

HARDIN COUNTY GENERAL HOSPITAL

TITLE XVIII MEDICARE COST REPORT

PROVIDER NO. 14-1328

YEAR ENDED MARCH 31, 2012

August 17, 2012

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

Re: Provider: Hardin County General Hospital
Provider Numbers: 14-1328, 14-Z328, 14-3479
Period ended: 03/31/2012
Protested amounts claimed on submitted cost report.

Dear Sir or Madam:

The cost report for Hardin County General Hospital, for the year ended March 31, 2012, claims additional amounts due the provider for an expense paid by the provider, but currently not classified as a reimbursable cost by National Government Services, Inc. The expenses in question relate to the Illinois State Medicaid Provider Tax Assessment in the amount of \$120,546 which we have included as adjustments to line 6 (A&G) on worksheet A-8. We feel as though the tax should be, and is, allowed as a reimbursable cost under Medicare Guidelines and should remain on line 6 (A&G) for inclusion in the B-1 allocation process.

The calculation of the additional amounts due the provider was calculated by removing the adjustments on worksheet A-8. The expense was then allowed to be allocated by the B-1 accumulated cost statistic to the various Hospital departments. The protested amounts claimed for the period ended March 31, 2012, are as follows:

Worksheet E, part B, line 44	\$ 21,572
Worksheet E-2, line 23	10,561
Worksheet E-3, part V, line 34	25,753
Worksheet M-3, line 30	<u>5,199</u>
Total	\$ 63,085

Sincerely,

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

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

- PROVIDER USE ONLY
1. ELECTRONICALLY FILED COST REPORT
 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.
- DATE: 08/17/2012 TIME: 11:29
- CONTRACTOR USE ONLY
5. COST REPORT STATUS
 - 1 - AS SUBMITTED
 - 2 - SETTLED WITHOUT AUDIT
 - 3 - SETTLED WITH AUDIT
 - 4 - REOPENED
 - 5 - AMENDED
6. DATE RECEIVED: _____
 7. CONTRACTOR NO: _____
 8. INITIAL REPORT FOR THIS PROVIDER CCN
 9. FINAL REPORT FOR THIS PROVIDER CCN
 10. NPR DATE: _____
 11. CONTRACTOR'S VENDOR CODE: _____
 12. IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED - 0-9.

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 HARDIN COUNTY GENERAL HOSPITAL (14-1328) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 04/01/2011 AND ENDING 03/31/2012, 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: 08/17/2012 11:29
 7cYvgVZIZ.5S.Ek9DxnBmwiHya5Ge0
 9ZFDi0x9:FPe2mjiIdjNb03y8TVc3v
 7fnj09OPx50LRyUT

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

 TITLE

 DATE

PI Encryption: 08/17/2012 11:29
 x7eSaDq7C3milHbPZ5hEcc80By7Be0
 5ncQu0MwHv52TzpT7LMX9Ut9of4vMY
 PrPe0ZFDrJ0UvbcC
 PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		139,527	124,783	40,779	411,203	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		64,025				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			38,230			10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		203,552	163,013	40,779	411,203	200

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: FERRELL ROAD
 2 CITY: ROSICLARE

STATE: IL

P.O. BOX: 2467
 ZIP CODE: 62982

COUNTY: HARDIN

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	1	CCN NUMBER	2	CBSA NUMBER	3	PROV TYPE	4	DATE CERTIFIED	5	PAYMENT SYSTEM			3
											6	7	8	
3	HOSPITAL	HARDIN COUNTY GENERAL HOSPITA	14-1328	99914	1	07/09/2003	N	O	O	3				
4	SUBPROVIDER - IPF													4
5	SUBPROVIDER - IRF													5
6	SUBPROVIDER - (OTHER)													6
7	SWING BEDS - SNF	HARDIN COUNTY SWING BED	14-Z328	99914		07/09/2003	N	O	N	7				
8	SWING BEDS - NF													8
9	HOSPITAL-BASED SNF													9
10	HOSPITAL-BASED NF													10
11	HOSPITAL-BASED OLTC													11
12	HOSPITAL-BASED HHA													12
13	SEPARATELY CERTIFIED ASC													13
14	HOSPITAL-BASED HOSPICE													14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	HARDIN COUNTY RHC	14-3479	99914		04/03/2006	N	O	N	15				
16	HOSPITAL-BASED HEALTH CLINIC - FQHC													16
17	HOSPITAL-BASED (CMHC)													17
18	RENAL DIALYSIS													18
19	OTHER													19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 04/01/2011				TO: 03/31/2012								20
21	TYPE OF CONTROL													21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPHS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							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 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.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.							26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 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
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	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)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTES NONPROVIDER SITE 3	UNWEIGHTED FTES IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 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.			N 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- SICAL ANATIONAL Y Y Y	RESPI- RATORY N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	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.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: AND/OR SELF INSURANCE:			118.01
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.	N		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	N		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 PART A	TITLE XVIII PART B	TITLE V	TITLE XIX
	1	2	3	4
155	HOSPITAL	N	N	N
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.	Y		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.	526,703		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	2	1
		N		

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	DATE	V/I	3
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)	1	2	3	2
		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	2	3	4
		Y	A		
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	1	2	3	5
		N			

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	2	6
		N		
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	1	2	7
		N		
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	1	2	8
		N		
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	1	2	9
		N		
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	1	2	10
		N		
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.	1	2	11
		N		
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	1	2	12
		Y		
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	1	2	13
		N		
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	1	2	14
		N		

BED COMPLEMENT		Y/N	
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	1	2
		N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	07/31/2012	Y	07/31/2012	16
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		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
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		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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. | Y | 28 |
| 29 | DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. | N | 29 |
| 30 | HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. | N | 30 |
| 31 | HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. | N | 31 |

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

- | | | 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: | LAST NAME: | TITLE: | 41 |
| 42 | EMPLOYER: | | | 42 |
| 43 | PHONE NUMBER: | E-MAIL ADDRESS: | | 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	5,817,034			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)		983,464	-113,085		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		747,294			27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT		177,910			30
31	LAUNDRY & LINEN SERVICE		56,259			31
32	HOUSEKEEPING		95,140	-9,568		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY		108,397	-53,115		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA			53,115		36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION			76,361		38
39	CENTRAL SERVICES AND SUPPLY		28,991	-21,743		39
40	PHARMACY		74,805			40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		242,360	-20,645		41
42	SOCIAL SERVICE		51,564			42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	5,817,034		5,817,034		1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	983,464	-113,085	870,379		2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	4,833,570	113,085	4,946,655		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)	4,833,570	113,085	4,946,655		6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	1,582,720	24,405	1,607,125		7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

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

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N 1	DATE 2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	07/09/2003	2

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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (COLS. 2 + 3)
	1	2	3	4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL			200

SNF SERVICES

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

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

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

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
08/17/2012 11:03

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

RHC I
COMPONENT NO: 14-3479

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 6 FERRELL ROAD 1
2 CITY: ROSICLARE STATE: IL ZIP CODE: 62982 COUNTY: HARDIN 2
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 1 4
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) 2 5
6 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) 6
7 APPALACHIAN REGIONAL COMMISSION 7
8 LOOK-ALIKES 8
9 OTHER 9

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

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
11 CLINIC			0900	1700	0900	1700	0900	1700	0900	1700	0900	1700		

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2 12
N

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

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO 15
IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED
BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)
Y/N V XVIII XIX
N

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)		0.698864	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)				
2	NET REVENUE FROM MEDICAID		1,817,516	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		2,883,699	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)		2,015,314	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)		197,798	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)		197,798	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	559,370		559,370	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	390,924		390,924	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	390,924		390,924	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)			962,145	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			229,321	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			732,824	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			512,144	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			903,068	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			1,100,866	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		38,182	38,182	40,768	1
2	00200		274,225	274,225	6,545	2
3	00300					3
4	00400				59,708	4
5	00500	747,294	2,349,835	3,097,129	-24,041	5
6	00600					6
7	00700	177,910	187,245	365,155		7
8	00800	56,259	12,910	69,169		8
9	00900	95,140	38,136	133,276	-11,531	9
10	01000	108,397	138,989	247,386	-120,910	10
11	01100				120,143	11
12	01200					12
13	01300				87,052	13
14	01400	28,991	6,646	35,637	-27,172	14
15	01500	74,805	165,179	239,984	-47,560	15
16	01600	242,360	64,538	306,898	-23,806	16
17	01700	51,564	15,787	67,351		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,360,647	463,701	1,824,348	-266,867	30
ANCILLARY SERVICE COST CENTERS						
54	05400	359,734	235,415	595,149	-2,467	54
60	06000	395,602	652,304	1,047,906	-765	60
62.30	06250					62.30
65	06500	149,636	68,646	218,282	-28,786	65
66	06600	109,083	71,343	180,426	-301	66
67	06700					67
68	06800					68
69	06900	11,132	1,052	12,184	20,771	69
71	07100				131,884	71
73	07300				362,093	73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	983,464	169,838	1,153,302	-119,300	88
91	09100	865,016	273,487	1,138,503	-46,304	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	11300		109,154	109,154	-109,154	113
118		5,817,034	5,336,612	11,153,646		118
NONREIMBURSABLE COST CENTERS						
190	19000					190
190.01	19001		12,406	12,406		190.01
200		5,817,034	5,349,018	11,166,052		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	78,950		78,950	1
2	00200	CAP REL COSTS-MVBLE EQUIP	280,770	-73,293	207,477	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	59,708		59,708	4
5	00500	ADMINISTRATIVE & GENERAL	3,073,088	-1,150,645	1,922,443	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	365,155		365,155	7
8	00800	LAUNDRY & LINEN SERVICE	69,169		69,169	8
9	00900	HOUSEKEEPING	121,745		121,745	9
10	01000	DIETARY	126,476		126,476	10
11	01100	CAFETERIA	120,143	-28,040	92,103	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	87,052		87,052	13
14	01400	CENTRAL SERVICES & SUPPLY	8,465		8,465	14
15	01500	PHARMACY	192,424		192,424	15
16	01600	MEDICAL RECORDS & LIBRARY	283,092	-3,989	279,103	16
17	01700	SOCIAL SERVICE	67,351		67,351	17
19	01900	NONPHYSICIAN ANESTHETISTS				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	1,557,481	-142,890	1,414,591	30
ANCILLARY SERVICE COST CENTERS						
54	05400	RADIOLOGY-DIAGNOSTIC	592,682		592,682	54
60	06000	LABORATORY	1,047,141	-123,123	924,018	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	189,496	-22,540	166,956	65
66	06600	PHYSICAL THERAPY	180,125		180,125	66
67	06700	OCCUPATIONAL THERAPY				67
68	06800	SPEECH PATHOLOGY				68
69	06900	ELECTROCARDIOLOGY	32,955		32,955	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	131,884		131,884	71
73	07300	DRUGS CHARGED TO PATIENTS	362,093		362,093	73
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)	1,034,002		1,034,002	88
91	09100	EMERGENCY	1,092,199	-324,808	767,391	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	11,153,646	-1,869,328	9,284,318	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
190.01	19001	VENDING MACHINE	12,406		12,406	190.01
200		TOTAL (SUM OF LINES 118-199)	11,166,052	-1,869,328	9,296,724	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER	
			LINE #				
	1	2	3	4	5		
1 TO RECLASS SUPPLY COST FROM CS	A	MEDICAL SUPPLIES CHRGED TO PA	71		21,743	5,429	1
500 TOTAL RECLASSIFICATIONS					21,743	5,429	500
CODE LETTER - A							
1 TO RECLASS DON COST	B	NURSING ADMINISTRATION	13		76,361	10,691	1
500 TOTAL RECLASSIFICATIONS					76,361	10,691	500
CODE LETTER - B							
1 TO RECLASS COST TO CLINC	C	RURAL HEALTH CLINIC (RHC)	88		30,213	5,124	1
2							2
3							3
500 TOTAL RECLASSIFICATIONS					30,213	5,124	500
CODE LETTER - C							
1 TO RECLASS SUPPLY COST	D	MEDICAL SUPPLIES CHRGED TO PA	71			104,712	1
2							2
3							3
4							4
5							5
6							6
500 TOTAL RECLASSIFICATIONS						104,712	500
CODE LETTER - D							
1 TO RECLASS INSURANCE EXPENSE	E	CAP REL COSTS-BLDG & FIXT	1			2,805	1
2		CAP REL COSTS-MVBLE EQUIP	2			6,545	2
3		EMPLOYEE BENEFITS	4			59,708	3
500 TOTAL RECLASSIFICATIONS						69,058	500
CODE LETTER - E							
1 TO RECLASS INTEREST	F	CAP REL COSTS-BLDG & FIXT	1			37,963	1
2		ADMINISTRATIVE & GENERAL	5			45,017	2
3		RADIOLOGY-DIAGNOSTIC	54			12,245	3
4		ADULTS & PEDIATRICS	30			6,504	4
5		RURAL HEALTH CLINIC (RHC)	88			4,424	5
6		ELECTROCARDIOLOGY	69			3,001	6
500 TOTAL RECLASSIFICATIONS						109,154	500
CODE LETTER - F							
1 TO RECLASS CAFE COST	G	CAFETERIA	11		53,115	67,028	1
500 TOTAL RECLASSIFICATIONS					53,115	67,028	500
CODE LETTER - G							
1 TO RECLASS CARDIAC MONITORING COST	H	ELECTROCARDIOLOGY	69		14,605	3,165	1
2							2
500 TOTAL RECLASSIFICATIONS					14,605	3,165	500
CODE LETTER - H							
1 TO RECLASS DRUG COST	I	DRUGS CHARGED TO PATIENTS	73			362,093	1
2							2
3							3
4							4
5							5
6							6
500 TOTAL RECLASSIFICATIONS						362,093	500
CODE LETTER - I							
1 TO RECLASS CLINIC COST	J	EMERGENCY	91		143,298	15,763	1
500 TOTAL RECLASSIFICATIONS					143,298	15,763	500
CODE LETTER - J							
GRAND TOTAL (INCREASES)					339,335	752,217	

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 SUPPLY COST FROM CS	A	CENTRAL SERVICES & SUPPLY	14	21,743	5,429	1
500 TOTAL RECLASSIFICATIONS				21,743	5,429	500
CODE LETTER - A						
1 TO RECLASS DON COST	B	ADULTS & PEDIATRICS	30	76,361	10,691	1
500 TOTAL RECLASSIFICATIONS				76,361	10,691	500
CODE LETTER - B						
1 TO RECLASS COST TO CLINC	C					1
2		HOUSEKEEPING	9	9,568	1,963	2
3		MEDICAL RECORDS & LIBRARY	16	20,645	3,161	3
500 TOTAL RECLASSIFICATIONS				30,213	5,124	500
CODE LETTER - C						
1 TO RECLASS SUPPLY COST	D	ADULTS & PEDIATRICS	30		39,674	1
2		EMERGENCY	91		20,589	2
3		RADIOLOGY-DIAGNOSTIC	54		14,709	3
4		LABORATORY	60		765	4
5		RESPIRATORY THERAPY	65		28,786	5
6		PHYSICAL THERAPY	66		189	6
500 TOTAL RECLASSIFICATIONS					104,712	500
CODE LETTER - D						
1 TO RECLASS INSURANCE EXPENSE	E					12 1
2						12 2
3		ADMINISTRATIVE & GENERAL	5		69,058	3
500 TOTAL RECLASSIFICATIONS					69,058	500
CODE LETTER - E						
1 TO RECLASS INTEREST	F					11 1
2						2
3						3
4						4
5		INTEREST EXPENSE	113		109,154	5
6						6
500 TOTAL RECLASSIFICATIONS					109,154	500
CODE LETTER - F						
1 TO RECLASS CAFE COST	G	DIETARY	10	53,115	67,028	1
500 TOTAL RECLASSIFICATIONS				53,115	67,028	500
CODE LETTER - G						
1 TO RECLASS CARDIAC MONITORING COST	H	ADULTS & PEDIATRICS	30	14,605	3,165	1
2					3,165	2
500 TOTAL RECLASSIFICATIONS				14,605	3,165	500
CODE LETTER - H						
1 TO RECLASS DRUG COST	I	ADULTS & PEDIATRICS	30		128,875	1
2		EMERGENCY	91		184,776	2
3		PHARMACY	15		47,560	3
4		RADIOLOGY-DIAGNOSTIC	54		3	4
5		PHYSICAL THERAPY	66		112	5
6		DIETARY	10		767	6
500 TOTAL RECLASSIFICATIONS					362,093	500
CODE LETTER - I						
1 TO RECLASS CLINIC COST	J	RURAL HEALTH CLINIC (RHC)	88	143,298	15,763	1
500 TOTAL RECLASSIFICATIONS				143,298	15,763	500
CODE LETTER - J						
GRAND TOTAL (DECREASES)				339,335	752,217	

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	17,000					17,000		1
2 LAND IMPROVEMENTS	148,424					148,424		2
3 BUILDINGS AND FIXTURES	1,380,448	201,532		201,532		1,581,980		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	3,047,352	183,038		183,038	122,500	3,107,890		6
7 HIT DESIGNATED ASSETS		526,703		526,703		526,703		7
8 SUBTOTAL (SUM OF LINES 1-7)	4,593,224	911,273		911,273	122,500	5,381,997		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	4,593,224	911,273		911,273	122,500	5,381,997		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)
1 CAP REL COSTS-BLDG & FIXT	38,182						38,182 1
2 CAP REL COSTS-MVBLE EQUIP	274,225						274,225 2
3 TOTAL (SUM OF LINES 1-2)	312,407						312,407 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	1,730,405		1,730,405	0.322536				1
2 CAP REL COSTS-MVBLE EQUIP	3,634,592		3,634,592	0.677464				2
3 TOTAL (SUM OF LINES 1-2)	5,364,997		5,364,997	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	38,182		37,963	2,805			78,950 1
2 CAP REL COSTS-MVBLE EQUIP	200,932			6,545			207,477 2
3 TOTAL	239,114		37,963	9,350			286,427 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

1	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7	
				COST CENTER 3	LINE NO. 4	REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)	B	-40,523	ADMINISTRATIVE & GENERAL	5		5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-2,720	ADMINISTRATIVE & GENERAL	5		7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-613,361				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-28,040	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	A	-3,989	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)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		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	A	-73,293	CAP REL COSTS-MVBLE EQUIP	2	9	32
33							33
34							34
35							35
36							36
37							37
38	CMS APPEAL COST	A	-1,274	ADMINISTRATIVE & GENERAL	5		38
39	BAD DEBT	A	-962,145	ADMINISTRATIVE & GENERAL	5		39
40	LATE FEES	A	-19,171	ADMINISTRATIVE & GENERAL	5		40
41							41
42	PROVIDER TAX	A	-120,546	ADMINISTRATIVE & GENERAL	5		42
43	LOBBING PORTION OF DUES	A	-4,266	ADMINISTRATIVE & GENERAL	5		43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-1,869,328				50

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

WORKSHEET A-8-1

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

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

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

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

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

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6					
7					
8					
9					
10					

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1		2	3	4	5	6	7	8	9
1	5	ADMINISTRATIVE & GENERAL MED STAFF DIREC	31,922		31,922				1
2	30	ADULTS & PEDIATRICS AGGREGATE	142,890	142,890					2
3	60	LABORATORY AGGREGATE	130,323	123,123	7,200				3
4	65	RESPIRATORY THERAPY AGGREGATE	22,540	22,540					4
5	91	EMERGENCY AGGREGATE	676,683	324,808	351,875				5
200		TOTAL	1,004,358	613,361	390,997				200

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
 PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
 08/17/2012 11:03

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.			12	13	14	15	16	17	18	
1	5	ADMINISTRATIVE & GENERAL MED STAFF DIREC								1
2	30	ADULTS & PEDIATRICS	AGGREGATE						142,890	2
3	60	LABORATORY	AGGREGATE						123,123	3
4	65	RESPIRATORY THERAPY	AGGREGATE						22,540	4
5	91	EMERGENCY	AGGREGATE						324,808	5
200		TOTAL							613,361	200

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
08/17/2012 11:03

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

WORKSHEET A-8-3
PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		391.00				9
10	AHSEA		68.52				10
11	STANDARD TRAVEL ALLOWANCE	34.26	34.26				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					26,791	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					26,791	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					26,791	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					68.52	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					53,446	22
23	TOTAL SALARY EQUIVALENCY					53,446	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	25
26 SUBTOTAL	26
27 STANDARD TRAVEL EXPENSE	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

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

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

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

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

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
 PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
 08/17/2012 11:03

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 [] 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					53,446	57
58						58
59						59
60						60
61						61
62						62
63					53,446	63
64					23,452	64
65						65

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
 PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
 08/17/2012 11:03

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						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		341.00				9
10	AHSEA		72.30				10
11	STANDARD TRAVEL ALLOWANCE	36.15	36.15				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					24,654	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					24,654	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					24,654	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					72.30	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					56,394	22
23	TOTAL SALARY EQUIVALENCY					56,394	23

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
08/17/2012 11:03

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

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

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

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

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

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

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
08/17/2012 11:03

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						57
58					56,394	58
59						59
60						60
61						61
62						62
63					56,394	63
64					20,448	64
65						65

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
 PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
 08/17/2012 11:03

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)					39	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					585	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		61.00				9
10	AHSEA		65.84				10
11	STANDARD TRAVEL ALLOWANCE	32.92	32.92				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					4,016	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					4,016	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					4,016	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					65.84	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					38,516	22
23	TOTAL SALARY EQUIVALENCY					38,516	23

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

WORKSHEET A-8-3
PARTS III & IV

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

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

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

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

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

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

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

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

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
08/17/2012 11:03

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	ASSISTANTS	AIDES	TRAINEES	TOTAL	
	1	2	3	4	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						57
58					38,516	58
59						59
60						60
61						61
62						62
63					38,516	63
64					3,654	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 BLDG & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS. 0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	78,950	78,950				1
2 CAP REL COSTS-MVBLE EQUIP	207,477		207,477			2
4 EMPLOYEE BENEFITS	59,708			59,708		4
5 ADMINISTRATIVE & GENERAL	1,922,443	13,804	36,418	7,670	1,980,335	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	365,155	7,827	20,650	1,826	395,458	7
8 LAUNDRY & LINEN SERVICE	69,169	3,529	9,311	577	82,586	8
9 HOUSEKEEPING	121,745			878	122,623	9
10 DIETARY	126,476	3,474	9,165	567	139,682	10
11 CAFETERIA	92,103	1,470	3,879	545	97,997	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	87,052	7,665	20,222	784	115,723	13
14 CENTRAL SERVICES & SUPPLY	8,465			74	8,539	14
15 PHARMACY	192,424	1,544	4,073	768	198,809	15
16 MEDICAL RECORDS & LIBRARY	279,103	4,191	11,056	2,276	296,626	16
17 SOCIAL SERVICE	67,351	689	1,818	529	70,387	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
INFANTILE ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,414,591	16,799	44,315	13,036	1,488,741	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	592,682	5,156	13,602	3,692	615,132	54
60 LABORATORY	924,018	2,083	5,496	4,060	935,657	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	166,956	1,544	4,073	1,536	174,109	65
66 PHYSICAL THERAPY	180,125	3,002	7,921	1,120	192,168	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	32,955			264	33,219	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	131,884	1,480	3,904	223	137,491	71
73 DRUGS CHARGED TO PATIENTS	362,093				362,093	73
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)	1,034,002			8,934	1,042,936	88
91 EMERGENCY	767,391	4,016	10,596	10,349	792,352	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	9,284,318	78,273	206,499	59,708	9,282,663	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		371	978		1,349	190
190.01 VENDING MACHINE	12,406	306			12,712	190.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	9,296,724	78,950	207,477	59,708	9,296,724	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	1,980,335					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	107,039	502,497				7
8 LAUNDRY & LINEN SERVICE	22,354	30,939	135,879			8
9 HOUSEKEEPING	33,190		4,192	160,005		9
10 DIETARY	37,808	30,456	5,291	10,334	223,571	10
11 CAFETERIA	26,525	12,891		4,374	118,846	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	31,323	67,197		22,801		13
14 CENTRAL SERVICES & SUPPLY	2,311					14
15 PHARMACY	53,812	13,536		4,593		15
16 MEDICAL RECORDS & LIBRARY	80,288	36,741		12,467		16
17 SOCIAL SERVICE	19,052	6,043		2,050		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	402,960	147,256	100,050	49,965	104,725	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	166,498	45,201	5,248	15,337		54
60 LABORATORY	253,255	18,263		6,197		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	47,126	13,536		4,593		65
66 PHYSICAL THERAPY	52,014	26,320	10,907	8,931		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	8,991					69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	37,215	12,972		4,402		71
73 DRUGS CHARGED TO PATIENTS	98,008					73
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)	282,293					88
91 EMERGENCY	214,467	35,210	10,191	11,947		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,976,529	496,561	135,879	157,991	223,571	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	365	3,250		1,103		190
190.01 VENDING MACHINE	3,441	2,686		911		190.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,980,335	502,497	135,879	160,005	223,571	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	260,633					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	4,294	241,338				13
14 CENTRAL SERVICES & SUPPLY	665	6,559	18,074			14
15 PHARMACY	5,675		1,109	277,534		15
16 MEDICAL RECORDS & LIBRARY	15,925		453		442,500	16
17 SOCIAL SERVICE	2,045		112			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
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	87,729	234,779	1,230		346,319	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	23,032		224		95,100	54
60 LABORATORY	27,122		10,272		1,081	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	7,490		292			65
66 PHYSICAL THERAPY	8,205		90			66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	2,863		52			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	2,045		3,139			71
73 DRUGS CHARGED TO PATIENTS				268,776		73
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)	51,917		831	8,758		88
91 EMERGENCY	21,626		270			91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	260,633	241,338	18,074	277,534	442,500	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.01 VENDING MACHINE						190.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	260,633	241,338	18,074	277,534	442,500	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
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					13
14					14
15					15
16					16
17	99,689				17
19					19
20					20
21					21
22					22
23					23
30	99,689	3,063,443		3,063,443	30
ANCILLARY SERVICE COST CENTERS					
54		965,772		965,772	54
60		1,251,847		1,251,847	60
62.30					62.30
65		247,146		247,146	65
66		298,635		298,635	66
67					67
68					68
69		45,125		45,125	69
71		197,264		197,264	71
73		728,877		728,877	73
76.97					76.97
76.98					76.98
76.99					76.99
OUTPATIENT SERVICE COST CENTERS					
88		1,386,735		1,386,735	88
91		1,086,063		1,086,063	91
92					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113					113
118	99,689	9,270,907		9,270,907	118
NONREIMBURSABLE COST CENTERS					
190		6,067		6,067	190
190.01		19,750		19,750	190.01
200					200
201					201
202	99,689	9,296,724		9,296,724	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	ADMINIS- TRATIVE & GENERAL 5	
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		13,804	36,418	50,222	50,222	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		7,827	20,650	28,477	2,714	7
8	LAUNDRY & LINEN SERVICE		3,529	9,311	12,840	567	8
9	HOUSEKEEPING					842	9
10	DIETARY		3,474	9,165	12,639	959	10
11	CAFETERIA		1,470	3,879	5,349	673	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		7,665	20,222	27,887	794	13
14	CENTRAL SERVICES & SUPPLY					59	14
15	PHARMACY		1,544	4,073	5,617	1,365	15
16	MEDICAL RECORDS & LIBRARY		4,191	11,056	15,247	2,036	16
17	SOCIAL SERVICE		689	1,818	2,507	483	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		16,799	44,315	61,114	10,221	30
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC		5,156	13,602	18,758	4,222	54
60	LABORATORY		2,083	5,496	7,579	6,422	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		1,544	4,073	5,617	1,195	65
66	PHYSICAL THERAPY		3,002	7,921	10,923	1,319	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY					228	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS		1,480	3,904	5,384	944	71
73	DRUGS CHARGED TO PATIENTS					2,485	73
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)					7,159	88
91	EMERGENCY		4,016	10,596	14,612	5,439	91
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)		78,273	206,499	284,772	50,126	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		371	978	1,349	9	190
190.01	VENDING MACHINE		306		306	87	190.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		78,950	207,477	286,427	50,222	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	31,191					7
8 LAUNDRY & LINEN SERVICE	1,920	15,327				8
9 HOUSEKEEPING		473	1,315			9
10 DIETARY	1,890	597	85	16,170		10
11 CAFETERIA	800		36	8,596	15,454	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	4,171		187		255	13
14 CENTRAL SERVICES & SUPPLY					39	14
15 PHARMACY	840		38		336	15
16 MEDICAL RECORDS & LIBRARY	2,281		102		944	16
17 SOCIAL SERVICE	375		17		121	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	9,140	11,285	412	7,574	5,203	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	2,806	592	126		1,366	54
60 LABORATORY	1,134		51		1,608	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	840		38		444	65
66 PHYSICAL THERAPY	1,634	1,230	73		487	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY					170	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	805		36		121	71
73 DRUGS CHARGED TO PATIENTS						73
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)					3,078	88
91 EMERGENCY	2,186	1,150	98		1,282	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	30,822	15,327	1,299	16,170	15,454	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	202		9			190
190.01 VENDING MACHINE	167		7			190.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	31,191	15,327	1,315	16,170	15,454	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 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	33,294					13
14 CENTRAL SERVICES & SUPPLY	905	1,003				14
15 PHARMACY		62	8,258			15
16 MEDICAL RECORDS & LIBRARY		25		20,635		16
17 SOCIAL SERVICE		6			3,509	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	32,389	68		16,150	3,509	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC		12		4,435		54
60 LABORATORY		571		50		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		16				65
66 PHYSICAL THERAPY		5				66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		3				69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		174				71
73 DRUGS CHARGED TO PATIENTS			7,997			73
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)		46	261			88
91 EMERGENCY		15				91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	33,294	1,003	8,258	20,635	3,509	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.01 VENDING MACHINE						190.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	33,294	1,003	8,258	20,635	3,509	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
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				13
14				14
15				15
16				16
17				17
19				19
20				20
21				21
22				22
23				23
30	157,065		157,065	30
INPATIENT ROUTINE SERV COST CENTERS				
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
54	32,317		32,317	54
60	17,415		17,415	60
62.30				62.30
65	8,150		8,150	65
66	15,671		15,671	66
67				67
68				68
69	401		401	69
71	7,464		7,464	71
73	10,482		10,482	73
76.97				76.97
76.98				76.98
76.99				76.99
OUTPATIENT SERVICE COST CENTERS				
88	10,544		10,544	88
91	24,782		24,782	91
92				92
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
113				113
118	284,291		284,291	118
NONREIMBURSABLE COST CENTERS				
190	1,569		1,569	190
190.01	567		567	190.01
200				200
201				201
202	286,427		286,427	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALA RIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
		1	2	4	5A	5	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	25,771					1
2	CAP REL COSTS-MVBLE EQUIP		25,671				2
4	EMPLOYEE BENEFITS			5,817,034			4
5	ADMINISTRATIVE & GENERAL	4,506	4,506	747,294	-1,980,335	7,316,389	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	2,555	2,555	177,910		395,458	7
8	LAUNDRY & LINEN SERVICE	1,152	1,152	56,259		82,586	8
9	HOUSEKEEPING			85,572		122,623	9
10	DIETARY	1,134	1,134	55,282		139,682	10
11	CAFETERIA	480	480	53,115		97,997	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	2,502	2,502	76,361		115,723	13
14	CENTRAL SERVICES & SUPPLY			7,248		8,539	14
15	PHARMACY	504	504	74,805		198,809	15
16	MEDICAL RECORDS & LIBRARY	1,368	1,368	221,715		296,626	16
17	SOCIAL SERVICE	225	225	51,564		70,387	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,483	5,483	1,269,681		1,488,741	30
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	1,683	1,683	359,734		615,132	54
60	LABORATORY	680	680	395,602		935,657	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	504	504	149,636		174,109	65
66	PHYSICAL THERAPY	980	980	109,083		192,168	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY			25,737		33,219	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	483	483	21,743		137,491	71
73	DRUGS CHARGED TO PATIENTS					362,093	73
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)			870,379		1,042,936	88
91	EMERGENCY	1,311	1,311	1,008,314		792,352	91
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (SUM OF LINES 1-117)	25,550	25,550	5,817,034	-1,980,335	7,302,328	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	121	121			1,349	190
190.01	VENDING MACHINE	100				12,712	190.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	78,950	207,477	59,708		1,980,335	202
203	UNIT COST MULT-WS B PT I	3.063521	8.082155	0.010264		0.270671	203
204	COST TO BE ALLOC PER B PT II					50,222	204
205	UNIT COST MULT-WS B PT II					0.006864	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA
	OF PLANT	& LINEN	KEEPING		
	SQUARE	SERVICE	SQUARE	MEALS SERV	FTE'S SERV
	FEET	POUNDS OF	FEET	ED	ED
	7	LAUNDRY	9	10	11
		8			
GENERAL SERVICE COST CENTERS					
1					1
2					2
4					4
5					5
6					6
7	18,710				7
8	1,152	187,990			8
9		5,800	17,558		9
10	1,134	7,320	1,134	21,722	10
11	480		480	11,547	11
12					12
13	2,502		2,502		168
14					26
15	504		504		222
16	1,368		1,368		623
17	225		225		80
19					19
20					20
21					21
22					22
23					23
INPATIENT ROUTINE SERV COST CENTERS					
30	5,483	138,420	5,483	10,175	3,432
ANCILLARY SERVICE COST CENTERS					
54	1,683	7,260	1,683		901
60	680		680		1,061
62.30					62.30
65	504		504		293
66	980	15,090	980		321
67					
68					112
69					80
71	483		483		
73					
76.97					76.97
76.98					76.98
76.99					76.99
OUTPATIENT SERVICE COST CENTERS					
88					2,031
91	1,311	14,100	1,311		846
92					
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118	18,489	187,990	17,337	21,722	10,196
NONREIMBURSABLE COST CENTERS					
190	121		121		
190.01	100		100		
200					
201					
202	502,497	135,879	160,005	223,571	260,633
203	26.857135	0.722799	9.112940	10.292376	25.562279
204	31,191	15,327	1,315	16,170	15,454
205	1.667076	0.081531	0.074895	0.744407	1.515692

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRS ING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQ UIS. 14	PHARMACY COSTED REQ UIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE PATIENT DA YS 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	81,248					13
14 CENTRAL SERVICES & SUPPLY	2,208	602,855				14
15 PHARMACY		36,977	373,892			15
16 MEDICAL RECORDS & LIBRARY		15,123		57,325		16
17 SOCIAL SERVICE		3,750			2,031	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	-79,040	41,011		44,865	2,031	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC		7,459		12,320		54
60 LABORATORY		342,641		140		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		9,744				65
66 PHYSICAL THERAPY		2,998				66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		1,736				69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		104,712				71
73 DRUGS CHARGED TO PATIENTS			362,093			73
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)		27,707	11,799			88
91 EMERGENCY		8,997				91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	81,248	602,855	373,892	57,325	2,031	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.01 VENDING MACHINE						190.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	241,338	18,074	277,534	442,500	99,689	202
203 UNIT COST MULT-WS B PT I	2.970387	0.029981	0.742284	7.719145	49.083703	203
204 COST TO BE ALLOC PER B PT II	33,294	1,003	8,258	20,635	3,509	204
205 UNIT COST MULT-WS B PT II	0.409782	0.001664	0.022087	0.359965	1.727720	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

	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	19
20	NURSING SCHOOL	20
21	I&R SRVCES-SALARY & FRINGES APPRVD	21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
	INPATIENT ROUTINE SERV COST CENTERS	
30	ADULTS & PEDIATRICS	30
	ANCILLARY SERVICE COST CENTERS	
54	RADIOLOGY-DIAGNOSTIC	54
60	LABORATORY	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
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
73	DRUGS CHARGED TO PATIENTS	73
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
91	EMERGENCY	91
92	OBSERVATION BEDS	92
	OTHER REIMBURSABLE COST CENTERS	
	SPECIAL PURPOSE COST CENTERS	
118	SUBTOTALS (SUM OF LINES 1-117)	118
	NONREIMBURSABLE COST CENTERS	
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190
190.01	VENDING MACHINE	190.01
200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	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	3,063,443		3,063,443		30
ANCILLARY SERVICE COST CENTERS					
54 RADIOLOGY-DIAGNOSTIC	965,772		965,772		54
60 LABORATORY	1,251,847		1,251,847		60
62.30 BLOOD CLOTTING FOR HEMOPHIL					62.30
65 RESPIRATORY THERAPY	247,146		247,146		65
66 PHYSICAL THERAPY	298,635		298,635		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	45,125		45,125		69
71 MEDICAL SUPPLIES CHRGED TO	197,264		197,264		71
73 DRUGS CHARGED TO PATIENTS	728,877		728,877		73
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)	1,386,735		1,386,735		88
91 EMERGENCY	1,086,063		1,086,063		91
92 OBSERVATION BEDS	346,066		346,066		92
OTHER REIMBURSABLE COST CENTERS					
113 INTEREST EXPENSE					113
200 SUBTOTAL (SEE INSTRUCTIONS)	9,616,973		9,616,973		200
201 LESS OBSERVATION BEDS	346,066		346,066		201
202 TOTAL (SEE INSTRUCTIONS)	9,270,907		9,270,907		202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,343,891		1,343,891			30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	410,544	2,727,090	3,137,634	0.307803		54
60 LABORATORY	442,524	1,893,385	2,335,909	0.535914		60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	175,144	216,138	391,282	0.631631		65
66 PHYSICAL THERAPY	153,902	746,688	900,590	0.331599		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	15,561	148,301	163,862	0.275384		69
71 MEDICAL SUPPLIES CHRGD TO	464,331	138,185	602,516	0.327400		71
73 DRUGS CHARGED TO PATIENTS	953,221	1,125,977	2,079,198	0.350557		73
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)		1,078,272	1,078,272			88
91 EMERGENCY	48,793	1,001,229	1,050,022	1.034324		91
92 OBSERVATION BEDS	10,736	171,777	182,513	1.896117		92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	4,018,647	9,247,042	13,265,689			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		9,247,042	13,265,689			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1328) [] 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	
54 ANCILLARY SERVICE COST CENTERS								
60 RADIOLOGY-DIAGNOSTIC	0.307803		837,715			257,851		54
62.30 LABORATORY	0.535914		997,154			534,389		60
65 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66 RESPIRATORY THERAPY	0.631631		27,064			17,094		65
67 PHYSICAL THERAPY	0.331599		252,912			83,865		66
68 OCCUPATIONAL THERAPY								67
69 SPEECH PATHOLOGY								68
71 ELECTROCARDIOLOGY	0.275384		148,290			40,837		69
73 MEDICAL SUPPLIES CHRGED TO PATI	0.327400		95,972			31,421		71
76.97 DRUGS CHARGED TO PATIENTS	0.350557		707,407			247,986		73
76.98 CARDIAC REHABILITATION								76.97
76.99 HYPERBARIC OXYGEN THERAPY								76.98
88 LITHOTRIPSY								76.99
91 OUTPATIENT SERVICE COST CENTERS								
92 RURAL HEALTH CLINIC (RHC)								88
EMERGENCY	1.034324		301,280			311,621		91
OBSERVATION BEDS	1.896117		64,282			121,886		92
200 OTHER REIMBURSABLE COST CENTERS								
SUBTOTAL (SEE INSTRUCTIONS)			3,432,076			1,646,950		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			3,432,076			1,646,950		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-Z328)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES				PROGRAM COSTS	
		PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
54 RADIOLOGY-DIAGNOSTIC	0.307803						54
60 LABORATORY	0.535914						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.631631						65
66 PHYSICAL THERAPY	0.331599						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.275384						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.327400						71
73 DRUGS CHARGED TO PATIENTS	0.350557						73
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
91 EMERGENCY	1.034324						91
92 OBSERVATION BEDS	1.896117						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM (COL.3 + COL.4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)	4	5	6	7	
	1	2	3					
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	157,065	33,334	123,731	2,371	52.19	404	21,085	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	157,065		123,731	2,371		404	21,085	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-1328) [] IPF [] IRF	[] SUB (OTHER)	[] PPS [] TEFRA [XX] OTHER	
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
54	RADIOLOGY-DIAGNOSTIC	32,317	3,137,634	0.010300	54
60	LABORATORY	17,415	2,335,909	0.007455	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA				62.30
65	RESPIRATORY THERAPY	8,150	391,282	0.020829	65
66	PHYSICAL THERAPY	15,671	900,590	0.017401	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	401	163,862	0.002447	69
71	MEDICAL SUPPLIES CHRGD TO PA	7,464	602,516	0.012388	71
73	DRUGS CHARGED TO PATIENTS	10,482	2,079,198	0.005041	73
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)	10,544	1,078,272	0.009779	88
91	EMERGENCY	24,782	1,050,022	0.023601	91
92	OBSERVATION BEDS	22,523	182,513	0.123405	92
OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (SUM OF LINES 50-199)	149,749	11,921,798		200

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
 PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
 08/17/2012 11:03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL	PER DIEM	INPATIENT	INPAT PGM
	PATIENT	COL.5 ÷	PROGRAM	PASS THRU
	DAYS	COL.6)	DAYS	COSTS
	6	7	8	(COL.7 x
				COL.8)
				9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	2,371		404	30
31 INTENSIVE CARE UNIT				31
32 CORONARY CARE UNIT				32
33 BURN INTENSIVE CARE UNIT				33
34 SURGICAL INTENSIVE CARE UNIT				34
35 OTHER SPECIAL CARE (SPECIFY)				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF				41
42 SUBPROVIDER I				42
43 NURSERY				43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	2,371		404	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK TITLE V HOSPITAL (14-1328) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX IRF NF OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
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
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK TITLE V HOSPITAL (14-1328) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX IRF NF OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
54 RADIOLOGY-DIAGNOSTIC	3,137,634						54
60 LABORATORY	2,335,909						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	391,282						65
66 PHYSICAL THERAPY	900,590						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	163,862						69
71 MEDICAL SUPPLIES CHRGD TO P	602,516						71
73 DRUGS CHARGED TO PATIENTS	2,079,198						73
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)	1,078,272						88
91 EMERGENCY	1,050,022						91
92 OBSERVATION BEDS	182,513						92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	11,921,798						200

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1328) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,038	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,371	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,031	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	476	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)	159	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	24	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)	8	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,381	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)	476	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)	159	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	119.54	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.43	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,063,443	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)	2,869	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	963	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	650,154	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,413,289	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,343,891	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,343,891	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	1.795748	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)	661.69	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)	2,413,289	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1328) [] 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) 1,017.83 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,405,623 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) 1,405,623 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)					558,461	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,964,084	49
PASS-THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)						50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)						51
52 TOTAL PROGRAM EXCLUDABLE COST						52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES 54

55 TARGET AMOUNT PER DISCHARGE 55

56 TARGET AMOUNT (LINE 54 x LINE 55) 56

57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57

58 BONUS PAYMENT (SEE INSTRUCTIONS) 58

59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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) 484,487 64

65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 161,835 65

66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 646,322 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) 340 87

88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 1,017.84 88

89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 346,066 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	157,065	2,413,289	0.065083	346,066	22,523	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1328) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,038	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,371	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,031	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	476	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)	159	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	24	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)	8	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	404	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	119.54	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.43	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,063,443	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)	2,869	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	963	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	650,154	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,413,289	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,343,891	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,343,891	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.795748	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)	661.69	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)	2,413,289	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1328) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,017.83 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 411,203 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) 411,203 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					411,203 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 21,085 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)
 52 TOTAL PROGRAM EXCLUDABLE COST 21,085 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
 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) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 340 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1328) 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		888,700		30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	0.307803	188,357	57,977	54
60 LABORATORY	0.535914	291,107	156,008	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.631631	88,154	55,681	65
66 PHYSICAL THERAPY	0.331599	15,225	5,049	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.275384	15,328	4,221	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.327400	273,765	89,631	71
73 DRUGS CHARGED TO PATIENTS	0.350557	535,734	187,805	73
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
91 EMERGENCY	1.034324	2,020	2,089	91
92 OBSERVATION BEDS	1.896117			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,409,690	558,461	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,409,690		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) S/B SNF (14-Z328) 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				
54 RADIOLOGY-DIAGNOSTIC	0.307803	13,114	4,037	54
60 LABORATORY	0.535914	33,766	18,096	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.631631	41,925	26,481	65
66 PHYSICAL THERAPY	0.331599	119,292	39,557	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.275384	228	63	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.327400	79,075	25,889	71
73 DRUGS CHARGED TO PATIENTS	0.350557	128,209	44,945	73
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
91 EMERGENCY	1.034324			91
92 OBSERVATION BEDS	1.896117			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		415,609	159,068	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		415,609		202

PROVIDER CCN: 14-1328 HARDIN COUNTY GENERAL HOSPITAL
 PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
 08/17/2012 11:03

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1328) 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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
30 INPATIENT ROUTINE SERVICE COST CENTERS				30
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	0.307803			54
60 LABORATORY	0.535914			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.631631			65
66 PHYSICAL THERAPY	0.331599			66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.275384			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.327400			71
73 DRUGS CHARGED TO PATIENTS	0.350557			73
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
91 EMERGENCY	1.034324			91
92 OBSERVATION BEDS	1.896117			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL [] IPF [] IRF	[] SUB (OTHER) [] SNF [XX] SWING BED SNF (14-Z328)	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
DESCRIPTION						
1				733,958		1
2				NONE		2
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.						
3				NONE		3.01
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT						
						3.02
		PROGRAM				3.03
		TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
			09/23/2011	11,101		3.50
			02/20/2012	3,734		3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
						3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)						
4				719,123		4
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)						
TO BE COMPLETED BY CONTRACTOR						
5				NONE		5.01
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				5.02
		TO				5.03
		PROVIDER				5.04
						5.05
						5.06
						5.07
						5.08
						5.09
		PROVIDER		NONE		5.50
		TO				5.51
		PROGRAM				5.52
						5.53
						5.54
						5.55
						5.56
						5.57
						5.58
						5.59
						5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						
6				64,025		6.01
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT						
		PROGRAM				6.02
		TO				6.02
		PROVIDER				6.02
		TO				6.02
		PROGRAM				6.02
7				783,148		7
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)						
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:	DATE:	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1328) [] 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	606	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,381	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	2,031	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	13,265,689	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	559,370	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	526,703	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	479,313	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	438,534	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	40,779	32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-Z328)
 APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
 BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A 1	PART B 2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	652,785	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)	160,659	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	635	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)	813,444	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	813,444	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	813,444	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	36,871	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)	776,573	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	6,575	17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	6,575	18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	783,148	19
20 INTERIM PAYMENTS	719,123	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	64,025	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	10,561	23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART V

CHECK HOSPITAL (14-1328)
 APPLICABLE BOX: SUB (OTHER)

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

1	INPATIENT SERVICES	1,964,084	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,964,084	4
5	PRIMARY PAYER PAYMENTS	465	5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	1,983,260	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)	1,983,260	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	261,210	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,722,050	22
23	COINSURANCE	6,557	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,715,493	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	64,202	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	64,202	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	60,968	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,779,695	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,779,695	30
31	INTERIM PAYMENTS	1,640,168	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	139,527	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	25,753	34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK TITLE V HOSPITAL (14-1328) SNF PPS
 APPLICABLE TITLE XIX IPF NF TEFRA
 BOXES: IRF ICF/MR OTHER
 SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	411,203 1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	411,203 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	411,203 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.0000000)	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	411,203 21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	411,203 29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	411,203 31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	411,203 36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	411,203 38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	411,203 40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	411,203 42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	71,038			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	3,425,859			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-978,243			6
7	INVENTORY	177,576			7
8	PREPAID EXPENSES	14,399			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS	250,000			10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	2,960,629			11
FIXED ASSETS					
12	LAND	17,000			12
13	LAND IMPROVEMENTS	148,425			13
14	ACCUMULATED DEPRECIATION	-106,514			14
15	BUILDINGS	1,581,980			15
16	ACCUMULATED DEPRECIATION	-1,012,053			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	3,710,499			23
24	ACCUMULATED DEPRECIATION	-2,366,349			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)	1,972,988			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	4,933,617			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	771,361			37
38	SALARIES, WAGES & FEES PAYABLE	637,154			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	819,747			40
41	DEFERRED INCOME	365,445			41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	4,071			43
44	OTHER CURRENT LIABILITIES				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,597,778			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	824,301			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	824,301			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	3,422,079			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	1,511,538			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)	1,511,538			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	4,933,617			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		955,776							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		555,762							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		1,511,538							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 PRIOR YEAR ADJUSTMENTS									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		1,511,538							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		1,511,538							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	1,609,007		1,609,007	2
3 SUBPROVIDER IPF				3
4 SUBPROVIDER IRF				4
5 SWING BED - SNF	317,870		317,870	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)	1,926,877		1,926,877	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	1,926,877		1,926,877	18
19 ANCILLARY SERVICES	2,793,741	7,231,759	10,025,500	19
20 OUTPATIENT SERVICES	81,360	2,097,054	2,178,414	20
21 RHC		1,078,272	1,078,272	21
22 FQHC				22
23 HOME HEALTH AGENCY				23
24 AMBULANCE				24
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)	4,801,978	10,407,085	15,209,063	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		11,166,052	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			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		11,166,052	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	15,209,063	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	4,644,757	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	10,564,306	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	11,166,052	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-601,746	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	325	6
7	INCOME FROM INVESTMENTS	7,624	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	40,523	12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	28,851	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	4,578	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	4,667	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISCELLANEOUS)	460,525	24
24.01	OTHER (GRANTS)	537,326	24.01
24.02	OTHER (DEFERRED REVENUE)	73,089	24.02
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,157,508	25
26	TOTAL (LINE 5 PLUS LINE 25)	555,762	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	555,762	29

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL	SUBTOTAL	I&R COST &	TOTAL
	NARY CAP- REL COSTS	(COLS. 0-4)		POST STEP- DOWN ADJS	
	0	2A	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					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88 RURAL HEALTH CLINIC (RHC)					88
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
190.01 VENDING MACHINE					190.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

RHC I
 COMPONENT NO: 14-3479

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	399,522	12,703	412,225	-159,061	253,164		253,164	1
2	83,736	9,793	93,529		93,529		93,529	2
3	92,993	11,024	104,017		104,017		104,017	3
4								4
5	225,772	40,410	266,182		266,182		266,182	5
6								6
7								7
8								8
9	181,441	37,684	219,125		219,125		219,125	9
10	983,464	111,614	1,095,078	-159,061	936,017		936,017	10
COSTS UNDER AGREEMENT								
11								11
12								12
13								13
14								14
OTHER HEALTH CARE COSTS								
15		2,451	2,451		2,451		2,451	15
16								16
17								17
18								18
19		11,799	11,799		11,799		11,799	19
20								20
21		14,250	14,250		14,250		14,250	21
22	983,464	125,864	1,109,328	-159,061	950,267		950,267	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26								26
27								27
28								28
FACILITY OVERHEAD								
29				39,761	39,761		39,761	29
30		43,974	43,974		43,974		43,974	30
31		43,974	43,974	39,761	83,735		83,735	31
32	983,464	169,838	1,153,302	-119,300	1,034,002		1,034,002	32

RHC I
 COMPONENT NO: 14-3479

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	1.48	7,810	4,200	6,216	1
2	PHYSICIAN ASSISTANTS	0.81	2,133	2,100	1,701	2
3	NURSE PRACTITIONERS	0.93	3,042	2,100	1,953	3
4	SUBTOTAL (SUM OF LINES 1-3)	3.22	12,985		9,870	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	3.22	12,985			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				950,267	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				950,267	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				83,735	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				352,733	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				436,468	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				436,468	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				436,468	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				1,386,735	20

RHC I
 COMPONENT NO: 14-3479

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)			1,386,735	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)			16,337	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)			1,370,398	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)			12,985	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)				5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)			12,985	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)			105.54	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)	93.13	106.73		8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	105.54	105.54	105.54	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	3,452	1,151		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	364,324	121,477		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)				15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	364,324	121,477		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)				16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		346,895		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		346,895		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		52,182		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)				19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		346,895		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		11,917		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		358,812		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		28,794		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		27,951		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		387,606		26
27	INTERIM PAYMENTS		349,376		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		38,230		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		5,199		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: 14-3479

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)	936,017	936,017	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000190	0.002660	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	178	2,490	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	1,213	7,314	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,391	9,804	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	950,267	950,267	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	436,468	436,468	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001464	0.010317	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	639	4,503	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	2,030	14,307	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	40	552	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	50.75	25.92	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	30	401	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	1,523	10,394	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)		16,337	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)		11,917	16

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

RHC I
 COMPONENT NO: 14-3479

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		331,799	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 09/23/2011	17,577	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50	NONE	3.50
	.51		3.51
	PROVIDER .52		3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
	.99	17,577	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)		349,376	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
	.99		5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)			
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01	38,230	6.01
	PROVIDER PROVIDER TO .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)	PROGRAM	387,606	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	DATE:

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	58.25		17.04				75.29 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	6.00	26.70					32.70 54
60 LABORATORY	12.46	42.69					55.15 60
65 RESPIRATORY THERAPY	22.53	6.92					29.45 65
66 PHYSICAL THERAPY	1.69	28.08					29.77 66
69 ELECTROCARDIOLOGY	9.35	90.50					99.85 69
71 MEDICAL SUPPLIES CHRGED TO PATI	45.44	15.93					61.37 71
73 DRUGS CHARGED TO PATIENTS	25.77	34.02					59.79 73
91 EMERGENCY	0.19	28.69					28.88 91
92 OBSERVATION BEDS		35.22					35.22 92
200 TOTAL CHARGES	11.82	28.79					40.61 200

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

SWING-BED SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	0.42						0.42 54
60 LABORATORY	1.45						1.45 60
65 RESPIRATORY THERAPY	10.71						10.71 65
66 PHYSICAL THERAPY	13.25						13.25 66
69 ELECTROCARDIOLOGY	0.14						0.14 69
71 MEDICAL SUPPLIES CHRGED TO PATI	13.12						13.12 71
73 DRUGS CHARGED TO PATIENTS	6.17						6.17 73
200 TOTAL CHARGES	3.49						3.49 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	78,950	0.85	-78,950	-2.15		1
2	CAP REL COSTS-MVBLE EQUIP	207,477	2.23	-207,477	-5.64		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	59,708	0.64	-59,708	-1.62		4
5	ADMINISTRATIVE & GENERAL	1,922,443	20.68	-1,922,443	-52.27		5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	365,155	3.93	-365,155	-9.93		7
8	LAUNDRY & LINEN SERVICE	69,169	0.74	-69,169	-1.88		8
9	HOUSEKEEPING	121,745	1.31	-121,745	-3.31		9
10	DIETARY	126,476	1.36	-126,476	-3.44		10
11	CAFETERIA	92,103	0.99	-92,103	-2.50		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	87,052	0.94	-87,052	-2.37		13
14	CENTRAL SERVICES & SUPPLY	8,465	0.09	-8,465	-0.23		14
15	PHARMACY	192,424	2.07	-192,424	-5.23		15
16	MEDICAL RECORDS & LIBRARY	279,103	3.00	-279,103	-7.59		16
17	SOCIAL SERVICE	67,351	0.72	-67,351	-1.83		17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCS-SALARY & FRINGES APP						21
22	I&R SRVCS-OTHER PRGM COSTS APP						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,414,591	15.22	1,648,852	44.83	3,063,443	32.95
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	592,682	6.38	373,090	10.14	965,772	10.39
60	LABORATORY	924,018	9.94	327,829	8.91	1,251,847	13.47
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	166,956	1.80	80,190	2.18	247,146	2.66
66	PHYSICAL THERAPY	180,125	1.94	118,510	3.22	298,635	3.21
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	32,955	0.35	12,170	0.33	45,125	0.49
71	MEDICAL SUPPLIES CHRGD TO PATI	131,884	1.42	65,380	1.78	197,264	2.12
73	DRUGS CHARGED TO PATIENTS	362,093	3.89	366,784	9.97	728,877	7.84
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	RURAL HEALTH CLINIC (RHC)	1,034,002	11.12	352,733	9.59	1,386,735	14.92
91	EMERGENCY	767,391	8.25	318,672	8.67	1,086,063	11.68
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CAN			6,067	0.16	6,067	0.07
190.01	VENDING MACHINE	12,406	0.13	7,344	0.20	19,750	0.21
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	9,296,724	100.00			9,296,724	100.00

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST
EXCLUDING SERVICES NOT SUBJECT TO OPPTS.
(WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1
LESS LINES 61, 66-68, 74, 94, 95 & 96)

2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES
EXCLUDING SERVICES NOT SUBJECT TO OPPTS.
(WKST D, PART V, LINE 202, COLUMNS 2, 2.01,
& 2.02 LESS LINES 61, 66-68, 74, 94, 95 &
96)

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