771	525581		525581		3047352		6
7 SUBTOTAL	4020689	573026		573026	491	4593224		7
8 RECONCILING ITEMS								8
9 TOTAL	4020689	573026		573026	491	4593224		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	1	2	3	4	5	6	7	8
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT	1528872		1528872	.334090				3
4 NEW CAP REL COSTS-MVBLE EQUIP	3047352		3047352	.665910				4
5 TOTAL	4576224		4576224	1.000000				5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	31098		42570	2188			75856 3
4 NEW CAP REL COSTS-MVBLE EQUIP	175454			6562			182016 4
5 TOTAL	206552		42570	8750			257872 5

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	31098						31098 3
4 NEW CAP REL COSTS-MVBLE EQUIP	175454						175454 4
5 TOTAL	206552						206552 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5 INVESTMENT INCOME-OTHER					5
6 TRADE, QUANTITY, AND TIME DISCOUNTS					6
7 REFUNDS AND REBATES OF EXPENSES	B	-21810	ADMINISTRATIVE & GENERAL	6	7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-2707	ADMINISTRATIVE & GENERAL	6	9
10 TELEVISION AND RADIO SERVICE					10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-490101			12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1				14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-27238	CAFETERIA	12	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19 SALE OF DRUGS TO OTHER THAN PATIENTS					19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	A	-5369	MEDICAL RECORDS & LIBRARY	17	20
21 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					21
22 VENDING MACHINES					22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71	27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		OCCUPATIONAL THERAPY	51	35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		SPEECH PATHOLOGY	52	36
37					37
38					38
39					39
40					40
41					41
42 CMS APPEAL COST	A	-15721	ADMINISTRATIVE & GENERAL	6	42
43 BAD DEBT	A	-844410	ADMINISTRATIVE & GENERAL	6	43
44 LATE FEES	A	-23448	ADMINISTRATIVE & GENERAL	6	44
45 PHARMACY REBATES	B	-9111	PHARMACY	16	45
46 PROVIDER TAX	A	-150680	ADMINISTRATIVE & GENERAL	6	46
47 LOBBING PORTION OF DUES	A	-4764	ADMINISTRATIVE & GENERAL	6	47
48 RENTAL COST	A	-24	OPERATION OF PLANT	8	48
49					49
50 TOTAL		-1595383			50

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

WORKSHEET A-8-1

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

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

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

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

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

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----

SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
1						1
2						2
3						3
4						4
5						5

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

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
 PERIOD FROM 04/01/2010 TO 03/31/2011

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

VERSION: 2011.03
 08/10/2011 10:05

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO. 1	2	3	4	5	6	7	8	9
1 6	ADMINISTRATIVE & GENERAL MED STAFF DIRECTOR	30096		30096				
2 25	ADULTS & PEDIATRICS AGGREGATE	87444	87444					
3 44	LABORATORY AGGREGATE	118638	111438	7200				
4 49	RESPIRATORY THERAPY AGGREGATE	29665	29665					
5 61	EMERGENCY AGGREGATE	556498	261554	294944				
101	TOTAL	822341	490101	332240				

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO.		11	12	13	14	15	16	17	18
1	6	ADMINISTRATIVE & GENERAL MED STAFF DIRECTOR							
2	25	ADULTS & PEDIATRICS							87444
3	44	LABORATORY							111438
4	49	RESPIRATORY THERAPY							29665
5	61	EMERGENCY							261554
101		TOTAL							490101

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

WORKSHEET A-8-4
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					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						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		570.00				9
10	AHSEA		68.39				10
11	STANDARD TRAVEL ALLOWANCE	34.20	34.20				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					38982	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					38982	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					38982	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					68.39	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					53344	22
23	TOTAL SALARY EQUIVALENCY					53344	23

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

WORKSHEET A-8-4
PARTS III & IV

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

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

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

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

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

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

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

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

WORKSHEET A-8-4
 PARTS V, VI & VII

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

PART V - OVERTIME COMPUTATION								
	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL			
	1	2	3	4	5			
47	OVERTIME HOURS WORKED						47	
	DURING REPORTING PERIOD							
48	OVERTIME RATE						48	
49	TOTAL OVERTIME						49	
	CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME						50	
	HOURS BY CATEGORY							
51	ALLOCATION OF PROVIDER'S						51	
	STANDARD WORKYEAR FOR ONE							
	FULL TIME EMPLOYEE TIMES							
	THE PERCENTAGES ON LINE 50							
	DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY						52	
	EQUIVALENCY AMOUNT							
53	OVERTIME COST LIMITATION						53	
54	MAXIMUM OVERTIME COST						54	
55	PORTION OF OVERTIME ALREADY						55	
	INCLUDED IN HOURLY							
	COMPUTATION AT THE AHSEA							
56	OVERTIME ALLOWANCE						56	
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57	SALARY EQUIVALENCY AMOUNT					53344	57	
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE						58	
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES						59	
60	OVERTIME ALLOWANCE						60	
61	EQUIPMENT COST						61	
62	SUPPLIES						62	
63	TOTAL ALLOWANCE					53344	63	
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES					34176	64	
65	EXCESS OVER LIMITATION						65	

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

WORKSHEET A-8-4
PARTS V, VI & VII

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

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	34176	66
67	TOTAL COST	34176	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
 PERIOD FROM 04/01/2010 TO 03/31/2011

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

VERSION: 2011.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		409.00				9
10	AHSEA		72.16				10
11	STANDARD TRAVEL ALLOWANCE	36.08	36.08				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					29513	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					29513	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					29513	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					72.16	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					56285	22
23	TOTAL SALARY EQUIVALENCY					56285	23

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

WORKSHEET A-8-4
PARTS III & IV

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

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

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

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

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

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
 PARTS V, VI & VII

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

PART V - OVERTIME COMPUTATION		THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED						47
	DURING REPORTING PERIOD						
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME						50
	HOURS BY CATEGORY						
51	ALLOCATION OF PROVIDER'S						51
	STANDARD WORKYEAR FOR ONE						
	FULL TIME EMPLOYEE TIMES						
	THE PERCENTAGES ON LINE 50						
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY						52
	EQUIVALENCY AMOUNT						
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY						55
	INCLUDED IN HOURLY						
	COMPUTATION AT THE AHSEA						
56	OVERTIME ALLOWANCE						56
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57	SALARY EQUIVALENCY AMOUNT					56285	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES						59
60	OVERTIME ALLOWANCE						60
61	EQUIPMENT COST						61
62	SUPPLIES						62
63	TOTAL ALLOWANCE					56285	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES					24558	64
65	EXCESS OVER LIMITATION						65

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
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FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V, VI & VII

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

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	24558	66
67	TOTAL COST	24558	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					39	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					585	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		51.00				9
10	AHSEA		65.72				10
11	STANDARD TRAVEL ALLOWANCE	32.86	32.86				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					3352	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					3352	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					3352	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					65.73	21
22	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					38452	22
23	TOTAL SALARY EQUIVALENCY					38452	23

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-4
PARTS III & IV

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

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

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

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

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

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

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-4
 PARTS V, VI & VII

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

PART V - OVERTIME COMPUTATION							
	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL		
	1	2	3	4	5		
47	OVERTIME HOURS WORKED						47
	DURING REPORTING PERIOD						
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME						50
	HOURS BY CATEGORY						
51	ALLOCATION OF PROVIDER'S						51
	STANDARD WORKYEAR FOR ONE						
	FULL TIME EMPLOYEE TIMES						
	THE PERCENTAGES ON LINE 50						
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY						52
	EQUIVALENCY AMOUNT						
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY						55
	INCLUDED IN HOURLY						
	COMPUTATION AT THE AHSEA						
56	OVERTIME ALLOWANCE						56
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57	SALARY EQUIVALENCY AMOUNT					38452	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES						59
60	OVERTIME ALLOWANCE						60
61	EQUIPMENT COST						61
62	SUPPLIES						62
63	TOTAL ALLOWANCE					38452	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES					8132	64
65	EXCESS OVER LIMITATION						65

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-4
PARTS V, VI & VII

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

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	8132	66
67	TOTAL COST	8132	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	
GENERAL SERVICE COST CENTERS									
3 NEW CAP REL COSTS-BLDG & FIXT	75856	75856							3
4 NEW CAP REL COSTS-MVBLE EQUIP	182016		182016						4
5 EMPLOYEE BENEFITS	66566			66566					5
6 ADMINIS-TRATIVE & GENERAL	1594515	13263	31949	8544	1648271	1648271			6
8 OPERATION OF PLANT	396586	7521	18116	2104	424327	98708	523035		8
9 LAUNDRY & LINEN SERVICE	69414	3391	8168	665	81638	18991	32204	132833	9
10 HOUSEKEEPING	116288			1028	117316	27290		3448	10
11 DIETARY	134136	3338	8040	645	146159	34000	31701	5288	11
12 CAFETERIA	71678	1413	3403	619	77113	17938	13418		12
14 NURSING ADMINISTRATION	85548	7365	17740	888	111541	25947	69943		14
15 CENTRAL SERVICES & SUPPLY	8219			86	8305	1932			15
16 PHARMACY	247947	1484	3574	2236	255241	59375	14089		16
17 MEDICAL RECORDS & LIBRARY	275760	4027	9700	2694	292181	67968	38242		17
18 SOCIAL SERVICE	62088	662	1595	601	64946	15108	6290		18
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	1340418	16136	38876	13765	1409195	327811	153277	98552	25
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC	620836	4954	11933	4551	642274	149408	47048	4679	41
44 LABORATORY	920595	2002	4821	4500	931918	216786	19009		44
49 RESPIRATORY THERAPY	182269	1484	3574	2099	189426	44065	14089		49
50 PHYSICAL THERAPY	166374	2885	6949	995	177203	41221	27396	12333	50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY	26801			284	27085	6301			53
55 MEDICAL SUPPLIES CHARGED TO PAT	131053	1422	3425	259	136159	31674	13502		55
56 DRUGS CHARGED TO PATIENTS	291463				291463	67801			56
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY	692974	3859	9295	10462	716590	166695	36649	8533	61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RURAL HEALTH CLINIC	961569			9541	971110	225903			63.50
OTHER REIMBURSABLE COST CENTERS									
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
95 SUBTOTALS	8720969	75206	181158	66566	8719461	1644922	516857	132833	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN		356	858		1214	282	3383		96
96.01 VENDING MACHINE	12892	294			13186	3067	2795		96.01
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	8733861	75856	182016	66566	8733861	1648271	523035	132833	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	HOUSE-KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINIS-TRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	
GENERAL SERVICE COST CENTERS									
3 NEW CAP REL COSTS-BLDG & FIXT									3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS									5
6 ADMINISTRATIVE & GENERAL									6
8 OPERATION OF PLANT									8
9 LAUNDRY & LINEN SERVICE									9
10 HOUSEKEEPING	148054								10
11 DIETARY	9562	226710							11
12 CAFETERIA	4047	116461	228977						12
14 NURSING ADMINISTRATION	21098		3761	232290					14
15 CENTRAL SERVICES & SUPPLY				8716	18953				15
16 PHARMACY	4250		6807		960	340722			16
17 MEDICAL RECORDS & LIBRARY	11535		17536		321		427783		17
18 SOCIAL SERVICE	1897		2307		58			90606	18
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	46234	110249	73257	223574	1602		320948	90606	25
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC	14192		21781		300		98083		41
44 LABORATORY	5734		23027		11186		8752		44
49 RESPIRATORY THERAPY	4250		11029		257				49
50 PHYSICAL THERAPY	8264		5514		113				50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY			2884		37				53
55 MEDICAL SUPPLIES CHARGED TO PAT	4073		2400		2918				55
56 DRUGS CHARGED TO PATIENTS						330147			56
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY	11055		20627		669				61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RURAL HEALTH CLINIC			38047		532	10575			63.50
OTHER REIMBURSABLE COST CENTERS									
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
95 SUBTOTALS	146191	226710	228977	232290	18953	340722	427783	90606	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN	1020								96
96.01 VENDING MACHINE	843								96.01
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	148054	226710	228977	232290	18953	340722	427783	90606	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	25	26	27	
GENERAL SERVICE COST CENTERS				
3 NEW CAP REL COSTS-BLDG & FIXT				3
4 NEW CAP REL COSTS-MVBLE EQUIP				4
5 EMPLOYEE BENEFITS				5
6 ADMINISTRATIVE & GENERAL				6
8 OPERATION OF PLANT				8
9 LAUNDRY & LINEN SERVICE				9
10 HOUSEKEEPING				10
11 DIETARY				11
12 CAFETERIA				12
14 NURSING ADMINISTRATION				14
15 CENTRAL SERVICES & SUPPLY				15
16 PHARMACY				16
17 MEDICAL RECORDS & LIBRARY				17
18 SOCIAL SERVICE				18
INPATIENT ROUTINE SERV COST CENTERS				
25 ADULTS & PEDIATRICS	2855305		2855305	25
ANCILLARY SERVICE COST CENTERS				
41 RADIOLOGY-DIAGNOSTIC	977765		977765	41
44 LABORATORY	1216412		1216412	44
49 RESPIRATORY THERAPY	263116		263116	49
50 PHYSICAL THERAPY	272044		272044	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	36307		36307	53
55 MEDICAL SUPPLIES CHARGED TO PAT	190726		190726	55
56 DRUGS CHARGED TO PATIENTS	689411		689411	56
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	960818		960818	61
62 OBSERVATION BEDS (NON-DISTINCT				62
63.50 RURAL HEALTH CLINIC	1246167		1246167	63.50
OTHER REIMBURSABLE COST CENTERS				
71 HOME HEALTH AGENCY				71
SPECIAL PURPOSE COST CENTERS				
95 SUBTOTALS	8708071		8708071	95
NONREIMBURSABLE COST CENTERS				
96 GIFT, FLOWER, COFFEE SHOP & CAN	5899		5899	96
96.01 VENDING MACHINE	19891		19891	96.01
101 CROSS FOOT ADJUSTMENTS				101
102 NEGATIVE COST CENTER				102
103 TOTAL	8733861		8733861	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIR ASSGND	NEW CAP	NEW CAP	CAP REL	ADMINIS-	OPERATION	LAUNDRY	HOUSE-
	CAP-REL	BLDGS &	MOVABLE	COST TO	TRATIVE &	OF PLANT	& LINEN	KEEPING
	COSTS	FIXTURES	EQUIPMENT	BE ALLOC	GENERAL		SERVICE	
	0	3	4	4A	6	8	9	10
GENERAL SERVICE COST CENTERS								
3								3
4								4
5								5
6		13263	31949	45212	45212			6
8		7521	18116	25637	2708	28345		8
9		3391	8168	11559	521	1745	13825	9
10					749		359	1108 10
11		3338	8040	11378	933	1718	550	72 11
12		1413	3403	4816	492	727		30 12
14		7365	17740	25105	712	3790		158 14
15					53			15
16		1484	3574	5058	1629	764		32 16
17		4027	9700	13727	1864	2072		86 17
18		662	1595	2257	414	341		14 18
INPATIENT ROUTINE SERV COST CENTERS								
25		16136	38876	55012	8988	8307	10257	346 25
ANCILLARY SERVICE COST CENTERS								
41		4954	11933	16887	4098	2550	487	106 41
44		2002	4821	6823	5947	1030		43 44
49		1484	3574	5058	1209	764		32 49
50		2885	6949	9834	1131	1485	1284	62 50
51								51
52					173			52
53					869	732		53
55		1422	3425	4847				30 55
56					1860			56
OUTPATIENT SERVICE COST CENTERS								
61		3859	9295	13154	4573	1986	888	83 61
62								62
63.50					6197			63.50
OTHER REIMBURSABLE COST CENTERS								
71								71
SPECIAL PURPOSE COST CENTERS								
95		75206	181158	256364	45120	28011	13825	1094 95
SUBTOTALS								
96		356	858	1214	8	183		8 96
96.01		294		294	84	151		6 96.01
101								101
102								102
103		75856	182016	257872	45212	28345	13825	1108 103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
	11	12	14	15	16	17	18	25	
GENERAL SERVICE COST CENTERS									
3 NEW CAP REL COSTS-BLDG & FIXT									3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS									5
6 ADMINISTRATIVE & GENERAL									6
8 OPERATION OF PLANT									8
9 LAUNDRY & LINEN SERVICE									9
10 HOUSEKEEPING									10
11 DIETARY	14651								11
12 CAFETERIA	7526	13591							12
14 NURSING ADMINISTRATION		223	29988						14
15 CENTRAL SERVICES & SUPPLY			1125	1178					15
16 PHARMACY		404		60	7947				16
17 MEDICAL RECORDS & LIBRARY		1041		20		18810			17
18 SOCIAL SERVICE		137		4			3167		18
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	7125	4349	28863	100		14112	3167	140626	25
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC		1293		19		4313		29753	41
44 LABORATORY		1367		694		385		16289	44
49 RESPIRATORY THERAPY		655		16				7734	49
50 PHYSICAL THERAPY		327		7				14130	50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY		171		2				346	53
55 MEDICAL SUPPLIES CHARGED TO PAT		142		181				6801	55
56 DRUGS CHARGED TO PATIENTS					7700			9560	56
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY		1224		42				21950	61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RURAL HEALTH CLINIC		2258		33	247			8735	63.50
OTHER REIMBURSABLE COST CENTERS									
71 HOME HEALTH AGENCY									71
95 SPECIAL PURPOSE COST CENTERS									95
95 SUBTOTALS	14651	13591	29988	1178	7947	18810	3167	255924	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN								1413	96
96.01 VENDING MACHINE								535	96.01
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	14651	13591	29988	1178	7947	18810	3167	257872	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	26	27	
GENERAL SERVICE COST CENTERS			
3 NEW CAP REL COSTS-BLDG & FIXT			3
4 NEW CAP REL COSTS-MVBLE EQUIP			4
5 EMPLOYEE BENEFITS			5
6 ADMINISTRATIVE & GENERAL			6
8 OPERATION OF PLANT			8
9 LAUNDRY & LINEN SERVICE			9
10 HOUSEKEEPING			10
11 DIETARY			11
12 CAFETERIA			12
14 NURSING ADMINISTRATION			14
15 CENTRAL SERVICES & SUPPLY			15
16 PHARMACY			16
17 MEDICAL RECORDS & LIBRARY			17
18 SOCIAL SERVICE			18
INPATIENT ROUTINE SERV COST CENTERS			
25 ADULTS & PEDIATRICS		140626	25
ANCILLARY SERVICE COST CENTERS			
41 RADIOLOGY-DIAGNOSTIC		29753	41
44 LABORATORY		16289	44
49 RESPIRATORY THERAPY		7734	49
50 PHYSICAL THERAPY		14130	50
51 OCCUPATIONAL THERAPY			51
52 SPEECH PATHOLOGY			52
53 ELECTROCARDIOLOGY		346	53
55 MEDICAL SUPPLIES CHARGED TO PAT		6801	55
56 DRUGS CHARGED TO PATIENTS		9560	56
OUTPATIENT SERVICE COST CENTERS			
61 EMERGENCY		21950	61
62 OBSERVATION BEDS (NON-DISTINCT			62
63.50 RURAL HEALTH CLINIC		8735	63.50
OTHER REIMBURSABLE COST CENTERS			
71 HOME HEALTH AGENCY			71
SPCIAL PURPOSE COST CENTERS			
95 SUBTOTALS		255924	95
NONREIMBURSABLE COST CENTERS			
96 GIFT, FLOWER, COFFEE SHOP & CAN		1413	96
96.01 VENDING MACHINE		535	96.01
101 CROSS FOOT ADJUSTMENTS			101
102 NEGATIVE COST CENTER			102
103 TOTAL		257872	103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT SQUARE FEET 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8
GENERAL SERVICE COST CENTERS						
3 NEW CAP REL COSTS-BLDG & FIXT	25771					3
4 NEW CAP REL COSTS-MVBLE EQUIP		25671				4
5 EMPLOYEE BENEFITS			5432621			5
6 ADMINISTRATIVE & GENERAL	4506	4506	697333	-1648271	7085590	6
8 OPERATION OF PLANT	2555	2555	171715		424327	8
9 LAUNDRY & LINEN SERVICE	1152	1152	54255		81638	9
10 HOUSEKEEPING			83875		117316	10
11 DIETARY	1134	1134	52605		146159	11
12 CAFETERIA	480	480	50542		77113	12
14 NURSING ADMINISTRATION	2502	2502	72498		111541	14
15 CENTRAL SERVICES & SUPPLY			7048		8305	15
16 PHARMACY	504	504	182526		255241	16
17 MEDICAL RECORDS & LIBRARY	1368	1368	219869		292181	17
18 SOCIAL SERVICE	225	225	49061		64946	18
25 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	5483	5483	1123332		1409195	25
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	1683	1683	371406		642274	41
44 LABORATORY	680	680	367239		931918	44
49 RESPIRATORY THERAPY	504	504	171269		189426	49
50 PHYSICAL THERAPY	980	980	81209		177203	50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY			23216		27085	53
55 MEDICAL SUPPLIES CHARGED TO P	483	483	21144		136159	55
56 DRUGS CHARGED TO PATIENTS					291463	56
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	1311	1311	853839		716590	61
62 OBSERVATION BEDS (NON-DISTINC						62
63.50 RURAL HEALTH CLINIC			778640		971110	63.50
OTHER REIMBURSABLE COST CENTERS						
71 HOME HEALTH AGENCY						71
SPECIAL PURPOSE COST CENTERS						
95 SUBTOTALS	25550	25550	5432621	-1648271	7071190	95
NONREIMBURSABLE COST CENTERS						
96 GIFT, FLOWER, COFFEE SHOP & C	121	121			1214	96
96.01 VENDING MACHINE	100				13186	96.01
101 CROSS FOOT ADJUSTMENTS						101
102 NEGATIVE COST CENTER						102
103 COST TO BE ALLOC PER B PT I	75856		66566		1648271	103
104 UNIT COST MULT-WS B PT I		7.090335				27.954837
104 UNIT COST MULT-WS B PT I	2.943464		.012253		.232623	104
105 COST TO BE ALLOC PER B PT II						104
106 UNIT COST MULT-WS B PT II						105
106 UNIT COST MULT-WS B PT II						106
107 COST TO BE ALLOC PER B PT III					45212	106
108 UNIT COST MULT-WS B PT III						28345
108 UNIT COST MULT-WS B PT III						1.514965
108 UNIT COST MULT-WS B PT III					.006381	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
	POUNDS OF LAUNDRY 9	SQUARE FEET 10	MEALS SERV ED 11	FTE'S SERV ED 12	DIRECT NRS ING HRS 14	COSTED REQ UIS. 15	COSTED REQ UIS. 16
GENERAL SERVICE COST CENTERS							
3							3
4							4
5							5
6							6
8							8
9	196451						9
10	5100	17558					10
11	7820	1134	21606				11
12		480	11099	9924			12
14		2502		163	77126		14
15					2894	675177	15
16		504		295		34183	16
17		1368		760		11444	17
18		225		100		2060	18
INPATIENT ROUTINE SERV COST CENTERS							
25	145751	5483	10507	3175	74232	57068	25
ADULTS & PEDIATRICS							
ANCILLARY SERVICE COST CENTERS							
41	6920	1683		944		10670	41
44		680		998		398518	44
49		504		478		9164	49
50	18240	980		239		4042	50
51							51
52							52
53				125		1329	53
55		483		104		103933	55
56							291463
61	12620	1311		894		23831	61
62							62
63.50				1649		18935	9336
RURAL HEALTH CLINIC							
OTHER REIMBURSABLE COST CENTERS							
71							71
HOME HEALTH AGENCY							
SPECIAL PURPOSE COST CENTERS							
95	196451	17337	21606	9924	77126	675177	300799
SUBTOTALS							
96		121					96
96.01		100					96.01
VENDING MACHINE							
CROSS FOOT ADJUSTMENTS							
102							102
103	132833	148054	226710	228977	232290	18953	340722
104	.676164		10.492919		3.011825		1.132723
104		8.432282		23.073055		.028071	104
105							105
106							106
106							106
107	13825	1108	14651	13591	29988	1178	7947
108	.070374		.678099		.388818		.026420
108		.063105		1.369508		.001745	108
108							108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL	SOCIAL	
	RECORDS & LIBRARY TIME SPENT	SERVICE PATIENT DA YS	
	17	18	
GENERAL SERVICE COST CENTERS			
3 NEW CAP REL COSTS-BLDG & FIXT			3
4 NEW CAP REL COSTS-MVBLE EQUIP			4
5 EMPLOYEE BENEFITS			5
6 ADMINISTRATIVE & GENERAL			6
8 OPERATION OF PLANT			8
9 LAUNDRY & LINEN SERVICE			9
10 HOUSEKEEPING			10
11 DIETARY			11
12 CAFETERIA			12
14 NURSING ADMINISTRATION			14
15 CENTRAL SERVICES & SUPPLY			15
16 PHARMACY			16
17 MEDICAL RECORDS & LIBRARY	53035		17
18 SOCIAL SERVICE		2060	18
INPATIENT ROUTINE SERV COST CENTERS			
25 ADULTS & PEDIATRICS	39790	2060	25
ANCILLARY SERVICE COST CENTERS			
41 RADIOLOGY-DIAGNOSTIC	12160		41
44 LABORATORY	1085		44
49 RESPIRATORY THERAPY			49
50 PHYSICAL THERAPY			50
51 OCCUPATIONAL THERAPY			51
52 SPEECH PATHOLOGY			52
53 ELECTROCARDIOLOGY			53
55 MEDICAL SUPPLIES CHARGED TO P			55
56 DRUGS CHARGED TO PATIENTS			56
OUTPATIENT SERVICE COST CENTERS			
61 EMERGENCY			61
62 OBSERVATION BEDS (NON-DISTINC			62
63.50 RURAL HEALTH CLINIC			63.50
OTHER REIMBURSABLE COST CENTERS			
71 HOME HEALTH AGENCY			71
SPECIAL PURPOSE COST CENTERS			
95 SUBTOTALS	53035	2060	95
NONREIMBURSABLE COST CENTERS			
96 GIFT, FLOWER, COFFEE SHOP & C			96
96.01 VENDING MACHINE			96.01
101 CROSS FOOT ADJUSTMENTS			101
102 NEGATIVE COST CENTER			102
103 COST TO BE ALLOC PER B PT I	427783	90606	103
104 UNIT COST MULT-WS B PT I	8.066051		104
104 UNIT COST MULT-WS B PT I		43.983495	104
105 COST TO BE ALLOC PER B PT II			105
106 UNIT COST MULT-WS B PT II			106
106 UNIT COST MULT-WS B PT II			106
107 COST TO BE ALLOC PER B PT III	18810	3167	107
108 UNIT COST MULT-WS B PT III	.354671		108
108 UNIT COST MULT-WS B PT III		1.537379	108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
25 INPATIENT ROUTINE SERV COST CENTERS						25
ADULTS & PEDIATRICS	2855305					
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	977765					41
44 LABORATORY	1216412					44
49 RESPIRATORY THERAPY	263116					49
50 PHYSICAL THERAPY	272044					50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	36307					53
55 MEDICAL SUPPLIES CHARGED TO	190726					55
56 DRUGS CHARGED TO PATIENTS	689411					56
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	960818					61
62 OBSERVATION BEDS (NON-DISTI	325507		325507		325507	62
63.50 RURAL HEALTH CLINIC	1246167					63.50
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	9033578		325507		325507	101
102 LESS OBSERVATION BEDS	325507		325507		325507	102
103 TOTAL	8708071					103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
25 INPATIENT ROUTINE SERV COST CENTERS						25
ADULTS & PEDIATRICS	1322190		1322190			
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	460719	2850352	3311071	.295302		41
44 LABORATORY	463148	1859103	2322251	.523807		44
49 RESPIRATORY THERAPY	159443	204793	364236	.722378		49
50 PHYSICAL THERAPY	136983	968568	1105551	.246071		50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	29840	115280	145120	.250186		53
55 MEDICAL SUPPLIES CHARGED TO	470772	151302	622074	.306597		55
56 DRUGS CHARGED TO PATIENTS	1019744	609255	1628999	.423211		56
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	44372	975195	1019567	.942378		61
62 OBSERVATION BEDS (NON-DISTI	2215	194387	196602	1.655665	1.655665	62
63.50 RURAL HEALTH CLINIC		939975	939975	1.325745		63.50
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	4109426	8868210	12977636			101
102 LESS OBSERVATION BEDS						102
103 TOTAL			12977636			103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1328) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES			
	PART II	PART I	PART II	OUTPATIENT	OUTPATIENT	OTHER	
	COL. 8	COL. 9	COL. 9	AMBULATORY	RADIOLOGY	OUTPATIENT	
	1	1.01	1.02	SURGICAL	CENTER	DIAGNOSTIC	
				2	3	4	
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC	.295302	.295302	.295302				41
44 LABORATORY	.523807	.523807	.523807				44
49 RESPIRATORY THERAPY	.722378	.722378	.722378				49
50 PHYSICAL THERAPY	.246071	.246071	.246071				50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY	.250186	.250186	.250186				53
55 MEDICAL SUPPLIES CHARGED TO PAT	.306597	.306597	.306597				55
56 DRUGS CHARGED TO PATIENTS	.423211	.423211	.423211				56
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	.942378	.942378	.942378				61
62 OBSERVATION BEDS (NON-DISTINCT)	1.655665	1.655665	1.655665				62
63.50 RURAL HEALTH CLINIC	1.325745	1.325745	1.325745				63.50
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)							65.03
101 SUBTOTAL							101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.423211	1
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)		2
2.01 VACCINE CHARGES - HEPATITIS B		2.01
3 VACCINE COSTS (OTHER THAN HEPATITIS B)		3
3.01 VACCINE COSTS - HEPATITIS B		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK	[]	TITLE V - O/P	[XX]	HOSPITAL (14-1328)	[]	SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[]	SUB I	[]	NF
BOXES	[]	TITLE XIX - O/P	[]	SUB II	[]	S/B-SNF
			[]	SUB III	[]	S/B-NF
			[]	SUB IV	[]	ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL OTHER (1) (SEE INSTRU.)	PPS SER- VICES (SEE INSTRU.)	ALL OTHER (SEE INSTRU.)	PPS SER- VICES (SEE INSTRU.)	PPS SER- VICES (SEE INSTRU.)	OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	5	5.01	5.02	5.03	5.04	6	7	8
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC	914358							41
44 LABORATORY	974433							44
49 RESPIRATORY THERAPY	25330							49
50 PHYSICAL THERAPY	171065							50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY	95924							53
55 MEDICAL SUPPLIES CHARGED TO PA	94360							55
56 DRUGS CHARGED TO PATIENTS	207780							56
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY	279068							61
62 OBSERVATION BEDS (NON-DISTINCT	63147							62
63.50 RURAL HEALTH CLINIC								63.50
OTHER REIMBURSABLE COST CENTERS								
65.01 AMBULANCE SERVICES (2ND PERIOD								65.01
65.02 AMBULANCE SERVICES (3RD PERIOD								65.02
65.03 AMBULANCE SERVICES (4TH PERIOD								65.03
101 SUBTOTAL	2825465							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	2825465							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK	[]	TITLE V - O/P	[XX]	HOSPITAL (14-1328)	[]	SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[]	SUB I	[]	NF
BOXES	[]	TITLE XIX - O/P	[]	SUB II	[]	S/B-SNF
			[]	SUB III	[]	S/B-NF
			[]	SUB IV	[]	ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL	
	ALL OTHER (COLS 1x5)	PPS SERVICES (COLUMNS 1.01x5.01)	ALL OTHER (COLUMNS 1.01x5.02)	PPS SERVICES (COLUMNS 1.01x5.03)	PPS SERVICES (COLUMNS 1.01x5.04)	I/P PART B CHARGES (SEE INSTRU.)	I/P PART B COST (COLUMNS 1.02x10)
	9	9.01	9.02	9.03	9.04	10	11
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC	270012						41
44 LABORATORY	510415						44
49 RESPIRATORY THERAPY	18298						49
50 PHYSICAL THERAPY	42094						50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY	23999						53
55 MEDICAL SUPPLIES CHARGED TO PAT	28930						55
56 DRUGS CHARGED TO PATIENTS	87935						56
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	262988						61
62 OBSERVATION BEDS (NON-DISTINCT	104550						62
63.50 RURAL HEALTH CLINIC							63.50
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)							65.03
101 SUBTOTAL	1349221						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	1349221						104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL			
	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	
	1	2	3	4	5	6	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS				140626	31567	109059	25
26 INTENSIVE CARE UNIT							26
27 CORONARY CARE UNIT							27
28 BURN INTENSIVE CARE UNIT							28
29 SURGICAL INTENSIVE CARE UNIT							29
30 OTHER SPECIAL CARE (SPECIFY)							30
31 SUBPROVIDER I							31
33 NURSERY							33
101 TOTAL				140626		109059	101

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL			
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST	
	7	8	9	10	11	12	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS	2415	284			45.16	12825	25
26 INTENSIVE CARE UNIT							26
27 CORONARY CARE UNIT							27
28 BURN INTENSIVE CARE UNIT							28
29 SURGICAL INTENSIVE CARE UNIT							29
30 OTHER SPECIAL CARE (SPECIFY)							30
31 SUBPROVIDER I							31
33 NURSERY							33
101 TOTAL	2415	284				12825	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-1328) [] SUB III [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SUB IV [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [XX] OTHER

COST CENTER DESCRIPTION	OLD	NEW	TOTAL	INPATIENT	OLD CAPITAL		NEW CAPITAL	
	CAPITAL	CAPITAL			RATIO OF	CAPITAL	RATIO OF	CAPITAL
	RELATED	RELATED	CHARGES	PROGRAM	COST TO	COSTS	COST TO	COSTS
	COST	COST		CHARGES	CHARGES		CHARGES	
	1	2	3	4	5	6	7	8
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC		29753	3311071				.008986	41
44 LABORATORY		16289	2322251				.007014	44
49 RESPIRATORY THERAPY		7734	364236				.021233	49
50 PHYSICAL THERAPY		14130	1105551				.012781	50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY		346	145120				.002384	53
55 MEDICAL SUPPLIES CHARGED TO P		6801	622074				.010933	55
56 DRUGS CHARGED TO PATIENTS		9560	1628999				.005869	56
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY		21950	1019567				.021529	61
62 OBSERVATION BEDS (NON-DISTINC			196602					62
63.50 RURAL HEALTH CLINIC			939975					63.50
OTHER REIMBURSABLE COST CENTERS								
101 TOTAL		106563	10715471					101

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
 PERIOD FROM 04/01/2010 TO 03/31/2011

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

VERSION: 2011.03
 08/10/2011 10:05

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL	TOTAL	PER	INPATIENT	INPATIENT
	ANESTHETIST	EDUCATION	ADJUSTMENT					
	COST	COST	AMOUNT	4	DAYS	DIEM	DAYS	PASS THRU
	1	2	3		5	6	7	8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					2415		284	25
26 INTENSIVE CARE UNIT								26
27 CORONARY CARE UNIT								27
28 BURN INTENSIVE CARE UNIT								28
29 SURGICAL INTENSIVE CARE UNIT								29
30 OTHER SPECIAL CARE (SPECIFY)								30
31 SUBPROVIDER I								31
33 NURSERY								33
34 SKILLED NURSING FACILITY								34
35 NURSING FACILITY								35
101 TOTAL					2415		284	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1328) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY							53
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RURAL HEALTH CLINIC							63.50
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1328) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH COSTS 3.01	CHARGES 4	COST TO CHARGES 5	RATIO OF COST TO CHARGES 5.01	PROGRAM CHARGES 6	PROGRAM PASS THROUGH COSTS 7	PROGRAM CHARGES 8
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC		3311071					41
44 LABORATORY		2322251					44
49 RESPIRATORY THERAPY		364236					49
50 PHYSICAL THERAPY		1105551					50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY		145120					53
55 MEDICAL SUPPLIES CHARGED TO P		622074					55
56 DRUGS CHARGED TO PATIENTS		1628999					56
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY		1019567					61
62 OBSERVATION BEDS (NON-DISTINC		196602					62
63.50 RURAL HEALTH CLINIC		939975					63.50
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		10715471					101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1328) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS
ANCILLARY SERVICE COST CENTERS					
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
53 ELECTROCARDIOLOGY					53
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RURAL HEALTH CLINIC					63.50
OTHER REIMBURSABLE COST CENTERS					
101 TOTAL	8.01	8.02	9	9.01	101

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	SNF	
	1	1	1	1	1	1	
INPATIENT DAYS							
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3164						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	2415						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2415						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	520						5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	173						6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	42						7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	14						8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1592						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	520						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	173						11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	98.38						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.38						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2855305						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	4132						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	1377						25
26 TOTAL SWING-BED COST	640935						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2214370						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1322190						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1322190						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.674774						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	547.49						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2214370						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	916.92					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1459737					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1459737					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM DAYS	PROGRAM COST
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	691646					48
49 TOTAL PROGRAM INPATIENT COSTS	2151383					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST						52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	1	1	1	1	1	54
54						PROGRAM DISCHARGES
55						TARGET AMOUNT PER DISCHARGE
56						TARGET AMOUNT
57						DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58						BONUS PAYMENT
58.01						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET
58.02						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET
58.03						IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT
58.04						RELIEF PAYMENT
59						ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01						ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)
59.02						PROGRAM DISCHARGES PRIOR TO JULY 1
59.03						PROGRAM DISCHARGES AFTER JULY 1
59.04						PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05						REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1
59.06						REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
59.07						REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)
59.08						REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)
PROGRAM INPATIENT ROUTINE SWING BED COST						
60	476798					MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
61	158627					MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
62	635425					TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65						TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

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

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

SNF

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

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	355	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	916.92	84
85 OBSERVATION BED COST	325507	85

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

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

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	NF
INPATIENT DAYS	1	1	1	1	1	1
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3164					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	2415					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)						3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2415					4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	520					5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	173					6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	42					7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	14					8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	284					9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)						14
15 TOTAL NURSERY DAYS						15
16 TITLE V OR XIX NURSERY DAYS						16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

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

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT							
	1	1	1	1	1	1	
17							17
MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							
18							18
MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							
19	98.38						19
MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							
20	98.38						20
MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							
21	2855305						21
TOTAL GENERAL INPATIENT ROUTINE SERVICE COST							
22							22
SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							
23							23
SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							
24	4132						24
SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							
25	1377						25
SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							
26	640935						26
TOTAL SWING-BED COST							
27	2214370						27
GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	1322190						28
GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)							
29							29
PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							
30	1322190						30
SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							
31	1.674774						31
GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO							
32							32
AVERAGE PRIVATE ROOM PER DIEM CHARGE							
33	547.49						33
AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE							
34							34
AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							
35							35
AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							
36							36
PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							
37	2214370						37
GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL							

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	916.92					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	260405					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	260405					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST						48
49 TOTAL PROGRAM INPATIENT COSTS	260405					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	12825					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST	12825					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

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

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

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

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
PERIOD FROM 04/01/2010 TO 03/31/2011

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

VERSION: 2011.03
08/10/2011 10:05

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT

[] TITLE XVIII-PART A

[XX] TITLE XIX-INPT

HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	355	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	916.92	84
85 OBSERVATION BED COST	325507	85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input checked="" type="checkbox"/> S/B-SNF (14-Z328)	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
ANCILLARY SERVICE COST CENTERS				
41 RADIOLOGY-DIAGNOSTIC	.295302	32453	9583	41
44 LABORATORY	.523807	51095	26764	44
49 RESPIRATORY THERAPY	.722378	29553	21348	49
50 PHYSICAL THERAPY	.246071	96955	23858	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	.250186	1434	359	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.306597	80822	24780	55
56 DRUGS CHARGED TO PATIENTS	.423211	175225	74157	56
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.942378	636	599	61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	1.655665			62
63.50 RURAL HEALTH CLINIC	1.325745			63.50
101 TOTAL		468173	181448	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		468173		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-1328)	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input checked="" type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	3
INPATIENT ROUTINE SERVICE COST CENTERS			
25 ADULTS & PEDIATRICS			25
ANCILLARY SERVICE COST CENTERS			
41 RADIOLOGY-DIAGNOSTIC	.295302		41
44 LABORATORY	.523807		44
49 RESPIRATORY THERAPY	.722378		49
50 PHYSICAL THERAPY	.246071		50
51 OCCUPATIONAL THERAPY			51
52 SPEECH PATHOLOGY			52
53 ELECTROCARDIOLOGY	.250186		53
55 MEDICAL SUPPLIES CHARGED TO PAT	.306597		55
56 DRUGS CHARGED TO PATIENTS	.423211		56
OUTPATIENT SERVICE COST CENTERS			
61 EMERGENCY	.942378		61
62 OBSERVATION BEDS (NON-DISTINCT	1.655665		62
OTHER REIMBURSABLE COST CENTERS			
63.50 RURAL HEALTH CLINIC	1.325745		63.50
101 TOTAL			101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			102
103 NET CHARGES			103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
DRG AMOUNT					
1	OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1				1
1.01	OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1				1.01
1.02	OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS				1.02
1.03	PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1				1.03
1.04	PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1				1.04
1.05	PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1				1.05
1.06	ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED				1.06
1.07	PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001				1.07
1.08	SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001				1.08
2	OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997				2
2.01	OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997 INDIRECT MEDICAL EDUCATION ADJUSTMENT				2.01
3	BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD				3
3.01	NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I				3.01
3.02	INDIRECT MEDICAL EDUCATION PERCENTAGE				3.02
3.03	INDIRECT MEDICAL EDUCATION ADJUSTMENT				3.03
3.04	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996				3.04
3.05	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)				3.05
3.06	ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [FOR CR PERIODS ENDING] [ON OR AFTER 7/1/2005] [E-3,PT.VI,LN.15][PLUS LN.3.06]				3.06
3.07	SUM OF LINES 3.04-3.06 0.00 0.00				3.07
3.08	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				3.08
3.09	FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1				3.09
3.10	FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1				3.10
3.11	FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09				3.11
3.12	FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10				3.12
3.13	FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS				3.13
3.14	CURRENT YEAR ALLOWABLE FTE				3.14
3.15	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..				3.15
3.16	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE.. RES. IN INIT YRS				3.16
3.17	SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE 0.00 NUMBER OF THOSE LINES IN EXCESS OF ZERO				3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
3.18						3.18
3.19						3.19
3.20						3.20
3.21						3.21
3.22						3.22
3.23						3.23
3.24						3.24
4						4
4.01						4.01
4.02						4.02
4.03						4.03
4.04						4.04
5						5
5.01						5.01
5.02						5.02
5.03						5.03
5.04						5.04
5.05						5.05
5.06						5.06
6						6
7						7
7.01						7.01
8						8
9						9
10						10
11						11
11.01						11.01
11.02						11.02
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
21.01						21.01
21.02						21.02
22						22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
23						23
24						24
25						25
26						26
27						27
28						28
28.01						28.01
29						29
30						30
50						50
51						51
52						52
53						53
54						54
55						55
56						56

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1328)	HOSPITAL (14-1328)	HOSPITAL (14-1328)
	1	1.01	1.02
1 MEDICAL AND OTHER SERVICES	1349221		1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000			1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS			1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO			1.03
1.04 LINE 1.01 TIMES LINE 1.03			1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04			1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT			1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101			1.07
2 INTERNS AND RESIDENTS			2
3 ORGAN ACQUISITIONS			3
4 COST OF TEACHING PHYSICIANS			4
5 TOTAL COST	1349221		5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES			
6 ANCILLARY SERVICE CHARGES			6
7 INTERNS AND RESIDENTS SERVICE CHARGES			7
8 ORGAN ACQUISITION CHARGES			8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS			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			13
14 TOTAL CUSTOMARY CHARGES			14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST			15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			16
17 LESSER OF COST OR CHARGES	1362713		17
17.01 TOTAL PPS PAYMENTS			17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1328) 1	HOSPITAL (14-1328) 1.01	HOSPITAL (14-1328) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES	16885		18
18.01 COINSURANCE	389141		18.01
19 SUBTOTAL	956687		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	956687		23
24 PRIMARY PAYER PAYMENTS			24
25 SUBTOTAL	956687		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	114316		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	114316		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	110455		27.02
28 SUBTOTAL	1071003		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	1071003		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	1064266		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	6737		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	23511		36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)			51
52 THE RATE USED TO CALCULATE THE TIME VALUE MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS) FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 HOSPITAL (14-1328)

WORKSHEET E-1

DESCRIPTION	INPATIENT PART A		PART B		
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2084813		966762	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM					
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .01		10/15/2010	75749	3.01
REVISION OF THE INTERIM RATE FOR THE COST	TO .02		03/04/2011	21755	3.02
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .03	NONE			3.03
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	TO .04				3.04
	PROGRAM .05				3.05
	PROVIDER .50	118355			3.50
	TO .51	67052			3.51
	PROGRAM .52			NONE	3.52
	TO .53				3.53
	PROGRAM .54				3.54
SUBTOTAL	.99	-185407		97504	3.99
4 TOTAL INTERIM PAYMENTS		1899406		1064266	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				5.01
	TO .02	NONE		NONE	5.02
	PROVIDER .03				5.03
	TO .50				5.50
	PROGRAM .51	NONE		NONE	5.51
	TO .52				5.52
SUBTOTAL	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01	98919		6737	6.01
	PROVIDER TO .02				6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		1998325		1071003	7
NAME OF INTERMEDIARY: _____			INTERMEDIARY NUMBER: _____		
SIGNATURE OF AUTHORIZED PERSON: _____			DATE (MO/DAY/YR): _____		

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 SWING BED SKILLED NURSING FACILITY (14-Z328)

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		649369		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 10/15/2010	51260		3.01
PROGRAM .02 03/04/2011		117845		3.02
TO .03			NONE	3.03
PROVIDER .04				3.04
.05				3.05
.50				3.50
PROVIDER .51				3.51
TO .52		NONE		3.52
PROGRAM .53			NONE	3.53
.54				3.54
SUBTOTAL .99		169105		3.99
4 TOTAL INTERIM PAYMENTS		818474		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02	NONE	NONE	5.02
	PROVIDER .03			5.03
	PROVIDER .50			5.50
	TO .51	NONE	NONE	5.51
	PROGRAM .52			5.52
SUBTOTAL .99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01			6.01
	PROVIDER TO .02	-12515		6.02
	PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY		805959		7
NAME OF INTERMEDIARY: _____		INTERMEDIARY NUMBER: _____		
SIGNATURE OF AUTHORIZED PERSON: _____		DATE (MO/DAY/YR): _____		

CALCULATION OF REIMBURSEMENT SETTLEMENT
 SWING BEDS

SUPPLEMENTAL
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

	TITLE V	--- TITLE XVIII ---		--- TITLE XIX ---		
	S/B NF	S/B SNF	S/B SNF	S/B SNF	S/B NF	
		PART A	PART B	(14-Z328)		
	1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		641779			1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF					2
3	ANCILLARY SERVICES		183262			3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					4
5	PROGRAM DAYS		693			5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY					7
8	SUBTOTAL		825041			8
9	PRIMARY PAYER PAYMENTS					9
10	SUBTOTAL		825041			10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)					11
12	SUBTOTAL		825041			12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		26353			13
14	80% OF PART B COSTS					14
15	SUBTOTAL		798688			15
16	OTHER ADJUSTMENTS					16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)		7271			17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		7271			17.01
18	TOTAL		805959			18
19	SEQUESTRATION ADJUSTMENT					19
20	INTERIM PAYMENTS		818474			20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					20.01
21	BALANCE DUE PROVIDER/PROGRAM		-12515			21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		14257			22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1328)	SUB I	SUB II	SUB III	SUB IV	SNF I
1						1
1.01	2151383					1.01
2						2
3						3
4	2151383					4
5						5
6	2172897					6
COMPUTATION OF LESSER OF COST OR CHARGES						
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1328)	SUB I	SUB II	SUB III	SUB IV	SNF I
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS					18
19	COST OF COVERED SERVICES	2172897				19
20	DEDUCTIBLES	252816				20
21	EXCESS REASONABLE COST					21
22	SUBTOTAL	1920081				22
23	COINSURANCE	8047				23
24	SUBTOTAL	1912034				24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	86291				25
25.01	REDUCED REIMBURSABLE BAD DEBTS	86291				25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	85267				25.02
26	SUBTOTAL	1998325				26
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					27
28	OTHER ADJUSTMENTS					28
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					29
30	SUBTOTAL	1998325				30
31	SEQUESTRATION ADJUSTMENT					31
32	INTERIM PAYMENTS	1899406				32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					32.01
33	BALANCE DUE PROVIDER/PROGRAM	98919				33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	37535				34

CALCULATION OF REIMBURSEMENT SETTLEMENT
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
 PART III

	[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX				
		HOSPITAL (14-1328) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1
1	INPATIENT HOSPITAL/SNF/NF SERVICES	260405					1
2	MEDICAL AND OTHER SERVICES						2
3	INTERNS AND RESIDENTS						3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O						4
5	COST OF TEACHING PHYSICIANS						5
6	SUBTOTAL	260405					6
7	INPATIENT PRIMARY PAYER PAYMENTS						7
8	OUTPATIENT PRIMARY PAYER PAYMENTS						8
9	SUBTOTAL	260405					9
	COMPUTATION OF LESSER OF COST OR CHARGES						
10	ROUTINE SERVICE CHARGES						10
11	ANCILLARY SERVICE CHARGES						11
12	INTERNS AND RESIDENTS SERVICE CHARGES						12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE						13
14	TEACHING PHYSICIANS						14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION						15
16	TOTAL REASONABLE CHARGES						16
	CUSTOMARY CHARGES						
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						18
19	RATIO OF LINE 17 TO LINE 18						19
20	TOTAL CUSTOMARY CHARGES						20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						22
23	COST OF COVERED SERVICES	260405					23
	PROSPECTIVE PAYMENT AMOUNT						
24	OTHER THAN OUTLIER PAYMENTS						24
25	OUTLIER PAYMENTS						25
26	PROGRAM CAPITAL PAYMENTS						26
27	CAPITAL EXCEPTION PAYMENTS						27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS						28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						29
30	SUBTOTAL	260405					30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED						31
32	LESSER OF LINES 30 OR 31	260405					32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)						33

CALCULATION OF REIMBURSEMENT SETTLEMENT
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
 PART III

	[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX		
	HOSPITAL (14-1328) (OTHER)	SUB I	SUB II	SUB III	
	1	1	1	1	
				NF I	
				1	
34	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
35	EXCESS OF REASONABLE COST				34
36	SUBTOTAL	260405			35
37	COINSURANCE				36
38	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,				37
38.01	REIMBURSABLE BAD DEBTS				38
38.02	REDUCED REIMBURSABLE BAD DEBTS				38.01
39	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE				38.02
40	BENEFICIARIES (SEE INSTRUCTIONS)				
41	UTILIZATION REVIEW				39
42	SUBTOTAL	260405			40
43	INPATIENT ROUTINE SERVICE COST				41
44	MEDICARE INPATIENT ROUTINE CHARGES				42
45	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE				43
46	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM				44
47	A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN				
48	ACCORDANCE WITH 42 CFR 413.13(E)				45
49	RATIO OF LINE 43 TO LINE 44				46
50	TOTAL CUSTOMARY CHARGES				47
51	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST				48
52	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				49
53	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM				
54	UTILIZATION				50
55	OTHER ADJUSTMENTS				51
56	AMOUNTS APPLICABLE TO PRIOR COST REPORTING				
57	DEPRECIABLE ASSETS				52
58	SUBTOTAL	260405			53
59	INDIRECT MEDICAL EDUCATION ADJUSTMENT				54
60	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				55
61	TOTAL AMOUNT PAYABLE TO THE PROVIDER	260405			56
62	SEQUESTRATION ADJUSTMENT				57
63	INTERIM PAYMENTS				57.01
64	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				58
65	BALANCE DUE PROVIDER/PROGRAM	260405			59
66	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT				
67	SECTION 115.2				

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	119492			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	2559804			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-809391			6
7 INVENTORY	172169			7
8 PREPAID EXPENSES	9548			8
9 OTHER CURRENT ASSETS				9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS	2051622			11
FIXED ASSETS				
12 LAND	17000			12
12.01 ACCUMULATED DEPRECIATION				12.01
13 LAND IMPROVEMENTS	148425			13
13.01 ACCUMULATED DEPRECIATION	-101770			13.01
14 BUILDINGS	1380448			14
14.01 ACCUMULATED DEPRECIATION	-979907			14.01
15 LEASEHOLD IMPROVEMENTS				15
15.01 ACCUMULATED AMORTIZATION				15.01
16 FIXED EQUIPMENT				16
16.01 ACCUMULATED DEPRECIATION				16.01
17 AUTOMOBILES AND TRUCKS				17
17.01 ACCUMULATED DEPRECIATION				17.01
18 MAJOR MOVABLE EQUIPMENT	3392846			18
18.01 ACCUMULATED DEPRECIATION	-2213333			18.01
19 MINOR EQUIPMENT DEPRECIABLE				19
19.01 ACCUMULATED DEPRECIATION				19.01
20 MINOR EQUIPMENT-NONDEPRECIABLE				20
21 TOTAL FIXED ASSETS	1643709			21
OTHER ASSETS				
22 INVESTMENTS				22
23 DEPOSITS ON LEASES				23
24 DUE FROM OWNERS/OFFICERS				24
25 OTHER ASSETS				25
26 TOTAL OTHER ASSETS				26
27 TOTAL ASSETS	3695331			27
LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	807530			28
29 SALARIES, WAGES & FEES PAYABLE	549509			29
30 PAYROLL TAXES PAYABLE				30
31 NOTES & LOANS PAYABLE (SHORT TERM)	368330			31
32 DEFERRED INCOME				32
33 ACCELERATED PAYMENTS				33
34 DUE TO OTHER FUNDS	21049			34
35 OTHER CURRENT LIABILITIES				35
36 TOTAL CURRENT LIABILITIES	1746418			36
LONG-TERM LIABILITIES				
37 MORTGAGE PAYABLE				37
38 NOTES PAYABLE	993137			38
39 UNSECURED LOANS				39
40 LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41 OTHER LONG TERM LIABILITIES				41
42 TOTAL LONG TERM LIABILITIES	993137			42
43 TOTAL LIABILITIES	2739555			43
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	955776			44
45 SPECIFIC PURPOSE FUND BALANCE				45
46 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49 PLANT FUND BALANCE - INVESTED IN PLANT				49
50 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51 TOTAL FUND BALANCES	955776			51
52 TOTAL LIABILITIES AND FUND BALANCES	3695331			52

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	355222			1
2 NET INCOME (LOSS)	600554			2
3 TOTAL	955776			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5 PRIOR YEAR ADJUSTMENTS				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	955776			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	955776			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	1542750		1542750	2
3 SUBPROVIDER I				3
4 SWING BED - SNF	353568		353568	4
5 SWING BED - NF				5
6 SKILLED NURSING FACILITY				6
7 NURSING FACILITY				7
8 OTHER LONG TERM CARE				8
9 TOTAL GENERAL INPATIENT CARE SERVICES	1896318		1896318	9
10 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				10
11 INTENSIVE CARE UNIT				11
12 CORONARY CARE UNIT				12
13 BURN INTENSIVE CARE UNIT				13
14 SURGICAL INTENSIVE CARE UNIT				14
15 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE	1896318		1896318	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES	2868483		9850168	17
18 ANCILLARY SERVICES	59934	6981685	9850168	18
19 OUTPATIENT SERVICES		2137120	2197054	19
20 RURAL HEALTH CLINIC		939975	939975	20
21 HOME HEALTH AGENCY				21
22 AMBULANCE				22
23 CORF				23
24 ASC				24
25 HOSPICE				25
TOTAL PATIENT REVENUES	4824735	10058780	14883515	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		10329244	26
27 ADD (SPECIFY)			27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS			33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		10329244	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	14883515	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	4312630	2
3	NET PATIENT REVENUES	10570885	3
4	LESS - TOTAL OPERATING EXPENSES	10329244	4
5	NET INCOME FROM SERVICE TO PATIENTS	241641	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	767	6
7	INCOME FROM INVESTMENTS	4346	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES	30921	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	30866	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	4937	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	11200	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	MISCELLANEOUS		24
24.01	GRANTS	275876	24.01
25	TOTAL OTHER INCOME	358913	25
26	TOTAL	600554	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	600554	31

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	4A	25	26	27
GENERAL SERVICE COST CENTERS					
3 NEW CAP REL COSTS-BLDG & FIXT					3
4 NEW CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6 ADMINISTRATIVE & GENERAL					6
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING					10
11 DIETARY					11
12 CAFETERIA					12
14 NURSING ADMINISTRATION					14
15 CENTRAL SERVICES & SUPPLY					15
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY					17
18 SOCIAL SERVICE					18
25 INPATIENT ROUTINE SERV COST CENTERS					25
ADULTS & PEDIATRICS					
ANCILLARY SERVICE COST CENTERS					
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
53 ELECTROCARDIOLOGY					53
55 MEDICAL SUPPLIES CHARGED TO PA					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINCT					62
63.50 RURAL HEALTH CLINIC					63.50
OTHER REIMBURSABLE COST CENTERS					
71 HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS					
95 SUBTOTALS					95
NONREIMBURSABLE COST CENTERS					
96 GIFT, FLOWER, COFFEE SHOP & CA					96
96.01 VENDING MACHINE					96.01
101 CROSS FOOT ADJUSTMENTS					101
102 NEGATIVE COST CENTER					102
103 TOTAL					103
104 TOTAL STATISTICAL BASIS					104
105 UNIT COST MULTIPLIER					105
105 UNIT COST MULTIPLIER					105

RHC I
 COMPONENT NO: 14-3479

WORKSHEET M-1

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

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	361759	33120	394879	-125778	269101		269101	1
2 PHYSICIAN ASSISTANT	69924	13733	83657		83657		83657	2
3 NURSE PRACTITIONER	86497	10208	96705		96705		96705	3
4 VISITING NURSE								4
5 OTHER NURSE	188202	46281	234483		234483		234483	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	153521	28633	182154		182154		182154	9
10 SUBTOTAL (SUM OF LINES 1-9)	859903	131975	991878	-125778	866100		866100	10
COSTS UNDER AGREEMENT								11
11 PHYSICIAN SERVICES UNDER AGREEMENT								12
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								13
13 OTHER COSTS UNDER AGREEMENT								14
14 SUBTOTAL (SUM OF LINES 11-13)								14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		2235	2235		2235		2235	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT		14339	14339		14339		14339	17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS		9336	9336		9336		9336	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		25910	25910		25910		25910	21
22 TOTAL COSTS OF HEALTH CARE SERVICES	859903	157885	1017788	-125778	892010		892010	22
COSTS OTHER THAN RHC/FQHC SERVICES								23
23 PHARMACY								24
24 DENTAL								25
25 OPTOMETRY								26
26 ALL OTHER NONREIMBURSABLE COSTS								27
27 NONALLOWABLE GME COSTS								28
28 TOTAL NONREIMBURSABLE COSTS								28
FACILITY OVERHEAD								
29 FACILITY COSTS				36640	36640		36640	29
30 ADMINISTRATIVE COSTS		32919	32919		32919		32919	30
31 TOTAL FACILITY OVERHEAD		32919	32919	36640	69559		69559	31
32 TOTAL FACILITY COSTS	859903	190804	1050707	-89138	961569		961569	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3479

WORKSHEET M-2

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1 PHYSICIANS	1.29	7074	4200	5418		1
2 PHYSICIAN ASSISTANTS	0.52	1781	2100	1092		2
3 NURSE PRACTITIONERS	0.69	2689	2100	1449		3
4 SUBTOTAL	2.50	11544		7959	11544	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	2.50	11544			11544	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					892010	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					892010	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD					69559	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					284598	15
16 TOTAL OVERHEAD					354157	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					354157	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					354157	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					1246167	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3479

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1246167	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	14042	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	1232125	3
4	TOTAL VISITS	11544	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	11544	6
7	ADJUSTED COST PER VISIT	106.73	7

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

8	PER VISIT PAYMENT LIMIT	111.58	93.13	8
9	RATE FOR PROGRAM COVERED VISITS	106.73	106.73	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	3121	1040	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	333104	110999	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES			14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST			15
16	TOTAL PROGRAM COST			444103 16
16.01	PRIMARY PAYOR PAYMENTS			16.01
17	LESS: BENEFICIARY DEDUCTIBLE			45062 17
18	NET PROGRAM COST EXCLUDING VACCINES			399041 18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			319233 19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			9421 20
21	TOTAL REIMBURSABLE PROGRAM COST			328654 21
22	REIMBURSABLE BAD DEBTS			15894 22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			15252 22.01
23	OTHER ADJUSTMENTS			23
24	NET REIMBURSABLE AMOUNT			344548 24
25	INTERIM PAYMENTS			279163 25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE COMPONENT/PROGRAM			65385 26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			6290 27

(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: 14-3479

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	H1N1 VACCINE (SERVICES ON/AFTER 10/1/2009) 2.01	COMBINATION INFLUENZA & H1N1 IN SAME VISIT 2.02	
1 HEALTH CARE STAFF COSTS	866100	866100	866100	866100	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000170	0.002700			2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	147	2338			3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	941	6625			4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	1088	8963			5
6 TOTAL DIRECT COST OF THE FACILITY	892010	892010	892010	892010	6
7 TOTAL OVERHEAD	354157	354157	354157	354157	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.001220	0.010048			8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	432	3559			9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	1520	12522			10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	31	500			11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	49.03	25.04			12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	19	339			13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	932	8489			14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		14042			15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		9421			16

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

RHC I
 COMPONENT NO: 14-3479

WORKSHEET M-5

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		292656	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			3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .01		3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .02	NONE	3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .03		3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROVIDER .04		3.05
	.05 10/15/2010	13493	3.50
	PROVIDER .51		3.51
	TO .52		3.52
	PROGRAM .53		3.53
	.54		3.54
SUBTOTAL	.99	-13493	3.99
4 TOTAL INTERIM PAYMENTS		279163	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01		5.01
	TO .02	NONE	5.02
	PROVIDER .03		5.03
	PROVIDER .50		5.50
	TO .51	NONE	5.51
	PROGRAM .52		5.52
SUBTOTAL	.99		5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01	65385	6.01
	PROVIDER TO .02		6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY		344548	7
NAME OF INTERMEDIARY: _____		INTERMEDIARY NUMBER: _____	
SIGNATURE OF AUTHORIZED PERSON: _____		DATE (MO/DAY/YR): _____	

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL	7
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6		
UTILIZATION PERCENTAGES BASED ON DAYS								
25 ADULTS & PEDIATRICS	65.92		11.76				77.68	25
UTILIZATION PERCENTAGES BASED ON CHARGES								
41 RADIOLOGY-DIAGNOSTIC	7.97	27.62					35.59	41
44 LABORATORY	13.61	41.96					55.57	44
49 RESPIRATORY THERAPY	29.08	6.95					36.03	49
50 PHYSICAL THERAPY	1.58	15.47					17.05	50
53 ELECTROCARDIOLOGY	12.32	66.10					78.42	53
55 MEDICAL SUPPLIES CHARGED TO PAT	45.29	15.17					60.46	55
56 DRUGS CHARGED TO PATIENTS	39.15	12.76					51.91	56
61 EMERGENCY	0.68	27.37					28.05	61
62 OBSERVATION BEDS (NON-DISTINCT)		32.12					32.12	62
101 TOTAL CHARGES	12.70	21.77					34.47	101

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
3	NEW CAP REL COSTS-BLDG & FIXT	75856	.87	-75856	-2.24		3
4	NEW CAP REL COSTS-MVBLE EQUIP	182016	2.08	-182016	-5.37		4
5	EMPLOYEE BENEFITS	66566	.76	-66566	-1.97		5
6	ADMINISTRATIVE & GENERAL	1594515	18.26	-1594515	-47.08		6
8	OPERATION OF PLANT	396586	4.54	-396586	-11.71		8
9	LAUNDRY & LINEN SERVICE	69414	.79	-69414	-2.05		9
10	HOUSEKEEPING	116288	1.33	-116288	-3.43		10
11	DIETARY	134136	1.54	-134136	-3.96		11
12	CAFETERIA	71678	.82	-71678	-2.12		12
14	NURSING ADMINISTRATION	85548	.98	-85548	-2.53		14
15	CENTRAL SERVICES & SUPPLY	8219	.09	-8219	-.24		15
16	PHARMACY	247947	2.84	-247947	-7.32		16
17	MEDICAL RECORDS & LIBRARY	275760	3.16	-275760	-8.14		17
18	SOCIAL SERVICE	62088	.71	-62088	-1.83		18
INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	1340418	15.35	1514887	44.73	2855305	32.69
ANCILLARY SERVICE COST CENTERS							
41	RADIOLOGY-DIAGNOSTIC	620836	7.11	356929	10.54	977765	11.20
44	LABORATORY	920595	10.54	295817	8.73	1216412	13.93
49	RESPIRATORY THERAPY	182269	2.09	80847	2.39	263116	3.01
50	PHYSICAL THERAPY	166374	1.90	105670	3.12	272044	3.11
51	OCCUPATIONAL THERAPY						51
52	SPERCH PATHOLOGY						52
53	ELECTROCARDIOLOGY	26801	.31	9506	.28	36307	.42
55	MEDICAL SUPPLIES CHARGED TO PAT	131053	1.50	59673	1.76	190726	2.18
56	DRUGS CHARGED TO PATIENTS	291463	3.34	397948	11.75	689411	7.89
61	EMERGENCY	692974	7.93	267844	7.91	960818	11.00
62	OBSERVATION BEDS (NON-DISTINCT						62
63.50	RURAL HEALTH CLINIC	961569	11.01	284598	8.40	1246167	14.27
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
71	HOME HEALTH AGENCY						71
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
96	GIFT, FLOWER, COFFEE SHOP & CAN			5899	.17	5899	.07
96.01	VENDING MACHINE	12892	.15	6999	.21	19891	.23
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL	8733861	100.00	0	.00	8733861	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 OPSS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	1307127
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	2654400
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.492

RURAL HEALTH CENTER DENTAL STATISTICS		14-3479	CLINIC NAME Hardin County Rural Health Clinic		REPORTING PERIOD			ATTACHMENT #:
COST CENTER (OMIT CENTES)		COMPENSATION 1	OTHER 2	COL.1&2 3	RECLASSI- FICATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3&4) 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES (COL.5&6) 7
							FROM: 1-Apr-10 TO: 31-Mar-11	
1	RHC DENTAL STAFF COST							
2	Dentists							
3	Dental Hygienist		N/A					
4								
5								
6	TOTAL - Dentists(Sum of lines 1 through 5)							
7	Other - Dental Staff							
8								
9								
10								
11	SUBTOTAL- Other Dental Staff(Sum of lines 7-10)							
12	TOTAL - Dental Staff (Sum of lines 6 and 11)							
13	Dental Services Under Agreement							
14								
15	TOTAL DENTAL COST(Sum of lines 12 through 14)							

DENTAL SERVICES PERSONNEL, EQUIVALENTS, HOURS ON SITE, AND ENCOUNTERS									
DENTAL SERVICES PERSONNEL									
	FULL TIME PERSONNEL EQUIVALENTS (FTEs) 1	HEALTH SERVICES HOURS 2	ENCOUNTERS	ON-SITE		OFF-SITE		TOTAL	
				3	4	5	6		
16	RHC DENTAL STAFF								
17	Dentists								
18	Dental Hygienist								
19									
20									
21	TOTAL - Dentists(Sum of lines 17 through 20)	0	0	0	0	0	0	0	0
22	Other - Dental Staff								
23									
24									
25									
26	SUBTOTAL-Other Dental Staff(Sum of lines 22 through 25)	0	0	0	0	0	0	0	0
27	TOTAL - Dental Staff(Sum of lines 21 and 26)	0	0	0	0	0	0	0	0
28	Dental Services Under Agreement								
29									
30	TOTAL DENTAL(Sum of lines 27 through 29)	0	0	0	0	0	0	0	0

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

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES		14-3479	CLINIC NAME Hardin County Rural Health Clinic		REPORTING PERIOD FROM: 1-Apr-10 TO: 31-Mar-11		ATTACHMENT #1
COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	TOTAL COL.1&2 3	RECLASSI- FICATIONS 4	RECLASSIFIED TRIAL BALANCE COL.3&4 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES COL.5&6 7
1 SUPPLEMENTAL COSTS							
2 Pharmacy							
3 Patient Transportation		N/A					
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 HMIHK 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.