

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: 06/22/2011
 APPLICABLE BOX MANUALLY SUBMITTED COST REPORT TIME: 16:32

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 CLAY COUNTY HOSPITAL (14-1351) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 03/01/2010 AND ENDING 02/28/2011, 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: 06/22/2011 16:32
 9GSdPKe0XCM5OJcZ1XqYFZPEwBrmy0
 4mc9.05ECFuAtBJfetjfpMHX9Ycq:d
 jF4S0rOQUv0De25r

(SIGNED)

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PI Encryption: 06/22/2011 16:32
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 curg90T8389Vlv2psIDp3Lmr9KvMjL
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PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	2	3	4	1
2	SUBPROVIDER I	31113	8066	210357	2
3	SWING BED - SNF	1321			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		68031		9
9.01	RURAL HEALTH CLINIC II				9.01
100	TOTAL	32434	76097	210357	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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 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 HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 911 STACY BURK DRIVE
 1.01 CITY: FLORA

STATE: IL

P.O.BOX:

ZIP CODE: 62839-0280 COUNTY: CLAY

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 4	XVIII 5	XIX 6		
2	HOSPITAL	CLAY COUNTY HOSPITAL	14-1351	12/21/2005	N	O	O	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	CLAY COUNTY SWING BED	14-Z351	12/21/2005	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	CLAY COUNTY MEDICAL CLINIC	14-3458	11/29/2005	N	O	N	14
14.01	HOSP-BASED RHC II	LOUISVILLE MEDICAL CLINIC	14-3487	12/18/2006	N	O	N	14.01
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16
17	COST REPORTING PERIOD (MM/DD/YYYY)		FROM: 03/01/2010	TO: 02/28/2011				17
18	TYPE OF CONTROL		1	2				18
			9					

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL			1				19
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			Y	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.			2				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.			2				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.	0.00		25.08
	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.			
			PROGRAM NAME(1) 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	01/25/1985	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
		NO	NO	NO	36.01
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? NO 42
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42.01
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 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 NHCNQ 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: 215681 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. YES 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 4 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:	STATE:	ZIP CODE	CBSA	FTE/ CAMPUS	
		1	2	3	4	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	LTCH NONCOVERED DAYS 4.01	TITLE XIX 5		
1 HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	22	8030	112128.0		2484		323	1	
2 HMO								2	
3 HOSPITAL ADULTS & PEDS - SWING BED SNF					306			3	
4 HOSPITAL ADULTS & PEDS - SWING BED NF								4	
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	22	8030	112128.0		2790		323	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	22	8030	112128.0		2790		323	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					6389			24	
24.01 RHC II								24.01	
25 TOTAL	22							25	
26 OBSERVATION BED DAYS							19	26	
27 AMBULANCE TRIPS					734			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.		OBS.		LESS I&R			EMPLOYEES ON PAYROLL	NONPAID WORKERS
	BEDS NOT ADMITTED	TOTAL ALL PATIENTS	BEDS ADMITTED	BEDS NOT ADMITTED	TOTAL	REPL NON- PHYS ANES	NET		
	5.02	6	6.01	6.02	7	8	9	10	11
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		3437							1
2 HMO XIX									2
3 HOSPITAL ADULTS & PEDS - SWING BED SNF		306							3
4 HOSPITAL ADULTS & PEDS - SWING BED NF									4
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		3743							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		3743						138.90	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		22945						26.60	24
24.01 RHC II									24.01
25 TOTAL								171.80	25
26 OBSERVATION BED DAYS		174							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 V	TITLE XVIII	TITLE XIX			
	12	13	14	15		
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		651	94	942		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		651	94	942		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
24.01 RHC II						24.01
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. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	
SALARIES		1	2	3	4	5	6	
1	TOTAL SALARIES	7532860			324493.00			1
2	NON-PHYSICIAN ANESTHETIST PART A	45						2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B	901552			38780.00			5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES	420402						8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR	1294437						9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS							11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	1455267				CMS 339		13
14	WAGE RELATED COSTS (OTHER)					CMS 339		14
15	EXCLUDED AREAS	110574				CMS 339		15
16	NON-PHYSICIAN ANESTHETIST PART A					CMS 339		16
17	NON-PHYSICIAN ANESTHETIST PART B					CMS 339		17
18	PHYSICIAN PART A					CMS 339		18
18.01	PART A TEACHING PHYSICIANS					CMS 339		18.01
19	PHYSICIAN PART B					CMS 339		19
19.01	WAGE RELATED COSTS (RHC/FQHC)	279914						19.01
20	INTERNS & RESIDENTS (IN APPR PGM)					CMS 339		20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	86809			4018.00			21
22	ADMINISTRATIVE & GENERAL	682391			42342.00			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT	305980						22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	145144			6948.00			24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING	191632			18173.00			26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	202694			15474.00			27
27.01	DIETARY UNDER CONTRACT	5733						27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	321200			2181.00			30
31	CENTRAL SERVICES AND SUPPLY	23655			2077.00			31
32	PHARMACY	169166			4255.00			32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	253200			16567.00			33
34	SOCIAL SERVICE							34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART III

PART III - HOSPITAL WAGE INDEX SUMMARY		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	
		1	2	3	4	5	
1	NET SALARIES	6942976		6942976	285713.00	24.30	1
2	EXCLUDED AREA SALARIES	420402		420402			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	6522574		6522574	285713.00	22.83	3
4	SUBTOTAL OTHER WAGES & REL COSTS	1294437		1294437			4
5	SUBTOTAL WAGE-RELATED COSTS	1455267		1455267		22.31½	5
6	TOTAL (SUM OF LINES 3 THRU 5)	9272278		9272278	285713.00	32.45	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	2387604		2387604	112035.00	21.31	13

RHC I
 COMPONENT NO: 14-3458

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 929 STACY BURK DRIVE 1
 1.01 CITY: FLORA STATE: IL ZIP CODE: 62839 COUNTY: CLAY 1.01
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

	1	2	3
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

PHYSICIAN NAME

HOURS

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

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

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		
12	CLINIC	0		1	2	3	4	5	6	7	8	9	10	11	12	13	14
				800	1700	800	1700	800	1700	800	1700	800	1700	800	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)? YES 2 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: CLAY COUNTY HOSPITAL CLIN PROVIDER NUMBER: 14-3458 15
 15.01 LOUISVILLE MEDICAL CLINIC 14-3487 15.01
 V XVIII XIX

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 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. IF YES, SEE INSTRUCTIONS. NO 17

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSI- FICATIONS	RECLASS. TRIAL BALANCE	ADJUST- MENTS	NET EXP FOR ALLOCATION	
		1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS									
1	0100 OLD CAP REL COSTS-BLDG & FIXT								1
2	0200 OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300 NEW CAP REL COSTS-BLDG & FIXT		946135	946135	-187098	759037	-116962	642075	3
3.01	0301 NEW CAP RHC REL COSTS-BLDG & FI		21996	21996	181020	203016		203016	3.01
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		690982	690982	6078	697060		697060	4
5	0500 EMPLOYEE BENEFITS	86809	2354911	2441720		2441720	-13033	2428687	5
6	0600 ADMINISTRATIVE & GENERAL	682391	1466723	2149114		2149114	-102972	2046142	6
7	0700 MAINTENANCE & REPAIRS								7
8	0800 OPERATION OF PLANT	145144	354864	500008		500008		500008	8
8.01	0801 RHC UTILITY EXPENSE		32356	32356		32356		32356	8.01
9	0900 LAUNDRY & LINEN SERVICE		76034	76034		76034		76034	9
10	1000 HOUSEKEEPING	191632	48399	240031		240031		240031	10
11	1100 DIETARY	202694	149139	351833		351833	-105681	246152	11
12	1200 CAFETERIA								12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION	321200	21246	342446		342446		342446	14
15	1500 CENTRAL SERVICES & SUPPLY	23655	11431	35086		35086		35086	15
16	1600 PHARMACY	169166	35003	204169		204169		204169	16
17	1700 MEDICAL RECORDS & LIBRARY	253200	47200	300400		300400	-6228	294172	17
18	1800 SOCIAL SERVICE								18
20	2000 NONPHYSICIAN ANESTHETISTS								20
21	2100 NURSING SCHOOL								21
22	2200 I&R SERVICES-SALARY & FRINGES A								22
23	2300 I&R SERVICES-OTHER PRGM COSTS A								23
24	2400 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS									
25	2500 ADULTS & PEDIATRICS	1025431	37234	1062665		1062665		1062665	25
ANCILLARY SERVICE COST CENTERS									
37	3700 OPERATING ROOM	339597	152278	491875	5192	497067		497067	37
40	4000 ANESTHESIOLOGY		243799	243799	-5192	238607	-238607		40
41	4100 RADIOLOGY-DIAGNOSTIC	332917	571400	904317		904317		904317	41
44	4400 LABORATORY	412082	693167	1105249		1105249		1105249	44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900 RESPIRATORY THERAPY	222923	30720	253643	-44584	209059	-3059	206000	49
50	5000 PHYSICAL THERAPY	340316	18928	359244		359244		359244	50
53	5300 ELECTROCARDIOLOGY	23390	6773	30163	33438	63601	-23390	40211	53
54	5400 ELECTROENCEPHALOGRAPHY		57568	57568	11146	68714	-57500	11214	54
55	5500 MEDICAL SUPPLIES CHARGED TO PAT		366820	366820		366820	-393	366427	55
55.30	5530 IMPL. DEV. CHARGED TO PATIENT								55.30
56	5600 DRUGS CHARGED TO PATIENTS		358733	358733		358733		358733	56
59	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVI		446180	446180		446180		446180	59
59.97	3997 CARDIAC REHABILITATION								59.97
59.98	3998 HYPERBARIC OXYGEN THERAPY								59.98
59.99	3999 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS									
61	6100 EMERGENCY	486104	1383610	1869714		1869714	-741579	1128135	61
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 RHC	1853807	183017	2036824		2036824	-14148	2022676	63.50
63.60	6320 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS									
65	6500 AMBULANCE SERVICES	394873	73828	468701		468701		468701	65
69.10	6910 CMHC								69.10
69.20	6920 OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940 OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS									
85.01	8510 PANCREAS ACQUISITION								85.01
85.02	8520 INTSTINAL ACQUISITION								85.02
85.03	8530 ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	7507331	10880474	18387805		18387805	-1423552	16964253	95
NONREIMBURSABLE COST CENTERS									
96	9600 GIFT, FLOWER, COFFEE SHOP & CAN								96
98	9800 PHYSICIANS' PRIVATE OFFICES	25529	20480	46009		46009		46009	98
101	TOTAL	7532860	10900954	18433814		18433814	-1423552	17010262	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----			
		COST CENTER	LINE #	SALARY	OTHER
1	1	2	3	4	5
1 DEPRICIATION	A	NEW CAP RHC REL COSTS-BLDG &	3.01		174768
2 RESPIRATORY THERAPY	B	ELECTROCARDIOLOGY	53	33438	
3	B	ELECTROENCEPHALOGRAPHY	54	11146	
4 INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	3.01		6252
5	C	NEW CAP REL COSTS-MVBLE EQUIP	4		6078
6 OPERATING ROOM	D	OPERATING ROOM	37		5192
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36 TOTAL RECLASSIFICATIONS				44584	192290

RECLASSIFICATIONS

WORKSHEET A-6
 PAGE 1

1	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- DECREASE -----			WKST A-7 REF.		
			COST CENTER 6	LINE # 7	SALARY 8		OTHER 9	
1	DEPRICIATION	A	NEW CAP REL COSTS-BLDG & FIXT	3		174768	9	1
2	RESPIRATORY THERAPY	B	RESPIRATORY THERAPY	49	44584			2
3		B						3
4	INSURANCE EXPENSE	C	NEW CAP REL COSTS-BLDG & FIXT	3			12330	12
5		C						12
6	OPERATING ROOM	D	ANESTHESIOLOGY	40			5192	6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36	TOTAL RECLASSIFICATIONS				44584		192290	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	132111					132111		1
2 LAND IMPROVEMENTS	345852					345852		2
3 BUILDINGS AND FIXTURES	11940811	134564		134564		12075375		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	5715925	991440		991440	66990	6640375		5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL	18134699	1126004		1126004	66990	19193713		7
8 RECONCILING ITEMS								8
9 TOTAL	18134699	1126004		1126004	66990	19193713		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL				TOTAL
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	
	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	11355976		11355976	.595751				3
3.01 NEW CAP RHC REL COSTS-BLDG & FI	1065251		1065251	.055885				3.01
4 NEW CAP REL COSTS-MVBLE EQUIP	6640375		6640375	.348364				4
5 TOTAL	19061602		19061602	1.000000				5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPREC-IATION	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	421965		190695	29415			642075 3
3.01 NEW CAP RHC REL COSTS-BLDG & FIX	174768	18144		6252	3852		203016 3.01
4 NEW CAP REL COSTS-MVBLE EQUIP	493148	197834		6078			697060 4
5 TOTAL	1089881	215978	190695	41745	3852		1542151 5

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPREC-IATION	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	596733		307657	41745			946135 3
3.01 NEW CAP RHC REL COSTS-BLDG & FIX		18144			3852		21996 3.01
4 NEW CAP REL COSTS-MVBLE EQUIP	493148	197834					690982 4
5 TOTAL	1089881	215978	307657	41745	3852		1659113 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
				COST CENTER 3	LINE NO. 4	
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	B	-116962	NEW CAP REL COSTS-BLDG & FIXT	3	11 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					7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS	B	-1200	ADMINISTRATIVE & GENERAL	6	8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-3264	ADMINISTRATIVE & GENERAL	6	9
10	TELEVISION AND RADIO SERVICE					10
11	PARKING LOT					11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-825528			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	-105681	DIETARY	11	16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-393	MEDICAL SUPPLIES CHARGED TO PAT	55	18
19	SALE OF DRUGS TO OTHER THAN PATIENTS					19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-6228	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				35
36	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4				36
37	EKG PHYSICIAN EMPLOYEE BENEFITS	A	-8199	EMPLOYEE BENEFITS	5	37
38	MISCELLANEOUS REVENUE	B	-28232	ADMINISTRATIVE & GENERAL	6	38
39	PUBLIC RELATIONS	A	-62554	ADMINISTRATIVE & GENERAL	6	39
40	LOBBYING EXPENSE	A	-7722	ADMINISTRATIVE & GENERAL	6	40
41	CRNA EXPENSE	A	-238607	ANESTHESIOLOGY	40	41
42	EMPLOYEE BENEFITS LAB TESTS	A	-4834	EMPLOYEE BENEFITS	5	42
43						43
44	PHYSICIAN CLINIC EXPENSE	A	-14148	RHC	63.50	44
45						45
46						46
47						47
48						48
49						49
50	TOTAL		-1423552			50

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

WORKSHEET A-8-1

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

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

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
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-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	LINE NO.	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
1	2		3	4	5	6	7	8	9
1	44	LABORATORY	26210		26210				
2	63.50	RHC							
3	53	ELECTROCARDIOLOGY	23390	23390					
4	61	EMERGENCY	1310210	741579	568631				
5	54	ELECTROENCEPHALOGRAPHY	57500	57500					
6	49	RESPIRATORY THERAPY	3059	3059					
101		TOTAL	1420369	825528	594841				

PROVIDER NO. 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2010 TO 02/28/2011

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

VERSION: 2011.03
 06/22/2011 11:06

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.		12	13	14	15	16	17	18
10	11							
1	44 LABORATORY							
2	63.50 RHC							
3	53 ELECTROCARDIOLOGY							23390
4	61 EMERGENCY							741579
5	54 ELECTROENCEPHALOGRAPHY							57500
6	49 RESPIRATORY THERAPY							3059
101	TOTAL							825528

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW RHC BUILDING FIXTURES 3.01	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT	642075	642075							3
3.01 NEW CAP RHC REL COSTS-BLDG & FI	203016		203016						3.01
4 NEW CAP REL COSTS-MVBLE EQUIP	697060			697060					4
5 EMPLOYEE BENEFITS	2428687			525	2429212				5
6 ADMINISTRATIVE & GENERAL	2046142	280198		28389	223845	2578574	2578574		6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	500008	4850		10411	47612	562881	100572	663453	8
8.01 RHC UTILITY EXPENSE	32356					32356	5781		8.01
9 LAUNDRY & LINEN SERVICE	76034					76034	13585		9
10 HOUSEKEEPING	240031	3532		519	62861	306943	54843	6563	10
11 DIETARY	246152	14937		1807	66490	329386	58853	27757	11
12 CAFETERIA									12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	342446	3036		833	105363	451678	80703	5641	14
15 CENTRAL SERVICES & SUPPLY	35086	5273		2297	7760	50416	9008	9799	15
16 PHARMACY	204169	5080		1777	55492	266518	47620	9440	16
17 MEDICAL RECORDS & LIBRARY	294172	39804		14084	83057	431117	77029	73967	17
18 SOCIAL SERVICE									18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	1062665	73875		31979	336372	1504891	268885	137279	25
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	497067	49189		66082	111398	723736	129313	91408	37
40 ANESTHESIOLOGY									40
41 RADIOLOGY-DIAGNOSTIC	904317	36333		351832	109207	1401689	250445	67516	41
44 LABORATORY	1105249	14490		59646	135175	1314560	234878	26926	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	206000	4064		9976	57497	277537	49589	7552	49
50 PHYSICAL THERAPY	359244		49933	18005	111634	538816	96272		50
53 ELECTROCARDIOLOGY	40211	4064		5176	10969	60420	10795	7552	53
54 ELECTROENCEPHALOGRAPHY	11214	4052		2672	3656	21594	3858	7529	54
55 MEDICAL SUPPLIES CHARGED TO PAT	366427					366427	65471		55
55.30 IMPL. DEV. CHARGED TO PATIENT									55.30
56 DRUGS CHARGED TO PATIENTS	358733					358733	64096		56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	446180	31229				477409	85301	58032	59
59.97 CARDIAC REHABILITATION									59.97
59.98 HYPERBARIC OXYGEN THERAPY									59.98
59.99 LITHOTRIPSY									59.99
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY	1128135	33805		15756	159457	1337153	238914	62819	61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC	2022676		141504	45480	603463	2813123	502640		63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
65 AMBULANCE SERVICES	468701	15046		29476	129530	642753	114843	27959	65
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	16964253	622857	191437	696722	2420838	16924744	2563294	627739	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN		3253				3253	581	6046	96
98 PHYSICIANS' PRIVATE OFFICES	46009	15965	11579	338	8374	82265	14699	29668	98
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	17010262	642075	203016	697060	2429212	17010262	2578574	663453	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	RHC UTILITY EXPENSE 8.01	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINIS- TRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT									3
3.01 NEW CAP RHC REL COSTS-BLDG & FI									3.01
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS									5
6 ADMINISTRATIVE & GENERAL									6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT									8
8.01 RHC UTILITY EXPENSE	38137								8.01
9 LAUNDRY & LINEN SERVICE		89619							9
10 HOUSEKEEPING			368349						10
11 DIETARY		1135	33689	450820					11
12 CAFETERIA				330072	330072				12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION			4707		13098	555827			14
15 CENTRAL SERVICES & SUPPLY		1534	6317		2620	6980	86674		15
16 PHARMACY			3963		5239	14767	218	347765	16
17 MEDICAL RECORDS & LIBRARY			9165		20957				17
18 SOCIAL SERVICE									18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS		43112	93141	120748	73348	197730	1612		25
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM		10648	42359		15718	41726	30543		37
40 ANESTHESIOLOGY									40
41 RADIOLOGY-DIAGNOSTIC		9480	22790		18337	51043	4048		41
44 LABORATORY			15730		28816	73221	35625		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY			12881		13098	37871	892		49
50 PHYSICAL THERAPY	9380	4240	20684		15718		777		50
53 ELECTROCARDIOLOGY		1585	1486				8		53
54 ELECTROENCEPHALOGRAPHY			991						54
55 MEDICAL SUPPLIES CHARGED TO PAT							8764		55
55.30 IMPL. DEV. CHARGED TO PATIENT									55.30
56 DRUGS CHARGED TO PATIENTS								347765	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI			20312						59
59.97 CARDIAC REHABILITATION									59.97
59.98 HYPERBARIC OXYGEN THERAPY									59.98
59.99 LITHOTRIPSY									59.99
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY		14067	45455		23577	62273	2336		61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC	26582	1388	20312		70730		1583		63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
65 AMBULANCE SERVICES		2430	991		26196	70216	267		65
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	35962	89619	354973	450820	327452	555827	86673	347765	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN									96
98 PHYSICIANS' PRIVATE OFFICES	2175		13376		2620		1		98
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	38137	89619	368349	450820	330072	555827	86674	347765	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	17	25	26	27
GENERAL SERVICE COST CENTERS				
1 OLD CAP REL COSTS-BLDG & FIXT				1
2 OLD CAP REL COSTS-MVBLE EQUIP				2
3 NEW CAP REL COSTS-BLDG & FIXT				3
3.01 NEW CAP RHC REL COSTS-BLDG & FI				3.01
4 NEW CAP REL COSTS-MVBLE EQUIP				4
5 EMPLOYEE BENEFITS				5
6 ADMINISTRATIVE & GENERAL				6
7 MAINTENANCE & REPAIRS				7
8 OPERATION OF PLANT				8
8.01 RHC UTILITY EXPENSE				8.01
9 LAUNDRY & LINEN SERVICE				9
10 HOUSEKEEPING				10
11 DIETARY				11
12 CAPETERIA				12
13 MAINTENANCE OF PERSONNEL				13
14 NURSING ADMINISTRATION				14
15 CENTRAL SERVICES & SUPPLY				15
16 PHARMACY				16
17 MEDICAL RECORDS & LIBRARY	612235			17
18 SOCIAL SERVICE				18
20 NONPHYSICIAN ANESTHETISTS				20
21 NURSING SCHOOL				21
22 I&R SERVICES-SALARY & FRINGES A				22
23 I&R SERVICES-OTHER PRGM COSTS A				23
24 PARAMED ED PRGM-(SPECIFY)				24
INPATIENT ROUTINE SERV COST CENTERS				
25 ADULTS & PEDIATRICS	110220	2550966		2550966
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	32019	1117470		1117470
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	336817	2162165		2162165
44 LABORATORY		1729756		1729756
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY		399420		399420
50 PHYSICAL THERAPY		685887		685887
53 ELECTROCARDIOLOGY		81846		81846
54 ELECTROENCEPHALOGRAPHY		33972		33972
55 MEDICAL SUPPLIES CHARGED TO PAT		440662		440662
55.30 IMPL. DEV. CHARGED TO PATIENT				55.30
56 DRUGS CHARGED TO PATIENTS		770594		770594
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI		641054		641054
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	133179	1919773		1919773
62 OBSERVATION BEDS (NON-DISTINCT				62
63.50 RHC		3436358		3436358
63.60 FQHC				63.60
OTHER REIMBURSABLE COST CENTERS				
65 AMBULANCE SERVICES		885655		885655
69.10 CMHC				69.10
69.20 OUTPATIENT PHYSICAL THERAPY				69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY				69.30
69.40 OUTPATIENT SPEECH PATHOLOGY				69.40
71 HOME HEALTH AGENCY				71
SPECIAL PURPOSE COST CENTERS				
85.01 PANCREAS ACQUISITION				85.01
85.02 INTESTINAL ACQUISITION				85.02
85.03 ISLET CELL ACQUISITION				85.03
95 SUBTOTALS	612235	16855578		16855578
NONREIMBURSABLE COST CENTERS				
96 GIFT, FLOWER, COFFEE SHOP & CAN		9880		9880
98 PHYSICIANS' PRIVATE OFFICES		144804		144804
101 CROSS FOOT ADJUSTMENTS				101
102 NEGATIVE COST CENTER				102
103 TOTAL	612235	17010262		17010262

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW RHC BUILDING FIXTURES 3.01	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	EMPLOYEE BENEFITS 5	ADMINIS- TRATIVE & GENERAL 6	OPERATION OF PLANT 8
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
3.01 NEW CAP RHC REL COSTS-BLDG & FI								3.01
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS				525	525	525		5
6 ADMINISTRATIVE & GENERAL		280198		28389	308587	48	308635	6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT		4850		10411	15261	10	12038	8
8.01 RHC UTILITY EXPENSE							692	8.01
9 LAUNDRY & LINEN SERVICE							1626	9
10 HOUSEKEEPING		3532		519	4051	14	6564	10
11 DIETARY		14937		1807	16744	14	7044	11
12 CAPETERIA								12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION		3036		833	3869	23	9660	14
15 CENTRAL SERVICES & SUPPLY		5273		2297	7570	2	1078	15
16 PHARMACY		5080		1777	6857	12	5700	16
17 MEDICAL RECORDS & LIBRARY		39804		14084	53888	18	9220	17
18 SOCIAL SERVICE								18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS		73875		31979	105854	73	32184	25
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		49189		66082	115271	24	15478	37
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC		36333		351832	388165	24	29977	41
44 LABORATORY		14490		59646	74136	29	28113	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY		4064		9976	14040	12	5935	49
50 PHYSICAL THERAPY			49933	18005	67938	24	11523	50
53 ELECTROCARDIOLOGY		4064		5176	9240	2	1292	53
54 ELECTROENCEPHALOGRAPHY		4052		2672	6724	1	462	54
55 MEDICAL SUPPLIES CHARGED TO PAT							7836	55
55.30 IMPL. DEV. CHARGED TO PATIENT								55.30
56 DRUGS CHARGED TO PATIENTS							7672	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI		31229			31229		10210	59
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY		33805		15756	49561	35	28596	61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC			141504	45480	186984	130	60160	63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES		15046		29476	44522	28	13746	65
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS		622857	191437	696722	1511016	523	306806	25839
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN		3253			3253		70	96
98 PHYSICIANS' PRIVATE OFFICES		15965	11579	338	27882	2	1759	98
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL		642075	203016	697060	1542151	525	308635	27309

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	RHC UTILITY EXPENSE 8.01	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINIS- TRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
3.01 NEW CAP RHC REL COSTS-BLDG & FI								3.01
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
8.01 RHC UTILITY EXPENSE	692							8.01
9 LAUNDRY & LINEN SERVICE		1626						9
10 HOUSEKEEPING			10899					10
11 DIETARY		21	997	25963				11
12 CAFETERIA				19009	19009			12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION			139		754	14677		14
15 CENTRAL SERVICES & SUPPLY		28	187		151	184	9603	15
16 PHARMACY			117		302	390	24	13791
17 MEDICAL RECORDS & LIBRARY			271		1207			17
18 SOCIAL SERVICE								18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS		782	2758	6954	4224	5222	179	25
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		193	1253		905	1102	3384	37
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC		172	674		1056	1348	449	41
44 LABORATORY			465		1660	1933	3946	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY			381		754	1000	99	49
50 PHYSICAL THERAPY	170	77	612		905		86	50
53 ELECTROCARDIOLOGY		29	44				1	53
54 ELECTROENCEPHALOGRAPHY			29					54
55 MEDICAL SUPPLIES CHARGED TO PAT							971	55
55.30 IMPL. DEV. CHARGED TO PATIENT								55.30
56 DRUGS CHARGED TO PATIENTS								13791
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI			601					59
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY		255	1345		1358	1644	259	61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC	483	25	601		4073		175	63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES		44	29		1509	1854	30	65
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	653	1626	10503	25963	18858	14677	9603	13791
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN								96
98 PHYSICIANS' PRIVATE OFFICES	39		396		151			98
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	692	1626	10899	25963	19009	14677	9603	13791

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	17	25	26	27
GENERAL SERVICE COST CENTERS				
1 OLD CAP REL COSTS-BLDG & FIXT				1
2 OLD CAP REL COSTS-MVBLE EQUIP				2
3 NEW CAP REL COSTS-BLDG & FIXT				3
3.01 NEW CAP RHC REL COSTS-BLDG & FI				3.01
4 NEW CAP REL COSTS-MVBLE EQUIP				4
5 EMPLOYEE BENEFITS				5
6 ADMINISTRATIVE & GENERAL				6
7 MAINTENANCE & REPAIRS				7
8 OPERATION OF PLANT				8
8.01 RHC UTILITY EXPENSE				8.01
9 LAUNDRY & LINEN SERVICE				9
10 HOUSEKEEPING				10
11 DIETARY				11
12 CAFETERIA				12
13 MAINTENANCE OF PERSONNEL				13
14 NURSING ADMINISTRATION				14
15 CENTRAL SERVICES & SUPPLY				15
16 PHARMACY				16
17 MEDICAL RECORDS & LIBRARY	67649			17
18 SOCIAL SERVICE				18
20 NONPHYSICIAN ANESTHETISTS				20
21 NURSING SCHOOL				21
22 I&R SERVICES-SALARY & FRINGES A				22
23 I&R SERVICES-OTHER PRGM COSTS A				23
24 PARAMED ED PRGM-(SPECIFY)				24
INPATIENT ROUTINE SERV COST CENTERS				
25 ADULTS & PEDIATRICS	12179	176058		176058
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	3538	144911		144911
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	37216	461860		461860
44 LABORATORY		111390		111390
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY		22532		22532
50 PHYSICAL THERAPY		81335		81335
53 ELECTROCARDIOLOGY		10919		10919
54 ELECTROENCEPHALOGRAPHY		7526		7526
55 MEDICAL SUPPLIES CHARGED TO PAT		8807		8807
55.30 IMPL. DEV. CHARGED TO PATIENT				55.30
56 DRUGS CHARGED TO PATIENTS		21463		21463
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI		44429		44429
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	14716	100355		100355
62 OBSERVATION BEDS (NON-DISTINCT				62
63.50 RHC		252631		252631
63.60 FQHC				63.60
OTHER REIMBURSABLE COST CENTERS				
65 AMBULANCE SERVICES		62913		62913
69.10 CMHC				69.10
69.20 OUTPATIENT PHYSICAL THERAPY				69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY				69.30
69.40 OUTPATIENT SPEECH PATHOLOGY				69.40
71 HOME HEALTH AGENCY				71
SPECIAL PURPOSE COST CENTERS				
85.01 PANCREAS ACQUISITION				85.01
85.02 INTESTINAL ACQUISITION				85.02
85.03 ISLET CELL ACQUISITION				85.03
95 SUBTOTALS	67649	1507129		1507129
NONREIMBURSABLE COST CENTERS				
96 GIFT, FLOWER, COFFEE SHOP & CAN		3572		3572
98 PHYSICIANS' PRIVATE OFFICES		31450		31450
101 CROSS FOOT ADJUSTMENTS				101
102 NEGATIVE COST CENTER				102
103 TOTAL	67649	1542151		1542151

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET	NEW RHC BUILDING FIXTURES SQUARE FEET	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	3	3.01	4	5	6A	6	
GENERAL SERVICE COST CENTERS							
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	53087						3
3.01 NEW CAP RHC REL COSTS-BLDG &		15885					3.01
4 NEW CAP REL COSTS-MVBLE EQUIP			681195				4
5 EMPLOYEE BENEFITS			513	7405454			5
6 ADMINISTRATIVE & GENERAL	23167		27743	682391	-2578574	14431688	6
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT	401		10174	145144		562881	8
8.01 RHC UTILITY EXPENSE						32356	8.01
9 LAUNDRY & LINEN SERVICE						76034	9
10 HOUSEKEEPING	292		507	191632		306943	10
11 DIETARY	1235		1766	202694		329386	11
12 CAFETERIA							12
13 MAINTENANCE OF PERSONNEL				321200		451678	13
14 NURSING ADMINISTRATION	251		814	23655		50416	14
15 CENTRAL SERVICES & SUPPLY	436		2245	169166		266518	15
16 PHARMACY	420		1737	253200		431117	16
17 MEDICAL RECORDS & LIBRARY	3291		13763				17
18 SOCIAL SERVICE							18
20 NONPHYSICIAN ANESTHETISTS							20
21 NURSING SCHOOL							21
22 I&R SERVICES-SALARY & FRINGES							22
23 I&R SERVICES-OTHER PRGM COSTS							23
24 PARAMED ED PRGM-(SPECIFY)							24
25 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	6108		31251	1025431		1504891	25
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	4067		64578	339597		723736	37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC	3004		343826	332917		1401689	41
44 LABORATORY	1198		58288	412082		1314560	44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY	336		9749	175280		277537	49
50 PHYSICAL THERAPY		3907	17595	340316		538816	50
53 ELECTROCARDIOLOGY	336		5058	33438		60420	53
54 ELECTROENCEPHALOGRAPHY	335		2611	11146		21594	54
55 MEDICAL SUPPLIES CHARGED TO P						366427	55
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS						358733	56
59 PSYCHIATRIC/PSYCHOLOGICAL SER	2582					477409	59
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	2795		15397	486104		1337153	61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC		11072	44445	1839659		2813123	63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES	1244		28805	394873		642753	65
69.10 CMHC							69.10
69.20 OUTPATIENT PHYSICAL THERAPY							69.20
69.30 OUTPATIENT OCCUPATIONAL THERA							69.30
69.40 OUTPATIENT SPEECH PATHOLOGY							69.40
71 HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS							
85.01 PANCREAS ACQUISITION							85.01
85.02 INTESTINAL ACQUISITION							85.02
85.03 ISLET CELL ACQUISITION							85.03
95 SUBTOTALS	51498	14979	680865	7379925	-2578574	14346170	95
NONREIMBURSABLE COST CENTERS							
96 GIFT, FLOWER, COFFEE SHOP & C	269					3253	96
98 PHYSICIANS' PRIVATE OFFICES	1320	906	330	25529		82265	98

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW RHC BUILDING FIXTURES SQUARE FEET 3.01	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON- CILIATION 6A	ADMINIS- TRATIVE & GENERAL ACCUM COST 6	
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	COST TO BE ALLOC PER B PT I	642075	203016	697060	2429212		2578574	103
104	UNIT COST MULT-WS B PT I		12.780359		.328030		.178674	
104	UNIT COST MULT-WS B PT I	12.094769		1.023290				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				525		308635	106
108	UNIT COST MULT-WS B PT III				.000071		.021386	107
108	UNIT COST MULT-WS B PT III							108
108	UNIT COST MULT-WS B PT III							108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	RHC	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	NURSING
	OF PLANT	UTILITY	& LINEN	KEEPING			ADMINIS-
	SQUARE	EXPENSE	SERVICE	HOURS OF	MEALS	FTE	TRATION
	FEET	SQUARE	POUNDS OF	SERVICE	SERVED		DIRECT
	8	FEET	LAUNDRY	10	11	12	NRSING
		8.01	9				HRS
							14
GENERAL SERVICE COST CENTERS							
1							1
2							2
3							3
3.01							3.01
4							4
5							5
6							6
7							7
8	29519						8
8.01		15885					8.01
9			19106				9
10	292			2974			10
11	1235		242	272	57060		11
12					41777	126	12
13							13
14	251			38		5	166259
15	436		327	51		1	2088
16	420			32		2	4417
17	3291			74		8	
18							18
20							20
21							21
22							22
23							23
24							24
25	6108		9191	752	15283	28	59145
INPATIENT ROUTINE SERV COST CENTERS							
25							25
ADULTS & PEDIATRICS							
ANCILLARY SERVICE COST CENTERS							
37	4067		2270	342		6	12481
40							37
41	3004		2021	184		7	15268
44	1198			127		11	21902
46.30							44
49	336			104		5	11328
50		3907	904	167		6	
53	336		338	12			50
54	335			8			53
55							54
55.30							55
56							55.30
59	2582			164			56
59.97							59
59.98							59.97
59.99							59.98
OUTPATIENT SERVICE COST CENTERS							
61	2795		2999	367		9	18627
62							61
63.50		11072	296	164		27	62
63.60							63.50
OTHER REIMBURSABLE COST CENTERS							
65	1244		518	8		10	21003
69.10							65
69.20							69.10
69.30							69.20
69.40							69.30
71							69.40
SPECIAL PURPOSE COST CENTERS							
85.01							71
85.02							85.01
85.03							85.02
95	27930	14979	19106	2866	57060	125	166259
SUBTOTALS							
NONREIMBURSABLE COST CENTERS							
96	269						95
98	1320	906		108		1	96
GIFT, FLOWER, COFFEE SHOP & C							
PHYSICIANS' PRIVATE OFFICES							

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	RHC	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	NURSING	
	OF PLANT	UTILITY	& LINEN	KEEPING			ADMINIS-	
	SQUARE	EXPENSE	SERVICE	HOURS OF	MEALS	FTE	TRATION	
	FEET	SQUARE	POUNDS OF	SERVICE	SERVED		DIRECT	
	8	FEET	LAUNDRY				NRSING	
		8.01	9	10	11	12	HRS	
							14	
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	663453	38137	89619	368349	450820	330072	555827	103
104 UNIT COST MULT-WS B PT I	22.475456		4.690621		7.900806		3.343139	
104 UNIT COST MULT-WS B PT I		2.400818		123.856422		2619.619048		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	27309	692	1626	10899	25963	19009	14677	106
108 UNIT COST MULT-WS B PT III	.925133		.085104		.455012		.088278	107
108 UNIT COST MULT-WS B PT III		.043563		3.664761		150.865079		108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CENTRAL	PHARMACY	MEDICAL	
	SERVICES & SUPPLY COSTED REQUIS. 15	COSTED REQUIS. 16	RECORDS & LIBRARY TIME SPENT 17	
GENERAL SERVICE COST CENTERS				
1 OLD CAP REL COSTS-BLDG & FIXT				1
2 OLD CAP REL COSTS-MVBLE EQUIP				2
3 NEW CAP REL COSTS-BLDG & FIXT				3
3.01 NEW CAP RHC REL COSTS-BLDG &				3.01
4 NEW CAP REL COSTS-MVBLE EQUIP				4
5 EMPLOYEE BENEFITS				5
6 ADMINISTRATIVE & GENERAL				6
7 MAINTENANCE & REPAIRS				7
8 OPERATION OF PLANT				8
8.01 RHC UTILITY EXPENSE				8.01
9 LAUNDRY & LINEN SERVICE				9
10 HOUSEKEEPING				10
11 DIETARY				11
12 CAFETERIA				12
13 MAINTENANCE OF PERSONNEL				13
14 NURSING ADMINISTRATION				14
15 CENTRAL SERVICES & SUPPLY	790129			15
16 PHARMACY	1983	306799		16
17 MEDICAL RECORDS & LIBRARY			6960	17
18 SOCIAL SERVICE				18
20 NONPHYSICIAN ANESTHETISTS				20
21 NURSING SCHOOL				21
22 I&R SERVICES-SALARY & FRINGES				22
23 I&R SERVICES-OTHER PRGM COSTS				23
24 PARAMED ED PRGM-(SPECIFY)				24
25 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	14697		1253	25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	278433		364	37
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	36904		3829	41
44 LABORATORY	324767			44
46.30 BLOOD CLOTTING FACTORS ADMIN				46.30
49 RESPIRATORY THERAPY	8129			49
50 PHYSICAL THERAPY	7084			50
53 ELECTROCARDIOLOGY	71			53
54 ELECTROENCEPHALOGRAPHY				54
55 MEDICAL SUPPLIES CHARGED TO P	79896			55
55.30 IMPL. DEV. CHARGED TO PATIENT				55.30
56 DRUGS CHARGED TO PATIENTS		306799		56
59 PSYCHIATRIC/PSYCHOLOGICAL SER				59
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	21292		1514	61
62 OBSERVATION BEDS (NON-DISTINC				62
63.50 RHC	14430			63.50
63.60 PQHC				63.60
OTHER REIMBURSABLE COST CENTERS				
65 AMBULANCE SERVICES	2437			65
69.10 CMHC				69.10
69.20 OUTPATIENT PHYSICAL THERAPY				69.20
69.30 OUTPATIENT OCCUPATIONAL THERA				69.30
69.40 OUTPATIENT SPEECH PATHOLOGY				69.40
71 HOME HEALTH AGENCY				71
SPECIAL PURPOSE COST CENTERS				
85.01 PANCREAS ACQUISITION				85.01
85.02 INTESTINAL ACQUISITION				85.02
85.03 ISLET CELL ACQUISITION				85.03
95 SUBTOTALS	790123	306799	6960	95
NONREIMBURSABLE COST CENTERS				
96 GIFT, FLOWER, COFFEE SHOP & C				96
98 PHYSICIANS' PRIVATE OFFICES	6			98

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 15	PHARMACY COSTED REQUIS. 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	
101 CROSS FOOT ADJUSTMENTS				101
102 NEGATIVE COST CENTER				102
103 COST TO BE ALLOC PER B PT I	86674	347765	612235	103
104 UNIT COST MULT-WS B PT I	.109696		87.964799	
104 UNIT COST MULT-WS B PT I		1.133527		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	9603	13791	67649	106
108 UNIT COST MULT-WS B PT III	.012154		9.719684	107
108 UNIT COST MULT-WS B PT III		.044951		108
				108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE	TOTAL COSTS
	(FROM WKST B, PART I, COL 27)	LIMIT ADJUSTMENT		DISALLOWANCE	
	1	2	3	4	5
INPATIENT ROUTINE SERV COST CENTERS					
25 ADULTS & PEDIATRICS	2550966				25
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM	1117470				37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC	2162165				41
44 LABORATORY	1729756				44
46.30 BLOOD CLOTTING FACTORS ADMI					46.30
49 RESPIRATORY THERAPY	399420				49
50 PHYSICAL THERAPY	685887				50
53 ELECTROCARDIOLOGY	81846				53
54 ELECTROENCEPHALOGRAPHY	33972				54
55 MEDICAL SUPPLIES CHARGED TO	440662				55
55.30 IMPL. DEV. CHARGED TO PATIE					55.30
56 DRUGS CHARGED TO PATIENTS	770594				56
59 PSYCHIATRIC/PSYCHOLOGICAL S	641054				59
59.97 CARDIAC REHABILITATION					59.97
59.98 HYPERBARIC OXYGEN THERAPY					59.98
59.99 LITHOTRIPSY					59.99
OUTPATIENT SERVICE COST CENTERS					
61 EMERGENCY	1919773				61
62 OBSERVATION BEDS (NON-DISTI	113318		113318		62
63.50 RHC	3436358				63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES	885655				65
101 SUBTOTAL	16968896		113318		101
102 LESS OBSERVATION BEDS	113318		113318		102
103 TOTAL	16855578				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						
ADULTS & PEDIATRICS	2147517		2147517			25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	446091	1795218	2241309	.498579		37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	821231	7085001	7906232	.273476		41
44 LABORATORY	1236239	5993963	7230202	.239240		44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	322986	152860	475846	.839389		49
50 PHYSICAL THERAPY	157669	1541773	1699442	.403595		50
53 ELECTROCARDIOLOGY	53171	532832	586003	.139668		53
54 ELECTROENCEPHALOGRAPHY	1445	314015	315460	.107690		54
55 MEDICAL SUPPLIES CHARGED TO	1266950	1475662	2742612	.160672		55
55.30 IMPL. DEV. CHARGED TO PATIE						55.30
56 DRUGS CHARGED TO PATIENTS	2770810	1812365	4583175	.168135		56
59 PSYCHIATRIC/PSYCHOLOGICAL S		908819	908819	.705370		59
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	87757	2435394	2523151	.760863		61
62 OBSERVATION BEDS (NON-DISTI	7885	147377	155262	.729850	.729850	62
63.50 RHC		2086193	2086193	1.647191		63.50
63.60 FOHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES		801295	801295	1.105280		65
101 SUBTOTAL	9319751	27082767	36402518			101
102 LESS OBSERVATION BEDS						102
103 TOTAL			36402518			103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1351)
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I
 BOXES [] TITLE XIX - O/P [] SUB II
 [] SUB III
 [] SUB IV

[] SNF
 [] NF
 [] S/B-SNF
 [] S/B-NF
 [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4
37 ANCILLARY SERVICE COST CENTERS						
40 OPERATING ROOM	.498579	.498579	.498579			37
41 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	.273476	.273476	.273476			41
44 LABORATORY	.239240	.239240	.239240			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	.839389	.839389	.839389			49
50 PHYSICAL THERAPY	.403595	.403595	.403595			50
53 ELECTROCARDIOLOGY	.139668	.139668	.139668			53
54 ELECTROENCEPHALOGRAPHY	.107690	.107690	.107690			54
55 MEDICAL SUPPLIES CHARGED TO PAT	.160672	.160672	.160672			55
55.30 IMPL. DEV. CHARGED TO PATIENT						55.30
56 DRUGS CHARGED TO PATIENTS	.168135	.168135	.168135			56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	.705370	.705370	.705370			59
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	.760863	.760863	.760863			61
62 OBSERVATION BEDS (NON-DISTINCT	.729850	.729850	.729850			62
63.50 RHC	1.647191	1.647191	1.647191			63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES	1.105280	1.105280	1.105280			65
65.01 AMBULANCE CHARGES (S-2 LINE 56.	1.105280	1.105280	1.105280			65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.	1.105280	1.105280	1.105280			65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.	1.105280	1.105280	1.105280			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	.168135	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 (14-1351) [] 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)	PPS SER- VICES	ALL OTHER	PPS SER- VICES	PPS SER- VICES	OUTPATIENT AMBULATORY	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT	
	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	CENTER	RADIOLOGY	DIAGNOSTIC	
	5	5.01	5.02	5.03	5.04	6	7	8	
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	949127								37
40 ANESTHESIOLOGY									40
41 RADIOLOGY-DIAGNOSTIC	3021137								41
44 LABORATORY	3044062								44
46.30 BLOOD CLOTTING FACTORS ADMIN C									46.30
49 RESPIRATORY THERAPY	108048								49
50 PHYSICAL THERAPY	493270								50
53 ELECTROCARDIOLOGY	286380								53
54 ELECTROENCEPHALOGRAPHY	99381								54
55 MEDICAL SUPPLIES CHARGED TO PA	591862								55
55.30 IMPL. DEV. CHARGED TO PATIENT									55.30
56 DRUGS CHARGED TO PATIENTS	722726								56
59 PSYCHIATRIC/PSYCHOLOGICAL SERV	908009								59
59.97 CARDIAC REHABILITATION									59.97
59.98 HYPERBARIC OXYGEN THERAPY									59.98
59.99 LITHOTRIPSY									59.99
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY	885746								61
62 OBSERVATION BEDS (NON-DISTINCT	66271								62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
65 AMBULANCE SERVICES									65
65.01 AMBULANCE CHARGES (S-2 LINE 56									65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56									65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56									65.03
101 SUBTOTAL	11176019								101
102 CRNA CHARGES									102
103 PBP CLINIC LAB									103
104 NET CHARGES	11176019								104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK TITLE V - O/P HOSPITAL (14-1351) SNF
 APPLICABLE 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) 9	PPS SERVICES (COLUMNS 1.01x5.01) 9.01	ALL OTHER (COLUMNS 1.01x5.02) 9.02	PPS SERVICES (COLUMNS 1.01x5.03) 9.03	PPS SERVICES (COLUMNS 1.01x5.04) 9.04	I/P PART B CHARGES (SEE INSTRU.) 10	I/P PART B COST (COLUMNS 1.02x10) 11
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	473215						37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC	826208						41
44 LABORATORY	728261						44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	90694						49
50 PHYSICAL THERAPY	199081						50
53 ELECTROCARDIOLOGY	39998						53
54 ELECTROENCEPHALOGRAPHY	10702						54
55 MEDICAL SUPPLIES CHARGED TO PAT	95096						55
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS	121516						56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	640482						59
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	673931						61
62 OBSERVATION BEDS (NON-DISTINCT	48368						62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
65.01 AMBULANCE CHARGES (S-2 LINE 56.							65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.							65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.							65.03
101 SUBTOTAL	3947552						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	3947552						104

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) (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF
INPATIENT DAYS	1	1	1	1	1	1
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3917					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3611					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)						3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3611					4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	255					5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	51					6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2484					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	255					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	51					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) (14-1351)	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	100.00						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2550966						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							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST	199286						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2351680						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2147517						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2147517						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.095069						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	594.72						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	2351680						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) (14-1351)	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	651.26					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1617730					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1617730					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
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						47
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	1188990					48
49 TOTAL PROGRAM INPATIENT COSTS	2806720					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) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54		1	1	1	1	54
54						55
56						56
57						57
58						58
58.01						58.01
58.02						58.02
58.03						58.03
58.04						58.04
59						59
59.01						59.01
59.02						59.02
59.03						59.03
59.04						59.04
59.05						59.05
59.06						59.06
59.07						59.07
59.08						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60	166071					60
61	33214					61
62	199285					62
63						63
64						64
65						65

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

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	174	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	651.25	84
85 OBSERVATION BED COST	113318	85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-1351)	<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 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		1551211		25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.498579	384804	191855	37
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.273476	455822	124656	41
44 LABORATORY	.239240	815663	195139	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.839389	226609	190213	49
50 PHYSICAL THERAPY	.403595	105164	42444	50
53 ELECTROCARDIOLOGY	.139668	48047	6711	53
54 ELECTROENCEPHALOGRAPHY	.107690	504	54	54
55 MEDICAL SUPPLIES CHARGED TO PAT	.160672	850341	136626	55
55.30 IMPL. DEV. CHARGED TO PATIENT				55.30
56 DRUGS CHARGED TO PATIENTS	.168135	1776677	298722	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	.705370			59
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.760863	1273	969	61
62 OBSERVATION BEDS (NON-DISTINCT	.729850	2193	1601	62
OTHER REIMBURSABLE COST CENTERS				
63.50 RHC	1.647191			63.50
63.60 FQHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		4667097	1188990	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		4667097		103

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-Z351)	<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				
37 OPERATING ROOM	.498579			37
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.273476	33392	9132	41
44 LABORATORY	.239240	49776	11908	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.839389	33119	27800	49
50 PHYSICAL THERAPY	.403595	37734	15229	50
53 ELECTROCARDIOLOGY	.139668	1466	205	53
54 ELECTROENCEPHALOGRAPHY	.107690			54
55 MEDICAL SUPPLIES CHARGED TO PAT	.160672	78159	12558	55
55.30 IMPL. DEV. CHARGED TO PATIENT				55.30
56 DRUGS CHARGED TO PATIENTS	.168135	174212	29291	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	.705370			59
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.760863			61
62 OBSERVATION BEDS (NON-DISTINCT	.729850			62
OTHER REIMBURSABLE COST CENTERS				
63.50 RHC	1.647191			63.50
63.60 FQHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		407858	106123	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		407858		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					1
1.01					1.01
1.02					1.02
1.03					1.03
1.04					1.04
1.05					1.05
1.06					1.06
1.07					1.07
1.08					1.08
2					2
2.01					2.01
3					3
3.01					3.01
3.02					3.02
3.03					3.03
3.04					3.04
3.05					3.05
3.06					3.06
3.07					3.07
3.08					3.08
3.09					3.09
3.10					3.10
3.11					3.11
3.12					3.12
3.13					3.13
3.14					3.14
3.15					3.15
3.16					3.16
3.17					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	CURRENT YEAR RESIDENT TO BED RATIO					3.18
3.19	PRIOR YEAR RESIDENT TO BED RATIO					3.19
3.20	FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19					3.20
3.21	IME PAYMENTS FOR DSCHGS OCCURRING PRIOR TO OCTOBER 1					3.21
3.22	IME PAYMENTS FOR DSCHGS AFTER SEP 30 BUT BEFORE JAN 1					3.22
3.23	IME PAYMENTS FOR DSCHGS OCCURRING ON OR AFTER JANUARY 1 [SUM OF LINES] [PLUS E-3, PT.VI] [3.21-3.23] [LINE 23]					3.23
3.24	SUM OF LINES 3.21-3.23 DISPROPORTIONATE SHARE ADJUSTMENT	0	0			3.24
4	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS					4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS					4.01
4.02	SUM OF 4 AND 4.01					4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE					4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES					4.04
5	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317					5
5.01	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, 316 AND 317					5.01
5.02	DIVIDE LINE 5.01 BY LINE 5					5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs 302, 316 AND 317					5.03
5.04	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK					5.04
5.05	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS					5.05
5.06	TOTAL ADDITIONAL PAYMENT					5.06
6	SUBTOTAL					6
7	HOSPITAL SPECIFIC PAYMENTS					7
7.01	HOSPITAL SPECIFIC PAYMENTS (1996 HSR)					7.01
8	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS					8
9	PAYMENT FOR INPATIENT PROGRAM CAPITAL					9
10	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL					10
11	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT					11
11.01	NURSING AND ALLIED HEALTH MANAGED CARE					11.01
11.02	ADD-ON PAYMENT FOR NEW TECHNOLOGIES					11.02
12	NET ORGAN ACQUISITION COST					12
13	COST OF TEACHING PHYSICIANS					13
14	ROUTINE SERVICE OTHER PASS THROUGH COSTS					14
15	ANCILLARY SERVICE OTHER PASS THROUGH COSTS					15
16	TOTAL					16
17	PRIMARY PAYER PAYMENTS					17
18	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES					18
19	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES					19
20	COINSURANCE BILLED TO PROGRAM BENEFICIARIES					20
21	REIMBURSABLE BAD DEBTS					21
21.01	REDUCED PROGRAM REIMBURSABLE BAD DEBTS					21.01
21.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES					21.02
22	SUBTOTAL					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	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					23
24	OTHER ADJUSTMENTS					24
25	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					25
26	AMOUNT DUE PROVIDER					26
27	SEQUESTRATION ADJUSTMENT					27
28	INTERIM PAYMENTS					28
28.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					28.01
29	BALANCE DUE PROVIDER (PROGRAM)					29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					30
	TO BE COMPLETED BY INTERMEDIARY					
50	OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01					50
51	CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01					51
52	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)					52
53	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)					53
54	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)					54
55	OPERATING TIME VALUE OF MONEY (SEE INSTRUCTIONS)					55
56	CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)					56

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1351)	HOSPITAL (14-1351)	HOSPITAL (14-1351)
	1	1.01	1.02
1 MEDICAL AND OTHER SERVICES	3947552		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	3947552		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	3987028		17
17.01 TOTAL PPS PAYMENTS			17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1351)	HOSPITAL (14-1351)	HOSPITAL (14-1351)
	1	1.01	1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES	56250		18
18.01 COINSURANCE	1625922		18.01
19 SUBTOTAL	2304856		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	2304856		23
24 PRIMARY PAYER PAYMENTS	679		24
25 SUBTOTAL	2304177		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	414568		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	414568		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	414568		27.02
28 SUBTOTAL	2718745		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	2718745		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	2710679		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	8066		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			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)			53
54 FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION TOTAL (SUM OF LINES 51 AND 53)			54

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 HOSPITAL (14-1351)

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		2020197		2722676	1	
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		NONE	2	
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 .05 .50 PROVIDER .51 TO .52 PROGRAM .53 .54	05/14/2010 08/27/2010 11/19/2010 02/25/2011	101609 84415 19999 250374	08/27/2010 11/19/2010 05/14/2010 02/25/2011	81853 11907 32437 73320	3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54
SUBTOTAL	.99	456397		-11997	3.99	
4 TOTAL INTERIM PAYMENTS		2476594		2710679	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 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52				5.01 5.02 5.03 5.50 5.51 5.52	
SUBTOTAL	.99				5.99	
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER .01 PROVIDER TO .02 PROGRAM				6.01 6.02	
7 TOTAL MEDICARE PROGRAM LIABILITY					7	

NAME OF INTERMEDIARY: _____
 SIGNATURE OF AUTHORIZED PERSON: _____

INTERMEDIARY NUMBER: _____
 DATE (MO/DAY/YR): _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 SWING BED SKILLED NURSING FACILITY (14-Z351)

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		248168		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		NONE 2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 TO .05 PROVIDER .51 TO .52 PROGRAM .53 .54	08/27/2010 6148 11/19/2010 2070 02/25/2011 39388		3.01 3.02 NONE 3.03 3.04 3.05 3.50 3.51 NONE 3.52 3.53 3.54
SUBTOTAL	.99	47606		3.99
4 TOTAL INTERIM PAYMENTS		295774		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 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52			5.01 5.02 5.03 5.50 5.51 5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER .01 PROVIDER TO .02 PROGRAM			6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				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-Z351)	(14-Z351)		
	1	1	2	1	1
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF	201278			1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF				2
3	ANCILLARY SERVICES	107184			3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM				4
5	PROGRAM DAYS	306			5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM				6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY				7
8	SUBTOTAL	308462			8
9	PRIMARY PAYER PAYMENTS				9
10	SUBTOTAL	308462			10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)				11
12	SUBTOTAL	308462			12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	11367			13
14	80% OF PART B COSTS				14
15	SUBTOTAL	297095			15
16	OTHER ADJUSTMENTS				16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)				17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES				17.01
18	TOTAL	297095			18
19	SEQUESTRATION ADJUSTMENT				19
20	INTERIM PAYMENTS	295774			20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				20.01
21	BALANCE DUE PROVIDER/PROGRAM	1321			21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF I	
1	INPATIENT SERVICES	2806720					1
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)						1.01
2	ORGAN ACQUISITION						2
3	COST OF TEACHING PHYSICIANS						3
4	SUBTOTAL	2806720					4
5	PRIMARY PAYER PAYMENTS						5
6	TOTAL COST	2834787					6
COMPUTATION OF LESSER OF COST OR CHARGES							
REASONABLE CHARGES							
7	ROUTINE SERVICE CHARGES						7
8	ANCILLARY SERVICE CHARGES						8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE						9
10	TEACHING PHYSICIANS						10
11	TOTAL REASONABLE CHARGES						11
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS						12
13	AMOUNT 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)						13
14	RATIO OF LINE 12 TO LINE 13						14
15	TOTAL CUSTOMARY CHARGES						15
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						16
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF I
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
25.01						25.01
25.02						25.02
26						26
27						27
28						28
29						29
30						30
31						31
32						32
32.01						32.01
33						33
34						34

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	2406276			1
2 TEMPORARY INVESTMENTS	6412147			2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	2526160			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7 INVENTORY	220176			7
8 PREPAID EXPENSES	245336			8
9 OTHER CURRENT ASSETS	77263			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS	11887358			11
FIXED ASSETS				
12 LAND	132111			12
12.01 ACCUMULATED DEPRECIATION				12.01
13 LAND IMPROVEMENTS	345852			13
13.01 ACCUMULATED DEPRECIATION	-239227			13.01
14 BUILDINGS	12075376			14
14.01 ACCUMULATED DEPRECIATION	-6329209			14.01
15 LEASEHOLD IMPROVEMENTS				15
15.01 ACCUMULATED AMORTIZATION				15.01
16 FIXED EQUIPMENT	6640374			16
16.01 ACCUMULATED DEPRECIATION	-4664287			16.01
17 AUTOMOBILES AND TRUCKS				17
17.01 ACCUMULATED DEPRECIATION				17.01
18 MAJOR MOVABLE EQUIPMENT				18
18.01 ACCUMULATED DEPRECIATION				18.01
19 MINOR EQUIPMENT DEPRECIABLE				19
19.01 ACCUMULATED DEPRECIATION				19.01
20 MINOR EQUIPMENT-NONDEPRECIABLE				20
21 TOTAL FIXED ASSETS	7960990			21
OTHER ASSETS				
22 INVESTMENTS				22
23 DEPOSITS ON LEASES				23
24 DUE FROM OWNERS/OFFICERS				24
25 OTHER ASSETS	3088066			25
26 TOTAL OTHER ASSETS	3088066			26
27 TOTAL ASSETS	22936414			27
LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1432154			28
29 SALARIES, WAGES & FEES PAYABLE	706687			29
30 PAYROLL TAXES PAYABLE				30
31 NOTES & LOANS PAYABLE (SHORT TERM)				31
32 DEFERRED INCOME				32
33 ACCELERATED PAYMENTS				33
34 DUE TO OTHER FUNDS				34
35 OTHER CURRENT LIABILITIES	216720			35
36 TOTAL CURRENT LIABILITIES	2355561			36
LONG-TERM LIABILITIES				
37 MORTGAGE PAYABLE				37
38 NOTES PAYABLE	5249290			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	5249290			42
43 TOTAL LIABILITIES	7604851			43
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	15331563			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	15331563			51
52 TOTAL LIABILITIES AND FUND BALANCES	22936414			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	15207735			1
2 NET INCOME (LOSS)	123828			2
3 TOTAL	15331563			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	15331563			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	15331563			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				
2 HOSPITAL	2227874		2227874	1
3 SUBPROVIDER I				2
4 SWING BED - SNF				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	2227874		2227874	9
10 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT				10
12 CORONARY CARE UNIT				11
13 BURN INTENSIVE CARE UNIT				12
14 SURGICAL INTENSIVE CARE UNIT				13
15 OTHER SPECIAL CARE (SPECIFY)				14
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
17 TOTAL INPATIENT ROUTINE CARE SERVICES	2227874		2227874	16
18 ANCILLARY SERVICES	7431926		7431926	17
19 OUTPATIENT SERVICES		26504960	26504960	18
20 RHC		2382367	2382367	18.50
21 FQHC				18.60
22 HOME HEALTH AGENCY				19
23 AMBULANCE		801295	801295	20
24 CORF				21
25 ASC				22
26 HOSPICE				23
27 TOTAL PATIENT REVENUES	9659800	29688622	39348422	24

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		18433814	26
27 PROVISION FOR UNCOLLECTIBLE ACCOUNT	2060954		27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS		2060954	33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		20494768	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	39348422	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	19478281	2
3	NET PATIENT REVENUES	19870141	3
4	LESS - TOTAL OPERATING EXPENSES	20494768	4
5	NET INCOME FROM SERVICE TO PATIENTS	-624627	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	108893	6
7	INCOME FROM INVESTMENTS	144141	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	105662	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	6228	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	TAX REVENUE	203364	24
24.01	RENTAL INCOME	42884	24.01
24.02	MISCELLANEOUS INCOME	137283	24.02
25	TOTAL OTHER INCOME	748455	25
26	TOTAL	123828	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	123828	31

RHC I
 COMPONENT NO: 14-3458

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	912774		912774		912774		898626	1
2								2
3	262855		262855		262855		262855	3
4								4
5	359015		359015		359015		359015	5
6								6
7								7
8								8
9	10227		10227		10227		10227	9
10	1544871		1544871		1544871	-14148	1530723	10
COSTS UNDER AGREEMENT								
11		77342	77342		77342		77342	11
12								12
13								13
14		77342	77342		77342		77342	14
OTHER HEALTH CARE COSTS								
15		23323	23323		23323		23323	15
16								16
17								17
18		21637	21637		21637		21637	18
19		60715	60715		60715		60715	19
20								20
21		105675	105675		105675		105675	21
22	1544871	183017	1727888		1727888	-14148	1713740	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26								26
27								27
28								28
FACILITY OVERHEAD								
29	308936		308936		308936		308936	29
30								30
31	308936		308936		308936		308936	31
32	1853807	183017	2036824		2036824	-14148	2022676	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-2

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1 PHYSICIANS	2.97	12413	4200	12474		1
2 PHYSICIAN ASSISTANTS			2100			2
3 NURSE PRACTITIONERS	2.93	10499	2100	6153		3
4 SUBTOTAL	5.90	22912		18627	22912	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	5.90	22912			22912	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS		33			33	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					1713740	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					1713740	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD					308936	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					1413682	15
16 TOTAL OVERHEAD					1722618	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					1722618	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					1722618	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					3436358	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3458

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		3436358	1
2	COST OF VACCINES AND THEIR ADMINISTRATION		5708	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE		3430650	3
4	TOTAL VISITS		22912	4
5	PHYSICIANS VISITS UNDER AGREEMENT		33	5
6	TOTAL ADJUSTED VISITS		22945	6
7	ADJUSTED COST PER VISIT		149.52	7

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

8	PER VISIT PAYMENT LIMIT			8
9	RATE FOR PROGRAM COVERED VISITS	149.52	149.52	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	6481		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	969039		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		969039	16
16.01	PRIMARY PAYOR PAYMENTS			16.01
17	LESS: BENEFICIARY DEDUCTIBLE		75698	17
18	NET PROGRAM COST EXCLUDING VACCINES		893341	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE		714673	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION		5708	20
21	TOTAL REIMBURSABLE PROGRAM COST		720381	21
22	REIMBURSABLE BAD DEBTS		40593	22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			22.01
23	OTHER ADJUSTMENTS			23
24	NET REIMBURSABLE AMOUNT		760974	24
25	INTERIM PAYMENTS		692943	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE COMPONENT/PROGRAM		68031	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			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: 14-3458

WORKSHEET M-4

CHECK [XX] RHC [] TITLE V
 APPLICABLE BOX: [] PQHC [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	1530723	1530723	1530723	1530723	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000029	0.000436			2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	44	667			3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	285	1850			4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	329	2517			5
6 TOTAL DIRECT COST OF THE FACILITY	1713740	1713740	1713740	1713740	6
7 TOTAL OVERHEAD	1722618	1722618	1722618	1722618	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.000192	0.001469			8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	331	2531			9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	660	5048			10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	5	74			11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	132.00	68.22			12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	5	74			13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	660	5048			14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		5708			15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		5708			16

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

RHC I
 COMPONENT NO: 14-3458

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		717565	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.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 .05 .50 PROVIDER .51 TO .52 PROGRAM .53 .54 .59	NONE	3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54 3.59
08/27/2010		24622	
SUBTOTAL	.99	-24622	3.99
4 TOTAL INTERIM PAYMENTS		692943	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 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52		5.01 5.02 5.03 5.50 5.51 5.52
SUBTOTAL	.99		5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01 PROVIDER TO .02 PROGRAM		6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY			7

NAME OF INTERMEDIARY: _____
 SIGNATURE OF AUTHORIZED PERSON: _____

INTERMEDIARY NUMBER: _____
 DATE (MO/DAY/YR): _____