

DR. JOHN WARNER HOSPITAL

CLINTON, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED APRIL 30, 2012

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 08/21/2012 TIME: 14:32
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY DR JOHN WARNER HOSPITAL (14-1303) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 05/01/2011 AND ENDING 04/30/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 08/21/2012 14:32
 EaH:2TiNTxSy6S10c1D:NpuQRbnEt0
 aibad0ZHkgY:lw1Le1JUNYYW3K5liQ
 Dz0V0tgVC0090aA0

(SIGNED)

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PI Encryption: 08/21/2012 14:32
 N.S:20IqZH8JNueBva8fS1b0sv1va0
 JQRTW0jDErgdgpalyGm9pUzZ0vezyl
 6jkB0Gof190bCbNY

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		-34,520	-17,342		59,792	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		-737				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			35,420			10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		-35,257	18,078		59,792	200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 422 WEST WHITE STREET
 2 CITY: CLINTON

STATE: IL

P.O. BOX:
 ZIP CODE: 61727

COUNTY: DEWITT

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	DR JOHN WARNER HOSPITAL	14-1303	00014	1	03/01/2000	N	O	O	3
4	SUBPROVIDER - IPF									
5	SUBPROVIDER - IRF									
6	SUBPROVIDER - (OTHER)									
7	SWING BEDS - SNF	SWING BED	14-Z303	00014		03/01/2000	N	O	N	7
8	SWING BEDS - NF									
9	HOSPITAL-BASED SNF									
10	HOSPITAL-BASED NF									
11	HOSPITAL-BASED OLTG									
12	HOSPITAL-BASED HHA									
13	SEPARATELY CERTIFIED ASC									
14	HOSPITAL-BASED HOSPICE									
15	HOSPITAL-BASED HEALTH CLINIC - RHC	RURAL HEALTH CENTER	14-3404	00014		07/03/1995	N	O	N	15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									
17	HOSPITAL-BASED (CMHC)									
18	RENAL DIALYSIS									
19	OTHER									
20	COST REPORTING PERIOD (MM/DD/YYYY)		FROM: 05/01/2011		TO: 04/30/2012					
21	TYPE OF CONTROL									

INPATIENT PPS INFORMATION

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

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

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

	V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?			
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.			
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.			
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.			

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	56
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER \$413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63
----	---	---	--	----

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

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2
 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY
 CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-
 PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY
 CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5
 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE
 INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010

66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66
----	--	--	--	----

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4). (SEE INSTRUCTIONS)

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTES NONPROVIDER SITE 3	UNWEIGHTED FTES IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V 1 XIX 2 N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			Y 106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			N N 107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			Y 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH Y Y Y RATORY	N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

		1	2
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	2	118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		118.01
	PREMIUMS: PAID LOSSES: AND/OR SELF INSURANCE:		
118.02	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.	N	118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N 120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

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

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

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

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

		TITLE XVIII		TITLE	TITLE
		PART A	PART B	V	XIX
		1	2	3	4
155	HOSPITAL	N	N		N 155
156	SUBPROVIDER - IPF	N	N		156
157	SUBPROVIDER - IRF	N	N		157
158	SUBPROVIDER - (OTHER)	N	N		158
159	SNF	N	N		159
160	HHA	N	N		160
161	CMHC		N		161

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	165			
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1 N	2	1	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	Y/N 1 N	DATE 2	V/I 3 2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1 Y	2 A	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N	2	6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y/N Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 Y	2 06/12/2012	3 Y	4 06/12/2012
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		Y	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

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

CAPITAL RELATED COST

- 22 HAVE ASSETS BEEN RELIEVED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. N 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 27

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- | | | | |
|-------------------------------------|-----------------------------------|------------------|----|
| 41 FIRST NAME: AMBER | LAST NAME: HALSTEAD | TITLE: IN-CHARGE | 41 |
| 42 EMPLOYER: KERBER, ECK & BRAECKEL | | | 42 |
| 43 PHONE NUMBER: 618-529-1040 | E-MAIL ADDRESS: AMBERH@KEBCPA.COM | | 43 |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
	1	2	3	4	5	6
SALARIES						
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	7,351,592	283,016		1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A					4
4.01	PHYSICIANS-PART A - DIRECT TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)					7.01
8	HOME OFFICE PERSONNEL					8
9	SNF	44				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		2,530,555			10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)					11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A					15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)					16
WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)					17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS					19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A					22
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)					25
OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS					26
27	ADMINISTRATIVE & GENERAL	1,008,918	283,016			27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT	152,089				30
31	LAUNDRY & LINEN SERVICE	8,110				31
32	HOUSEKEEPING	114,962				32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY	192,244	-17,110			34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA		17,110			36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION	166,748				38
39	CENTRAL SERVICES AND SUPPLY	14,377				39
40	PHARMACY	124,055				40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	134,407				41
42	SOCIAL SERVICE	34,297				42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	7,351,592	283,016	7,634,608	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2,530,555		2,530,555	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	4,821,037	283,016	5,104,053	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)				4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)				5
6	TOTAL (SUM OF LINES 3 THRU 5)	4,821,037	283,016	5,104,053	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	1,950,207	283,016	2,233,223	7

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.618103	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,364,643	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				5,165,092	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				3,192,559	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				1,827,916	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				1,827,916	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	272,000	86,311	358,311		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	168,124	53,349	221,473		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	31,159	27,172	58,331		22
23	COST OF CHARITY CARE	136,965	26,177	163,142		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			1,500,582		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			311,128		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,189,454		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			735,205		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			898,347		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			2,726,263		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		307,340	307,340	90,970	1
2	00200		627,634	627,634	11,782	2
3	00300					3
4	00400		2,356,008	2,356,008		4
5	00500	1,008,918	865,064	1,873,982	283,131	5
6	00600					6
7	00700	152,089	388,521	540,610		7
8	00800	8,110	101,615	109,725		8
9	00900	114,962	50,154	165,116		9
10	01000	192,244	145,401	337,645	-30,051	10
11	01100				30,051	11
12	01200					12
13	01300	166,748	6,074	172,822	5,194	13
14	01400	14,377	133,325	147,702	-133,244	14
15	01500	124,055	584,219	708,274	-310,816	15
16	01600	134,407	130,642	265,049	294	16
17	01700	34,297	2,492	36,789		17
19	01900				206,400	19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	942,052	229,841	1,171,893	-11,186	30
ANCILLARY SERVICE COST CENTERS						
50	05000	376,234	128,871	505,105	-196	50
53	05300		211,569	211,569	-206,400	53
54	05400	260,137	638,278	898,415		54
60	06000	367,734	597,671	965,405	7,381	60
62	06200				3,346	62
62.30	06250					62.30
64	06400				7,781	64
65	06500	172,980	66,897	239,877	-29,506	65
66	06600	41,909	417,957	459,866	-11,473	66
67	06700					67
68	06800					68
69	06900	56,009	26,445	82,454		69
71	07100				164,933	71
72	07200		198,371	198,371		72
73	07300				312,804	73
76	03950	46,312	2,114	48,426		76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	1,821,015	289,697	2,110,712	-358,564	88
90	09000				2,183	90
90.01	09001	473	403	876		90.01
91	09100	606,990	1,392,091	1,999,081	6,054	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	652,211	62,499	714,710	7,132	95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
113	11300		68,073	68,073	-68,073	113
118		7,294,263	10,029,266	17,323,529	-20,073	118
NONREIMBURSABLE COST CENTERS						
192	19200	57,329	3,093	60,422		192
192.01	19201		1,628	1,628		192.01
192.02	19202					192.02
192.03	19203				20,073	192.03
192.04	19204					192.04
200		7,351,592	10,033,987	17,385,579		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	398,310	-5,290	393,020	1
2	00200	CAP REL COSTS-MVBLE EQUIP	639,416	-276	639,140	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	2,356,008		2,356,008	4
5	00500	ADMINISTRATIVE & GENERAL	2,157,113	-27,322	2,129,791	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	540,610		540,610	7
8	00800	LAUNDRY & LINEN SERVICE	109,725		109,725	8
9	00900	HOUSEKEEPING	165,116		165,116	9
10	01000	DIETARY	307,594	-199,425	108,169	10
11	01100	CAFETERIA	30,051	-16,840	13,211	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	178,016	-2,730	175,286	13
14	01400	CENTRAL SERVICES & SUPPLY	14,458		14,458	14
15	01500	PHARMACY	397,458		397,458	15
16	01600	MEDICAL RECORDS & LIBRARY	265,343	-4,846	260,497	16
17	01700	SOCIAL SERVICE	36,789		36,789	17
19	01900	NONPHYSICIAN ANESTHETISTS	206,400		206,400	19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,160,707		1,160,707	30
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	504,909	-69,851	435,058	50
53	05300	ANESTHESIOLOGY	5,169		5,169	53
54	05400	RADIOLOGY-DIAGNOSTIC	898,415	-3,167	895,248	54
60	06000	LABORATORY	972,786	-3,538	969,248	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,346		3,346	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	06400	INTRAVENOUS THERAPY	7,781		7,781	64
65	06500	RESPIRATORY THERAPY	210,371		210,371	65
66	06600	PHYSICAL THERAPY	448,393	-8,499	439,894	66
67	06700	OCCUPATIONAL THERAPY				67
68	06800	SPEECH PATHOLOGY				68
69	06900	ELECTROCARDIOLOGY	82,454	-32,211	50,243	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	164,933	-1,300	163,633	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	198,371		198,371	72
73	07300	DRUGS CHARGED TO PATIENTS	312,804	-1,099	311,705	73
76	03950	CARDIAC REHAB	48,426		48,426	76
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC (RHC)	1,752,148	-115,205	1,636,943	88
90	09000	CLINIC	2,183		2,183	90
90.01	09001	PROVIDER BASED CLINIC	876		876	90.01
91	09100	EMERGENCY	2,005,135	-880,404	1,124,731	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
95	09500	AMBULANCE SERVICES	721,842		721,842	95
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	17,303,456	-1,372,003	15,931,453	118
NONREIMBURSABLE COST CENTERS						
192	19200	PHYSICIANS' PRIVATE OFFICES	60,422		60,422	192
192.01	19201	LIFELINE	1,628		1,628	192.01
192.02	19202	HOME MEDICAL EQUIPMENT				192.02
192.03	19203	COMMUNITY BENEFIT	20,073		20,073	192.03
192.04	19204	RENTAL PROPERTIES		221	221	192.04
200		TOTAL (SUM OF LINES 118-199)	17,385,579	-1,371,782	16,013,797	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		OTHER
			LINE #	SALARY	
	1	2	3	4	5
1 TO RECLASS CAFETERIA COSTS FROM DIET	A	CAFETERIA	11	17,110	12,941
500 TOTAL RECLASSIFICATIONS				17,110	12,941
CODE LETTER - A					500
1 TO RECLASS DRUGS SOLD TO PATIENTS	B	DRUGS CHARGED TO PATIENTS	73		312,804
500 TOTAL RECLASSIFICATIONS					312,804
CODE LETTER - B					500
1 TO RECLASS INTEREST EXPENSE	C	CAP REL COSTS-BLDG & FIXT	1		68,073
500 TOTAL RECLASSIFICATIONS					68,073
CODE LETTER - C					500
1 TO RECLASS SUPPLIES CHARGED TO PTS	D	MEDICAL SUPPLIES CHRGED TO PA	71		133,244
500 TOTAL RECLASSIFICATIONS					133,244
CODE LETTER - D					500
1 TO RECLASS ER PHYSICIAN CONTRACTED	E	ADMINISTRATIVE & GENERAL	5		25,484
500 TOTAL RECLASSIFICATIONS					25,484
CODE LETTER - E					500
1 TO RECLASS PROPERTY INS EXP	F	OTHER CAPITAL RELATED COSTS	3		34,679
500 TOTAL RECLASSIFICATIONS					34,679
CODE LETTER - F					500
1 TO RECLASS RHC ADMIN EXPENSES	G	ADMINISTRATIVE & GENERAL	5		68,167
500 TOTAL RECLASSIFICATIONS					68,167
CODE LETTER - G					500
1 TO RECLASS OXYGEN SUPPLIES	H	MEDICAL SUPPLIES CHRGED TO PA	71		31,689
500 TOTAL RECLASSIFICATIONS					31,689
CODE LETTER - H					500
1 TO RECLASS NURSING COST	I	INTRAVENOUS THERAPY	64	7,781	
500 TOTAL RECLASSIFICATIONS				7,781	
CODE LETTER - I					500
1 TO RECLASS NURSING COST	J	WHOLE BLOOD & PACKED RED BLOO	62	3,346	
500 TOTAL RECLASSIFICATIONS				3,346	
CODE LETTER - J					500
1 TO RECLASS NURSING COST	K	CLINIC	90	1,987	
500 TOTAL RECLASSIFICATIONS				1,987	
CODE LETTER - K					500
1 TO RECLASS NURSING COST	L	CLINIC	90	196	
500 TOTAL RECLASSIFICATIONS				196	
CODE LETTER - L					500
1 TO RECLASS NURSING COST	M	EMERGENCY	91	801	
500 TOTAL RECLASSIFICATIONS				801	
CODE LETTER - M					500
1 TO RECLASS GRANT EXPENSES	N	NURSING ADMINISTRATION	13		5,194
2		PHARMACY	15		1,988
3		MEDICAL RECORDS & LIBRARY	16		294
4		ADULTS & PEDIATRICS	30		2,729
5		RESPIRATORY THERAPY	65		2,183
6		EMERGENCY	91		20,542
7		AMBULANCE SERVICES	95		3,874
8					
500 TOTAL RECLASSIFICATIONS					36,804
CODE LETTER - N					500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
		COST CENTER	LINE #	SALARY	OTHER
	1	2	3	4	5
1 TO RECLASS RESTRICTED DONATIONS	O				
2		PHYSICAL THERAPY	66		8,600 1
3		EMERGENCY	91		10,195 2
4		AMBULANCE SERVICES	95		3,258 3
500 TOTAL RECLASSIFICATIONS					22,053 4
CODE LETTER - O					500
1 TO RECLASS RHC PHYSICIAN ADMIN TIME	P	ADMINISTRATIVE & GENERAL	5	283,016	1
500 TOTAL RECLASSIFICATIONS				283,016	500
CODE LETTER - P					
1 TO RECLASS ATHLETIC TRAINER BENEFIT	Q	COMMUNITY BENEFIT	192.03		20,073 1
500 TOTAL RECLASSIFICATIONS					20,073 500
CODE LETTER - Q					
1 TO RECLASS CRNA EXPENSE AFTER 12/31	R	NONPHYSICIAN ANESTHETISTS	19		206,400 1
500 TOTAL RECLASSIFICATIONS					206,400 500
CODE LETTER - R					
1 TO RECLASS LAB TESTS DONE IN RHC	S	LABORATORY	60		7,381 1
500 TOTAL RECLASSIFICATIONS					7,381 500
CODE LETTER - S					
GRAND TOTAL (INCREASES)				314,237	979,792

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 TO RECLASS CAFETERIA COSTS FROM DIET	A	DIETARY	10	17,110	12,941	1
500 TOTAL RECLASSIFICATIONS				17,110	12,941	500
CODE LETTER - A						
1 TO RECLASS DRUGS SOLD TO PATIENTS	B	PHARMACY	15		312,804	1
500 TOTAL RECLASSIFICATIONS					312,804	500
CODE LETTER - B						
1 TO RECLASS INTEREST EXPENSE	C	INTEREST EXPENSE	113		68,073	11 1
500 TOTAL RECLASSIFICATIONS					68,073	500
CODE LETTER - C						
1 TO RECLASS SUPPLIES CHARGED TO PTS	D	CENTRAL SERVICES & SUPPLY	14		133,244	1
500 TOTAL RECLASSIFICATIONS					133,244	500
CODE LETTER - D						
1 TO RECLASS ER PHYSICIAN CONTRACTED	E	EMERGENCY	91		25,484	1
500 TOTAL RECLASSIFICATIONS					25,484	500
CODE LETTER - E						
1 TO RECLASS PROPERTY INS EXP	F	ADMINISTRATIVE & GENERAL	5		34,679	12 1
500 TOTAL RECLASSIFICATIONS					34,679	500
CODE LETTER - F						
1 TO RECLASS RHC ADMIN EXPENSES	G	RURAL HEALTH CLINIC (RHC)	88		68,167	1
500 TOTAL RECLASSIFICATIONS					68,167	500
CODE LETTER - G						
1 TO RECLASS OXYGEN SUPPLIES	H	RESPIRATORY THERAPY	65		31,689	1
500 TOTAL RECLASSIFICATIONS					31,689	500
CODE LETTER - H						
1 TO RECLASS NURSING COST	I	ADULTS & PEDIATRICS	30	7,781		1
500 TOTAL RECLASSIFICATIONS				7,781		500
CODE LETTER - I						
1 TO RECLASS NURSING COST	J	ADULTS & PEDIATRICS	30	3,346		1
500 TOTAL RECLASSIFICATIONS				3,346		500
CODE LETTER - J						
1 TO RECLASS NURSING COST	K	ADULTS & PEDIATRICS	30	1,987		1
500 TOTAL RECLASSIFICATIONS				1,987		500
CODE LETTER - K						
1 TO RECLASS NURSING COST	L	OPERATING ROOM	50	196		1
500 TOTAL RECLASSIFICATIONS				196		500
CODE LETTER - L						
1 TO RECLASS NURSING COST	M	ADULTS & PEDIATRICS	30	801		1
500 TOTAL RECLASSIFICATIONS				801		500
CODE LETTER - M						
1 TO RECLASS GRANT EXPENSES	N	ADMINISTRATIVE & GENERAL	5		36,804	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
500 TOTAL RECLASSIFICATIONS					36,804	500
CODE LETTER - N						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 TO RECLASS RESTRICTED DONATIONS	O	ADMINISTRATIVE & GENERAL	5		22,053	1
2						2
3						3
4						4
500 TOTAL RECLASSIFICATIONS					22,053	500
CODE LETTER - O						
1 TO RECLASS RHC PHYSICIAN ADMIN TIME	P	RURAL HEALTH CLINIC (RHC)	88		283,016	1
500 TOTAL RECLASSIFICATIONS					283,016	500
CODE LETTER - P						
1 TO RECLASS ATHLETIC TRAINER BENEFIT	Q	PHYSICAL THERAPY	66		20,073	1
500 TOTAL RECLASSIFICATIONS					20,073	500
CODE LETTER - Q						
1 TO RECLASS CRNA EXPENSE AFTER 12/31	R	ANESTHESIOLOGY	53		206,400	1
500 TOTAL RECLASSIFICATIONS					206,400	500
CODE LETTER - R						
1 TO RECLASS LAB TESTS DONE IN RHC	S	RURAL HEALTH CLINIC (RHC)	88		7,381	1
500 TOTAL RECLASSIFICATIONS					7,381	500
CODE LETTER - S						
GRAND TOTAL (DECREASES)				31,221	1,262,808	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND	310,078					310,078	1
2 LAND IMPROVEMENTS							2
3 BUILDINGS AND FIXTURES	9,292,540	695,611		695,611	5,441	9,982,710	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT	192,305				62,440	129,865	5
6 MOVABLE EQUIPMENT	4,858,773	453,170		453,170	108,315	5,203,628	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	14,653,696	1,148,781		1,148,781	176,196	15,626,281	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	14,653,696	1,148,781		1,148,781	176,196	15,626,281	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	307,340						307,340 1
2 CAP REL COSTS-MVBLE EQUIP	627,634						627,634 2
3 TOTAL (SUM OF LINES 1-2)	934,974						934,974 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	10,112,575		10,112,575	0.660253	22,897			22,897 1
2 CAP REL COSTS-MVBLE EQUIP	5,203,628		5,203,628	0.339747	11,782			11,782 2
3 TOTAL (SUM OF LINES 1-2)	15,316,203		15,316,203	1.000000	34,679			34,679 3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	307,340		62,783	22,897			393,020 1
2 CAP REL COSTS-MVBLE EQUIP	627,358			11,782			639,140 2
3 TOTAL	934,698		62,783	34,679			1,032,160 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7	
			COST CENTER	LINE NO.	REF	
	1	2	3	4	5	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-5,290	CAP REL COSTS-BLDG & FIXT	1	11	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9 PARKING LOT (CHAPTER 21)						9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST					
	A-8-2	-1,090,544				10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-3,167	RADIOLOGY-DIAGNOSTIC	54		11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST					
	A-8-1	48,905				12
13 LAUNDRY AND LINEN SERVICE						13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-16,840	CAFETERIA	11		14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-1,300	MEDICAL SUPPLIES CHRGD TO PATI	71		16
17 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-1,099	DRUGS CHARGED TO PATIENTS	73		17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4,846	MEDICAL RECORDS & LIBRARY	16		18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						19
20 VENDING MACHINES						20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST					
	A-8-3					23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST					
	A-8-3		PHYSICAL THERAPY	66		24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)					114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			UTILIZATION REVIEW-SNF	1		26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-BLDG & FIXT	2		27
28 NON-PHYSICIAN ANESTHETIST			CAP REL COSTS-MVBLE EQUIP	19		28
29 PHYSICIANS' ASSISTANT			NONPHYSICIAN ANESTHETISTS			29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST					
	A-8-3		OCCUPATIONAL THERAPY	67		30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST					
	A-8-3		SPEECH PATHOLOGY	68		31
32 CAH HIT ADJ FOR DEPRECIATION AND						32
33 OTHER INCOME	B	-5,763	ADMINISTRATIVE & GENERAL	5		33
34 OUTSIDE DIETARY SERVICES	B	-199,425	DIETARY	10		34
35 DEPRECIATION OF NON-ALLOW TVS	A	-276	CAP REL COSTS-MVBLE EQUIP	2	9	35
36 FITNESS MGMT	B	-7,970	PHYSICAL THERAPY	66		36
37 OUTSIDE LAB SERVICES	B	-3,538	LABORATORY	60		37
38 OTHER REVENUE - RHC	B	-7,127	RURAL HEALTH CLINIC (RHC)	88		38
39 CONTRIBUTIONS	A	-2,465	ADMINISTRATIVE & GENERAL	5		39
40 LOBBYING EXPENSE	A	-6,602	ADMINISTRATIVE & GENERAL	5		40
41 ADVERTISING EXPENSE	A	-43,582	ADMINISTRATIVE & GENERAL	5		41
42 MARKETING OTHER EXPENSE	A	-17,815	ADMINISTRATIVE & GENERAL	5		42
43 RENTAL HOUSE EXPENSE	A	221	RENTAL PROPERTIES	192.04		43
44 CLINICAL TRAINING CLASSES	A	-2,730	NURSING ADMINISTRATION	13		44
45 NON-ALLOW PURCH SVC - CABLE TV	A	-529	PHYSICAL THERAPY	66		45
46						46
47						47
48						48
49						49
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,371,782				50
TRANSFER TO WKST A, COL. 6, LINE 200)						

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJUSTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	5	ADMINISTRATIVE & GENERAL	ADMINISTRATION & GENERAL	48,905		
2					48,905	
3						
4						
5		TOTALS (SUM OF LINES 1-4)		48,905	48,905	
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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

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

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

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

SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
B			CITY OF CLINTON		CITY GOVERNMENT

(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	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.		2	3	4	5	6	7	8	9
1	60	LABORATORY	3,105		3,105				1
2	69	ELECTROCARDIOLOGY	AGGREGATE 32,211	32,211					2
3	91	EMERGENCY	AGGREGATE 1,308,919	880,404	428,515				3
4	88	RURAL HEALTH CLINIC (RHC)	AGGREGATE 1,229,128	108,078	1,121,050				4
5	50	OPERATING ROOM	AGGREGATE 69,851	69,851					5
200		TOTAL	2,643,214	1,090,544	1,552,670				200

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
 08/15/2012 08:27

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.		11	12	13	14	15	16	17	18	
1	60	LABORATORY								1
2	69	ELECTROCARDIOLOGY	AGGREGATE						32,211	2
3	91	EMERGENCY	AGGREGATE						880,404	3
4	88	RURAL HEALTH CLINIC (RHC	AGGREGATE						108,078	4
5	50	OPERATING ROOM	AGGREGATE						69,851	5
200		TOTAL							1,090,544	200

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
 08/15/2012 08:27

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

WORKSHEET A-8-3
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					1	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					15	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE					1	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					0.49	8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED			1.00			9
10	AHSEA		72.49	54.37			10
11	STANDARD TRAVEL ALLOWANCE	36.25	36.25	27.19			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS						15
16	ASSISTANTS					54	16
17	SUBTOTAL ALLOWANCE AMOUNT					54	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					54	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					54.00	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					810	22
23	TOTAL SALARY EQUIVALENCY					810	23

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

WORKSHEET A-8-3
PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS		24
25	ASSISTANTS	27	25
26	SUBTOTAL	27	26
27	STANDARD TRAVEL EXPENSE	5	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	32	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	32	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
08/15/2012 08:27

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					810	57
58					32	58
59						59
60						60
61						61
62						62
63					842	63
64					48	64
65						65

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
 08/15/2012 08:27

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

WORKSHEET A-8-3
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)				52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK				780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE				255	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE				189	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS					5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS					6
7	STANDARD TRAVEL EXPENSE RATE				4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE				0.49	8

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9		3,707.00	2,145.25			9
10		76.32	57.24			10
11	STANDARD TRAVEL ALLOWANCE 38.16	38.16	28.62			11
12	NO OF TRAVEL HRS (PROV SITE)					12
12.01	NO OF TRAVEL HRS (OFFSITE)					12.01
13	MILES DRIVEN (PROV SITE)					13
13.01	MILES DRIVEN (OFFSITE)					13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS					14
15	THERAPISTS				282,918	15
16	ASSISTANTS				122,794	16
17	SUBTOTAL ALLOWANCE AMOUNT				405,712	17
18	AIDES					18
19	TRAINEES					19
20	TOTAL ALLOWANCE AMOUNT				405,712	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					22
23	TOTAL SALARY EQUIVALENCY				405,712	23

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
08/15/2012 08:27

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

WORKSHEET A-8-3
PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE		
24 THERAPISTS	9,731	24
25 ASSISTANTS	5,409	25
26 SUBTOTAL	15,140	26
27 STANDARD TRAVEL EXPENSE	2,153	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	17,293	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29 THERAPISTS		29
30 ASSISTANTS		30
31 SUBTOTAL		31
32 OPTIONAL TRAVEL EXPENSE		32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	17,293	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

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

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

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
08/15/2012 08:27

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					405,712	57
58					17,293	58
59						59
60						60
61						61
62						62
63					423,005	63
64					257,700	64
65						65

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
 08/15/2012 08:27

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

WORKSHEET A-8-3
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					3	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					45	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					8	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					0.49	8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		21.90				9
10	AHSEA		64.39				10
11	STANDARD TRAVEL ALLOWANCE	32.20	32.20				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					1,410	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					1,410	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					1,410	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					64.38	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					2,897	22
23	TOTAL SALARY EQUIVALENCY					2,897	23

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
08/15/2012 08:27

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

WORKSHEET A-8-3
PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE		
24 THERAPISTS	258	24
25 ASSISTANTS		25
26 SUBTOTAL	258	26
27 STANDARD TRAVEL EXPENSE	39	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	297	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29 THERAPISTS		29
30 ASSISTANTS		30
31 SUBTOTAL		31
32 OPTIONAL TRAVEL EXPENSE		32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	297	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

STANDARD TRAVEL EXPENSE

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

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

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

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
 08/15/2012 08:27

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					2,897	57
58					297	58
59						59
60						60
61						61
62						62
63					3,194	63
64					1,471	64
65						65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS. 0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	393,020	393,020				1
2 CAP REL COSTS-MVBLE EQUIP	639,140		639,140			2
4 EMPLOYEE BENEFITS	2,356,008	2,319		2,358,327		4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	2,129,791	41,628	203,051	414,441	2,788,911	5
7 OPERATION OF PLANT	540,610	68,033	10,088	48,789	667,520	7
8 LAUNDRY & LINEN SERVICE	109,725	4,577		2,602	116,904	8
9 HOUSEKEEPING	165,116	2,269		36,879	204,264	9
10 DIETARY	108,169	11,971	1,393	56,181	177,714	10
11 CAFETERIA	13,211			5,489	18,700	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	175,286	2,191		53,491	230,968	13
14 CENTRAL SERVICES & SUPPLY	14,458	7,805	532	4,612	27,407	14
15 PHARMACY	397,458	6,657	3,711	39,796	447,622	15
16 MEDICAL RECORDS & LIBRARY	260,497	8,621	1,250	43,117	313,485	16
17 SOCIAL SERVICE	36,789			11,002	47,791	17
19 NONPHYSICIAN ANESTHETISTS	206,400				206,400	19
20 NURSING SCHOOL						20
21 I&R SRVCS-SALARY & FRINGES APPRVD						21
22 I&R SRVCS-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,160,707	47,286	24,007	297,675	1,529,675	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	435,058	26,628	38,453	120,692	620,831	50
53 ANESTHESIOLOGY	5,169	993	15,574		21,736	53
54 RADIOLOGY-DIAGNOSTIC	895,248	24,431	191,766	83,450	1,194,895	54
60 LABORATORY	969,248	5,858	38,463	117,966	1,131,535	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	3,346			1,073	4,419	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	7,781			2,496	10,277	64
65 RESPIRATORY THERAPY	210,371	1,365	11,870	55,490	279,096	65
66 PHYSICAL THERAPY	439,894	13,941	325	13,444	467,604	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	50,243	1,365	1,345	17,967	70,920	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	163,633				163,633	71
72 IMPL. DEV. CHARGED TO PATIENT	198,371				198,371	72
73 DRUGS CHARGED TO PATIENTS	311,705				311,705	73
76 CARDIAC REHAB	48,426	1,587	183	14,856	65,052	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,636,943	47,431	18,393	493,379	2,196,146	88
90 CLINIC	2,183			700	2,883	90
90.01 PROVIDER BASED CLINIC	876	438		152	1,466	90.01
91 EMERGENCY	1,124,731	15,588	23,566	194,974	1,358,859	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	721,842	13,957	54,698	209,223	999,720	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	15,931,453	356,939	638,668	2,339,936	15,876,509	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	60,422	24,908	472	18,391	104,193	192
192.01 LIFELINE	1,628				1,628	192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT	20,073				20,073	192.03
192.04 RENTAL PROPERTIES	221	11,173			11,394	192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	16,013,797	393,020	639,140	2,358,327	16,013,797	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	2,788,911					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	140,769	808,289				7
8 LAUNDRY & LINEN SERVICE	24,653	13,708	155,265			8
9 HOUSEKEEPING	43,076	6,796		254,136		9
10 DIETARY	37,477	35,856		11,567	262,614	10
11 CAFETERIA	3,944					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	48,707	6,563		2,117		13
14 CENTRAL SERVICES & SUPPLY	5,780	23,378		7,542		14
15 PHARMACY	94,396	19,938		6,432		15
16 MEDICAL RECORDS & LIBRARY	66,109	25,820		8,330		16
17 SOCIAL SERVICE	10,078					17
19 NONPHYSICIAN ANESTHETISTS	43,526					19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	322,584	141,630	49,265	45,689	253,603	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	130,923	79,754	20,097	25,728	6,030	50
53 ANESTHESIOLOGY	4,584	2,974		959		53
54 RADIOLOGY-DIAGNOSTIC	251,984	73,174	14,469	23,606		54
60 LABORATORY	238,623	17,546		5,660		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	932					62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	2,167					64
65 RESPIRATORY THERAPY	58,857	4,087	2,109	1,319		65
66 PHYSICAL THERAPY	98,610	41,754	8,734	13,470		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	14,956	4,087	2,105	1,319		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	34,508					71
72 IMPL. DEV. CHARGED TO PATIENT	41,833					72
73 DRUGS CHARGED TO PATIENTS	65,734					73
76 CARDIAC REHAB	13,718	4,752		1,533		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	463,127	142,063	2,423	45,827		88
90 CLINIC	608					90
90.01 PROVIDER BASED CLINIC	309	1,313		423		90.01
91 EMERGENCY	286,562	46,689	47,385	15,062	2,981	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	210,825	41,804	7,709	13,486		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	2,759,959	733,686	154,296	230,069	262,614	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	21,973	74,603	969	24,067		192
192.01 LIFELINE	343					192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT	4,233					192.03
192.04 RENTAL PROPERTIES	2,403					192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,788,911	808,289	155,265	254,136	262,614	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11	13	14	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	22,644					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	540	288,895				13
14 CENTRAL SERVICES & SUPPLY	142		64,249			14
15 PHARMACY	763		225	569,376		15
16 MEDICAL RECORDS & LIBRARY	774		31		414,549	16
17 SOCIAL SERVICE	77	1,427				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,089	57,595	2,163		77,851	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,637	49,159	1,622		9,526	50
53 ANESTHESIOLOGY			16			53
54 RADIOLOGY-DIAGNOSTIC	1,310		4,834		88,363	54
60 LABORATORY	1,656		16,627		70,953	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY	1,153		422		328	65
66 PHYSICAL THERAPY	309		554			66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	162		172			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			12,837			71
72 IMPL. DEV. CHARGED TO PATIENT			19,111			72
73 DRUGS CHARGED TO PATIENTS				569,376		73
76 CARDIAC REHAB	151	2,818	89			76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	3,883	72,387	1,532		2,956	88
90 CLINIC			82			90
90.01 PROVIDER BASED CLINIC	3		39			90.01
91 EMERGENCY	2,177	40,593	2,328		153,403	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	3,482	64,916	1,565			95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	22,308	288,895	64,249	569,376	403,380	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	336				11,169	192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES						192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	22,644	288,895	64,249	569,376	414,549	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	19	24	25	26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY						16
17 SOCIAL SERVICE	59,373					17
19 NONPHYSICIAN ANESTHETISTS		249,926				19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	53,261		2,536,405		2,536,405	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			946,307		946,307	50
53 ANESTHESIOLOGY		249,926	280,195		280,195	53
54 RADIOLOGY-DIAGNOSTIC			1,652,635		1,652,635	54
60 LABORATORY			1,482,600		1,482,600	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			5,351		5,351	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY			12,444		12,444	64
65 RESPIRATORY THERAPY			347,371		347,371	65
66 PHYSICAL THERAPY			631,035		631,035	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY			93,721		93,721	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			210,978		210,978	71
72 IMPL. DEV. CHARGED TO PATIENT			259,315		259,315	72
73 DRUGS CHARGED TO PATIENTS			946,815		946,815	73
76 CARDIAC REHAB			88,113		88,113	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			2,930,344		2,930,344	88
90 CLINIC			3,573		3,573	90
90.01 PROVIDER BASED CLINIC			3,553		3,553	90.01
91 EMERGENCY	4,075		1,960,114		1,960,114	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES			1,343,507		1,343,507	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	57,336	249,926	15,734,376		15,734,376	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES			237,310		237,310	192
192.01 LIFELINE			1,971		1,971	192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT	2,037		26,343		26,343	192.03
192.04 RENTAL PROPERTIES			13,797		13,797	192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	59,373	249,926	16,013,797		16,013,797	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		2,319		2,319	2,319	4
5 ADMINISTRATIVE & GENERAL		41,628	203,051	244,679	407	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		68,033	10,088	78,121	48	7
8 LAUNDRY & LINEN SERVICE		4,577		4,577	3	8
9 HOUSEKEEPING		2,269		2,269	36	9
10 DIETARY		11,971	1,393	13,364	55	10
11 CAFETERIA					5	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		2,191		2,191	53	13
14 CENTRAL SERVICES & SUPPLY		7,805	532	8,337	5	14
15 PHARMACY		6,657	3,711	10,368	39	15
16 MEDICAL RECORDS & LIBRARY		8,621	1,250	9,871	42	16
17 SOCIAL SERVICE					11	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		47,286	24,007	71,293	292	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		26,628	38,453	65,081	119	50
53 ANESTHESIOLOGY		993	15,574	16,567		53
54 RADIOLOGY-DIAGNOSTIC		24,431	191,766	216,197	82	54
60 LABORATORY		5,858	38,463	44,321	116	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS					1	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					2	64
65 RESPIRATORY THERAPY		1,365	11,870	13,235	54	65
66 PHYSICAL THERAPY		13,941	325	14,266	13	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		1,365	1,345	2,710	18	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB		1,587	183	1,770	15	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		47,431	18,393	65,824	488	88
90 CLINIC					1	90
90.01 PROVIDER BASED CLINIC		438		438		90.01
91 EMERGENCY		15,588	23,566	39,154	191	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		13,957	54,698	68,655	205	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		356,939	638,668	995,607	2,301	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		24,908	472	25,380	18	192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES		11,173		11,173		192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		393,020	639,140	1,032,160	2,319	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	245,086					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	12,370	90,539				7
8 LAUNDRY & LINEN SERVICE	2,166	1,535	8,281			8
9 HOUSEKEEPING	3,785	761		6,851		9
10 DIETARY	3,293	4,016		312	21,040	10
11 CAFETERIA	347					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	4,280	735		57		13
14 CENTRAL SERVICES & SUPPLY	508	2,619		203		14
15 PHARMACY	8,295	2,233		173		15
16 MEDICAL RECORDS & LIBRARY	5,810	2,892		225		16
17 SOCIAL SERVICE	886					17
19 NONPHYSICIAN ANESTHETISTS	3,825					19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	28,348	15,864	2,628	1,232	20,318	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	11,505	8,933	1,072	694	483	50
53 ANESTHESIOLOGY	403	333		26		53
54 RADIOLOGY-DIAGNOSTIC	22,144	8,196	772	636		54
60 LABORATORY	20,970	1,965		153		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	82					62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	190					64
65 RESPIRATORY THERAPY	5,172	458	112	36		65
66 PHYSICAL THERAPY	8,666	4,677	466	363		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	1,314	458	112	36		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,032					71
72 IMPL. DEV. CHARGED TO PATIENT	3,676					72
73 DRUGS CHARGED TO PATIENTS	5,777					73
76 CARDIAC REHAB	1,206	532		41		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	40,703	15,915	129	1,234		88
90 CLINIC	53					90
90.01 PROVIDER BASED CLINIC	27	147		11		90.01
91 EMERGENCY	25,182	5,230	2,527	406	239	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	18,527	4,683	411	364		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	242,542	82,182	8,229	6,202	21,040	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	1,931	8,357	52	649		192
192.01 LIFELINE	30					192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT	372					192.03
192.04 RENTAL PROPERTIES	211					192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	245,086	90,539	8,281	6,851	21,040	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY. 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	352					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	8	7,324				13
14 CENTRAL SERVICES & SUPPLY	2		11,674			14
15 PHARMACY	12		41	21,161		15
16 MEDICAL RECORDS & LIBRARY	12		6		18,858	16
17 SOCIAL SERVICE	1	36				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	48	1,460	393		3,541	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	41	1,246	295		433	50
53 ANESTHESIOLOGY			3			53
54 RADIOLOGY-DIAGNOSTIC	20		878		4,020	54
60 LABORATORY	26		3,021		3,228	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY	18		77		15	65
66 PHYSICAL THERAPY	5		101			66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	3		31			69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			2,332			71
72 IMPL. DEV. CHARGED TO PATIENT			3,473			72
73 DRUGS CHARGED TO PATIENTS				21,161		73
76 CARDIAC REHAB	2	71	16			76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	61	1,836	278		134	88
90 CLINIC			15			90
90.01 PROVIDER BASED CLINIC			7			90.01
91 EMERGENCY	34	1,029	423		6,979	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	54	1,646	284			95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	347	7,324	11,674	21,161	18,350	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	5				508	192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES						192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	352	7,324	11,674	21,161	18,858	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	19	24	25	26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY						16
17 SOCIAL SERVICE	934					17
19 NONPHYSICIAN ANESTHETISTS		3,825				19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	838		146,255		146,255	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			89,902		89,902	50
53 ANESTHESIOLOGY			17,332		17,332	53
54 RADIOLOGY-DIAGNOSTIC			252,945		252,945	54
60 LABORATORY			73,800		73,800	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			83		83	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY			192		192	64
65 RESPIRATORY THERAPY			19,177		19,177	65
66 PHYSICAL THERAPY			28,557		28,557	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY			4,682		4,682	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			5,364		5,364	71
72 IMPL. DEV. CHARGED TO PATIENT			7,149		7,149	72
73 DRUGS CHARGED TO PATIENTS			26,938		26,938	73
76 CARDIAC REHAB			3,653		3,653	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			126,602		126,602	88
90 CLINIC			69		69	90
90.01 PROVIDER BASED CLINIC			630		630	90.01
91 EMERGENCY	64		81,458		81,458	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES			94,829		94,829	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	902		979,617		979,617	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES			36,900		36,900	192
192.01 LIFELINE			30		30	192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT	32		404		404	192.03
192.04 RENTAL PROPERTIES			11,384		11,384	192.04
200 CROSS FOOT ADJUSTMENTS		3,825	3,825		3,825	200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	934	3,825	1,032,160		1,032,160	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP	CAP	EMPLOYEE	RECON-	ADMINIS-	
	BLDGS & FIXTURES SQUARE FEET	MOVABLE EQUIPMENT DOLLAR VALUE	BENEFITS			
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	70,847					1
2 CAP REL COSTS-MVBLE EQUIP		627,360				2
4 EMPLOYEE BENEFITS	418		7,351,592			4
5 ADMINISTRATIVE & GENERAL	7,504	199,308	1,291,934	-2,788,911	13,224,886	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	12,264	9,902	152,089		667,520	7
8 LAUNDRY & LINEN SERVICE	825		8,110		116,904	8
9 HOUSEKEEPING	409		114,962		204,264	9
10 DIETARY	2,158	1,367	175,134		177,714	10
11 CAFETERIA			17,110		18,700	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	395		166,748		230,968	13
14 CENTRAL SERVICES & SUPPLY	1,407	522	14,377		27,407	14
15 PHARMACY	1,200	3,643	124,055		447,622	15
16 MEDICAL RECORDS & LIBRARY	1,554	1,227	134,407		313,485	16
17 SOCIAL SERVICE			34,297		47,791	17
19 NONPHYSICIAN ANESTHETISTS					206,400	19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS:						
30 ADULTS & PEDIATRICS	8,524	23,565	927,941		1,529,675	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,800	37,744	376,234		620,831	50
53 ANESTHESIOLOGY	179	15,287			21,736	53
54 RADIOLOGY-DIAGNOSTIC	4,404	188,232	260,137		1,194,895	54
60 LABORATORY	1,056	37,754	367,734		1,131,535	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			3,346		4,419	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY			7,781		10,277	64
65 RESPIRATORY THERAPY	246	11,651	172,980		279,096	65
66 PHYSICAL THERAPY	2,513	319	41,909		467,604	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	246	1,320	56,009		70,920	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					163,633	71
72 IMPL. DEV. CHARGED TO PATIENT					198,371	72
73 DRUGS CHARGED TO PATIENTS					311,705	73
76 CARDIAC REHAB	286	180	46,312		65,052	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	8,550	18,054	1,537,999		2,196,146	88
90 CLINIC			2,183		2,883	90
90.01 PROVIDER BASED CLINIC	79		473		1,466	90.01
91 EMERGENCY	2,810	23,132	607,791		1,358,859	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	2,516	53,690	652,211		999,720	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	64,343	626,897	7,294,263	-2,788,911	13,087,598	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	4,490	463	57,329		104,193	192
192.01 LIFELINE					1,628	192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT					20,073	192.03
192.04 RENTAL PROPERTIES	2,014				11,394	192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2011 To 04/30/2012

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

VERSION: 2011.10
 08/15/2012 08:27

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	393,020	639,140	2,358,327		2,788,911	202
203	UNIT COST MULT-WS B PT I	5.547447	1.018777	0.320791		0.210884	203
204	COST TO BE ALLOC PER B PT II			2,319		245,086	204
205	UNIT COST MULT-WS B PT II			0.000315		0.018532	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	SERVICE	SQUARE	MEALS	PAID	
	FEET	POUNDS OF	FEET	SERVED	HOURS	
	7	LAUNDRY	9	10	11	
		8				
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5						5
6						6
7	48,647					7
8	825	50,294				8
9	409		47,413			9
10	2,158		2,158	3,876		10
11					264,260	11
12						12
13	395		395		6,304	13
14	1,407		1,407		1,659	14
15	1,200		1,200		8,907	15
16	1,554		1,554		9,028	16
17					893	17
19						19
20						20
21						21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	8,524	15,958	8,524	3,743	36,053	30
ANCILLARY SERVICE COST CENTERS						
50	4,800	6,510	4,800	89	30,772	50
53	179		179			53
54	4,404	4,687	4,404		15,283	54
60	1,056		1,056		19,328	60
62						62
62.30						62.30
64						64
65	246	683	246		13,460	65
66	2,513	2,829	2,513		3,608	66
67						67
68						68
69	246	682	246		1,892	69
71						71
72						72
73						73
76	286		286		1,764	76
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
88	8,550	785	8,550		45,312	88
90						90
90.01	79		79		33	90.01
91	2,810	15,349	2,810	44	25,410	91
92						92
OTHER REIMBURSABLE COST CENTERS						
95	2,516	2,497	2,516		40,636	95
99.10						99.10
99.20						99.20
99.30						99.30
99.40						99.40
118	44,157	49,980	42,923	3,876	260,342	118
NONREIMBURSABLE COST CENTERS						
192	4,490	314	4,490		3,918	192
192.01						192.01
192.02						192.02
192.03						192.03
192.04						192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
 08/15/2012 08:27

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET	MEALS SERVED	PAID HOURS	
		7	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	808,289	155,265	254,136	262,614	22,644	202
203	UNIT COST MULT-WS B PT I	16.615393	3.087148	5.360049	67.753870	0.085688	203
204	COST TO BE ALLOC PER B PT II	90,539	8,281	6,851	21,040	352	204
205	UNIT COST MULT-WS B PT II	1.861143	0.164652	0.144496	5.428277	0.001332	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13	180,841					13
14		666,878				14
15		2,333	708,274			15
16		326		1,262		16
17	893				204	17
19						19
20						20
21						21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	36,053	22,449		237	183	30
ANCILLARY SERVICE COST CENTERS						
50	30,772	16,835		29		50
53		171				53
54		50,171		269		54
60		172,578		216		60
62						62
62.30						62.30
64						64
65		4,379		1		65
66		5,750				66
67						67
68						68
69		1,783				69
71		133,244				71
72		198,371				72
73			708,274			73
76	1,764	919				76
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
88	45,313	15,898		9		88
90		851				90
90.01		403				90.01
91	25,410	24,168		467	14	91
92						92
OTHER REIMBURSABLE COST CENTERS						
95	40,636	16,249				95
99.10						99.10
99.20						99.20
99.30						99.30
99.40						99.40
118	180,841	666,878	708,274	1,228	197	118
NONREIMBURSABLE COST CENTERS						
192				34		192
192.01						192.01
192.02						192.02
192.03					7	192.03
192.04						192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
 08/15/2012 08:27

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	288,895	64,249	569,376	414,549	59,373	202
203	UNIT COST MULT-WS B PT I	1.597508	0.096343	0.803892	328.485737	291.044118	203
204	COST TO BE ALLOC PER B PT II	7,324	11,674	21,161	18,858	934	204
205	UNIT COST MULT-WS B PT II	0.040500	0.017505	0.029877	14.942948	4.578431	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NONPHYSIC. ANESTHET.	ASSIGNED TIME	
		19	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS	100		19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
30 INPATIENT ROUTINE SERV COST CENTERS			30
ADULTS & PEDIATRICS			
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
53 ANESTHESIOLOGY	100		53
54 RADIOLOGY-DIAGNOSTIC			54
60 LABORATORY			60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
64 INTRAVENOUS THERAPY			64
65 RESPIRATORY THERAPY			65
66 PHYSICAL THERAPY			66
67 OCCUPATIONAL THERAPY			67
68 SPEECH PATHOLOGY			68
69 ELECTROCARDIOLOGY			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			71
72 IMPL. DEV. CHARGED TO PATIENT			72
73 DRUGS CHARGED TO PATIENTS			73
76 CARDIAC REHAB			76
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
88 RURAL HEALTH CLINIC (RHC)			88
90 CLINIC			90
90.01 PROVIDER BASED CLINIC			90.01
91 EMERGENCY			91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
95 AMBULANCE SERVICES			95
99.10 CORF			99.10
99.20 OUTPATIENT PHYSICAL THERAPY			99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40 OUTPATIENT SPEECH PATHOLOGY			99.40
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	100		118
NONREIMBURSABLE COST CENTERS			
192 PHYSICIANS' PRIVATE OFFICES			192
192.01 LIFELINE			192.01
192.02 HOME MEDICAL EQUIPMENT			192.02
192.03 COMMUNITY BENEFIT			192.03
192.04 RENTAL PROPERTIES			192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
08/15/2012 08:27

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NONPHYSIC. ANESTHET.	ASSIGNED TIME	
200 CROSS FOOT ADJUSTMENTS		19	200
201 NEGATIVE COST CENTER			201
202 COST TO BE ALLOC PER B PT I		249,926	202
203 UNIT COST MULT-WS B PT I	2,499.260000		203
204 COST TO BE ALLOC PER B PT II		3,825	204
205 UNIT COST MULT-WS B PT II	38.250000		205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
30 INPATIENT ROUTINE SERV COST CENTERS					
ADULTS & PEDIATRICS	2,536,405		2,536,405		30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	946,307		946,307		50
53 ANESTHESIOLOGY	280,195		280,195		53
54 RADIOLOGY-DIAGNOSTIC	1,652,635		1,652,635		54
60 LABORATORY	1,482,600		1,482,600		60
62 WHOLE BLOOD & PACKED RED BL	5,351		5,351		62
62.30 BLOOD CLOTTING FOR HEMOPHIL					62.30
64 INTRAVENOUS THERAPY	12,444		12,444		64
65 RESPIRATORY THERAPY	347,371		347,371		65
66 PHYSICAL THERAPY	631,035		631,035		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	93,721		93,721		69
71 MEDICAL SUPPLIES CHRGED TO	210,978		210,978		71
72 IMPL. DEV. CHARGED TO PATIE	259,315		259,315		72
73 DRUGS CHARGED TO PATIENTS	946,815		946,815		73
76 CARDIAC REHAB	88,113		88,113		76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	2,930,344		2,930,344		88
90 CLINIC	3,573		3,573		90
90.01 PROVIDER BASED CLINIC	3,553		3,553		90.01
91 EMERGENCY	1,960,114		1,960,114		91
92 OBSERVATION BEDS	531,722		531,722		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	1,343,507		1,343,507		95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THE					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
113 INTEREST EXPENSE					113
200 SUBTOTAL (SEE INSTRUCTIONS)	16,266,098		16,266,098		200
201 LESS OBSERVATION BEDS	531,722		531,722		201
202 TOTAL (SEE INSTRUCTIONS)	15,734,376		15,734,376		202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
30 INPATIENT ROUTINE SERV COST CENTERS						30
ADULTS & PEDIATRICS	768,399		768,399			
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	106,219	1,157,871	1,264,090	0.748607		50
53 ANESTHESIOLOGY	55,427	641,135	696,562	0.402254		53
54 RADIOLOGY-DIAGNOSTIC	354,467	5,220,265	5,574,732	0.296451		54
60 LABORATORY	396,163	3,787,397	4,183,560	0.354387		60
62 WHOLE BLOOD & PACKED RED BL	1,691	29,847	31,538	0.169668		62
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
64 INTRAVENOUS THERAPY		167,095	167,095	0.074473		64
65 RESPIRATORY THERAPY	170,304	313,069	483,373	0.718640		65
66 PHYSICAL THERAPY	26,962	2,090,943	2,117,905	0.297952		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	56,157	380,872	437,029	0.214450		69
71 MEDICAL SUPPLIES CHRGED TO	233,729	338,120	571,849	0.368940		71
72 IMPL. DEV. CHARGED TO PATIE	12,202	267,316	279,518	0.927722		72
73 DRUGS CHARGED TO PATIENTS	944,324	1,458,533	2,402,857	0.394037		73
76 CARDIAC REHAB		119,142	119,142	0.739563		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	132,362	1,969,709	2,102,071			88
90 CLINIC	1,614	16,136	17,750	0.201296		90
90.01 PROVIDER BASED CLINIC		46,364	46,364	0.076633		90.01
91 EMERGENCY	39,779	2,708,997	2,748,776	0.713086		91
92 OBSERVATION BEDS	5,319	211,741	217,060	2.449654		92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	9,622	1,216,618	1,226,240	1.095631		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	3,314,740	22,141,170	25,455,910			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		22,141,170	25,455,910			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.748607		365,974			273,971		50
53 ANESTHESIOLOGY	0.402254		206,091			82,901		53
54 RADIOLOGY-DIAGNOSTIC	0.296451		1,856,282			550,297		54
60 LABORATORY	0.354387		1,592,899			564,503		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.169668		9,514			1,614		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64 INTRAVENOUS THERAPY	0.074473		73,926			5,505		64
65 RESPIRATORY THERAPY	0.718640		105,164			75,575		65
66 PHYSICAL THERAPY	0.297952		625,134			186,260		66
67 OCCUPATIONAL THERAPY								67
68 SPEECH PATHOLOGY								68
69 ELECTROCARDIOLOGY	0.214450		262,400			56,272		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.368940		108,297			39,955		71
72 IMPL. DEV. CHARGED TO PATIENT	0.927722		23,400			21,709		72
73 DRUGS CHARGED TO PATIENTS	0.394037		690,663			272,147		73
76 CARDIAC REHAB	0.739563		65,001			48,072		76
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
90 CLINIC	0.201296		9,506			1,914		90
90.01 PROVIDER BASED CLINIC	0.076633		31,451			2,410		90.01
91 EMERGENCY	0.713086		812,493			579,377		91
92 OBSERVATION BEDS	2.449654		124,908			305,981		92
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	1.095631							95
200 SUBTOTAL (SEE INSTRUCTIONS)			6,963,103			3,068,463		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			6,963,103			3,068,463		202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (14-Z303)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	COST SERVICES DED & COINS 5	COST SVCS NOT SUBJECT TO DED & COINS 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	0.748607					50
53 ANESTHESIOLOGY	0.402254					53
54 RADIOLOGY-DIAGNOSTIC	0.296451					54
60 LABORATORY	0.354387					60
62 WHOLE BLOOD & PACKED RED BLOOD	0.169668					62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	0.074473					64
65 RESPIRATORY THERAPY	0.718640					65
66 PHYSICAL THERAPY	0.297952					66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	0.214450					69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.368940					71
72 IMPL. DEV. CHARGED TO PATIENT	0.927722					72
73 DRUGS CHARGED TO PATIENTS	0.394037					73
76 CARDIAC REHAB	0.739563					76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
90 CLINIC	0.201296					90
90.01 PROVIDER BASED CLINIC	0.076633					90.01
91 EMERGENCY	0.713086					91
92 OBSERVATION BEDS	2.449654					92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1.095631					95
200 SUBTOTAL (SEE INSTRUCTIONS)						200
201 LESS PBP CLINIC LAB SERVICES						201
202 NET CHARGES (LINE 200 - LINE 201)						202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] ICF/MR [] PFS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	1,201	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,070	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	821	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	78	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	39	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	9	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	5	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	635	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	78	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	39	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	117.54	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.73	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,536,405	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	1,058	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	589	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	251,492	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,284,913	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	768,399	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	768,399	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.973602	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	935.93	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,284,913	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 2,135.43 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,355,998 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,355,998 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					571,810 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,927,808 49
PASS-THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					51
52 TOTAL PROGRAM EXCLUDABLE COST					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					53

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
54 TARGET AMOUNT AND LIMIT COMPUTATION					
PROGRAM DISCHARGES					54
55 TARGET AMOUNT PER DISCHARGE					55
56 TARGET AMOUNT (LINE 54 x LINE 55)					56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT					57
58 BONUS PAYMENT (SEE INSTRUCTIONS)					58
59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET					59
60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET					60
61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)					61
62 RELIEF PAYMENT (SEE INSTRUCTIONS)					62
63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)					63
PROGRAM INPATIENT ROUTINE SWING BED COST					
64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					166,564 64
65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					83,282 65
66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					249,846 66
67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)					67
68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)					68
69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)					69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 249 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 2,135.43 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 531,722 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST	146,255	2,284,913	0.064009	531,722	34,035 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1303) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		528,014		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.748607	31,351	23,470	50
53 ANESTHESIOLOGY	0.402254	14,085	5,666	53
54 RADIOLOGY-DIAGNOSTIC	0.296451	205,692	60,978	54
60 LABORATORY	0.354387	278,034	98,532	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.169668	1,216	206	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.074473			64
65 RESPIRATORY THERAPY	0.718640	108,264	77,803	65
66 PHYSICAL THERAPY	0.297952	13,276	3,956	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.214450	55,958	12,000	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.368940	138,635	51,148	71
72 IMPL. DEV. CHARGED TO PATIENT	0.927722	920	854	72
73 DRUGS CHARGED TO PATIENTS	0.394037	600,700	236,698	73
76 CARDIAC REHAB	0.739563			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
90 CLINIC	0.201296	573	115	90
90.01 PROVIDER BASED CLINIC	0.076633			90.01
91 EMERGENCY	0.713086	538	384	91
92 OBSERVATION BEDS	2.449654			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,449,242	571,810	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,449,242		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) S/B SNF (14-Z303) PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.748607			50
53 ANESTHESIOLOGY	0.402254			53
54 RADIOLOGY-DIAGNOSTIC	0.296451	6,428	1,906	54
60 LABORATORY	0.354387	13,369	4,738	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.169668			62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.074473			64
65 RESPIRATORY THERAPY	0.718640	23,785	17,093	65
66 PHYSICAL THERAPY	0.297952	10,564	3,148	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.214450	199	43	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.368940	18,830	6,947	71
72 IMPL. DEV. CHARGED TO PATIENT	0.927722			72
73 DRUGS CHARGED TO PATIENTS	0.394037	102,702	40,468	73
76 CARDIAC REHAB	0.739563			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
90 CLINIC	0.201296			90
90.01 PROVIDER BASED CLINIC	0.076633			90.01
91 EMERGENCY	0.713086			91
92 OBSERVATION BEDS	2.449654			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		175,877	74,343	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		175,877		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-1303) [] IPF [] IRF
 [] SUB (OTHER) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,068,463	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS):		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	3,068,463	11
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	3,099,148	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 \$2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	21,211	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,069,008	26
27	SUBTOTAL ((LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23) (SEE INSTRUCTIONS)	2,008,929	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	2,008,929	30
31	PRIMARY PAYER PAYMENTS	144	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,008,785	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	254,502	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	254,502	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	226,789	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	2,263,287	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	2,263,287	40
41	INTERIM PAYMENTS	2,280,629	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-17,342	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[XX] HOSPITAL (14-1303) [] IPF [] IRF	[] SUB (OTHER) [] SNF [] SWING BED SNF	INPATIENT		PART B		
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,851,358		2,280,629	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.			NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.						
		.01		NONE		NONE	3.01
		.02					3.02
		PROGRAM .03					3.03
		TO .04					3.04
		PROVIDER .05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
		PROVIDER .52					3.52
		TO .53					3.53
		PROGRAM .54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
		.99					3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)						
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			1,851,358		2,280,629	4
TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.						
		PROGRAM .01		NONE		NONE	5.01
		TO .02					5.02
		PROVIDER .03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		PROVIDER .50		NONE		NONE	5.50
		TO .51					5.51
		PROGRAM .52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
		.99					5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT						
		PROGRAM .01					6.01
		TO .02					6.02
		PROVIDER .02		-34,520		-17,342	6.02
		PROGRAM					
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			1,816,838		2,263,287	7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:		DATE:	

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
08/15/2012 08:27

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1303) [] CAH
APPLICABLE BOX

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	251	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	635	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	821	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	25,455,910	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	358,311	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK TITLE V SWING BED - SNF (14-Z303)
 APPLICABLE TITLE XVIII SWING BED - NF
 BOXES TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	252,344	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	75,086	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	117	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	327,430	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	327,430	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	327,430	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	1,338	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	326,092	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	326,092	19
20 INTERIM PAYMENTS	326,829	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	-737	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART V

CHECK HOSPITAL (14-1303)
 APPLICABLE BOX: SUB (OTHER)

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

1	INPATIENT SERVICES	1,927,808	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,927,808	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	1,947,086	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6, 17 AND 18)	1,947,086	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	153,215	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,793,871	22
23	COINSURANCE	1,526	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,792,345	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	24,493	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	24,493	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	17,114	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,816,838	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,816,838	30
31	INTERIM PAYMENTS	1,851,358	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	-34,520	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		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	305,901			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	7,307,212			4
5 OTHER RECEIVABLES	236,000			5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4,211,354			6
7 INVENTORY	343,782			7
8 PREPAID EXPENSES	534,909			8
9 OTHER CURRENT ASSETS				9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	4,516,450			11
FIXED ASSETS				
12 LAND	310,078			12
13 LAND IMPROVEMENTS				13
14 ACCUMULATED DEPRECIATION				14
15 BUILDINGS	9,986,337			15
16 ACCUMULATED DEPRECIATION	-6,442,645			16
17 LEASEHOLD IMPROVEMENTS				17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT				19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	5,333,491			23
24 ACCUMULATED DEPRECIATION	-3,780,152			24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS				27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	5,407,109			30
OTHER ASSETS				
31 INVESTMENTS	648,794			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	312,163			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	960,957			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	10,884,516			36
LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	620,932			37
38 SALARIES, WAGES & FEES PAYABLE	782,117			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	225,000			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	291,079			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,919,128			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	1,075,000			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES				49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	1,075,000			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	2,994,128			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	7,890,388			52
53 SPECIFIC PURPOSE FUND BALANCE				53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57 PLANT FUND BALANCE - INVESTED IN PLANT				57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)	7,890,388			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	10,884,516			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		8,454,170							.1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		-941,046							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		7,513,124							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 CAPITAL GRANTS		375,460							5
6 UNREALIZED GAIN		1,804							6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		377,264							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		7,890,388							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 UNREALIZED LOSS									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		7,890,388							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	771,813		771,813	1
2 SUBPROVIDER IPF				2
3 SUBPROVIDER IRF				3
5 SWING BED - SNF				5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	771,813		771,813	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT				11
12 CORONARY CARE UNIT				12
13 BURN INTENSIVE CARE UNIT				13
14 SURGICAL INTENSIVE CARE UNIT				14
15 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	771,813		771,813	17
18 ANCILLARY SERVICES	2,465,466		2,465,466	18
19 OUTPATIENT SERVICES		21,114,471	21,114,471	19
20 RHC	132,362	2,008,468	2,140,830	20
21 FOHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE	9,622	1,216,618	1,226,240	23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	3,379,263	24,339,557	27,718,820	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		17,385,579	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38 INTEREST EXPENSE	-68,073		38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)	-68,073		42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		17,317,506	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	27,718,820	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	11,910,367	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	15,808,453	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	17,317,506	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,509,053	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	55,641	6
7	INCOME FROM INVESTMENTS	20,151	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	16,840	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	6,000	15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	1,300	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	1,099	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	11,551	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	1,425	21
22	RENTAL OF HOSPITAL SPACE	24,455	22
23	GOVERNMENTAL APPROPRIATIONS	251,067	23
24	OTHER (OTHER DIETARY REVENUE)	199,425	24
24.01	OTHER (GRANT REVENUE)		24.01
24.02	OTHER (FITNESS CENTER)	7,970	24.02
24.03	OTHER (GAIN (LOSS) SALE/DISPOSE ASSET)		24.03
24.04	OTHER (LIFELINE)	1,580	24.04
24.05	OTHER (MISC OTHER)	37,797	24.05
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	636,301	25
26	TOTAL (LINE 5 PLUS LINE 25)	-872,752	26
27	OTHER EXPENSES (INTEREST EXPENSE)	68,073	27
27.01	OTHER EXPENSES (RENTAL EXPENSE)	221	27.01
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	68,294	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-941,046	29

RHC I
 COMPONENT NO: 14-3404

WORKSHEET M-1

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

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1	1,218,312		1,218,312	-283,016	935,296	-108,078	827,218	1
2								2
3	81,173		81,173		81,173		81,173	3
4								4
5	232,596		232,596		232,596		232,596	5
6								6
7		11,550	11,550		11,550		11,550	7
8								8
9	288,934		288,934		288,934		288,934	9
10	1,821,015	11,550	1,832,565	-283,016	1,549,549	-108,078	1,441,471	10
COSTS UNDER AGREEMENT								
11		10,816	10,816		10,816		10,816	11
12								12
13		21,529	21,529		21,529		21,529	13
14		32,345	32,345		32,345		32,345	14
OTHER HEALTH CARE COSTS								
15		45,791	45,791		45,791		45,791	15
16		9,261	9,261		9,261		9,261	16
17								17
18		65,247	65,247	-65,247				18
19		58,664	58,664	-2,920	55,744		55,744	19
20								20
21		178,963	178,963	-68,167	110,796		110,796	21
22	1,821,015	222,858	2,043,873	-351,183	1,692,690	-108,078	1,584,612	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26				-7,381	-7,381		-7,381	26
27								27
28				-7,381	-7,381		-7,381	28
FACILITY OVERHEAD								
29								29
30		66,839	66,839		66,839	-7,127	59,712	30
31		66,839	66,839		66,839	-7,127	59,712	31
32	1,821,015	289,697	2,110,712	-358,564	1,752,148	-115,205	1,636,943	32

RHC I
 COMPONENT NO: 14-3404

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	2.99	10,987	4,200	12,558	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	0.43	1,200	2,100	903	3
4	SUBTOTAL (SUM OF LINES 1-3)	3.42	12,187		13,461	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER		192			7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	3.42	12,379		13,653	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		154		154	9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				1,584,612	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)				-7,381	11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				1,577,231	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.004680	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				59,712	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				1,293,401	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				1,353,113	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				1,353,113	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				1,359,446	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				2,944,058	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES
 RHC I COMPONENT NO: 14-3404

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	2,944,058	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	13,011	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	2,931,047	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	13,653	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)	154	5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	13,807	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	212.29	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)	155.00	8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	212.29	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	3,628	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	770,188	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	14	12
13	PROGRAM COVERED COST FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	2,972	13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	2,229	14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)		15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	772,417	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)	567,438	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)	825	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	1,123	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	578,982	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	580,105	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	47,566	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	104,488	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	580,105	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	5,009	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	585,114	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	32,133	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	31,152	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	617,247	26
27	INTERIM PAYMENTS	581,827	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	35,420	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		30

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I
 COMPONENT NO: 14-3404

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,441,471	1,441,471	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000140	0.001920	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	202	2,768	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	970	3,078	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,172	5,846	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,584,612	1,584,612	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,353,113	1,353,113	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.000740	0.003689	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	1,001	4,992	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	2,173	10,838	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	19	260	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	114.37	41.68	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	15	79	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	1,716	3,293	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		13,011	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		5,009	16

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

RHC I
 COMPONENT NO: 14-3404

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		581,827	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)			
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		581,827	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)			
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM	35,420	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		617,247	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	DATE: