

CRAWFORD MEMORIAL HOSPITAL

ROBINSON, ILLINOIS

MEDICARE COST ANALYSIS

YEAR ENDED APRIL 30, 2012

National Government Services, Inc.
Medicare Audit and Reimbursement
P.O. Box 2952
Milwaukee, WI 53201-2952

Dear Sir or Madam:

This cost report of Crawford Memorial Hospital for the fiscal year ended April 30, 2012, includes two Level 20000 Errors.

The 20300 error, which reads the cost to charge ratio on Wkst C, Part I, Col. 11 should not be more than 100% or less than .1%. Line 76 is a result of the department not having enough volume to cover the direct expense plus allocated overhead.

The 20300 error, which reads the cost to charge ratio on Wkst C, Part I, Col. 11 should not be more than 100% or less than .1%, Line 90 is a result of a majority of revenue generated in this cost center resulting from surgeries being performed by Clinic physicians at the Hospital for Short Stay Surgery. Since the surgery is performed at the hospital, technical component charges are properly billed and posted to the operating room cost center where the cost is incurred. The physician charges and other clinic charges are posted to the Clinic cost center. Therefore, the Clinic cost center does not generate enough charges to cover the expense of running the clinic which includes the cost report allocated overhead expenses.



CPAs and
Management Consultants

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Board of Directors
Crawford Memorial Hospital

We have compiled the Hospital Health Care Complex Cost Report Form HCFA 2552-10 of Crawford Memorial Hospital for the year ended April 30, 2012, included in the accompanying prescribed form in accordance with Statements on Standard for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form prescribed by the Centers for Medicare and Medicaid Services information that is the representation of management. We have not audited or reviewed the cost report referred to above and, accordingly; do not express an opinion or any other form of assurance on it.

The Hospital Health Care Complex Cost Report Form HCFA 2552-10 is presented in accordance with the requirements of the Centers for Medicare and Medicaid Services, which differ from generally accepted accounting principles. Accordingly, the cost report is not designed for those who are not informed about such differences.

Kerber, Eck & Braeckel LLP

Carbondale, Illinois
September 18, 2012

Other Locations

Belleville, IL • Springfield, IL • Jacksonville, IL • Cape Girardeau, MO • St. Louis, MO • Milwaukee, WI

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: 09/18/2012 TIME: 10:48
- 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 CRAWFORD MEMORIAL HOSPITAL (14-1343) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 05/01/2011 AND ENDING 04/30/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 09/18/2012 10:48
 26mFkZx:UPeuaUqUasYtQWmfjQkJn0
 qlHa0EwJkxZ4SHZ3qnedCxZgjXTqN
 rDH311qeTn0cKh63

(SIGNED)

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PI Encryption: 09/18/2012 10:48
 gN8UvNGE7TvkIvAmu.Efp0j0wpRmq0
 ruvsu0GrZG5VvJFvaUIRpx4VZVo6zu
 wK420BiQEL056:8L

PART III - SETTLEMENT SUMMARY

	TITLE XVIII				
	TITLE V 1	PART A 2	PART B 3	HIT 4	TITLE XIX 5
1 HOSPITAL		-329,529	409,376	10,744	1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF		44,216			5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC				-60,689	10
10.01 HEALTH CLINIC - RHC II				-625	10.01
10.02 HEALTH CLINIC - RHC III				4,838	10.02
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-285,313	352,900	10,744	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: 1000 NORTH ALLEN STREET P.O. BOX: 1
 2 CITY: ROBINSON STATE: IL ZIP CODE: 62454 COUNTY: CRAWFORD 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	CRAWFORD MEMORIAL HOSPITAL	14-1343	00014	1	05/01/2005	N	O	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	CRAWFORD MEMORIAL HOSPITAL	14-2343	00014		05/01/2005	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	CRAWFORD MEMORIAL HHA	14-7175	00014		08/01/1979	N	P		12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	CMH RURAL HEALTH CLINIC	14-3429	00014		11/11/1996	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	PALESTINE RURAL HEALTH CLINIC	14-3486	00014		11/21/2006	N	O	N	15.01
15.02	HOSPITAL-BASED HEALTH CLINIC - RHC III	OBLONG RURAL HEALTH CLINIC	14-3488	00014		05/01/2007	N	O	N	15.02
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: 05/01/2011				TO: 04/30/2012				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 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6		
								24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.						25	
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.						2	26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.						2	27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

	V 1	XVIII 2	XIX 3		
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	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)

		1	2	3	
TEACHING HOSPITALS					
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.3+COL.4) 5
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)?			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- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	1	2	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	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: 269,295 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.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

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

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

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

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

	TITLE XVIII	TITLE	TITLE	
	PART A	PART B	V	
	1	2	3	
	Y	Y	N	
155	HOSPITAL		N	155
156	SUBPROVIDER - IPF		N	156
157	SUBPROVIDER - IRF		N	157
158	SUBPROVIDER - (OTHER)		N	158
159	SNF		N	159
160	HHA		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.		982,181	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

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
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)	N		1	
		Y/N	DATE	V/I	
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.	N	2	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)	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.	Y	A	3	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES			Y/N	Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		1	2	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y/N	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			Y 12 N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
		PART A		PART B	
PS&R REPORT DATA		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	07/17/2012	Y	07/17/2012
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- | | | | | |
|----|--------------------------|-----------------------------------|----------------|----|
| 41 | FIRST NAME: DAVID | LAST NAME: SCHNAKE | TITLE: PARTNER | 41 |
| 42 | EMPLOYER: KEB | | | 42 |
| 43 | PHONE NUMBER: 6185291040 | E-MAIL ADDRESS: DAVIDS@KEBCPA.COM | | 43 |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

LINE NO.	COMPONENT	WKST A LINE NO.	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS			TOTAL ALL PATIENTS 8	TRIPS 9
						TITLE V 5	TITLE XVIII 6	TITLE XIX 7		
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	21	7,686	92,544.00		2,112	548	3,801	1
2	HMO									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						378		378	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								20	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		21	7,686	92,544.00		2,490	548	4,199	7
8	INTENSIVE CARE UNIT	31	4	1,464			26	14	85	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						242	333	13
14	TOTAL (SEE INSTRUCTIONS)		25	9,150	92,544.00		2,516	804	4,617	14
15	CAH VISITS						17,020	12,217	51,096	15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					4,420		6,901	22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88					8,165		32,537	26
26.01	RHC II	88.01					433		4,789	26.01
26.02	RHC III	88.02					269		4,034	26.02
27	TOTAL (SUM OF LINES 14-26)		25							27
28	OBSERVATION BED DAYS							78	350	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

LINE	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---			----- DISCHARGES -----			TOTAL ALL PATIENTS 15	
			TOTAL INTERNS & RESIDENTS 9	EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14		
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					529	274	1,131	1
2	HMO									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)			242.21			529	274	1,131	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101		8.81						22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88		36.31						26
26.01	RHC II	88.01		4.10						26.01
26.02	RHC III	88.02		2.66						26.02
27	TOTAL (SUM OF LINES 14-26)			294.09						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	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 5	AVERAGE HOURLY WAGE (COL. 4 + COL. 5) 6	
	1	2	3	4			
SALARIES							
1	200	16,689,329			663,386.00		1
2							2
3							3
4							4
4.01							4.01
5		1,753,700			16,397.00		5
6		754,543			58,326.00		6
7	21						7
7.01							7.01
8							8
9	44						9
10		5,315,318	-4,820				10
11		482,868			6,322.00		11
12							12
13							13
14							14
15							15
16							16
17		2,200,307					17
18							18
19		302,163					19
20							20
21							21
22							22
22.01							22.01
23		377,398					23
24		162,379					24
25							25
26		162,763	4,891				26
27		1,312,976	-71				27
28							28
29							29
30		388,495					30
31		87,106					31
32		296,819					32
33							33
34		401,589	-206,148				34
35							35
36			206,148				36
37							37
38		591,717					38
39							39
40		518,925					40
41		491,996					41
42		39,016					42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	14,181,086		14,181,086	588,663.00	24.09	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	5,315,318	-4,820	5,310,498			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	8,865,768	4,820	8,870,588	588,663.00	15.07	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	482,868		482,868	6,322.00	76.38	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	2,200,307		2,200,307		24.80%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	11,548,943	4,820	11,553,763	594,985.00	19.42	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	4,291,402	4,820	4,296,222			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 LABOR	BENEFIT COST	
0		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
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II			14.01
14.02	HOSPITAL-BASED HEALTH CLINIC - RHC III			14.02
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7175

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: CLICK HERE TO ENTER

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		878		30	908	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		178.00		111.00	289.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00	NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)			TOTAL 3		
	STAFF 1	CONTRACT 2				
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)					3	
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			1.37		1.37	4
5 OTHER ADMINISTRATIVE PERSONNEL			1.00		1.00	5
6 DIRECT NURSING SERVICE			4.47		4.47	6
7 NURSING SUPERVISOR						7
8 PHYSICAL THERAPY SERVICE			0.38		0.38	8
9 PHYSICAL THERAPY SUPERVISOR						9
10 OCCUPATIONAL THERAPY SERVICE			0.11		0.11	10
11 OCCUPATIONAL THERAPY SUPERVISOR						11
12 SPEECH PATHOLOGY SERVICE						12
13 SPEECH PATHOLOGY SUPERVISOR						13
14 MEDICAL SOCIAL SERVICE						14
15 MEDICAL SOCIAL SERVICE SUPERVISOR						15
16 HOME HEALTH AIDE			1.38		1.38	16
17 HOME HEALTH AIDE SUPERVISOR						17
18 OTHER (SPECIFY)						18

HOME HEALTH AGENCY CBSA CODES

19 ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.					1	19
20 LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).					99914	20

PPS ACTIVITY

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2				
21 SKILLED NURSING VISITS	2,352	227	32	13	2,624	21
22 SKILLED NURSING VISIT CHARGES	381,432	36,221	5,204	2,119	424,976	22
23 PHYSICAL THERAPY VISITS	664	17	5	4	690	23
24 PHYSICAL THERAPY VISIT CHARGES	110,480	2,839	835	668	114,822	24
25 OCCUPATIONAL THERAPY VISITS	196	2		1	199	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	32,516	334		167	33,017	26
27 SPEECH PATHOLOGY VISITS	25				25	27
28 SPEECH PATHOLOGY VISIT CHARGES	4,067				4,067	28
29 MEDICAL SOCIAL SERVICE VISITS	3	1			4	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	673	230			903	30
31 HOME HEALTH AIDE VISITS	826	45		7	878	31
32 HOME HEALTH AIDE VISIT CHARGES	63,380	3,465		539	67,384	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	4,066	292	37	25	4,420	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	592,548	43,089	6,039	3,493	645,169	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	212		12	2	226	36
37 TOTAL NUMBER OF OUTLIER EPISODES		6			6	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	24,875	2,793	250	521	28,439	38

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	09/19/1994	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 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4
69.	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL			200

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

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

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

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
09/18/2012 10:47

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

RHC I
COMPONENT NO: 14-3429

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1000 N ALLEN 1
2 CITY: ROBINSON STATE: IL ZIP CODE: 62454 COUNTY: CRAWFORD 2
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS: GRANT AWARD DATE
1 2
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 4
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) 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
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

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			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

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

14 PROVIDER NAME: CCN NUMBER: 14

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

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
09/18/2012 10:47

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

RHC II
COMPONENT NO: 14-3486

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 209 EAST GRAND PRAIRIE 1
2 CITY: PALESTINE STATE: IL ZIP CODE: 62451 COUNTY: CRAWFORD 2
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS: GRANT AWARD DATE
1 2
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 4
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) 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
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

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			0800	1630	0800	1630	0800	1630	0800	1630	0800	1630			11

(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
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 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. N 13

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO Y/N V XVIII XIX 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) N

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

RHC III
 COMPONENT NO: 14-3488

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1000 N ALLEN 1
 2 CITY: ROBINSON STATE: IL ZIP CODE: 62454 COUNTY: CRAWFORD 2
 3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:	GRANT AWARD	DATE	
	1	2	
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)			4
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)			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
 IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

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			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

(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
 13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 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. N 13

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO 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 15

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)				0.467949	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				2,538,355	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				2,324,287	5
6	MEDICAID CHARGES				14,412,397	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				6,744,267	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				1,881,625	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				1,881,625	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	2,130,900	318,660	2,449,560		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	997,153	149,117	1,146,270		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	168,414	25,186	193,600		22
23	COST OF CHARITY CARE	828,739	123,931	952,670		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)				2,109,338	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				412,378	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				1,696,960	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				794,091	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				1,746,761	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				3,628,386	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		1,743,414	1,743,414	88,683	1
2	00200		909,083	909,083	4,388	2
3	00300		19,820	19,820	-19,820	3
4	00400	162,763	2,962,201	3,124,964	5,616	4
5.01	00540		634	634	28,561	5.01
5.02	00550	177,863	756,264	934,127		5.02
5.03	00560	115,460	32,399	147,859		5.03
5.04	00570	284,116	34,613	318,729	-28,641	5.04
5.05	00580	254,557	287,824	542,381		5.05
5.06	00590	480,980	2,046,086	2,527,066		5.06
7	00700	388,495	1,088,274	1,476,769	33,112	7
8	00800	87,106	48,496	135,602		8
9	00900	296,819	145,870	442,689		9
10	01000	401,589	365,176	766,765	-393,604	10
11	01100				393,604	11
13	01300	591,717	83,104	674,821		13
14	01400					14
15	01500	518,925	132,938	651,863		15
16	01600	491,996	122,882	614,878	5,234	16
17	01700	39,016	3,355	42,371		17
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,585,546	288,896	1,874,442	-151,826	30
31	03100	124,732	23,977	148,709		31
43	04300		3	3	54,523	43
45	04500	610,770	139,986	750,756	116,989	45
ANCILLARY SERVICE COST CENTERS						
50	05000	744,714	359,403	1,104,117	319,016	50
52	05200		7,487	7,487	97,303	52
53	05300	158,022	160,994	319,016	-319,016	53
54	05400	628,185	666,125	1,294,310	-12,550	54
54.01	05401		191,353	191,353		54.01
60	06000	515,370	1,022,302	1,537,672	-92,382	60
62	06200				92,382	62
65	06500	291,381	169,983	461,364		65
66	06600	559,873	227,911	787,784	-23,430	66
69	06900	15,889	1,490	17,379		69
71	07100		1,277,815	1,277,815	-131,880	71
72	07200		105,127	105,127	147,178	72
73	07300		1,080,362	1,080,362	12,550	73
76	03950	59,189	11,624	70,813		76
OUTPATIENT SERVICE COST CENTERS						
88	08800	3,546,792	401,214	3,948,006	131,458	88
88.01	08801	282,628	141,569	424,197	9,178	88.01
88.02	08802	231,508	98,842	330,350	22,436	88.02
90	09000	1,730,362	1,428,991	3,159,353	10,756	90
91	09100	669,346	1,436,828	2,106,174		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
101	10100	430,838	133,595	564,433	-11,294	101
SPECIAL PURPOSE COST CENTERS						
113	11300		424,143	424,143	-424,143	113
118		16,476,547	20,582,453	37,059,000	-35,619	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
192	19200	84,834	153,528	238,362	16,246	192
194	07950					194
194.01	07951		94,072	94,072	21,411	194.01
194.02	07952	28,812	9,235	38,047		194.02
194.03	07953	99,136	14,700	113,836	-2,038	194.03
194.04	07954					194.04
200		16,689,329	20,853,988	37,543,317		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	1,832,097	-56,498	1,775,599	1
2	00200	CAP REL COSTS-MVBLE EQUIP	913,471	-108,641	804,830	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	3,130,580	-166,112	2,964,468	4
5.01	00540	NONPATIENT TELEPHONES	29,195		29,195	5.01
5.02	00550	DATA PROCESSING	934,127		934,127	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	147,859		147,859	5.03
5.04	00570	ADMITTING	290,088		290,088	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	542,381		542,381	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	2,527,066	-264,965	2,262,101	5.06
7	00700	OPERATION OF PLANT	1,509,881	-2,811	1,507,070	7
8	00800	LAUNDRY & LINEN SERVICE	135,602		135,602	8
9	00900	HOUSEKEEPING	442,689		442,689	9
10	01000	DIETARY	373,161		373,161	10
11	01100	CAFETERIA	393,604	-151,541	242,063	11
13	01300	NURSING ADMINISTRATION	674,821		674,821	13
14	01400	CENTRAL SERVICES & SUPPLY				14
15	01500	PHARMACY	651,863	-26,763	625,100	15
16	01600	MEDICAL RECORDS & LIBRARY	620,112	-7,247	612,865	16
17	01700	SOCIAL SERVICE	42,371		42,371	17
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,722,616	-19,500	1,703,116	30
31	03100	INTENSIVE CARE UNIT	148,709		148,709	31
43	04300	NURSERY	54,526		54,526	43
45	04500	NURSING FACILITY	867,745		867,745	45
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	1,423,133	-268,193	1,154,940	50
52	05200	DELIVERY ROOM & LABOR ROOM	104,790		104,790	52
53	05300	ANESTHESIOLOGY				53
54	05400	RADIOLOGY-DIAGNOSTIC	1,281,760		1,281,760	54
54.01	05401	RADIOLOGY-ULTRASOUND	191,353		191,353	54.01
60	06000	LABORATORY	1,445,290		1,445,290	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	92,382		92,382	62
65	06500	RESPIRATORY THERAPY	461,364	-38,400	422,964	65
66	06600	PHYSICAL THERAPY	764,354		764,354	66
69	06900	ELECTROCARDIOLOGY	17,379	-3,329	14,050	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	1,145,935		1,145,935	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	252,305		252,305	72
73	07300	DRUGS CHARGED TO PATIENTS	1,092,912		1,092,912	73
76	03950	CARDIAC REHAB	70,813	-976	69,837	76
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC (RHC)	4,079,464	-410,225	3,669,239	88
88.01	08801	RHC II	433,375	-17,238	416,137	88.01
88.02	08802	RHC III	352,786	-10,720	342,066	88.02
90	09000	CLINIC	3,170,109	-1,815,025	1,355,084	90
91	09100	EMERGENCY	2,106,174	-938,259	1,167,915	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
101	10100	HOME HEALTH AGENCY	553,139	-28,115	525,024	101
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	37,023,381	-4,334,558	32,688,823	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
192	19200	PHYSICIANS' PRIVATE OFFICES	254,608		254,608	192
194	07950	NONREIMBURSEABLE				194
194.01	07951	PROFESSIONAL BUILDINGS	115,483		115,483	194.01
194.02	07952	FOUNDATION SERVICES	38,047		38,047	194.02
194.03	07953	WELLNESS	111,798		111,798	194.03
194.04	07954	RENTED SPACE				194.04
200		TOTAL (SUM OF LINES 118-199)	37,543,317	-4,334,558	33,208,759	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 R/C HHA MED SUPPLIES	A	MEDICAL SUPPLIES CHRGD TO PA	71			15,298 1
500 TOTAL RECLASSIFICATIONS						15,298 500
CODE LETTER - A						
1 LTC ADMITTING COSTS	D	NURSING FACILITY	45		71	9 1
500 TOTAL RECLASSIFICATIONS					71	9 500
CODE LETTER - D						
1 R/C CAFETERIA COSTS	F	CAFETERIA	11		206,148	187,456 1
500 TOTAL RECLASSIFICATIONS					206,148	187,456 500
CODE LETTER - F						
1 R/C COST OF BLOOD	G	WHOLE BLOOD & PACKED RED BLOO	62			92,382 1
500 TOTAL RECLASSIFICATIONS						92,382 500
CODE LETTER - G						
1 PBX COST	H	NONPATIENT TELEPHONES	5.01		25,459	3,102 1
500 TOTAL RECLASSIFICATIONS					25,459	3,102 500
CODE LETTER - H						
1 R/C DEPR OBLONG CLINIC	I					1
500 TOTAL RECLASSIFICATIONS						500
CODE LETTER - I						
1 R/C DEPR PROF BLDGS	J	PROFESSIONAL BUILDINGS	194.01			21,411 1
2 RURAL HEALTH CLINIC (RHC)			88			174,399 2
3 RHC II			88.01			7,747 3
4 CLINIC			90			22,844 4
5 HOME HEALTH AGENCY			101			4,004 5
6 WELLNESS			194.03			3,578 6
500 TOTAL RECLASSIFICATIONS						233,983 500
CODE LETTER - J						
1 R/C SNF DEPR	K	NURSING FACILITY	45			116,909 1
500 TOTAL RECLASSIFICATIONS						116,909 500
CODE LETTER - K						
1 R/C LABOR/DEL & NB COSTS	L	NURSERY	43		43,199	11,324 1
2 DELIVERY ROOM & LABOR ROOM			52		77,095	20,208 2
500 TOTAL RECLASSIFICATIONS					120,294	31,532 500
CODE LETTER - L						
1 R/C TRANSCRIPTION TXFR	N	MEDICAL RECORDS & LIBRARY	16			5,234 1
2						2
500 TOTAL RECLASSIFICATIONS						5,234 500
CODE LETTER - N						
1 RADIOLOGY CONTRAST ISOVIEW DRUGS	O	DRUGS CHARGED TO PATIENTS	73			12,550 1
500 TOTAL RECLASSIFICATIONS						12,550 500
CODE LETTER - O						
1 COST OF IMPLANTS SOLD	P	IMPL. DEV. CHARGED TO PATIENT	72			147,178 1
500 TOTAL RECLASSIFICATIONS						147,178 500
CODE LETTER - P						
1 R/C OR COST	Q	OPERATING ROOM	50		158,022	160,994 1
500 TOTAL RECLASSIFICATIONS					158,022	160,994 500
CODE LETTER - Q						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		
			LINE #	SALARY	OTHER
1	1	2	3	4	5
1 R/C PALESTINE/OBLONG DRS	R	RHC II	88.01		1,431 1
2		PHYSICIANS' PRIVATE OFFICES	192		16,246 2
3		RHC III	88.02		22,436 3
500 TOTAL RECLASSIFICATIONS					40,113 500
CODE LETTER - R					
1 HEALTHWORKS COST	U	EMPLOYEE BENEFITS	4	4,891	725 1
500 TOTAL RECLASSIFICATIONS				4,891	725 500
CODE LETTER - U					
1 UTILITIES	V	OPERATION OF PLANT	7		33,112 1
2					2
3					3
500 TOTAL RECLASSIFICATIONS					33,112 500
CODE LETTER - V					
1 INTEREST EXPENSE	W	CAP REL COSTS-BLDG & FIXT	1		424,143 1
500 TOTAL RECLASSIFICATIONS					424,143 500
CODE LETTER - W					
GRAND TOTAL (INCREASES)				514,885	1,504,720

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 R/C HHA MED SUPPLIES 500 TOTAL RECLASSIFICATIONS CODE LETTER - A	A	HOME HEALTH AGENCY	101		15,298	1 500
1 LTC ADMITTING COSTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - D	D	ADMITTING	5.04	71	9	1 500
1 R/C CAFETERIA COSTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - F	F	DIETARY	10	206,148	187,456	1 500
1 R/C COST OF BLOOD 500 TOTAL RECLASSIFICATIONS CODE LETTER - G	G	LABORATORY	60		92,382	1 500
1 PBX COST 500 TOTAL RECLASSIFICATIONS CODE LETTER - H	H	ADMITTING	5.04	25,459	3,102	1 500
1 R/C DEPR OBLONG CLINIC 500 TOTAL RECLASSIFICATIONS CODE LETTER - I	I					9 1 500
1 R/C DEPR PROF BLDGS 2 3 4 5 6 500 TOTAL RECLASSIFICATIONS CODE LETTER - J	J	CAP REL COSTS-BLDG & FIXT	1		233,983	9 1 9 2 9 3 9 4 9 5 6 6 500
1 R/C SNF DEPR 500 TOTAL RECLASSIFICATIONS CODE LETTER - K	K	CAP REL COSTS-BLDG & FIXT	1		116,909	9 1 500
1 R/C LABOR/DEL & NB COSTS 2 500 TOTAL RECLASSIFICATIONS CODE LETTER - L	L	ADULTS & PEDIATRICS	30	120,294	31,532	1 2 500
1 R/C TRANSCRIPTION TXFR 2 500 TOTAL RECLASSIFICATIONS CODE LETTER - N	N	RURAL HEALTH CLINIC (RHC) CLINIC	88 90		2,828 2,406 5,234	1 2 500
1 RADIOLOGY CONTRAST ISOVIEW DRUGS 500 TOTAL RECLASSIFICATIONS CODE LETTER - O	O	RADIOLOGY-DIAGNOSTIC	54		12,550	1 500
1 COST OF IMPLANTS SOLD 500 TOTAL RECLASSIFICATIONS CODE LETTER - P	P	MEDICAL SUPPLIES CHRGD TO PA	71		147,178	10 1 500
1 R/C OR COST 500 TOTAL RECLASSIFICATIONS CODE LETTER - Q	Q	ANESTHESIOLOGY	53	158,022	160,994	1 500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE 1	COST CENTER 6	DECREASE			WKST A-7 REF. 10
			LINE # 7	SALARY 8	OTHER 9	
1 R/C PALESTINE/OBLONG DRS 2 3	R	RURAL HEALTH CLINIC (RHC)	88		40,113	1 2 3
500 TOTAL RECLASSIFICATIONS CODE LETTER - R					40,113	500
1 HEALTHWORKS COST 500 TOTAL RECLASSIFICATIONS CODE LETTER - U	U	WELLNESS	194.03	4,891	725	1 500
1 UTILITIES 2 3	V	PHYSICAL THERAPY CLINIC	66 90		23,430 9,682	1 2 3
500 TOTAL RECLASSIFICATIONS CODE LETTER - V					33,112	500
1 INTEREST EXPENSE 500 TOTAL RECLASSIFICATIONS CODE LETTER - W GRAND TOTAL (DECREASES)	W	INTEREST EXPENSE	113		424,143 424,143	11 1 500
				514,885	1,504,720	

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	48,365					48,365	1
2 LAND IMPROVEMENTS	1,485,155					1,485,155	2
3 BUILDINGS AND FIXTURES	28,875,248	10,323,214		10,323,214	5,753,043	33,445,419	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	10,377,734	875,950		875,950		11,253,684	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	40,786,502	11,199,164		11,199,164	5,753,043	46,232,623	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	40,786,502	11,199,164		11,199,164	5,753,043	46,232,623	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	1,743,414						1,743,414 1
2 CAP REL COSTS-MVBLE EQUIP	909,083						909,083 2
3 TOTAL (SUM OF LINES 1-2)	2,652,497						2,652,497 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)
1 CAP REL COSTS-BLDG & FIXT	39,574,774		39,574,774	0.778595			15,432	15,432 1
2 CAP REL COSTS-MVBLE EQUIP	11,253,684		11,253,684	0.221405			4,388	4,388 2
3 TOTAL (SUM OF LINES 1-2)	50,828,458		50,828,458	1.000000			19,820	19,820 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)
1 CAP REL COSTS-BLDG & FIXT	1,392,522	-56,498	424,143			15,432	1,775,599 1
2 CAP REL COSTS-MVBLE EQUIP	800,442					4,388	804,830 2
3 TOTAL	2,192,964	-56,498	424,143			19,820	2,580,429 3

ADJUSTMENTS TO EXPENSES

1	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8	
				COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	A	-56,498	CAP REL COSTS-BLDG & FIXT	1	10	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-974,373				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	-151,541	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	B	-7,247	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					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					30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					31
32	CAH HIT ADJ FOR DEPRECIATION AND	A	-108,641	CAP REL COSTS-MVBLE EQUIP	2	9	32
33	PHYS RECRUITING	A	-84,440	OTHER ADMINISTRATIVE AND GENERA	5.06		33
33.11	EMPLOYEE INJURY	A	-4,428	EMPLOYEE BENEFITS	4		33.11
33.22	EMPLOYEE PHYSICALS	A	-34	EMPLOYEE BENEFITS	4		33.22
34	ADVERTISING	A	-130,853	OTHER ADMINISTRATIVE AND GENERA	5.06		34
35	TV ADMINISTRATION	A	-6,000	OTHER ADMINISTRATIVE AND GENERA	5.06		35
36	TV UTILITIES & REPAIR	A	-2,811	OPERATION OF PLANT	7		36
37							37
38	EMPLOYEE DISCOUNTS	A	-40,634	EMPLOYEE BENEFITS	4		38
39	OTHER A & G	A	-52,474	OTHER ADMINISTRATIVE AND GENERA	5.06		39
40	EMPLOYEE SALES - PHARMACY	B	-26,763	PHARMACY	15		40
41	OTHER INCOME PALESTINE	B	-16,522	RHC II	88.01		41
42	CONSULTING CLINIC	B	-54,636	CLINIC	90		42
42.11	OTHER INCOME ROBINSON RHC	B	-140,272	RURAL HEALTH CLINIC (RHC)	88		42.11
43							43
44	PHYSICIAN EXPENSES	A	-1,009,596	CLINIC	90		44
45	PHYSICIAN EXPENSES	A	-108,959	EMPLOYEE BENEFITS	4		45
46	PHYSICIAN EXPENSES	A	-269,581	RURAL HEALTH CLINIC (RHC)	88		46
47	PHYSICIAN EXPENSES	A	-716	RHC II	88.01		47
48	PHYSICIAN EXPENSES	A	-10,720	RHC III	88.02		48
49	NON ALLOWABLE ADS	A	-372	RURAL HEALTH CLINIC (RHC)	88		49
49.01	NONALLOW CARELINK COST	A	-28,115	HOME HEALTH AGENCY	101		49.01
49.02	MISC INCOME	B	-37,256	OTHER ADMINISTRATIVE AND GENERA	5.06		49.02
49.03	AHA & IHA DUES	A	-10,708	OTHER ADMINISTRATIVE AND GENERA	5.06		49.03
49.04	OB LOCUM TENUMS	A	-19,500	ADULTS & PEDIATRICS	30		49.04
49.05	NONPATIENT CPR	B	-705	OTHER ADMINISTRATIVE AND GENERA	5.06		49.05
49.06	OTHER INCOME - ER	B	-1,600	EMERGENCY	91		49.06
49.07	DONATIONS, PROJECTS	B	-40,049	OTHER ADMINISTRATIVE AND GENERA	5.06		49.07
49.08	DME - A&P	A	-4,991	EMERGENCY	91		49.08
49.09	DME - OR	A	-211	CLINIC	90		49.09

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2011 TO 04/30/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM VERSION: 2011.10
 IN LIEU OF FORM CMS-2552-10 (08/2011) 09/18/2012 10:47

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
49.10 DME -ER	A	-362	CLINIC	90	49.10
49.12 CRNA FEES	A	-126,000	OPERATING ROOM	50	49.12
49.13 ADMIN CLAIMS FEES	A	97,520	OTHER ADMINISTRATIVE AND GENERA	5.06	49.13
49.15 PHYSICIAN FEES	A	-750,220	CLINIC	90	49.15
49.16 CRNA	A	-142,193	OPERATING ROOM	50	49.16
49.17 CRNA	A	-12,057	EMPLOYEE BENEFITS	4	49.17
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-4,334,558			50

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

WORKSHEET A-8-1

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

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

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	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	65	RESPIRATORY THERAPY	AGGREGATE	38,400	38,400					1
2	69	ELECTROCARDIOLOGY	AGGREGATE	3,329	3,329					2
3	76	CARDIAC REHAB	AGGREGATE	976	976					3
5	91	EMERGENCY	AGGREGATE	1,229,600	931,668	297,932				5
200		TOTAL		1,272,305	974,373	297,932				200

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
 09/18/2012 10:47

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT		
LINE NO.		11		12	COLUMN 12	14	COLUMN 14	16	17	18		
1	65	RESPIRATORY THERAPY	AGGREGATE								38,400	1
2	69	ELECTROCARDIOLOGY	AGGREGATE								3,329	2
3	76	CARDIAC REHAB	AGGREGATE								976	3
5	91	EMERGENCY	AGGREGATE								931,668	5
200		TOTAL									974,373	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL. 7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	NONPATIENT TELEPHONE S 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,775,599	1,775,599				1
2 CAP REL COSTS-MVBLE EQUIP	804,830		804,830			2
4 EMPLOYEE BENEFITS	2,964,468	17,908	5,590	2,987,966		4
5.01 NONPATIENT TELEPHONES	29,195		242	5,041	34,478	5.01
5.02 DATA PROCESSING	934,127	17,184	113,647	35,221	283	5.02
5.03 PURCHASING RECEIVING AND STORES	147,859	45,722	2,496	22,864	567	5.03
5.04 ADMITTING	290,088	15,116	2,267	51,206	756	5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	542,381	25,001	1,575	50,408	945	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	2,262,101	198,520	10,707	95,246	1,417	5.06
7 OPERATION OF PLANT	1,507,070	128,728	17,512	76,931	567	7
8 LAUNDRY & LINEN SERVICE	135,602	52,504	2,668	17,249	94	8
9 HOUSEKEEPING	442,689	15,137	965	58,777	94	9
10 DIETARY	373,161	69,275	24,100	38,702	756	10
11 CAFETERIA	242,063	40,655		40,822		11
13 NURSING ADMINISTRATION	674,821	9,450		117,174	567	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	625,100	26,221	75,985	102,760	850	15
16 MEDICAL RECORDS & LIBRARY	612,865	64,271	11,745	97,427	1,228	16
17 SOCIAL SERVICE	42,371	1,034	257	7,726	189	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,703,116	218,708	99,605	290,155	3,684	30
31 INTENSIVE CARE UNIT	148,709	18,549	6,632	24,700	472	31
43 NURSERY	54,526	8,623		8,554	94	43
45 NURSING FACILITY	867,745		7,349	120,961	2,456	45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,154,940	173,002	160,161	150,606	1,700	50
52 DELIVERY ROOM & LABOR ROOM	104,790	25,870		15,267		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,281,760	70,247	52,074	124,396	1,417	54
54.01 RADIOLOGY-ULTRASOUND	191,353	10,029	326			54.01
60 LABORATORY	1,445,290	46,321	18,155	102,056	661	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	92,382	2,275				62
65 RESPIRATORY THERAPY	422,964	23,781	19,040	57,701	472	65
66 PHYSICAL THERAPY	764,354	207,268	14,460	110,868	661	66
69 ELECTROCARDIOLOGY	14,050	5,625	527	3,146	189	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,145,935	19,852				71
72 IMPL. DEV. CHARGED TO PATIENT	252,305	1,737				72
73 DRUGS CHARGED TO PATIENTS	1,092,912					73
76 CARDIAC REHAB	69,837	63,113	2,799	11,721	189	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	3,669,239		48,969	648,976	6,237	88
88.01 RHC II	416,137		268	55,825	661	88.01
88.02 RHC III	342,066		4,053	43,721	567	88.02
90 CLINIC	1,355,084		38,353	142,729	4,156	90
91 EMERGENCY	1,167,915	56,185	47,226	132,547	1,039	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	525,024		7,356	85,316	850	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	32,688,823	1,677,911	797,109	2,946,799	33,818	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		14,475				190
192 PHYSICIANS' PRIVATE OFFICES	254,608			16,799		192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS	115,483				472	194.01
194.02 FOUNDATION SERVICES	38,047	1,034		5,705	94	194.02
194.03 WELLNESS	111,798		7,721	18,663	94	194.03
194.04 RENTED SPACE		82,179				194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	33,208,759	1,775,599	804,830	2,987,966	34,478	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DATA PROCES- SING	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (COLS. 0-4) 4A	
	5.02	5.03	5.04	5.05		
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING	1,100,462					5.02
5.03 PURCHASING RECEIVING AND STORES		219,508				5.03
5.04 ADMITTING		959	360,392			5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	693,621	240		1,314,171		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	406,841	4,313			2,979,145	5.06
7 OPERATION OF PLANT		5,751			1,736,559	7
8 LAUNDRY & LINEN SERVICE		1,677			209,794	8
9 HOUSEKEEPING		3,115			520,777	9
10 DIETARY		1,438			507,432	10
11 CAFETERIA					323,540	11
13 NURSING ADMINISTRATION		959			802,971	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		1,438			832,354	15
16 MEDICAL RECORDS & LIBRARY		1,677			789,213	16
17 SOCIAL SERVICE					51,577	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		9,586	70,345	58,116	2,453,315	30
31 INTENSIVE CARE UNIT		479	20,133	14,657	234,331	31
43 NURSERY			6,905	5,027	83,729	43
45 NURSING FACILITY		4,553			1,003,064	45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		13,899	52,031	226,198	1,932,537	50
52 DELIVERY ROOM & LABOR ROOM		479	21,220	15,446	183,072	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		8,627	27,168	284,017	1,849,706	54
54.01 RADIOLOGY-ULTRASOUND			8,546	50,444	260,698	54.01
60 LABORATORY		29,236	45,016	278,970	1,965,705	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			4,545	5,165	104,367	62
65 RESPIRATORY THERAPY		2,396	13,666	30,430	570,450	65
66 PHYSICAL THERAPY		1,198	8,324	53,488	1,160,621	66
69 ELECTROCARDIOLOGY			2,852	9,007	35,396	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		99,448	27,020	40,784	1,333,039	71
72 IMPL. DEV. CHARGED TO PATIENT		8,148	7,949	7,935	278,074	72
73 DRUGS CHARGED TO PATIENTS			42,703	109,817	1,245,432	73
76 CARDIAC REHAB		240	8	2,766	150,673	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		7,908			4,381,329	88
88.01 RHC II		959			473,850	88.01
88.02 RHC III		719			391,126	88.02
90 CLINIC		6,470		30,586	1,577,378	90
91 EMERGENCY		2,157	1,961	73,199	1,482,229	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY		959		18,119	637,624	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,100,462	219,028	360,392	1,314,171	32,541,107	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					14,475	190
192 PHYSICIANS' PRIVATE OFFICES					271,407	192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS					115,955	194.01
194.02 FOUNDATION SERVICES		240			45,120	194.02
194.03 WELLNESS		240			138,516	194.03
194.04 RENTED SPACE					82,179	194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,100,462	219,508	360,392	1,314,171	33,208,759	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	OTHER ADMINSTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	2,979,145					5.06
7 OPERATION OF PLANT	171,140	1,907,699				7
8 LAUNDRY & LINEN SERVICE	20,675	57,521	287,990			8
9 HOUSEKEEPING	51,323	16,583		588,683		9
10 DIETARY	50,008	75,894	6,160	20,346	659,840	10
11 CAFETERIA	31,885	44,539		11,940		11
13 NURSING ADMINISTRATION	79,134	10,353		2,776		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	82,029	28,726		7,701		15
16 MEDICAL RECORDS & LIBRARY	77,778	70,411		18,876		16
17 SOCIAL SERVICE	5,083	1,133		304		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	241,777	239,598	112,256	64,232	237,315	30
31 INTENSIVE CARE UNIT	23,094	20,321	1,327	5,448	8,371	31
43 NURSERY	8,252	9,447	2,878	2,533		43
45 NURSING FACILITY	98,853	246,621	67,970	66,114	312,768	45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	190,453	189,531	38,381	50,810	10,672	50
52 DELIVERY ROOM & LABOR ROOM	18,042	28,341	2,516	7,598		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	182,290	76,959	17,502	20,631		54
54.01 RADIOLOGY-ULTRASOUND	25,692	10,988		2,946		54.01
60 LABORATORY	193,722	50,747	242	13,604		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	10,285	2,492		668		62
65 RESPIRATORY THERAPY	56,218	26,053	2,692	6,984		65
66 PHYSICAL THERAPY	114,380	227,070	5,693	60,873		66
69 ELECTROCARDIOLOGY	3,488	6,162		1,652		69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	131,372	21,749		5,830		71
72 IMPL. DEV. CHARGED TO PATIENT	27,404	1,903		510		72
73 DRUGS CHARGED TO PATIENTS	122,739					73
76 CARDIAC REHAB	14,849	69,143		18,536		76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	431,773		3,821	82,275		88
88.01 RHC II	46,698		221			88.01
88.02 RHC III	38,546		226			88.02
90 CLINIC	155,452	217,804	3,209	58,389		90
91 EMERGENCY	146,075	61,553	18,255	16,501	90,714	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	62,838			2,733		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	2,913,347	1,811,642	283,349	550,810	659,840	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,427	15,858		4,251		190
192 PHYSICIANS' PRIVATE OFFICES	26,747					192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS	11,427			12,122		194.01
194.02 FOUNDATION SERVICES	4,447	1,133		304		194.02
194.03 WELLNESS	13,651	79,066	4,641	21,196		194.03
194.04 RENTED SPACE	8,099					194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,979,145	1,907,699	287,990	588,683	659,840	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	411,904					11
13 NURSING ADMINISTRATION	16,188	911,422				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	12,591	56,266	1,019,667			15
16 MEDICAL RECORDS & LIBRARY	26,981			983,259		16
17 SOCIAL SERVICE	1,799	8,825			68,721	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	61,156	291,829		45,155	34,360	30
31 INTENSIVE CARE UNIT	3,597	17,842		11,389		31
43 NURSERY	1,799	5,528		3,906		43
45 NURSING FACILITY	32,377	158,037			34,361	45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	25,182	119,268		175,753		50
52 DELIVERY ROOM & LABOR ROOM	1,799	9,862		12,002		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	21,584			220,684		54
54.01 RADIOLOGY-ULTRASOUND				39,195		54.01
60 LABORATORY	19,786			216,757		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				4,013		62
65 RESPIRATORY THERAPY	12,591	55,951		23,644		65
66 PHYSICAL THERAPY	19,786			41,559		66
69 ELECTROCARDIOLOGY				6,998		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				31,688		71
72 IMPL. DEV. CHARGED TO PATIENT				6,165		72
73 DRUGS CHARGED TO PATIENTS			1,019,667	85,327		73
76 CARDIAC REHAB	1,799			2,149		76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	77,344					88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC	28,779					90
91 EMERGENCY	23,383	112,023		56,875		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	16,188	75,991				101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	404,709	911,422	1,019,667	983,259	68,721	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS						194.01
194.02 FOUNDATION SERVICES	1,799					194.02
194.03 WELLNESS	5,396					194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	411,904	911,422	1,019,667	983,259	68,721	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5.01 NONPATIENT TELEPHONES				5.01
5.02 DATA PROCESSING				5.02
5.03 PURCHASING RECEIVING AND STORES				5.03
5.04 ADMITTING				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL				5.06
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	3,780,993		3,780,993	30
31 INTENSIVE CARE UNIT	325,720		325,720	31
43 NURSERY	118,072		118,072	43
45 NURSING FACILITY	2,020,165		2,020,165	45
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	2,732,587		2,732,587	50
52 DELIVERY ROOM & LABOR ROOM	263,232		263,232	52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	2,389,356		2,389,356	54
54.01 RADIOLOGY-ULTRASOUND	339,519		339,519	54.01
60 LABORATORY	2,460,563		2,460,563	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	121,825		121,825	62
65 RESPIRATORY THERAPY	754,583		754,583	65
66 PHYSICAL THERAPY	1,629,982		1,629,982	66
69 ELECTROCARDIOLOGY	53,696		53,696	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,523,678		1,523,678	71
72 IMPL. DEV. CHARGED TO PATIENT	314,056		314,056	72
73 DRUGS CHARGED TO PATIENTS	2,473,165		2,473,165	73
76 CARDIAC REHAB	257,149		257,149	76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	4,976,542		4,976,542	88
88.01 RHC II	520,769		520,769	88.01
88.02 RHC III	429,898		429,898	88.02
90 CLINIC	2,041,011		2,041,011	90
91 EMERGENCY	2,007,608		2,007,608	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
101 HOME HEALTH AGENCY	795,374		795,374	101
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
118 SUBTOTALS (SUM OF LINES 1-117).	32,329,543		32,329,543	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,011		36,011	190
192 PHYSICIANS' PRIVATE OFFICES	298,154		298,154	192
194 NONREIMBURSEABLE				194
194.01 PROFESSIONAL BUILDINGS	139,504		139,504	194.01
194.02 FOUNDATION SERVICES	52,803		52,803	194.02
194.03 WELLNESS	262,466		262,466	194.03
194.04 RENTED SPACE	90,278		90,278	194.04
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	33,208,759		33,208,759	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		17,908	5,590	23,498	23,498	4
5.01 NONPATIENT TELEPHONES			242	242	40	5.01
5.02 DATA PROCESSING		17,184	113,647	130,831	277	5.02
5.03 PURCHASING RECEIVING AND STORES		45,722	2,496	48,218	180	5.03
5.04 ADMITTING		15,116	2,267	17,383	403	5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE		25,001	1,575	26,576	396	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL		198,520	10,707	209,227	749	5.06
7 OPERATION OF PLANT		128,728	17,512	146,240	605	7
8 LAUNDRY & LINEN SERVICE		52,504	2,668	55,172	136	8
9 HOUSEKEEPING		15,137	965	16,102	462	9
10 DIETARY		69,275	24,100	93,375	304	10
11 CAFETERIA		40,655		40,655	321	11
13 NURSING ADMINISTRATION		9,450		9,450	921	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		26,221	75,985	102,206	808	15
16 MEDICAL RECORDS & LIBRARY		64,271	11,745	76,016	766	16
17 SOCIAL SERVICE		1,034	257	1,291	61	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		218,708	99,605	318,313	2,281	30
31 INTENSIVE CARE UNIT		18,549	6,632	25,181	194	31
43 NURSERY		8,623		8,623	67	43
45 NURSING FACILITY			7,349	7,349	951	45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		173,002	160,161	333,163	1,184	50
52 DELIVERY ROOM & LABOR ROOM		25,870		25,870	120	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		70,247	52,074	122,321	978	54
54.01 RADIOLOGY-ULTRASOUND		10,029	326	10,355		54.01
60 LABORATORY		46,321	18,155	64,476	802	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		2,275		2,275		62
65 RESPIRATORY THERAPY		23,781	19,040	42,821	454	65
66 PHYSICAL THERAPY		207,268	14,460	221,728	872	66
69 ELECTROCARDIOLOGY		5,625	527	6,152	25	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		19,852		19,852		71
72 IMPL. DEV. CHARGED TO PATIENT		1,737		1,737		72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB		63,113	2,799	65,912	92	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			48,969	48,969	5,107	88
88.01 RHC II			268	268	439	88.01
88.02 RHC III			4,053	4,053	344	88.02
90 CLINIC			38,353	38,353	1,122	90
91 EMERGENCY		56,185	47,226	103,411	1,042	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY			7,356	7,356	671	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		1,677,911	797,109	2,475,020	23,174	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		14,475		14,475		190
192 PHYSICIANS' PRIVATE OFFICES					132	192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS						194.01
194.02 FOUNDATION SERVICES		1,034		1,034	45	194.02
194.03 WELLNESS			7,721	7,721	147	194.03
194.04 RENTED SPACE		82,179		82,179		194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		1,775,599	804,830	2,580,429	23,498	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NONPATIENT TELEPHONE S 5.01	DATA PROCE SSING 5.02	PURCHASING RECEIVING AND STORE 5.03	ADMITTING 5.04	CASHIERING /ACCOUNTS RECEIVABLE 5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES	282					5.01
5.02 DATA PROCESSING	2	131,110				5.02
5.03 PURCHASING RECEIVING AND STORES	5		48,403			5.03
5.04 ADMITTING	6		211	18,003		5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	8	82,639	53		109,672	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	12	48,471	951			5.06
7 OPERATION OF PLANT	5		1,268			7
8 LAUNDRY & LINEN SERVICE	1		370			8
9 HOUSEKEEPING	1		687			9
10 DIETARY	6		317			10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	5		211			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	7		317			15
16 MEDICAL RECORDS & LIBRARY	10		370			16
17 SOCIAL SERVICE	2					17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	30		2,114	3,520	4,849	30
31 INTENSIVE CARE UNIT	4		106	1,005	1,223	31
43 NURSERY	1			345	419	43
45 NURSING FACILITY	20		1,004			45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	14		3,065	2,598	18,873	50
52 DELIVERY ROOM & LABOR ROOM			106	1,060	1,289	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	12		1,902	1,357	23,717	54
54.01 RADIOLOGY-ULTRASOUND				427	4,209	54.01
60 LABORATORY	5		6,447	2,248	23,277	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				227	431	62
65 RESPIRATORY THERAPY	4		528	682	2,539	65
66 PHYSICAL THERAPY	5		264	416	4,463	66
69 ELECTROCARDIOLOGY	2			142	752	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			21,928	1,349	3,403	71
72 IMPL. DEV. CHARGED TO PATIENT			1,797	397	662	72
73 DRUGS CHARGED TO PATIENTS				2,132	9,163	73
76 CARDIAC REHAB	2		53		231	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	48		1,744			88
88.01 RHC II	5		211			88.01
88.02 RHC III	5		159			88.02
90 CLINIC	34		1,427		2,552	90
91 EMERGENCY	8		476	98	6,108	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	7		211		1,512	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	276	131,110	48,297	18,003	109,672	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS	4					194.01
194.02 FOUNDATION SERVICES	1		53			194.02
194.03 WELLNESS	1		53			194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	282	131,110	48,403	18,003	109,672	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OTHER ADMINSTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	259,410					5.06
7 OPERATION OF PLANT	14,901	163,019				7
8 LAUNDRY & LINEN SERVICE	1,800	4,915	62,394			8
9 HOUSEKEEPING	4,469	1,417		23,138		9
10 DIETARY	4,354	6,485	1,335	800	106,976	10
11 CAFETERIA	2,776	3,806		469		11
13 NURSING ADMINISTRATION	6,890	885		109		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	7,142	2,455		303		15
16 MEDICAL RECORDS & LIBRARY	6,772	6,017		742		16
17 SOCIAL SERVICE	443	97		12		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	21,052	20,474	24,321	2,525	38,474	30
31 INTENSIVE CARE UNIT	2,011	1,737	288	214	1,357	31
43 NURSERY	718	807	624	100		43
45 NURSING FACILITY	8,607	21,076	14,726	2,599	50,708	45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	16,583	16,196	8,315	1,997	1,730	50
52 DELIVERY ROOM & LABOR ROOM	1,571	2,422	545	299		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	15,872	6,576	3,792	811		54
54.01 RADIOLOGY-ULTRASOUND	2,237	939		116		54.01
60 LABORATORY	16,868	4,336	52	535		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	896	213		26		62
65 RESPIRATORY THERAPY	4,895	2,226	583	275		65
66 PHYSICAL THERAPY	9,959	19,404	1,233	2,393		66
69 ELECTROCARDIOLOGY	304	527		65		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	11,439	1,858		229		71
72 IMPL. DEV. CHARGED TO PATIENT	2,386	163		20		72
73 DRUGS CHARGED TO PATIENTS	10,687					73
76 CARDIAC REHAB	1,293	5,908		729		76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	37,609		828	3,231		88
88.01 RHC II	4,066		48			88.01
88.02 RHC III	3,356		49			88.02
90 CLINIC	13,535	18,612	695	2,295		90
91 EMERGENCY	12,719	5,260	3,955	649	14,707	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	5,471			107		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	253,681	154,811	61,389	21,650	106,976	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	124	1,355		167		190
192 PHYSICIANS' PRIVATE OFFICES	2,329					192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS	995			476		194.01
194.02 FOUNDATION SERVICES	387	97		12		194.02
194.03 WELLNESS	1,189	6,756	1,005	833		194.03
194.04 RENTED SPACE	705					194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	259,410	163,019	62,394	23,138	106,976	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	48,027					11
13 NURSING ADMINISTRATION	1,888	20,359				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,468	1,257	115,963			15
16 MEDICAL RECORDS & LIBRARY	3,146			93,839		16
17 SOCIAL SERVICE	210	197			2,313	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,131	6,520		4,310	1,156	30
31 INTENSIVE CARE UNIT	419	399		1,087		31
43 NURSERY	210	123		373		43
45 NURSING FACILITY	3,775	3,530			1,157	45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,936	2,664		16,776		50
52 DELIVERY ROOM & LABOR ROOM	210	220		1,146		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	2,517			21,049		54
54.01 RADIOLOGY-ULTRASOUND				3,741		54.01
60 LABORATORY	2,307			20,690		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				383		62
65 RESPIRATORY THERAPY	1,468	1,250		2,257		65
66 PHYSICAL THERAPY	2,307			3,967		66
69 ELECTROCARDIOLOGY				668		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				3,025		71
72 IMPL. DEV. CHARGED TO PATIENT				588		72
73 DRUGS CHARGED TO PATIENTS			115,963	8,145		73
76 CARDIAC REHAB	210			205		76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	9,016					88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC	3,356					90
91 EMERGENCY	2,726	2,502		5,429		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	1,888	1,697				101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	47,188	20,359	115,963	93,839	2,313	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS						194.01
194.02 FOUNDATION SERVICES	210					194.02
194.03 WELLNESS	629					194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	48,027	20,359	115,963	93,839	2,313	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 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5.01 NONPATIENT TELEPHONES				5.01
5.02 DATA PROCESSING				5.02
5.03 PURCHASING RECEIVING AND STORES				5.03
5.04 ADMITTING				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL				5.06
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	457,070		457,070	30
31 INTENSIVE CARE UNIT	35,225		35,225	31
43 NURSERY	12,410		12,410	43
45 NURSING FACILITY	115,502		115,502	45
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	426,094		426,094	50
52 DELIVERY ROOM & LABOR ROOM	34,858		34,858	52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	200,904		200,904	54
54.01 RADIOLOGY-ULTRASOUND	22,024		22,024	54.01
60 LABORATORY	142,043		142,043	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	4,451		4,451	62
65 RESPIRATORY THERAPY	59,982		59,982	65
66 PHYSICAL THERAPY	267,011		267,011	66
69 ELECTROCARDIOLOGY	8,637		8,637	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	63,083		63,083	71
72 IMPL. DEV. CHARGED TO PATIENT	7,750		7,750	72
73 DRUGS CHARGED TO PATIENTS	146,090		146,090	73
76 CARDIAC REHAB	74,635		74,635	76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	106,552		106,552	88
88.01 RHC II	5,037		5,037	88.01
88.02 RHC III	7,966		7,966	88.02
90 CLINIC	81,981		81,981	90
91 EMERGENCY	159,090		159,090	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
101 HOME HEALTH AGENCY	18,920		18,920	101
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
118 SUBTOTALS (SUM OF LINES 1-117)	2,457,315		2,457,315	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,121		16,121	190
192 PHYSICIANS' PRIVATE OFFICES	2,461		2,461	192
194 NONREIMBURSEABLE				194
194.01 PROFESSIONAL BUILDINGS	1,475		1,475	194.01
194.02 FOUNDATION SERVICES	1,839		1,839	194.02
194.03 WELLNESS	18,334		18,334	194.03
194.04 RENTED SPACE	82,884		82,884	194.04
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	2,580,429		2,580,429	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME	
	1	2	4	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	85,864					1
2 CAP REL COSTS-MVBLE EQUIP		909,595				2
4 EMPLOYEE BENEFITS	866	6,318	15,088,872			4
5.01 NONPATIENT TELEPHONES		273	25,459	365		5.01
5.02 DATA PROCESSING	831	128,440	177,863	3	10,000	5.02
5.03 PURCHASING RECEIVING AND STORES	2,211	2,821	115,460	6		5.03
5.04 ADMITTING	731	2,562	258,586	8		5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	1,209	1,780	254,557	10	6,303	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	9,600	12,101	480,980	15	3,697	5.06
7 OPERATION OF PLANT	6,225	19,791	388,495	6		7
8 LAUNDRY & LINEN SERVICE	2,539	3,015	87,106	1		8
9 HOUSEKEEPING	732	1,091	296,819	1		9
10 DIETARY	3,350	27,237	195,441	8		10
11 CAFETERIA	1,966		206,148			11
13 NURSING ADMINISTRATION	457		591,717	6		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,268	85,876	518,925	9		15
16 MEDICAL RECORDS & LIBRARY	3,108	13,274	491,996	13		16
17 SOCIAL SERVICE	50	291	39,016	2		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	10,576	112,571	1,465,252	39		30
31 INTENSIVE CARE UNIT	897	7,495	124,732	5		31
43 NURSERY	417		43,199	1		43
45 NURSING FACILITY		8,306	610,841	26		45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,366	181,006	760,543	18		50
52 DELIVERY ROOM & LABOR ROOM	1,251		77,095			52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	3,397	58,853	628,185	15		54
54.01 RADIOLOGY-ULTRASOUND	485	369				54.01
60 LABORATORY	2,240	20,518	515,370	7		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	110					62
65 RESPIRATORY THERAPY	1,150	21,519	291,384	5		65
66 PHYSICAL THERAPY	10,023	16,342	559,873	7		66
69 ELECTROCARDIOLOGY	272	596	15,889	2		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	960					71
72 IMPL. DEV. CHARGED TO PATIENT	84					72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB	3,052	3,163	59,189	2		76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		55,343	3,277,211	66		88
88.01 RHC II		303	281,912	7		88.01
88.02 RHC III		4,581	220,788	6		88.02
90 CLINIC		43,346	720,766	44		90
91 EMERGENCY	2,717	53,374	669,346	11		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY		8,314	430,838	9		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	81,140	900,869	14,880,981	358	10,000	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	700					190
192 PHYSICIANS' PRIVATE OFFICES			84,834			192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS				5		194.01
194.02 FOUNDATION SERVICES	50		28,812	1		194.02
194.03 WELLNESS		8,726	94,245	1		194.03
194.04 RENTED SPACE	3,974					194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,775,599	804,830	2,987,966	34,478	1,100,462	202
203 UNIT COST MULT-WS B PT I	20.679202	0.884822	0.198024	94.460274	110.046200	203
204 COST TO BE ALLOC PER B PT II			23,498	282	131,110	204
205 UNIT COST MULT-WS B PT II			0.001557	0.772603	13.111000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING RECEIVING AND STORE COST REQ'S 5.03	ADMITTING INPATIENT REVENUE 5.04	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE 5.05	RECON- CILIATION 5A.06	OTHER ADMI NISTRATIVE AND GENER ACCUM COST 5.06	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES	916					5.03
5.04 ADMITTING	4	12,160,343				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	1		60,916,109			5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	18			-2,979,145	30,229,614	5.06
7 OPERATION OF PLANT	24				1,736,559	7
8 LAUNDRY & LINEN SERVICE	7				209,794	8
9 HOUSEKEEPING	13				520,777	9
10 DIETARY	6				507,432	10
11 CAFETERIA					323,540	11
13 NURSING ADMINISTRATION	4				802,971	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	6				832,354	15
16 MEDICAL RECORDS & LIBRARY	7				789,213	16
17 SOCIAL SERVICE					51,577	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	40	2,373,696	2,693,912		2,453,315	30
31 INTENSIVE CARE UNIT	2	679,316	679,433		234,331	31
43 NURSERY		233,000	233,000		83,729	43
45 NURSING FACILITY	19				1,003,064	45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	58	1,755,607	10,485,224		1,932,537	50
52 DELIVERY ROOM & LABOR ROOM	2	715,997	715,997		183,072	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	36	916,708	13,164,192		1,849,706	54
54.01 RADIOLOGY-ULTRASOUND		288,343	2,338,310		260,698	54.01
60 LABORATORY	122	1,518,913	12,931,443		1,965,705	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		153,345	239,399		104,367	62
65 RESPIRATORY THERAPY	10	461,101	1,410,548		570,450	65
66 PHYSICAL THERAPY	5	280,855	2,479,386		1,160,621	66
69 ELECTROCARDIOLOGY		96,241	417,505		35,396	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	415	911,706	1,890,493		1,333,039	71
72 IMPL. DEV. CHARGED TO PATIENT	34	268,199	367,801		278,074	72
73 DRUGS CHARGED TO PATIENTS		1,440,862	5,090,479		1,245,432	73
76 CARDIAC REHAB	1	280	128,220		150,673	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	33				4,381,329	88
88.01 RHC II	4				473,850	88.01
88.02 RHC III	3				391,126	88.02
90 CLINIC	27		1,417,780		1,577,378	90
91 EMERGENCY	9	66,174	3,393,086		1,482,229	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	4		839,901		637,624	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	914	12,160,343	60,916,109	-2,979,145	29,561,962	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					14,475	190
192 PHYSICIANS' PRIVATE OFFICES					271,407	192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS					115,955	194.01
194.02 FOUNDATION SERVICES	1				45,120	194.02
194.03 WELLNESS	1				138,516	194.03
194.04 RENTED SPACE					82,179	194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	219,508	360,392	1,314,171		2,979,145	202
203 UNIT COST MULT-WS B PT I	239.637555	0.029637	0.021573		0.098551	203
204 COST TO BE ALLOC PER B PT II	48,403	18,003	109,672		259,410	204
205 UNIT COST MULT-WS B PT II	52.841703	0.001480	0.001800		0.008581	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	SERVICE	SQUARE	MEALS	FTE'S	
	FEET	POUNDS	FEET			
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5.01						5.01
5.02						5.02
5.03						5.03
5.04						5.04
5.05						5.05
5.06						5.06
7	84,207					7
8	2,539	181,200				8
9	732		96,929			9
10	3,350	3,876	3,350	57,936		10
11	1,966		1,966		229	11
13	457		457		9	13
14						14
15	1,268		1,268		7	15
16	3,108		3,108		15	16
17	50		50		1	17
INPATIENT ROUTINE SERV COST CENTERS						
30	10,576	70,630	10,576	20,837	34	30
31	897	835	897	735	2	31
43	417	1,811	417		1	43
45	10,886	42,766	10,886	27,462	18	45
ANCILLARY SERVICE COST CENTERS						
50	8,366	24,149	8,366	937	14	50
52	1,251	1,583	1,251		1	52
53						53
54	3,397	11,012	3,397		12	54
54.01	485		485			54.01
60	2,240	152	2,240		11	60
62	110		110			62
65	1,150	1,694	1,150		7	65
66	10,023	3,582	10,023		11	66
69	272		272			69
71	960		960			71
72	84		84			72
73						73
76	3,052		3,052		1	76
OUTPATIENT SERVICE COST CENTERS						
88		2,404	13,547		43	88
88.01		139				88.01
88.02		142				88.02
90	9,614	2,019	9,614		16	90
91	2,717	11,486	2,717	7,965	13	91
92						92
OTHER REIMBURSABLE COST CENTERS						
101			450		9	101
SPECIAL PURPOSE COST CENTERS						
118	79,967	178,280	90,693	57,936	225	118
NONREIMBURSABLE COST CENTERS						
190	700		700			190
192						192
194						194
194.01			1,996			194.01
194.02	50		50		1	194.02
194.03	3,490	2,920	3,490		3	194.03
194.04						194.04
200						200
201						201
202	1,907,699	287,990	588,683	659,840	411,904	202
203	22,654,874	1,589,349	6,073,342	11,389,119	1,798,707,424	203
204	163,019	62,394	23,138	106,976	48,027	204
205	1,935,932	0,344,338	0,238,711	1,846,451	209,724,891	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING HOURS 13	PHARMACY RX CSTD REQ'S 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME 17	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORES					5.03
5.04 ADMITTING					5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL					5.06
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
13 NURSING ADMINISTRATION	219,763				13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY	13,567	100			15
16 MEDICAL RECORDS & LIBRARY			58,658,428		16
17 SOCIAL SERVICE	2,128			100	17
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	70,366		2,693,912	50	30
31 INTENSIVE CARE UNIT	4,302		679,433		31
43 NURSERY	1,333		233,000		43
45 NURSING FACILITY	38,106			50	45
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	28,758		10,485,224		50
52 DELIVERY ROOM & LABOR ROOM	2,378		715,997		52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC			13,164,192		54
54.01 RADIOLOGY-ULTRASOUND			2,338,310		54.01
60 LABORATORY			12,931,443		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			239,399		62
65 RESPIRATORY THERAPY	13,491		1,410,548		65
66 PHYSICAL THERAPY			2,479,386		66
69 ELECTROCARDIOLOGY			417,505		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,890,493		71
72 IMPL. DEV. CHARGED TO PATIENT			367,801		72
73 DRUGS CHARGED TO PATIENTS		100	5,090,479		73
76 CARDIAC REHAB			128,220		76
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
88.02 RHC III					88.02
90 CLINIC					90
91 EMERGENCY	27,011		3,393,086		91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
101 HOME HEALTH AGENCY	18,323				101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	219,763	100	58,658,428	100	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
192 PHYSICIANS' PRIVATE OFFICES					192
194 NONREIMBURSEABLE					194
194.01 PROFESSIONAL BUILDINGS					194.01
194.02 FOUNDATION SERVICES					194.02
194.03 WELLNESS					194.03
194.04 RENTED SPACE					194.04
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	911,422	1,019,667	983,259	68,721	202
203 UNIT COST MULT-WS B PT I	4.147295	10,196.670000	0.016762	687.210000	203
204 COST TO BE ALLOC PER B PT II	20,359	115,963	93,839	2,313	204
205 UNIT COST MULT-WS B PT II	0.092641	1,159.630000	0.001600	23.130000	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	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,780,993		3,780,993		3,780,993	30
31 INTENSIVE CARE UNIT	325,720		325,720		325,720	31
43 NURSERY	118,072		118,072		118,072	43
45 NURSING FACILITY	2,020,165		2,020,165		2,020,165	45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,732,587		2,732,587		2,732,587	50
52 DELIVERY ROOM & LABOR ROOM	263,232		263,232		263,232	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	2,389,356		2,389,356		2,389,356	54
54.01 RADIOLOGY-ULTRASOUND	339,519		339,519		339,519	54.01
60 LABORATORY	2,460,563		2,460,563		2,460,563	60
62 WHOLE BLOOD & PACKED RED BL	121,825		121,825		121,825	62
65 RESPIRATORY THERAPY	754,583		754,583		754,583	65
66 PHYSICAL THERAPY	1,629,982		1,629,982		1,629,982	66
69 ELECTROCARDIOLOGY	53,696		53,696		53,696	69
71 MEDICAL SUPPLIES CHRGED TO	1,523,678		1,523,678		1,523,678	71
72 IMPL. DEV. CHARGED TO PATIE	314,056		314,056		314,056	72
73 DRUGS CHARGED TO PATIENTS	2,473,165		2,473,165		2,473,165	73
76 CARDIAC REHAB	257,149		257,149		257,149	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	4,976,542		4,976,542		4,976,542	88
88.01 RHC II	520,769		520,769		520,769	88.01
88.02 RHC III	429,898		429,898		429,898	88.02
90 CLINIC	2,041,011		2,041,011		2,041,011	90
91 EMERGENCY	2,007,608		2,007,608		2,007,608	91
92 OBSERVATION BEDS	292,009		292,009		292,009	92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	795,374		795,374		795,374	101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	32,621,552		32,621,552		32,621,552	200
201 LESS OBSERVATION BEDS	292,009		292,009		292,009	201
202 TOTAL (SEE INSTRUCTIONS)	32,329,543		32,329,543		32,329,543	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	2,382,637		2,382,637			30
31 INTENSIVE CARE UNIT	679,433		679,433			31
43 NURSERY	233,000		233,000			43
45 NURSING FACILITY	940,519		940,519			45
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,755,607	8,729,616	10,485,223	0.260613	0.260613	0.260613 50
52 DELIVERY ROOM & LABOR ROOM	690,997	25,000	715,997	0.367644	0.367644	0.367644 52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	916,708	12,247,484	13,164,192	0.181504	0.181504	0.181504 54
54.01 RADIOLOGY-ULTRASOUND	288,343	2,049,967	2,338,310	0.145198	0.145198	0.145198 54.01
60 LABORATORY	1,518,913	11,412,529	12,931,442	0.190278	0.190278	0.190278 60
62 WHOLE BLOOD & PACKED RED BL	153,345	86,054	239,399	0.508878	0.508878	0.508878 62
65 RESPIRATORY THERAPY	461,101	949,447	1,410,548	0.534957	0.534957	0.534957 65
66 PHYSICAL THERAPY	280,855	2,198,531	2,479,386	0.657414	0.657414	0.657414 66
69 ELECTROCARDIOLOGY	96,241	321,264	417,505	0.128612	0.128612	0.128612 69
71 MEDICAL SUPPLIES CHRGED TO	911,706	978,787	1,890,493	0.805969	0.805969	0.805969 71
72 IMPL. DEV. CHARGED TO PATIE	175,199	192,602	367,801	0.853875	0.853875	0.853875 72
73 DRUGS CHARGED TO PATIENTS	1,440,862	3,649,617	5,090,479	0.485841	0.485841	0.485841 73
76 CARDIAC REHAB	280	127,940	128,220	2.005530	2.005530	2.005530 76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		6,077,034	6,077,034			88
88.01 RHC II		615,267	615,267			88.01
88.02 RHC III		538,726	538,726			88.02
90 CLINIC	11,000	1,406,870	1,417,870	1.439491	1.439491	1.439491 90
91 EMERGENCY	66,530	3,326,556	3,393,086	0.591676	0.591676	0.591676 91
92 OBSERVATION BEDS	10,000	301,275	311,275	0.938106	0.938106	0.938106 92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY		839,901	839,901			101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	13,013,276	56,074,467	69,087,743			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	13,013,276	56,074,467	69,087,743			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1343) [] 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		200	201	202
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES SUBJECT TO DED & COINS 5			
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.260613		2,255,788		587,888			50
52 DELIVERY ROOM & LABOR ROOM	0.367644							52
53 ANESTHESIOLOGY								53
54 RADIOLOGY-DIAGNOSTIC	0.181504		3,967,899		720,190			54
54.01 RADIOLOGY-ULTRASOUND	0.145198		658,993		95,684			54.01
60 LABORATORY	0.190278			4,654,628				60
62 WHOLE BLOOD & PACKED RED BLOOD	0.508878		77,095		39,232			62
65 RESPIRATORY THERAPY	0.534957		361,233		193,244			65
66 PHYSICAL THERAPY	0.657414		691,443		454,564			66
69 ELECTROCARDIOLOGY	0.128612		237,121		30,497			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.805969		183,515		147,907			71
72 IMPL. DEV. CHARGED TO PATIENT	0.853875		170,640		145,705			72
73 DRUGS CHARGED TO PATIENTS	0.485841		1,887,873		917,206			73
76 CARDIAC REHAB	2.005530		23,140		46,408			76
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
88.01 RHC II								88.01
88.02 RHC III								88.02
90 CLINIC	1.439491		487,616		701,919			90
91 EMERGENCY	0.591676		947,838		560,813			91
92 OBSERVATION BEDS	0.938106		140,672		131,965			92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			12,090,866	4,654,628	4,773,222	885,673	200	
201 LESS PBP CLINIC LAB SERVICES							201	
202 NET CHARGES (LINE 200 - LINE 201)			12,090,866	4,654,628	4,773,222	885,673	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 (14-2343)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.260613							50
52 DELIVERY ROOM & LABOR ROOM	0.367644							52
53 ANESTHESIOLOGY								53
54 RADIOLOGY-DIAGNOSTIC	0.181504							54
54.01 RADIOLOGY-ULTRASOUND	0.145198							54.01
60 LABORATORY	0.190278							60
62 WHOLE BLOOD & PACKED RED BLOOD	0.508878							62
65 RESPIRATORY THERAPY	0.534957							65
66 PHYSICAL THERAPY	0.657414							66
69 ELECTROCARDIOLOGY	0.128612							69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.805969							71
72 IMPL. DEV. CHARGED TO PATIENT	0.853875							72
73 DRUGS CHARGED TO PATIENTS	0.485841							73
76 CARDIAC REHAB	2.005530							76
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
88.01 RHC II								88.01
88.02 RHC III								88.02
90 CLINIC	1.439491							90
91 EMERGENCY	0.591676							91
92 OBSERVATION BEDS	0.938106							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	SWING-BED	REDUCED	TOTAL	PER	INPAT	INPAT PGM
	COST (FROM WKST B, PT. II, COL. 26)	ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)	PATIENT DAYS	DIEM (COL.3 + COL.4)	PGM DAYS	CAP COST (COL.5 x COL.6)
	1	2	3	4	5	6	7
30 INPAT ROUTINE SERV COST CTRS							
ADULTS & PEDIATRICS	457,070	38,414	418,656	4,151	100.86	548	55,271
31 INTENSIVE CARE UNIT	35,225		35,225	85	414.41	14	5,802
32 CORONARY CARE UNIT							
33 BURN INTENSIVE CARE UNIT							
34 SURGICAL INTENSIVE CARE UNIT							
35 OTHER SPECIAL CARE (SPECIFY)							
40 SUBPROVIDER - IPF							
41 SUBPROVIDER - IRF							
42 SUBPROVIDER I							
43 NURSERY	12,410		12,410	333	37.27	242	9,019
44 SKILLED NURSING FACILITY							
45 NURSING FACILITY	115,502		115,502				
200 TOTAL (LINES 30-199)	620,207		581,793	4,569		804	70,092

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 (14-1343) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	426,094	10,485,223	0.040638	555,319	22,567	50
52	DELIVERY ROOM & LABOR ROOM	34,858	715,997	0.048685	361,355	17,593	52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	200,904	13,164,192	0.015261	260,770	3,980	54
54.01	RADIOLOGY-ULTRASOUND	22,024	2,338,310	0.009419	51,884	489	54.01
60	LABORATORY	142,043	12,931,442	0.010984	362,639	3,983	60
62	WHOLE BLOOD & PACKED RED BLOO	4,451	239,399	0.018592			62
65	RESPIRATORY THERAPY	59,982	1,410,548	0.042524	50,939	2,166	65
66	PHYSICAL THERAPY	267,011	2,479,386	0.107692	18,304	1,971	66
69	ELECTROCARDIOLOGY	8,637	417,505	0.020687	8,436	175	69
71	MEDICAL SUPPLIES CHRGD TO PA	63,083	1,890,493	0.033369	129,931	4,336	71
72	IMPL. DEV. CHARGED TO PATIENT	7,750	367,801	0.021071	4,757	100	72
73	DRUGS CHARGED TO PATIENTS	146,090	5,090,479	0.028699	164,535	4,722	73
76	CARDIAC REHAB	74,635	128,220	0.582085			76
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)	106,552	6,077,034	0.017534			88
88.01	RHC II	5,037	615,267	0.008187			88.01
88.02	RHC III	7,966	538,726	0.014787			88.02
90	CLINIC	81,981	1,417,870	0.057820	1,082	63	90
91	EMERGENCY	159,090	3,393,086	0.046887	50,190	2,353	91
92	OBSERVATION BEDS	38,539	311,275	0.123810	8,076	1,000	92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	1,856,727	64,012,253		2,028,217	65,498	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 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 PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	4,151		548		30
31	INTENSIVE CARE UNIT	85		14		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	333		242		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	4,569		804		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1343) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 RADIOLOGY-ULTRASOUND						54.01
60 LABORATORY						60
62 WHOLE BLOOD & PACKED RED BLOO						62
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB						76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX]	HOSPITAL (14-1343)	[] SUB (OTHER)	[] ICF/MR	[XX]	PPS
APPLICABLE	[] TITLE XVIII-PT A	[]	IPF	[] SNF		[]	TEFRA
BOXES	[XX] TITLE XIX	[]	IRF	[] NF		[]	OTHER
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	10,485,223			555,319		50
52	DELIVERY ROOM & LABOR ROOM	715,997			361,355		52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	13,164,192			260,770		54
54.01	RADIOLOGY-ULTRASOUND	2,338,310			51,884		54.01
60	LABORATORY	12,931,442			362,639		60
62	WHOLE BLOOD & PACKED RED BLO	239,399					62
65	RESPIRATORY THERAPY	1,410,548			50,939		65
66	PHYSICAL THERAPY	2,479,386			18,304		66
69	ELECTROCARDIOLOGY	417,505			8,436		69
71	MEDICAL SUPPLIES CHRGED TO P	1,890,493			129,931		71
72	IMPL. DEV. CHARGED TO PATIEN	367,801			4,757		72
73	DRUGS CHARGED TO PATIENTS	5,090,479			164,535		73
76	CARDIAC REHAB	128,220					76
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)	6,077,034					88
88.01	RHC II	615,267					88.01
88.02	RHC III	538,726					88.02
90	CLINIC	1,417,870			1,082		90
91	EMERGENCY	3,393,086			50,190		91
92	OBSERVATION BEDS	311,275			8,076		92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	64,012,253			2,028,217		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1343) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS			
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7		
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.260613		1,822,201			474,889			50
52 DELIVERY ROOM & LABOR ROOM	0.367644		17,840			6,559			52
53 ANESTHESIOLOGY									53
54 RADIOLOGY-DIAGNOSTIC	0.181504		3,826,269			694,483			54
54.01 RADIOLOGY-ULTRASOUND	0.145198		786,374			114,180			54.01
60 LABORATORY	0.190278		2,616,136			497,793			60
62 WHOLE BLOOD & PACKED RED BLOOD	0.508878								62
65 RESPIRATORY THERAPY	0.534957		210,439			112,576			65
66 PHYSICAL THERAPY	0.657414		454,837			299,016			66
69 ELECTROCARDIOLOGY	0.128612		63,371			8,150			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.805969		233,513			188,204			71
72 IMPL. DEV. CHARGED TO PATIENT	0.853875		20,657			17,638			72
73 DRUGS CHARGED TO PATIENTS	0.485841		134,320			65,258			73
76 CARDIAC REHAB	2.005530		3,438			6,895			76
OUTPATIENT SERVICE COST CENTERS									
88 RURAL HEALTH CLINIC (RHC)									88
88.01 RHC II									88.01
88.02 RHC III									88.02
90 CLINIC	1.439491		224,342			322,938			90
91 EMERGENCY	0.591676		1,151,756			681,466			91
92 OBSERVATION BEDS	0.938106		71,823			67,378			92
OTHER REIMBURSABLE COST CENTERS									
200 SUBTOTAL (SEE INSTRUCTIONS)			11,637,316			3,557,423			200
201 LESS PBP CLINIC LAB SERVICES									201
202 NET CHARGES (LINE 200 - LINE 201)			11,637,316			3,557,423			202

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (14-1343) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX-INPT IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,549	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,151	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	91	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,710	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	252	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)	126	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	13	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)	7	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,112	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)	252	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)	126	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)	3,780,993	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	1,554	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	843	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	317,766	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,463,227	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,268,352	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	79,716	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,188,636	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.526759	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	876.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	589.93	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	286.07	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	436.76	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	39,745	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,423,482	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1343) [] SUB (OTHER)
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] PPS
 BOXES [] TITLE XIX-INPT [] IRF [] TEFRA
 [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) 824.74 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,741,851 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) 1,741,851 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	325,720	85	3,832.00	26	99,632	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)					1,749,529	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					3,591,012	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) 207,834 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 103,917 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 311,751 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) 350 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 834.31 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 292,009 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	457,070	3,463,227	0.131978	292,009	38,539	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 (14-1343)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF	[]		[]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[]	IRF	[]	NF	[]		[]	OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS										
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,549	1							
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,151	2							
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	91	3							
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,710	4							
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	252	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)	126	6							
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	13	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)	7	8							
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	548	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)	333	15							
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	242	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)	3,780,993	21							
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22							
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23							
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	1,554	24							
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	843	25							
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	317,766	26							
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,463,227	27							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT										
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,268,352	28							
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	79,716	29							
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,188,636	30							
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 3)	1.526759	31							
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	876.00	32							
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	589.93	33							
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	286.07	34							
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	436.76	35							
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	39,745	36							
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,423,482	37							

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (14-1343) SUB (OTHER) PPS
 APPLICABLE TITLE XVIII-PT A IPF TEFRA
 BOXES TITLE XIX-INPT IRF OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 834.31 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 457,202 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) 457,202 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)	118,072	333	354.57	242	85,806 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	325,720	85	3,832.00	14	53,648 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)					669,357 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,266,013 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 70,092 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 65,498 51
 52 TOTAL PROGRAM EXCLUDABLE COST 135,590 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 1,130,423 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) 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) 350 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 (14-1343) 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		1,705,476		30
31 INTENSIVE CARE UNIT		38,558		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.260613	553,081	144,140	50
52 DELIVERY ROOM & LABOR ROOM	0.367644			52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.181504	595,321	108,053	54
54.01 RADIOLOGY-ULTRASOUND	0.145198	211,851	30,760	54.01
60 LABORATORY	0.190278	862,256	164,068	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.508878	120,133	61,133	62
65 RESPIRATORY THERAPY	0.534957	256,397	137,161	65
66 PHYSICAL THERAPY	0.657414	143,521	94,353	66
69 ELECTROCARDIOLOGY	0.128612	83,102	10,688	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.805969	585,044	471,527	71
72 IMPL. DEV. CHARGED TO PATIENT	0.853875	120,659	103,028	72
73 DRUGS CHARGED TO PATIENTS	0.485841	844,240	410,166	73
76 CARDIAC REHAB	2.005530			76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
88.02 RHC III				88.02
90 CLINIC	1.439491	8,039	11,572	90
91 EMERGENCY	0.591676	4,163	2,463	91
92 OBSERVATION BEDS	0.938106	444	417	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,388,251	1,749,529	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,388,251		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z343) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] 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
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.260613	684	178	50
52 DELIVERY ROOM & LABOR ROOM	0.367644			52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.181504	17,946	3,257	54
54.01 RADIOLOGY-ULTRASOUND	0.145198	3,578	520	54.01
60 LABORATORY	0.190278	50,913	9,688	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.508878	7,076	3,601	62
65 RESPIRATORY THERAPY	0.534957	20,999	11,234	65
66 PHYSICAL THERAPY	0.657414	107,749	70,836	66
69 ELECTROCARDIOLOGY	0.128612	985	127	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.805969	34,493	27,800	71
72 IMPL. DEV. CHARGED TO PATIENT	0.853875			72
73 DRUGS CHARGED TO PATIENTS	0.485841	56,820	27,605	73
76 CARDIAC REHAB	2.005530			76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
88.02 RHC III				88.02
90 CLINIC	1.439491			90
91 EMERGENCY	0.591676			91
92 OBSERVATION BEDS	0.938106			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		301,243	154,846	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		301,243		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1343) 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		519,317		30
31 INTENSIVE CARE UNIT		38,558		31
43 NURSERY		189,552		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.260613	555,319	144,723	50
52 DELIVERY ROOM & LABOR ROOM	0.367644	361,355	132,850	52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.181504	260,770	47,331	54
54.01 RADIOLOGY-ULTRASOUND	0.145198	51,884	7,533	54.01
60 LABORATORY	0.190278	362,639	69,002	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.508878			62
65 RESPIRATORY THERAPY	0.534957	50,939	27,250	65
66 PHYSICAL THERAPY	0.657414	18,304	12,033	66
69 ELECTROCARDIOLOGY	0.128612	8,436	1,085	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.805969	129,931	104,720	71
72 IMPL. DEV. CHARGED TO PATIENT	0.853875	4,757	4,062	72
73 DRUGS CHARGED TO PATIENTS	0.485841	164,535	79,938	73
76 CARDIAC REHAB	2.005530			76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
88.02 RHC III				88.02
90 CLINIC	1.439491	1,082	1,558	90
91 EMERGENCY	0.591676	50,190	29,696	91
92 OBSERVATION BEDS	0.938106	8,076	7,576	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,028,217	669,357	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,028,217		202

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-1343) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A
 PART B
 MM/DD/YYYY AMOUNT MM/DD/YYYY AMOUNT
 1 2 3 4

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,541,519		3,117,347	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.			02/24/2012	29,648	3.01
					3.02
					3.03
					3.04
					3.05
					3.06
					3.07
					3.08
					3.09
	02/24/2012	2,773		NONE	3.50
					3.51
					3.52
					3.53
					3.54
					3.55
					3.56
					3.57
					3.58
					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-2,773		29,648	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		3,538,746		3,146,995	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE	5.01
					5.02
					5.03
					5.04
					5.05
					5.06
					5.07
					5.08
					5.09
					5.50
					5.51
					5.52
					5.53
					5.54
					5.55
					5.56
					5.57
					5.58
					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT				409,376	6.01
					6.02
					6.03
					6.04
					6.05
					6.06
					6.07
					6.08
					6.09
					6.50
					6.51
					6.52
					6.53
					6.54
					6.55
					6.56
					6.57
					6.58
					6.59
					6.99
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		3,209,217		3,556,371	7

8 NAME OF CONTRACTOR:

CONTRACTOR NUMBER:

DATE:

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL [] IPF [] IRF	[] SUB (OTHER) [] SNF [XX] SWING BED. SNF (14-Z343)	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
DESCRIPTION						
1				408,120		1
2				NONE	NONE	2
3			02/24/2012	14,836	NONE	3.01
						3.02
		PROGRAM				3.03
		TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
				NONE	NONE	3.50
						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)				14,836		
4				422,956		4
TO BE COMPLETED BY CONTRACTOR						
5				NONE	NONE	5.01
		PROGRAM				5.02
		TO				5.03
		PROVIDER				5.04
						5.05
						5.06
						5.07
						5.08
						5.09
		PROVIDER		NONE	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				44,216		6.01
		PROGRAM				
		TO				
		PROVIDER				
		PROVIDER				
		TO				
		PROGRAM				
7				467,172		7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:	DATE:	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1343) [] 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	1,131 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,138 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,886 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	69,087,743 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,449,560 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	982,181 7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	756,710 8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	745,966 30
31	OTHER ADJUSTMENTS (SPECIFY)	31 31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	10,744 32

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2011 TO 04/30/2012

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

VERSION: 2011.10
 09/18/2012 10:47

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-Z343)
 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)	314,869	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)	156,394	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	378	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)	471,263	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	471,263	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)	2,664	11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	468,599	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	1,427	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)	467,172	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	467,172	19
20 INTERIM PAYMENTS	422,956	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	44,216	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART V

CHECK HOSPITAL (14-1343)
 APPLICABLE BOX: SUB (OTHER)

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

1	INPATIENT SERVICES	3,591,012	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	3,591,012	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	3,626,922	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)	3,626,922	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	468,433	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	3,158,489	22
23	COINSURANCE	4,528	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	3,153,961	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	55,256	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	55,256	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	36,970	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	3,209,217	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	3,209,217	30
31	INTERIM PAYMENTS	3,538,746	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	-329,529	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK TITLE V HOSPITAL (14-1343) SNF PPS
 APPLICABLE TITLE XIX IPF NF TEFRA
 BOXES: IRF ICF/MR OTHER
 SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES		1
2	MEDICAL AND OTHER SERVICES	3,557,423	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	3,557,423	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	3,557,423	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	443,108	8
9	ANCILLARY SERVICE CHARGES	13,665,533	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)		15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 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)	3,557,423	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	3,557,423	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)	3,557,423	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)	3,557,423	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)	3,557,423	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)	3,557,423	40
41	INTERIM PAYMENTS	3,557,423	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	3,444,228			1
2	TEMPORARY INVESTMENTS	880,627			2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	7,711,950			4
5	OTHER RECEIVABLES	745,966			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	712,024			7
8	PREPAID EXPENSES	571,317			8
9	OTHER CURRENT ASSETS	217,554			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	14,283,666			11
FIXED ASSETS					
12	LAND	48,365			12
13	LAND IMPROVEMENTS	1,485,155			13
14	ACCUMULATED DEPRECIATION	-723,145			14
15	BUILDINGS	39,574,774			15
16	ACCUMULATED DEPRECIATION	-15,278,724			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	10,271,503			23
24	ACCUMULATED DEPRECIATION	-7,760,469			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS	982,181			27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	28,599,640			30
OTHER ASSETS					
31	INVESTMENTS	11,587,197			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	329,775			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	11,916,972			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	54,800,278			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	720,837			37
38	SALARIES, WAGES & FEES PAYABLE	2,271,963			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	820,361			40
41	DEFERRED INCOME	206,327			41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	2,188,938			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	6,208,426			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	12,409,656			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	457,127			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	12,866,783			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	19,075,209			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	35,725,069			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)	35,725,069			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	54,800,278			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		33,221,600							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		2,503,469							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		35,725,069							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		35,725,069							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)		35,725,069							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	1,997,215		1,997,215	2
3 SUBPROVIDER IPF				3
5 SWING BED - SNF	142,150		142,150	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)	2,139,365		2,139,365	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
12 INTENSIVE CARE UNIT	679,433		679,433	11
13 CORONARY CARE UNIT				12
14 BURN INTENSIVE CARE UNIT				13
15 SURGICAL INTENSIVE CARE UNIT				14
16 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	679,433		679,433	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,818,798		2,818,798	17
18 ANCILLARY SERVICES	10,862,788	48,956,445	59,819,233	18
19 OUTPATIENT SERVICES		6,134,043	6,134,043	19
20 RHC		5,481,387	5,481,387	20
20.01 RHC II		843,290	843,290	20.01
20.02 RHC III		702,742	702,742	20.02
21 FQHC				21
22 HOME HEALTH AGENCY		839,901	839,901	22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 PHYSICIAN PRIVATE OFFICE		347,844	347,844	27
27.01 LONG TERM CARE		943,216	943,216	27.01
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	13,681,586	64,248,868	77,930,454	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		37,543,317	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)		37,543,317	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	77,930,454	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	39,387,458	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	38,542,996	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	37,543,317	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	999,679	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	101,935	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	151,541	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	26,763	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	109,342	22
23	GOVERNMENTAL APPROPRIATIONS	487,349	23
24	OTHER (CONSULTING CLINIC)	53,193	24
24.01	OTHER (WELLNESS)	101,140	24.01
24.02	OTHER (GRANTS)	39,625	24.02
24.03	OTHER (OTHER PROFESSIONAL INCOME)	246,412	24.03
24.04	OTHER (FOUNDATION REIMBURSEMENT)	13,211	24.04
24.05	OTHER (DONATIONS)	40,929	24.05
24.06	OTHER (OTHER INCOME)	132,350	24.06
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,503,790	25
26	TOTAL (LINE 5 PLUS LINE 25)	2,503,469	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)	2,503,469	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7175

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF COLS. 1-5) 6	
GENERAL SERVICE COST CENTER							1
1 CAPITAL RELATED-BLDGS & FIXTURES							2
2 CAPITAL RELATED-MOVABLE EQUIPMENT							3
3 PLANT OPERATION & MAINTENANCE							4
4 TRANSPORTATION (SEE INSTRUCTIONS)							5
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	109,445	6,263	1,540	26,104	39,347	182,699	6
6 SKILLED NURSING CARE	252,523	16,414	21,527			290,464	7
7 PHYSICAL THERAPY	21,766	1,415	4,999			28,180	8
8 OCCUPATIONAL THERAPY	7,303	475	1,301			9,079	9
9 SPEECH PATHOLOGY				1,560		1,560	10
10 MEDICAL SOCIAL SERVICES				450		450	11
11 HOME HEALTH AIDE	39,801	2,587	9,613			52,001	12
12 SUPPLIES (SEE INSTRUCTIONS)							13
13 DRUGS							14
14 DME							15
HHA NONREIMBURSABLE SERVICES							16
15 HOME DIALYSIS AIDE SERVICES							17
16 RESPIRATORY THERAPY							18
17 PRIVATE DUTY NURSING							19
18 CLINIC							20
19 HEALTH PROMOTION ACTIVITIES							21
20 DAY CARE PROGRAM							22
21 HOME DELIVERED MEALS PROGRAM							23
22 HOMEMAKER SERVICE							24
23 ALL OTHERS							
24 TOTAL (SUM OF LINES 1-23)	430,838	27,154	38,980	28,114	39,347	564,433	

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7175

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5	-11,294	171,405	-28,115	143,290	5
6		290,464		290,464	6
7		28,180		28,180	7
8		9,079		9,079	8
9		1,560		1,560	9
10		450		450	10
11		52,001		52,001	11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24	-11,294	553,139	-28,115	525,024	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7175

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	0	1	2	3	4	4A	5	6	
1									1
2									2
3									3
4									4
5		143,290				143,290	143,290		5
6		290,464				290,464	109,030	399,494	6
7		28,180				28,180	10,578	38,758	7
8		9,079				9,079	3,408	12,487	8
9		1,560				1,560	586	2,146	9
10		450				450	169	619	10
11		52,001				52,001	19,519	71,520	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24		525,024				525,024		525,024	24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7175

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
1							1
2							2
3							3
4							4
5					-143,290	381,734	5
6							6
7						290,464	7
8						28,180	8
9						9,079	9
10						1,560	10
11						450	11
12						52,001	12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
23.50							23.50
24					-143,290	381,734	24
25						143,290	25
26						0.375366	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7175

WORKSHEET H-2
 PART I

HHA COST CENTER	HHA TRIAL BALANCE 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS 4	NONPATIENT TELEPHONE S 5.01	DATA PROCE SSING 5.02	PURCHASING RECEIVING AND STORE 5.03		
1 ADMINISTRATIVE AND GENERAL			7,356		21,673	850		959	1	
2 SKILLED NURSING CARE	399,494				50,005				2	
3 PHYSICAL THERAPY	38,758				4,310				3	
4 OCCUPATIONAL THERAPY	12,487				1,446				4	
5 SPEECH PATHOLOGY	2,146								5	
6 MEDICAL SOCIAL SERVICES	619								6	
7 HOME HEALTH AIDE	71,520				7,882				7	
8 SUPPLIES									8	
9 DRUGS									9	
10 DME									10	
11 HOME DIALYSIS AIDE SERVICES									11	
12 RESPIRATORY THERAPY									12	
13 PRIVATE DUTY NURSING									13	
14 CLINIC									14	
15 HEALTH PROMOTION ACTIVITIES									15	
16 DAY CARE PROGRAM									16	
17 HOME DELIVERED MEALS PROGRAM									17	
18 HOMEMAKER SERVICE									18	
19 ALL OTHERS									19	
20 TOTAL (SUM OF LINES 1-19)	525,024		7,356		85,316	850		959	20	
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7175

WORKSHEET H-2
 PART I

HHA COST CENTER	ADMITTING 5.04	CASHIERING /ACCOUNTS RECEIVABLE 5.05	SUBTOTAL (COLS.0-4) 4A	OTHER ADMNISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
1 ADMINISTRATIVE AND GENERAL		18,119	48,957	4,825			2,733		1
2 SKILLED NURSING CARE			449,499	44,299					2
3 PHYSICAL THERAPY			43,068	4,244					3
4 OCCUPATIONAL THERAPY			13,933	1,373					4
5 SPEECH PATHOLOGY			2,146	211					5
6 MEDICAL SOCIAL SERVICES			619	61					6
7 HOME HEALTH AIDE			79,402	7,825					7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
20 TOTAL (SUM OF LINES 1-19)		18,119	637,624	62,838			2,733		20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7175

WORKSHEET H-2
 PART I

HHA COST CENTER	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL (SUM OF COL. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25
1 ADMINISTRATIVE AND GENERAL	16,188	75,991					148,694	1
2 SKILLED NURSING CARE							493,798	2
3 PHYSICAL THERAPY							47,312	3
4 OCCUPATIONAL THERAPY							15,306	4
5 SPEECH PATHOLOGY							2,357	5
6 MEDICAL SOCIAL SERVICES							680	6
7 HOME HEALTH AIDE							87,227	7
8 SUPPLIES								8
9 DRUGS								9
10 DME								10
11 HOME DIALYSIS AIDE SERVICES								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIES								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGRAM								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
20 TOTAL (SUM OF LINES 1-19)	16,188	75,991					795,374	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.								21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7175

WORKSHEET H-2
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL. 4A-23) 26	ALLOCATED HHA A&G (SEE PT. 2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	148,694			1
2 SKILLED NURSING CARE	493,798	113,542	607,340	2
3 PHYSICAL THERAPY	47,312	10,879	58,191	3
4 OCCUPATIONAL THERAPY	15,306	3,519	18,825	4
5 SPEECH PATHOLOGY	2,357	542	2,899	5
6 MEDICAL SOCIAL SERVICES	680	156	836	6
7 HOME HEALTH AIDE	87,227	20,056	107,283	7
8 SUPPLIES				8
9 DRUGS				9
10 DME				10
11 HOME DIALYSIS AIDE SERVICES				11
12 RESPIRATORY THERAPY				12
13 PRIVATE DUTY NURSING				13
14 CLINIC				14
15 HEALTH PROMOTION ACTIVITIES				15
16 DAY CARE PROGRAM				16
17 HOME DELIVERED MEALS PROGRAM				17
18 HOMEMAKER SERVICE				18
19 ALL OTHERS				19
20 TOTAL (SUM OF LINES 1-19)	795,374	148,694	795,374	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.		0.229934		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7175

WORKSHEET H-2
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	ADMITTING INPATIENT REVENUE
	1	2	3	4	5.01	5.02	5.03	5.04
1 ADMINISTRATIVE AND GENERAL		8,314		109,445	9		4	
2 SKILLED NURSING CARE				252,523				
3 PHYSICAL THERAPY				21,766				
4 OCCUPATIONAL THERAPY				7,303				
5 SPEECH PATHOLOGY								
6 MEDICAL SOCIAL SERVICES								
7 HOME HEALTH AIDE				39,801				
8 SUPPLIES								
9 DRUGS								
10 DME								
11 HOME DIALYSIS AIDE SERVICES								
12 RESPIRATORY THERAPY								
13 PRIVATE DUTY NURSING								
14 CLINIC								
15 HEALTH PROMOTION ACTIVITIES								
16 DAY CARE PROGRAM								
17 HOME DELIVERED MEALS PROGRAM								
18 HOMEMAKER SERVICE								
19 ALL OTHERS								
19.50 TELEMEDICINE								
20 TOTAL (SUM OF LINES 1-19)		8,314		430,838	9		4	
21 TOTAL COST TO BE ALLOCATED		7,356		85,316	850		959	
22 UNIT COST MULTIPLIER					94.444444		239.750000	
22 UNIT COST MULTIPLIER		0.884773		0.198023				

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7175

WORKSHEET H-2
 PART II

HHA COST CENTER	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON- CILIATION 4A.06	OTHER ADMI NISTRATIVE AND GENER ACCUM COST 5.06	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS 8	HOUSE- KEEPING SQUARE FEET 9	DIETARY MEALS 10	CAFETERIA FTE'S 11
1 ADMINISTRATIVE AND GENERAL	839,901		48,957			450		9
2 SKILLED NURSING CARE			449,499					2
3 PHYSICAL THERAPY			43,068					3
4 OCCUPATIONAL THERAPY			13,933					4
5 SPEECH PATHOLOGY			2,146					5
6 MEDICAL SOCIAL SERVICES			619					6
7 HOME HEALTH AIDE			79,402					7
8 SUPPLIES								8
9 DRUGS								9
10 DME								10
11 HOME DIALYSIS AIDE SERVICES								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIES								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGRAM								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTAL (SUM OF LINES 1-19)	839,901		637,624			450		9
21 TOTAL COST TO BE ALLOCATED	18,119		62,838			2,733		16,188
22 UNIT COST MULTIPLIER	0.021573		0.098550					
22 UNIT COST MULTIPLIER						6.073333		1,798.666667

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7175

WORKSHEET H-2
 PART II

HHA COST CENTER	NURSING ADMINIS- TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME	
	13	14	15	16	17	
1 ADMINISTRATIVE AND GENERAL	18,323					1
2 SKILLED NURSING CARE						2
3 PHYSICAL THERAPY						3
4 OCCUPATIONAL THERAPY						4
5 SPEECH PATHOLOGY						5
6 MEDICAL SOCIAL SERVICES						6
7 HOME HEALTH AIDE						7
8 SUPPLIES						8
9 DRUGS						9
10 DME						10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY						12
13 PRIVATE DUTY NURSING						13
14 CLINIC						14
15 HEALTH PROMOTION ACTIVITIES						15
16 DAY CARE PROGRAM						16
17 HOME DELIVERED MEALS PROGRAM						17
18 HOMEMAKER SERVICE						18
19 ALL OTHERS						19
19.50 TELEMEDICINE						19.50
20 TOTAL (SUM OF LINES 1-19)	18,323					20
21 TOTAL COST TO BE ALLOCATED	75,991					21
22 UNIT COST MULTIPLIER	4.147301					22
22 UNIT COST MULTIPLIER						22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7175

WORKSHEET H-3
 PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	AVERAGE	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	COSTS (FROM WKST H-2, PART I) 1	ANCILLARY COSTS (FROM PART II) 2	COSTS (COLS. 1+2) 3	VISITS 4	COST PER VISIT (COL.3 ÷ COL.4) 5	
1	SKILLED NURSING CARE	2	607,340		607,340	4,957	122.52	1
2	PHYSICAL THERAPY	3	58,191		58,191	813	71.58	2
3	OCCUPATIONAL THERAPY	4	18,825		18,825	207	90.94	3
4	SPEECH PATHOLOGY	5	2,899		2,899	13	223.00	4
5	MEDICAL SOCIAL SERVICES	6	836		836	3	278.67	5
6	HOME HEALTH AIDE	7	107,283		107,283	908	118.15	6
7	TOTAL (SUM OF LINES 1-6)		795,374		795,374	6,901		7

PATIENT SERVICES

8	SKILLED NURSING CARE							8
9	PHYSICAL THERAPY							9
10	OCCUPATIONAL THERAPY							10
11	SPEECH PATHOLOGY							11
12	MEDICAL SOCIAL SERVICES							12
13	HOME HEALTH AIDE							13
14	TOTAL (SUM OF LINES 8-13)							14

SUPPLIES AND DRUGS COST COMPUTATIONS		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	RATIO	
OTHER PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	COSTS (FROM WKST H-2, PART I) 1	ANCILLARY COSTS (FROM PART II) 2	COSTS (COLS. 1+2) 3	CHARGES (FROM HHA RECORD) 4	(COL.3 ÷ COL.4) 5	
15	COST OF MEDICAL SUPPLIES	8		35,756	35,756	44,364	0.805969	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7175

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS. 9-10)
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
PATIENT SERVICES							
1 SKILLED NURSING CARE	1,276	1,348	8	156,336	165,157	11	321,493
2 PHYSICAL THERAPY	436	254		31,209	18,181		49,390
3 OCCUPATIONAL THERAPY	120	79		10,913	7,184		18,097
4 SPEECH PATHOLOGY	21	4		4,683	892		5,575
5 MEDICAL SOCIAL SERVICES	4			1,115			1,115
6 HOME HEALTH AIDE	434	444		51,277	52,459		103,736
7 TOTAL (SUM OF LINES 1-6)	2,291	2,129		255,533	243,873		499,406

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS			TOTAL
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	99914	1,276	1,348	8	
9 PHYSICAL THERAPY	99914	436	254	9	
10 OCCUPATIONAL THERAPY	99914	120	79	10	
11 SPEECH PATHOLOGY	99914	21	4	11	
12 MEDICAL SOCIAL SERVICES	99914	4		12	
13 HOME HEALTH AIDE	99914	434	444	13	
14 TOTAL (SUM OF LINES 8-13)		2,291	2,129	14	

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES		
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR
OTHER PATIENT SERVICES						
15 COST OF MEDICAL SUPPLIES						
16 COST OF DRUGS						

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

LINE	FROM WKST C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL. 1 x COL. 2)	TRANSFER TO PART I AS INDICATED
1	PHYSICAL THERAPY 66	0.657414			COL 2, LINE 2
2	OCCUPATIONAL THERAPY 67				COL 2, LINE 3
3	SPEECH PATHOLOGY 68				COL 2, LINE 4
4	MEDICAL SUPPLIES CHRGD TO PAT 71	0.805969	44,364	35,756	COL 2, LINE 15
5	DRUGS CHARGED TO PATIENTS 73	0.485841			COL 2, LINE 16

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7175

WORKSHEET H-4
 PARTS I & II

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

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

DESCRIPTION	PART A 1	PART B		
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
1 REASONABLE COST OF PART A & PART B SERVICES				1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)				2
2 TOTAL CHARGES				2
CUSTOMARY CHARGES				
3 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)				3
4 AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)				4
5 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				5
6 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)				6
7 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)				7
8 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)				8
9 PRIMARY PAYER PAYMENTS				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	274,928	217,711	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	7,069	6,793	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	4,153	384	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	1,184	1,734	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	1,766	2,679	15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	289,100	229,301	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	289,100	229,301	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	289,100	229,301	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	289,100	229,301	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	289,100	229,301	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	289,100	229,301	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

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

RHC I
 COMPONENT NO: 14-3429

WORKSHEET M-1

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	2,173,346		2,173,346		2,173,346	-269,581	1,903,765	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	60,818		60,818		60,818		60,818	3
4 VISITING NURSE								4
5 OTHER NURSE								5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	551,230	144,707	695,937	-42,940	652,997	-140,644	512,353	9
10 SUBTOTAL (SUM OF LINES 1-9)	2,785,394	144,707	2,930,101	-42,940	2,887,161	-410,225	2,476,936	10
COSTS UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13)								14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		92,471	92,471		92,471		92,471	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT				174,398	174,398		174,398	17
18 PROFESSIONAL LIABILITY INSURANCE		164,036	164,036		164,036		164,036	18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		256,507	256,507	174,398	430,905		430,905	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,785,394	401,214	3,186,608	131,458	3,318,066	-410,225	2,907,841	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS	761,398		761,398		761,398		761,398	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	761,398		761,398		761,398		761,398	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	3,546,792	401,214	3,948,006	131,458	4,079,464	-410,225	3,669,239	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3429

WORKSHEET M-2

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3) COL.4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	5.38	29,900	4,200	22,596	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	0.47	2,637	2,100	987	3
4	SUBTOTAL (SUM OF LINES 1-3)	5.85	32,537		23,583	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	5.85	32,537			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)				2,907,841	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)				2,907,841	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)				761,398	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				1,307,303	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				2,068,701	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				2,068,701	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				2,068,701	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				4,976,542	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3429

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	4,976,542	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	47,576	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	4,928,966	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	32,537	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	32,537	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	151.49	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	151.49	151.49	151.49 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	7,971	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	1,207,527	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	194	12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	29,389	13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	22,042	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)	1,229,569	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)	1,146,907	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)	16,456	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	17,642	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	880,786	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	898,428	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	110,945	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	213,844	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	898,428	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	32,230	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	930,658	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	44,752	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	44,752	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	975,410	26
27	INTERIM PAYMENTS	1,036,099	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	-60,689	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		30

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I
 COMPONENT NO: 14-3429

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)	2,476,936	2,476,936	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000264	0.001335	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	654	3,307	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	9,588	14,250	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	10,242	17,557	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	2,907,841	2,907,841	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	2,068,701	2,068,701	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.003522	0.006038	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	7,286	12,491	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	17,528	30,048	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	94	475	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	186.47	63.26	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	67	312	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	12,493	19,737	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)		47,576	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)		32,230	16

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

RHC I
 COMPONENT NO: 14-3429

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		1,030,247	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 02/24/2012	5,852	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
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	5,852	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		1,036,099	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
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99		5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01		6.01
	PROVIDER PROVIDER TO .02	-60,689	6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		975,410	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	DATE:

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

RHC II
 COMPONENT NO: 14-3486

WORKSHEET M-1

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	6,615	6,615		6,615		6,615	1
2	PHYSICIAN ASSISTANT							2
3	NURSE PRACTITIONER	161,080	161,080		161,080		161,080	3
4	VISITING NURSE							4
5	OTHER NURSE							5
6	CLINICAL PSYCHOLOGIST							6
7	CLINICAL SOCIAL WORKER							7
8	LABORATORY TECHNICIAN							8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	87,090	43,968	1,431	132,489		132,489	9
10	SUBTOTAL (SUM OF LINES 1-9)	254,785	43,968	298,753	1,431	300,184	300,184	10
COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT							11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13	OTHER COSTS UNDER AGREEMENT							13
14	SUBTOTAL (SUM OF LINES 11-13)							14
OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		12,145	12,145		12,145	12,145	15
16	TRANSPORTATION (HEALTH CARE STAFF)							16
17	DEPRECIATION-MEDICAL EQUIPMENT							17
18	PROFESSIONAL LIABILITY INSURANCE		4,929	4,929		4,929	4,929	18
19	OTHER HEALTH CARE COSTS							19
20	ALLOWABLE GME COSTS							20
21	SUBTOTAL (SUM OF LINES 15-20)		17,074	17,074		17,074	17,074	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	254,785	61,042	315,827	1,431	317,258	317,258	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY							23
24	DENTAL							24
25	OPTOMETRY							25
26	ALL OTHER NONREIMBURSABLE COSTS							26
27	NONALLOWABLE GME COSTS							27
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)							28
FACILITY OVERHEAD								
29	FACILITY COSTS		14,347	14,347	7,747	22,094	22,094	29
30	ADMINISTRATIVE COSTS	27,843	66,180	94,023		94,023	-17,238	76,785
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	27,843	80,527	108,370	7,747	116,117	-17,238	98,879
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	282,628	141,569	424,197	9,178	433,375	-17,238	416,137

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC II
 COMPONENT NO: 14-3486

WORKSHEET M-2

CHECK APPLICABLE BOX [XX] RHC [] FQHC
 VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	0.03	74	4,200	126	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	0.79	4,715	2,100	1,659	3
4	SUBTOTAL (SUM OF LINES 1-3)	0.82	4,789		1,785	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.82	4,789			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)				317,258	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)				317,258	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)				98,879	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				104,632	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				203,511	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				203,511	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				203,511	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				520,769	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC II
 COMPONENT NO: 14-3486

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	520,769	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	1,847	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	518,922	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	4,789	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,789	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	108.36	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)			8	
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	108.36	108.36	108.36	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	430	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	46,595	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	3	12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	325	13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	244	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)	46,839	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)	56,529	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)	1,660	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	1,375	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	28,408	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	29,783	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	9,954	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	9,412	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	29,783	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	775	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	30,558	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	3,395	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	3,395	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	33,953	26
27	INTERIM PAYMENTS	34,578	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	-625	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		30

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC II
 COMPONENT NO: 14-3486

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)	300,184	300,184	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000130	0.000281	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	39	84	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	612	390	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	651	474	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	317,258	317,258	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	203,511	203,511	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.002052	0.001494	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	418	304	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,069	778	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	6	13	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	178.17	59.85	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	2	7	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	356	419	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)		1,847	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)		775	16

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

RHC II
 COMPONENT NO: 14-3486

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		33,749	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 02/24/2012	829	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	829	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)		34,578	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
	.99		5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)			
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01		6.01
	PROVIDER PROVIDER TO .02	-625	6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		33,953	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	DATE:

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

RHC III
 COMPONENT NO: 14-3488

WORKSHEET M-1

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	96,644		96,644		96,644	-10,720	85,924	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	33,661		33,661		33,661		33,661	3
4 VISITING NURSE								4
5 OTHER NURSE								5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	79,405	49,458	128,863	22,436	151,299		151,299	9
10 SUBTOTAL (SUM OF LINES 1-9) COSTS UNDER AGREEMENT	209,710	49,458	259,168	22,436	281,604	-10,720	270,884	10
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS								14
15 MEDICAL SUPPLIES		9,513	9,513		9,513		9,513	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		9,513	9,513		9,513		9,513	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21) COSTS OTHER THAN RHC/FQHC SERVICES	209,710	58,971	268,681	22,436	291,117	-10,720	280,397	22
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27) FACILITY OVERHEAD								28
29 FACILITY COSTS		7,582	7,582		7,582		7,582	29
30 ADMINISTRATIVE COSTS	21,798	32,289	54,087		54,087		54,087	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	21,798	39,871	61,669		61,669		61,669	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	231,508	98,842	330,350	22,436	352,786	-10,720	342,066	32

RHC III
 COMPONENT NO: 14-3488

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	0.41	2,080	4,200	1,722	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	0.41	1,954	2,100	861	3
4	SUBTOTAL (SUM OF LINES 1-3)	0.82	4,034		2,583	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.82	4,034			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)				280,397	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)				280,397	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)				61,669	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				87,832	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				149,501	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				149,501	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				149,501	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				429,898	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC III
 COMPONENT NO: 14-3488

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	429,898	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	3,652	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	426,246	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	4,034	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,034	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	105.66	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)			8	
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	105.66	105.66	105.66	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	268		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	28,317		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	106		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	80		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)	28,397		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)	35,174		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)	1,897		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	1,532		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	17,683		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	19,215		16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	4,761		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	6,110		19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	19,215		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	1,076		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	20,291		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	1,510		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	1,510		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	21,801		26
27	INTERIM PAYMENTS	16,963		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	4,838		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			30

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC III
 COMPONENT NO: 14-3488

WORKSHEET M-4

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

[] TITLE XIX

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	270,884	270,884	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000199	0.001462	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	54	396	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	612	1,320	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	666	1,716	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	280,397	280,397	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	149,501	149,501	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.002375	0.006120	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	355	915	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,021	2,631	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	6	44	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	170.17	59.80	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		18	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		1,076	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)		3,652	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)		1,076	16

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

RHC III
 COMPONENT NO: 14-3488

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		20,873	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.		NONE	
	.01		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 02/24/2012	3,910	3.50
	.51		3.51
	PROVIDER .52		3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
	.99	-3,910	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)		16,963	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.		NONE	
	PROGRAM .01		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.		4,838	6.01
	PROGRAM .01		
	TO .02		
	PROVIDER .01		6.02
	TO .02		
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		21,801	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	50.88		13.20				64.08 30
31 INTENSIVE CARE UNIT	30.59		16.47				47.06 31
43 NURSERY			72.67				72.67 43
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	5.27	21.51	5.30	17.38			49.46 50
52 DELIVERY ROOM & LABOR ROOM			50.47	2.49			52.96 52
54 RADIOLOGY-DIAGNOSTIC	4.52	30.14	1.98	29.07			65.71 54
54.01 RADIOLOGY-ULTRASOUND	9.06	28.18	2.22	33.63			73.09 54.01
60 LABORATORY	6.67	35.99	2.80	20.23			65.69 60
62 WHOLE BLOOD & PACKED RED BLOOD	50.18	32.20					82.38 62
65 RESPIRATORY THERAPY	18.18	25.61	3.61	14.92			62.32 65
66 PHYSICAL THERAPY	5.79	27.89	0.74	18.34			52.76 66
69 ELECTROCARDIOLOGY	19.90	56.79	2.02	15.18			93.89 69
71 MEDICAL SUPPLIES CHRGD TO PATI	30.95	9.71	6.87	12.35			59.88 71
72 IMPL. DEV. CHARGED TO PATIENT	32.81	46.39	1.29	5.62			86.11 72
73 DRUGS CHARGED TO PATIENTS	16.58	37.09	3.23	2.64			59.54 73
76 CARDIAC REHAB		18.05		2.68			20.73 76
90 CLINIC	0.57	34.39	0.08	15.82			50.86 90
91 EMERGENCY	0.12	27.93	1.48	33.94			63.47 91
92 OBSERVATION BEDS	0.14	45.19	2.59	23.07			70.99 92
200 TOTAL CHARGES	6.86	26.16	3.17	18.18			54.37 200

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

SWING-BED SNF / NF

COST CENTERS	----- TITLE XVIII -----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	0.01						0.01 50
54 RADIOLOGY-DIAGNOSTIC	0.14						0.14 54
54.01 RADIOLOGY-ULTRASOUND	0.15						0.15 54.01
60 LABORATORY	0.39						0.39 60
62 WHOLE BLOOD & PACKED RED BLOOD	2.96						2.96 62
65 RESPIRATORY THERAPY	1.49						1.49 65
66 PHYSICAL THERAPY	4.35						4.35 66
69 ELECTROCARDIOLOGY	0.24						0.24 69
71 MEDICAL SUPPLIES CHRGED TO PATI	1.82						1.82 71
73 DRUGS CHARGED TO PATIENTS	1.12						1.12 73
200 TOTAL CHARGES	0.47						0.47 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1 CAP REL COSTS-BLDG & FIXT	1,775,599	5.35	-1,775,599	-12.33			1
2 CAP REL COSTS-MVBLE EQUIP	804,830	2.42	-804,830	-5.59			2
3 OTHER CAPITAL RELATED COSTS							3
4 EMPLOYEE BENEFITS	2,964,468	8.93	-2,964,468	-20.58			4
5.01 NONPATIENT TELEPHONES	29,195	0.09	-29,195	-0.20			5.01
5.02 DATA PROCESSING	934,127	2.81	-934,127	-6.48			5.02
5.03 PURCHASING RECEIVING AND STORES	147,859	0.45	-147,859	-1.03			5.03
5.04 ADMITTING	290,088	0.87	-290,088	-2.01			5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	542,381	1.63	-542,381	-3.76			5.05
5.06 OTHER ADMINISTRATIVE AND GENERA	2,262,101	6.81	-2,262,101	-15.70			5.06
7 OPERATION OF PLANT	1,507,070	4.54	-1,507,070	-10.46			7
8 LAUNDRY & LINEN SERVICE	135,602	0.41	-135,602	-0.94			8
9 HOUSEKEEPING	442,689	1.33	-442,689	-3.07			9
10 DIETARY	373,161	1.12	-373,161	-2.59			10
11 CAFETERIA	242,063	0.73	-242,063	-1.68			11
13 NURSING ADMINISTRATION	674,821	2.03	-674,821	-4.68			13
14 CENTRAL SERVICES & SUPPLY							14
15 PHARMACY	625,100	1.88	-625,100	-4.34			15
16 MEDICAL RECORDS & LIBRARY	612,865	1.85	-612,865	-4.25			16
17 SOCIAL SERVICE	42,371	0.13	-42,371	-0.29			17
INPATIENT ROUTINE SERV COST CENTERS							
30 ADULTS & PEDIATRICS	1,703,116	5.13	2,077,877	14.42	3,780,993	11.39	30
31 INTENSIVE CARE UNIT	148,709	0.45	177,011	1.23	325,720	0.98	31
43 NURSERY	54,526	0.16	63,546	0.44	118,072	0.36	43
45 NURSING FACILITY	867,745	2.61	1,152,420	8.00	2,020,165	6.08	45
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	1,154,940	3.48	1,577,647	10.95	2,732,587	8.23	50
52 DELIVERY ROOM & LABOR ROOM	104,790	0.32	158,442	1.10	263,232	0.79	52
53 ANESTHESIOLOGY							53
54 RADIOLOGY-DIAGNOSTIC	1,281,760	3.86	1,107,596	7.69	2,389,356	7.19	54
54.01 RADIOLOGY-ULTRASOUND	191,353	0.58	148,166	1.03	339,519	1.02	54.01
60 LABORATORY	1,445,290	4.35	1,015,273	7.05	2,460,563	7.41	60
62 WHOLE BLOOD & PACKED RED BLOOD	92,382	0.28	29,443	0.20	121,825	0.37	62
65 RESPIRATORY THERAPY	422,964	1.27	331,619	2.30	754,583	2.27	65
66 PHYSICAL THERAPY	764,354	2.30	865,628	6.01	1,629,982	4.91	66
69 ELECTROCARDIOLOGY	14,050	0.04	39,646	0.28	53,696	0.16	69
71 MEDICAL SUPPLIES CHRGD TO PATI	1,145,935	3.45	377,743	2.62	1,523,678	4.59	71
72 IMPL. DEV. CHARGED TO PATIENT	252,305	0.76	61,751	0.43	314,056	0.95	72
73 DRUGS CHARGED TO PATIENTS	1,092,912	3.29	1,380,253	9.58	2,473,165	7.45	73
76 CARDIAC REHAB	69,837	0.21	187,312	1.30	257,149	0.77	76
88 RURAL HEALTH CLINIC (RHC)	3,669,239	11.05	1,307,303	9.07	4,976,542	14.99	88
88.01 RHC II	416,137	1.25	104,632	0.73	520,769	1.57	88.01
88.02 RHC III	342,066	1.03	87,832	0.61	429,898	1.29	88.02
90 CLINIC	1,355,084	4.08	685,927	4.76	2,041,011	6.15	90
91 EMERGENCY	1,167,915	3.52	839,693	5.83	2,007,608	6.05	91
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
101 HOME HEALTH AGENCY	525,024	1.58	270,350	1.88	795,374	2.40	101
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
190 GIFT, FLOWER, COFFEE SHOP & CAN			36,011	0.25	36,011	0.11	190
192 PHYSICIANS' PRIVATE OFFICES	254,608	0.77	43,546	0.30	298,154	0.90	192
194 NONREIMBURSEABLE							194
194.01 PROFESSIONAL BUILDINGS	115,483	0.35	24,021	0.17	139,504	0.42	194.01
194.02 FOUNDATION SERVICES	38,047	0.11	14,756	0.10	52,803	0.16	194.02
194.03 WELLNESS	111,798	0.34	150,668	1.05	262,466	0.79	194.03
194.04 RENTED SPACE			90,278	0.63	90,278	0.27	194.04
200 CROSS FOOT ADJUSTMENTS							200
201 NEGATIVE COST CENTER							201
202 TOTAL	33,208,759	100.00			33,208,759	100.00	202

**** 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 OPFS.
(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 OPFS.
(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)

MEDIICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES		14-3488 14-3486 14-3429		CLINIC NAME CMH Rural Health Clinic Oblong		REPORTING PERIOD FROM: 5-1-11 TO: 4-30-12		ATTACHMENT #1	
COST CENTER (OMIT CENTES)	COMPENSATION	OTHER	TOTAL COL.1&2	RECLASSI- FICATIONS	RECLASSIFIED TRIAL BALANCE COL.3&4	ADJUSTMENTS INCREASES (DECREASES)	NET EXPENSES COL.5&6		
	1	2	3	4	5	6	7		
1 SUPPLEMENTAL COSTS									
2 Pharmacy									
3 Patient Transportation									
4 Medical Case Management									
5 Health Education									
6 Nutrition Counseling									
7 Others(specify)									
8									
9									
10									
11									
12 Supplemental Subtotal(sum of lines 2 through 11)									
13 DENTAL									
14 NON-ALLOWABLE COST CENTERS									
15 HWMHK Case Management									
16 WIC(Women,Infants, & Children)									
17 Fundraising & Public Relations									
18 Social Services									
19 Unlicensed Social Workers									
20 Others(specify)									
21									
22									
23									
24									
25 Non-Allowable Subtotal(sum of lines 15 - 24)									
26 Totals for schedule C (sum of lines 12,13, &25)									

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

RURAL HEALTH CENTER DENTAL STATISTICS		CLINIC NAME		REPORTING PERIOD		ATTACHMENT #2		
NONE		CMH RHC, Palestine, Oblong		FROM: 5-1-1 TO: 4-30-12				
	COST CENTER (OMIT CENTS)	COMPENSATION	OTHER	COL.1&2	RECLASSI- FICATIONS	RECLASSIFIED TRIAL BALANCE	ADJUSTMENTS	NET
		1	2	3	4	5	6	7
1	RHC DENTAL STAFF COST							
2	Dentists							
3	Dental Hygienist							
4								
5								
6	TOTAL - Dentists(Sum of lines 1 through 5)							
7	Other - Dental Staff							
8								
9								
10								
11	SUBTOTAL- Other Dental Staff(Sum of lines 7-10)							
12	TOTAL - Dental Staff (Sum of lines 6 and 11)							
13	Dental Services Under Agreement							
14								
15	TOTAL DENTAL COST(Sum of lines 12 through 14)							

DENTAL SERVICES PERSONNEL, EQUIVALENTS, HOURS ON SITE, AND ENCOUNTERS

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

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