

CLAY COUNTY HOSPITAL
FLORA, ILLINOIS
MEDICARE COST REPORT
YEAR ENDED FEBRUARY 29, 2012

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 06/26/2012 TIME: 15:31
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY CLAY COUNTY HOSPITAL (14-1351) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 03/01/2011 AND ENDING 02/29/2012, 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: 06/26/2012 15:31
 Mk3heICaTWdx.P6PxvdTLg0H6R3ws0
 oYb9M05ZUOVCMtbUGfcVcpTbJbfjle
 eFct0ua6iW0jdQio

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

PI Encryption: 06/26/2012 15:31
 CleBH3t.LeRzYkTJeBGcEtZ06QLl20
 .c83U0v3NrR3vTZQ..qnByRODLjOm.
 yOAG0YqvOg0YxxAK

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1	HOSPITAL	65,293	-378,773		284,754	1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF	8,195				5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC		35,482			10
10.01	HEALTH CLINIC - RHC II					10.01
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL	73,488	-343,291		284,754	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: 911 STACY BURK DRIVE
 2 CITY: FLORA

STATE: IL

P.O. BOX:
 ZIP CODE: 62839-0280 COUNTY: CLAY

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)		
						V 6	XVIII 7	XIX 8
3	HOSPITAL	14-1351	99914	1	12/21/2005	N	O	O
4	SUBPROVIDER - IPF							
5	SUBPROVIDER - IRF							
6	SUBPROVIDER - (OTHER)							
7	SWING BEDS - SNF	14-2351	99914		12/21/2005	N	O	N
8	SWING BEDS - NF							
9	HOSPITAL-BASED SNF							
10	HOSPITAL-BASED NF							
11	HOSPITAL-BASED OLTC							
12	HOSPITAL-BASED HHA							
13	SEPARATELY CERTIFIED ASC							
14	HOSPITAL-BASED HOSPICE							
15	HOSPITAL-BASED HEALTH CLINIC - RHC	14-3458	99914		11/29/2005	N	O	N
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	14-3487	99914		12/18/2006	N	O	N
16	HOSPITAL-BASED HEALTH CLINIC - FQHC							
17	HOSPITAL-BASED (CMHC)							
18	RENAL DIALYSIS							
19	OTHER							

20 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 03/01/2011 TO: 02/29/2012
 21 TYPE OF CONTROL 9

20
 21

INPATIENT PPS INFORMATION

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

	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.					24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID 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.			2		27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.					35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:	ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.					37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:	ENDING:	38

	V	XVIII	XIX
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	1	2
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
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	1 N	2	3	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.				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 TIME 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	TIME AVERAGE	DIRECT GME AVERAGE	61
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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
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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
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ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)

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

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

66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66
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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	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	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	93		
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		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	96		
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97		
RURAL PROVIDERS						
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?		Y	105		
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.		Y	106		
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.		N	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- SICAL N	OCCUP- ATIONAL N	RESPI- RATORY N	109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	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.	Y		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
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.	1,000,000	3,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1	2	140
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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)		PART A	PART B	
155	HOSPITAL	1	2	
156	SUBPROVIDER - IPF	N	N	155
157	SUBPROVIDER - IRF	N	N	156
158	SUBPROVIDER - (OTHER)	N	N	157
159	SNF	N	N	158
160	HHA	N	N	159
161	CMHC	N	N	160

MULTICAMPUS

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
		1	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	
		1	2	3	
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	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	
		Y/N	TYPE	DATE	
		1	2	3	
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	4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
		Y/N	Y/N		
		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?			6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
			Y/N		
			Y	12	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		N	13	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.				
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N	14	
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	04/30/2012	Y	04/30/2012 17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

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

CAPITAL RELATED COST

- 22 HAVE ASSETS BEEN 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. Y 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. Y 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. Y 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 |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
	1	2	3	4	5	6
SALARIES						
1	200	7,989,764				1
2						2
3		45				3
4						4
4.01						4.01
5						5
6						6
7	21					7
7.01						7.01
8						8
9	44					9
10		469,559				10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26		90,879				26
27		791,032				27
28						28
29						29
30		147,464				30
31						31
32		197,650				32
33						33
34		202,452				34
35						35
36						36
37						37
38		332,890	-28,818			38
39		28,575				39
40		172,804				40
41		276,554				41
42						42
43						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	7,989,719		7,989,719		1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	469,559		469,559		2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	7,520,160		7,520,160		3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)					4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)					5
6	TOTAL (SUM OF LINES 3 THRU 5)	7,520,160		7,520,160		6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	2,240,300	-28,818	2,211,482		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

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
PERIOD FROM 03/01/2011 TO 02/29/2012

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

VERSION: 2011.10
06/21/2012 13:48

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT	
0		LABOR	COST	
		1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II			14.01
15	HOSPITAL-BASED HEALTH CLINIC - PQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
PERIOD FROM 03/01/2011 TO 02/29/2012

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

VERSION: 2011.10
06/21/2012 13:48

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

RHC I
COMPONENT NO: 14-3458

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 929 STACY BURK DRIVE 1
2 CITY: FLORA STATE: IL ZIP CODE: 62839 COUNTY: CLAY 2
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 1 2 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 10
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N

FACILITY HOURS OF OPERATIONS(1)

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

13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? Y 2 13
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.

14 PROVIDER NAME: CLAY COUNTY HOSPITAL CLIN CCN NUMBER: 14-3458 14
14.01 LOUISVILLE MEDICAL CLINIC 14-3487 14.01

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)

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET 8-10

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) 0.434328 1

MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)

2 NET REVENUE FROM MEDICAID 3,485,986 2
 3 DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID? N 3
 4 IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID? 4
 5 IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID 5
 6 MEDICAID CHARGES 7,937,981 6
 7 MEDICAID COST (LINE 1 TIMES LINE 6) 3,447,687 7
 8 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) 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 24,846 17
 18 GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS 270,048 18
 19 TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16) 19

	UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3
20 TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	470,053	119,877	589,930 20
21 COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	204,157	52,066	256,223 21
22 PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	10,027	6,993	17,020 22
23 COST OF CHARITY CARE	194,130	45,073	239,203 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)			2,201,589 26
27 MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			548,277 27
28 NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,653,312 28
29 COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			718,080 29
30 COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			957,283 30
31 TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			957,283 31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		940,601	940,601	-187,055	1
1.01	00101		9,545	9,545	180,998	1.01
2	00200		808,437	808,437	6,057	2
3	00300					3
4	00400	90,879	2,860,029	2,950,908		4
5	00500	791,032	1,379,796	2,170,828		5
6	00600					6
7	00700	147,464	379,416	526,880		7
7.01	00701		30,871	30,871		7.01
8	00800		80,349	80,349		8
9	00900	197,650	45,335	242,985		9
10	01000	202,452	147,641	350,093		10
11	01100					11
12	01200					12
13	01300	332,890	25,063	357,953	-28,818	13
14	01400	28,575	8,019	36,594		14
15	01500	172,804	21,738	194,542		15
16	01600	276,554	44,886	321,440	-4,905	16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,088,030	38,233	1,126,263		30
ANCILLARY SERVICE COST CENTERS						
50	05000	339,986	143,261	483,247	7,576	50
53	05300		227,004	227,004	-7,576	53
54	05400	351,173	624,369	975,542		54
60	06000	436,597	813,213	1,249,810		60
62.30	06250					62.30
65	06500	251,898	30,485	282,383	-50,380	65
66	06600	333,283	15,177	348,460		66
69	06900	21,930	6,978	28,908	37,785	69
70	07000		55,161	55,161	12,595	70
71	07100		331,476	331,476		71
73	07300		445,169	445,169		73
76	03550		466,255	466,255		76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	1,911,561	172,119	2,083,680		88
90	09000		27,525	27,525	28,818	90
91	09100	545,447	1,506,481	2,051,928		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	441,401	76,988	518,389		95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
118		7,961,606	11,761,620	19,723,226	-4,905	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
192	19200	28,158	9,605	37,763	4,905	192
200		7,989,764	11,771,225	19,760,989		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	753,546	-60,274	693,272	1
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	190,543		190,543	1.01
2	00200	CAP REL COSTS-MVBLE EQUIP	814,494		814,494	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	2,950,908	-26,997	2,923,911	4
5	00500	ADMINISTRATIVE & GENERAL	2,170,828	-154,475	2,016,353	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	526,880		526,880	7
7.01	00701	RHC UTILITY EXPENSE	30,871		30,871	7.01
8	00800	LAUNDRY & LINEN SERVICE	80,349		80,349	8
9	00900	HOUSEKEEPING	242,985		242,985	9
10	01000	DIETARY	350,093	-110,934	239,159	10
11	01100	CAPETERIA				11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	329,135		329,135	13
14	01400	CENTRAL SERVICES & SUPPLY	36,594		36,594	14
15	01500	PHARMACY	194,542		194,542	15
16	01600	MEDICAL RECORDS & LIBRARY	316,535	-6,200	310,335	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,126,263		1,126,263	30
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	490,823		490,823	50
53	05300	ANESTHESIOLOGY	219,428	-219,428		53
54	05400	RADIOLOGY-DIAGNOSTIC	975,542		975,542	54
60	06000	LABORATORY	1,249,810		1,249,810	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	232,003	-1,840	230,163	65
66	06600	PHYSICAL THERAPY	348,460		348,460	66
69	06900	ELECTROCARDIOLOGY	66,693	-21,930	44,763	69
70	07000	ELECTROENCEPHALOGRAPHY	67,756	-55,000	12,756	70
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	331,476	-370	331,106	71
73	07300	DRUGS CHARGED TO PATIENTS	445,169		445,169	73
76	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	466,255		466,255	76
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC (RHC)	2,083,680	-41,348	2,042,332	88
90	09000	CLINIC	56,343		56,343	90
91	09100	EMERGENCY	2,051,928	-984,934	1,066,994	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
95	09500	AMBULANCE SERVICES	518,389		518,389	95
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117)	19,718,321	-1,683,730	18,034,591	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
192	19200	PHYSICIANS' PRIVATE OFFICES	42,668		42,668	192
200		TOTAL (SUM OF LINES 118-199)	19,760,989	-1,683,730	18,077,259	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
1		2	3		4	5
1 DEPRICIATION	A	NEW CAP RHC REL COSTS-BLDG &	1.01			174,768 1
500 TOTAL RECLASSIFICATIONS						174,768 500
CODE LETTER - A						
1 RESPIRATORY THERAPY	B	ELECTROCARDIOLOGY	69		37,785	1
2		ELECTROENCEPHALOGRAPHY	70		12,595	2
500 TOTAL RECLASSIFICATIONS					50,380	500
CODE LETTER - B						
1 INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	1.01			6,230 1
2		CAP REL COSTS-MVBLE EQUIP	2			6,057 2
500 TOTAL RECLASSIFICATIONS						12,287 500
CODE LETTER - C						
1 OPERATING ROOM	D	OPERATING ROOM	50			7,576 1
500 TOTAL RECLASSIFICATIONS						7,576 500
CODE LETTER - D						
1 TRANSCRIPTION SERVICES	E	PHYSICIANS' PRIVATE OFFICES	192			4,905 1
500 TOTAL RECLASSIFICATIONS						4,905 500
CODE LETTER - E						
1 DIABETES EDUCATION	F	CLINIC	90		28,818	1
500 TOTAL RECLASSIFICATIONS					28,818	500
CODE LETTER - F						
GRAND TOTAL (INCREASES)					79,198	199,536

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 DEPRICIATION	A	CAP REL COSTS-BLDG & FIXT	1		174,768	9 1
500 TOTAL RECLASSIFICATIONS					174,768	500
CODE LETTER - A						
1 RESPIRATORY THERAPY	B	RESPIRATORY THERAPY	65	50,380		1
2						2
500 TOTAL RECLASSIFICATIONS				50,380		500
CODE LETTER - B						
1 INSURANCE EXPENSE	C	CAP REL COSTS-BLDG & FIXT	1		12,287	12 1
2						12 2
500 TOTAL RECLASSIFICATIONS					12,287	500
CODE LETTER - C						
1 OPERATING ROOM	D	ANESTHESIOLOGY	53		7,576	1
500 TOTAL RECLASSIFICATIONS					7,576	500
CODE LETTER - D						
1 TRANSCRIPTION SERVICES	E	MEDICAL RECORDS & LIBRARY	16		4,905	1
500 TOTAL RECLASSIFICATIONS					4,905	500
CODE LETTER - E						
1 DIABETES EDUCATION	F	NURSING ADMINISTRATION	13	28,818		1
500 TOTAL RECLASSIFICATIONS				28,818		500
CODE LETTER - F						
GRAND TOTAL (DECREASES)				79,198	199,536	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND	BALANCE	DEPRECIATED
	1	2	3	4	RETIREMENTS	6	ASSETS
					5		7
1 LAND	132,111					132,111	1
2 LAND IMPROVEMENTS	345,852					345,852	2
3 BUILDINGS AND FIXTURES	12,075,375	230,815		230,815		12,306,190	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	6,640,375	1,072,420		1,072,420	116,282	7,596,513	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	19,193,713	1,303,235		1,303,235	116,282	20,380,666	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	19,193,713	1,303,235		1,303,235	116,282	20,380,666	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL (1)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14) 15
	9	10	11	(SEE INSTR.) 12	(SEE INSTR.) 13	14	
1 CAP REL COSTS-BLDG & FIXT	609,343		289,658	41,600			940,601 1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT		6,048			3,497		9,545 1.01
2 CAP REL COSTS-MVBLE EQUIP	619,435	189,002					808,437 2
3 TOTAL (SUM OF LINES 1-2)	1,228,778	195,050	289,658	41,600	3,497		1,758,583 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	RATIOS		INSURANCE	TAXES	OTHER	TOTAL
			FOR RATIO (COL. 1 - COL. 2)	RATIO (SEE INSTR.)			CAPITAL- RELATED COSTS	(SUM OF COLS. 5-7) 8
	1	2	3	4	5	6	7	
1 CAP REL COSTS-BLDG & FIXT	12,784,153		12,784,153	0.627269				1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT								1.01
2 CAP REL COSTS-MVBLE EQUIP	7,596,513		7,596,513	0.372731				2
3 TOTAL (SUM OF LINES 1-2)	20,380,666		20,380,666	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL (2)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14) 15
	9	10	11	(SEE INSTR.) 12	(SEE INSTR.) 13	14	
1 CAP REL COSTS-BLDG & FIXT	434,575		229,384	29,313			693,272 1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT	174,768	6,048		6,230	3,497		190,543 1.01
2 CAP REL COSTS-MVBLE EQUIP	619,435	189,002		6,057			814,494 2
3 TOTAL	1,228,778	195,050	229,384	41,600	3,497		1,698,309 3

ADJUSTMENTS TO EXPENSES

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8	
			COST CENTER	LINE NO.	WKST A-7	REF
	1	2	3	4	5	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-60,274	CAP REL COSTS-BLDG & FIXT	1	11	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-439	ADMINISTRATIVE & GENERAL	5		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)	A	-3,227	ADMINISTRATIVE & GENERAL	5		7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9 PARKING LOT (CHAPTER 21)						9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST					
	A-8-2	-1,091,302				10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-4,233	ADMINISTRATIVE & GENERAL	5		11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST					
	A-8-1					12
13 LAUNDRY AND LINEN SERVICE						13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-110,934	DIETARY	10		14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-370	MEDICAL SUPPLIES CHRGED TO PATI	71		16
17 SALE OF DRUGS TO OTHER THAN PATIENTS						17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-6,200	MEDICAL RECORDS & LIBRARY	16		18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						19
20 VENDING MACHINES	B	-158	ADMINISTRATIVE & GENERAL	5		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						32
33 EKG PHYSICIAN EMPLOYEE BENEFITS	A	-17,979	EMPLOYEE BENEFITS	4		33
34 MISCELLANEOUS REVENUE	B	-29,294	ADMINISTRATIVE & GENERAL	5		34
35 PUBLIC RELATIONS	A	-110,691	ADMINISTRATIVE & GENERAL	5		35
36 LOBBYING EXPENSE	A	-6,433	ADMINISTRATIVE & GENERAL	5		36
37 CRNA EXPENSE	A	-219,428	ANESTHESIOLOGY	53		37
38 EMPLOYEE BENEFITS LAB TESTS	A	-8,011	EMPLOYEE BENEFITS	4		38
39 PHYSICIAN CLINIC EXPENSE	A	-13,750	RURAL HEALTH CLINIC (RHC)	88		39
40 PHYSICIAN RECRUITMENT	A	-1,007	EMPLOYEE BENEFITS	4		40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,683,730				50
TRANSFER TO WKST A, COL. 6, LINE 200)						

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4)					5
	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	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE	NO.	2	3	4	5	6	7	8	9	
1	60	LABORATORY	27,150		27,150					1
2	88	RURAL HEALTH CLINIC (RHC AGGREGATE	27,598	27,598						2
3	69	ELECTROCARDIOLOGY AGGREGATE	21,930	21,930						3
4	91	EMERGENCY AGGREGATE	1,427,440	984,934	442,506					4
5	70	ELECTROENCEPHALOGRAPHY AGGREGATE	55,000	55,000						5
6	65	RESPIRATORY THERAPY AGGREGATE	1,840	1,840						6
200		TOTAL	1,560,958	1,091,302	469,656					200

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2011 TO 02/29/2012

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

VERSION: 2011.10
 06/21/2012 13:48

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11	12	13	14	15	16	17	18	
1	60	LABORATORY							1
2	88	RURAL HEALTH CLINIC (RHC	AGGREGATE					27,598	2
3	69	ELECTROCARDIOLOGY	AGGREGATE					21,930	3
4	91	EMERGENCY	AGGREGATE					984,934	4
5	70	ELECTROENCEPHALOGRAPHY	AGGREGATE					55,000	5
6	65	RESPIRATORY THERAPY	AGGREGATE					1,840	6
200		TOTAL						1,091,302	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	NEW RHC BUILDING FIXTURES 1.01	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 GENERAL SERVICE COST CENTERS						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT	693,272	693,272				1.01
2 CAP REL COSTS-MVBLE EQUIP	190,543		190,543			2
4 EMPLOYEE BENEFITS	814,494			814,494		4
5 ADMINISTRATIVE & GENERAL	2,923,911			215	2,924,126	5
6 MAINTENANCE & REPAIRS	2,016,353	302,540		158,738	295,270	6
7 OPERATION OF PLANT	526,880	5,237		10,016	55,044	7
7.01 RHC UTILITY EXPENSE	30,871					7.01
8 LAUNDRY & LINEN SERVICE	80,349					8
9 HOUSEKEEPING	242,985	3,813			73,777	9
10 DIETARY	239,159	16,128		1,570	75,570	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	329,135	3,278		380	113,502	13
14 CENTRAL SERVICES & SUPPLY	36,594	5,694		2,254	10,666	14
15 PHARMACY	194,542	5,485		14,890	64,503	15
16 MEDICAL RECORDS & LIBRARY	310,335	42,978		12,343	103,230	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,126,263	79,765		35,224	406,131	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	490,823	53,112		64,744	126,907	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	975,542	39,230		306,733	131,083	54
60 LABORATORY	1,249,810	15,645		70,533	162,969	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	230,163	4,388		16,589	74,534	65
66 PHYSICAL THERAPY	348,460		46,865	15,705	124,405	66
69 ELECTROCARDIOLOGY	44,763	4,388		5,078	14,104	69
70 ELECTROENCEPHALOGRAPHY	12,756	4,375		2,621	4,701	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	331,106					71
73 DRUGS CHARGED TO PATIENTS	445,169					73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	466,255	33,719				76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	2,042,332		132,810	38,537	698,099	88
90 CLINIC	56,343				10,757	90
91 EMERGENCY	1,066,994	36,500		15,457	203,600	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	518,389	16,246		42,536	164,763	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	18,034,591	672,521	179,675	814,163	2,913,615	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,513				190
192 PHYSICIANS' PRIVATE OFFICES	42,668	17,238	10,868	331	10,511	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	18,077,259	693,272	190,543	814,494	2,924,126	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL (COLS.0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	RHC UTILITY EXPENSE 7.01	LAUNDRY & LINEN SERVICE 8	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	2,772,901	2,772,901				5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	597,177	108,199	705,376			7
7.01 RHC UTILITY EXPENSE	30,871	5,593		36,464		7.01
8 LAUNDRY & LINEN SERVICE	80,349	14,558			94,907	8
9 HOUSEKEEPING	320,575	58,083	6,978			9
10 DIETARY	332,427	60,230	29,511		1,522	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	446,295	80,862	5,998			13
14 CENTRAL SERVICES & SUPPLY	55,208	10,003	10,419		1,626	14
15 PHARMACY	279,420	50,626	10,036			15
16 MEDICAL RECORDS & LIBRARY	468,886	84,955	78,641			16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,647,383	298,479	145,953		47,157	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	735,586	133,276	97,184		10,873	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,452,588	263,186	71,783		10,364	54
60 LABORATORY	1,498,957	271,587	28,627			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	325,674	59,007	8,029			65
66 PHYSICAL THERAPY	535,435	97,012		8,969	3,544	66
69 ELECTROCARDIOLOGY	68,333	12,381	8,029		1,314	69
70 ELECTROENCEPHALOGRAPHY	24,453	4,430	8,005			70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	331,106	59,991				71
73 DRUGS CHARGED TO PATIENTS	445,169	80,658				73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	499,974	90,587	61,699			76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	2,911,778	527,565		25,415	1,290	88
90 CLINIC	67,100	12,157				90
91 EMERGENCY	1,322,551	239,625	66,788		13,340	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	741,934	134,427	29,726		3,877	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	17,992,130	2,757,477	667,406	34,384	94,907	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,513	636	6,428			190
192 PHYSICIANS' PRIVATE OFFICES	81,616	14,788	31,542	2,080		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	18,077,259	2,772,901	705,376	36,464	94,907	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	HOUSE-KEEPING 9	DIETARY 10	CAFETERIA 11	NURSING ADMINIS-TRATION 13	CENTRAL SERVICES & SUPPLY 14	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	385,636					9
10 DIETARY	27,293	450,983				10
11 CAFETERIA	11,455	318,477	329,932			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,687			12,311	548,153	13
14 CENTRAL SERVICES & SUPPLY	4,101			2,462	7,210	14
15 PHARMACY	2,828			4,924	13,228	15
16 MEDICAL RECORDS & LIBRARY	7,071			22,160		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	105,495	132,506	76,328	194,485	1,665	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	61,232		14,773	38,369	26,051	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	25,030		19,697	47,863	6,192	54
60 LABORATORY	19,091		27,084	70,518	42,243	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	12,162		14,773	38,305	969	65
66 PHYSICAL THERAPY	14,990		14,773		594	66
69 ELECTROCARDIOLOGY	3,677				7	69
70 ELECTROENCEPHALOGRAPHY	2,828				11	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					8,450	71
73 DRUGS CHARGED TO PATIENTS						73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,101					76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	18,525		64,017		1,349	88
90 CLINIC						90
91 EMERGENCY	50,485		27,084	67,366	2,451	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,131		27,084	70,809	507	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	374,182	450,983	327,470	548,153	91,029	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,414					190
192 PHYSICIANS' PRIVATE OFFICES	10,040		2,462			192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	385,636	450,983	329,932	548,153	91,029	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	361,602					15
16 MEDICAL RECORDS & LIBRARY		661,713				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		112,879	2,762,330		2,762,330	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		22,766	1,140,110		1,140,110	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		182,810	2,079,513		2,079,513	54
60 LABORATORY		177,032	2,135,139		2,135,139	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		4,417	463,336		463,336	65
66 PHYSICAL THERAPY		16,310	691,627		691,627	66
69 ELECTROCARDIOLOGY		5,437	99,178		99,178	69
70 ELECTROENCEPHALOGRAPHY		1,291	41,018		41,018	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			399,547		399,547	71
73 DRUGS CHARGED TO PATIENTS	361,602		887,429		887,429	73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		1,563	657,924		657,924	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			3,549,939		3,549,939	88
90 CLINIC			79,257		79,257	90
91 EMERGENCY		121,442	1,911,132		1,911,132	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		15,766	1,025,261		1,025,261	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	361,602	661,713	17,922,740		17,922,740	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEN			11,991		11,991	190
192 PHYSICIANS' PRIVATE OFFICES			142,528		142,528	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	361,602	661,713	18,077,259		18,077,259	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	NEW RHC BUILDING FIXTURES 1.01	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS				215	215	4
5 ADMINISTRATIVE & GENERAL		302,540		158,738	461,278	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		5,237		10,016	15,253	7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING		3,813			3,813	9
10 DIETARY		16,128		1,570	17,698	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		3,278		380	3,658	13
14 CENTRAL SERVICES & SUPPLY		5,694		2,254	7,948	14
15 PHARMACY		5,485		14,890	20,375	15
16 MEDICAL RECORDS & LIBRARY		42,978		12,343	55,321	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		79,765		35,224	114,989	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		53,112		64,744	117,856	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		39,230		306,733	345,963	54
60 LABORATORY		15,645		70,533	86,178	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		4,388		16,589	20,977	65
66 PHYSICAL THERAPY			46,865	15,705	62,570	66
69 ELECTROCARDIOLOGY		4,388		5,078	9,466	69
70 ELECTROENCEPHALOGRAPHY		4,375		2,621	6,996	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		33,719			33,719	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			132,810	38,537	171,347	88
90 CLINIC						90
91 EMERGENCY		36,500		15,457	51,957	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		16,246		42,536	58,782	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)		672,521	179,675	814,163	1,666,359	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEN		3,513			3,513	190
192 PHYSICIANS' PRIVATE OFFICES		17,238	10,868	331	28,437	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		693,272	190,543	814,494	1,698,309	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	EMPLOYEE BENEFITS 4	ADMINIS-TRATIVE & GENERAL 5	OPERATION OF PLANT 7	RHC UTILITY EXPENSE 7.01	LAUNDRY & LINEN SERVICE 8	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS	215					4
5 ADMINISTRATIVE & GENERAL	21	461,299				5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	4	18,000	33,257			7
7.01 RHC UTILITY EXPENSE		931		931		7.01
8 LAUNDRY & LINEN SERVICE		2,422			2,422	8
9 HOUSEKEEPING	5	9,663	329			9
10 DIETARY	5	10,020	1,391		39	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	8	13,452	283			13
14 CENTRAL SERVICES & SUPPLY	1	1,664	491		41	14
15 PHARMACY	5	8,422	473			15
16 MEDICAL RECORDS & LIBRARY	7	14,133	3,708			16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	29	49,655	6,881		1,205	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	9	22,172	4,582		277	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	9	43,784	3,384		264	54
60 LABORATORY	12	45,182	1,350			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	5	9,816	379			65
66 PHYSICAL THERAPY	9	16,139		229	90	66
69 ELECTROCARDIOLOGY	1	2,060	379		34	69
70 ELECTROENCEPHALOGRAPHY		737	377			70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		9,980				71
73 DRUGS CHARGED TO PATIENTS		13,418				73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		15,070	2,909			76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	56	87,763		649	33	88
90 CLINIC	1	2,023				90
91 EMERGENCY	15	39,864	3,149		340	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	12	22,363	1,402		99	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	214	458,733	31,467	878	2,422	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		106	303			190
192 PHYSICIANS' PRIVATE OFFICES	1	2,460	1,487	53		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	215	461,299	33,257	931	2,422	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	HOUSE-	DIETARY	CAFETERIA	NURSING	CENTRAL	
	KEEPING			ADMINIS-	SERVICES &	
	9	10	11	TRATION	SUPPLY	
				13	14	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	13,810					9
10 DIETARY	977	30,130				10
11 CAFETERIA	410	21,277	21,687			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	96		809	18,306		13
14 CENTRAL SERVICES & SUPPLY	147		162	241	10,695	14
15 PHARMACY	101		324	442	63	15
16 MEDICAL RECORDS & LIBRARY	253		1,457			16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,777	8,853	5,017	6,495	196	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,193		971	1,281	3,061	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	896		1,295	1,598	727	54
60 LABORATORY	684		1,780	2,355	4,962	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	436		971	1,279	114	65
66 PHYSICAL THERAPY	537		971		70	66
69 ELECTROCARDIOLOGY	132				1	69
70 ELECTROENCEPHALOGRAPHY	101				1	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					993	71
73 DRUGS CHARGED TO PATIENTS						73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	147					76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	663		4,208		159	88
90 CLINIC						90
91 EMERGENCY	1,808		1,780	2,250	288	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	41		1,780	2,365	60	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	13,399	30,130	21,525	18,306	10,695	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	51					190
192 PHYSICIANS' PRIVATE OFFICES	360		162			192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	13,810	30,130	21,687	18,306	10,695	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	30,205					15
16 MEDICAL RECORDS & LIBRARY		74,879				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		12,773	209,870		209,870	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		2,576	154,978		154,978	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		20,687	418,607		418,607	54
60 LABORATORY		20,033	162,536		162,536	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		500	34,477		34,477	65
66 PHYSICAL THERAPY		1,846	82,461		82,461	66
69 ELECTROCARDIOLOGY		615	12,688		12,688	69
70 ELECTROENCEPHALOGRAPHY		146	8,358		8,358	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			10,973		10,973	71
73 DRUGS CHARGED TO PATIENTS	30,205		43,623		43,623	73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		177	52,022		52,022	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			264,878		264,878	88
90 CLINIC			2,024		2,024	90
91 EMERGENCY		13,742	115,193		115,193	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		1,784	88,688		88,688	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
118 SUBTOTALS (SUM OF LINES 1-117)	30,205	74,879	1,661,376		1,661,376	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			3,973		3,973	190
192 PHYSICIANS' PRIVATE OFFICES			32,960		32,960	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	30,205	74,879	1,698,309		1,698,309	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	NEW RHC BUILDING FIXTURES SQUARE FEET 1.01	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	53,087					1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT		15,885				1.01
2 CAP REL COSTS-MVBLE EQUIP			811,317			2
4 EMPLOYEE BENEFITS			214	7,833,767		4
5 ADMINISTRATIVE & GENERAL	23,167		158,119	791,032	-2,772,901	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	401		9,977	147,464		7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	292			197,650		9
10 DIETARY	1,235		1,564	202,452		10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	251		379	304,072		13
14 CENTRAL SERVICES & SUPPLY	436		2,245	28,575		14
15 PHARMACY	420		14,832	172,804		15
16 MEDICAL RECORDS & LIBRARY	3,291		12,295	276,554		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,108		35,087	1,088,030		30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,067		64,491	339,986		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	3,004		305,535	351,173		54
60 LABORATORY	1,198		70,258	436,597		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	336		16,524	199,678		65
66 PHYSICAL THERAPY		3,907	15,644	333,283		66
69 ELECTROCARDIOLOGY	336		5,058	37,785		69
70 ELECTROENCEPHALOGRAPHY	335		2,611	12,595		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582					76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		11,072	38,387	1,870,213		88
90 CLINIC				28,818		90
91 EMERGENCY	2,795		15,397	545,447		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,244		42,370	441,401		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	51,498	14,979	810,987	7,805,609	-2,772,901	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	269					190
192 PHYSICIANS' PRIVATE OFFICES	1,320	906	330	28,158		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	693,272	190,543	814,494	2,924,126		202
203 UNIT COST MULT-WS B PT I	13.059167	11.995153	1.003916	0.373272		203
204 COST TO BE ALLOC PER B PT II				215		204
205 UNIT COST MULT-WS B PT II				0.000027		205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	OPERATION OF PLANT SQUARE FEET 7	RHC UTILITY EXPENSE SQUARE FEET 7.01	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE- KEEPING HOURS OF SERVICE 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	15,304,358					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	597,177	29,519				7
7.01 RHC UTILITY EXPENSE	30,871		15,885			7.01
8 LAUNDRY & LINEN SERVICE	80,349			23,699		8
9 HOUSEKEEPING	320,575	292			2,727	9
10 DIETARY	332,427	1,235		380	193	10
11 CAFETERIA					81	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	446,295	251			19	13
14 CENTRAL SERVICES & SUPPLY	55,208	436		406	29	14
15 PHARMACY	279,420	420			20	15
16 MEDICAL RECORDS & LIBRARY	468,886	3,291			50	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM- (SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	1,647,383	6,108		11,776	746	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	735,586	4,067		2,715	433	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,452,588	3,004		2,588	177	54
60 LABORATORY	1,498,957	1,198			135	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	325,674	336			86	65
66 PHYSICAL THERAPY	535,435		3,907	885	106	66
69 ELECTROCARDIOLOGY	68,333	336		328	26	69
70 ELECTROENCEPHALOGRAPHY	24,453	335			20	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	331,106					71
73 DRUGS CHARGED TO PATIENTS	445,169					73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	499,974	2,582			29	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	2,911,778		11,072	322	131	88
90 CLINIC	67,100					90
91 EMERGENCY	1,322,551	2,795		3,331	357	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	741,934	1,244		968	8	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	15,219,229	27,930	14,979	23,699	2,646	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,513	269			10	190
192 PHYSICIANS' PRIVATE OFFICES	81,616	1,320	906		71	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,772,901	705,376	36,464	94,907	385,636	202
203 UNIT COST MULT-WS B PT I	0.181184	23.895660	2.295499	4.004684	141.414008	203
204 COST TO BE ALLOC PER B PT II	461,299	33,257	931	2,422	13,810	204
205 UNIT COST MULT-WS B PT II	0.030142	1.126630	0.058609	0.102198	5.064173	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING	CENTRAL	PHARMACY
	MEALS SERVED	FTE	ADMINIS- TRATION DIRECT NRSING HRS	SERVICES & SUPPLY COSTED REQUIS.	COSTED REQUIS.
	10	11	13	14	15
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT					1.01
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
7.01 RHC UTILITY EXPENSE					7.01
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY	59,265				10
11 CAFETERIA	41,852	134			11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION		5	179,266		13
14 CENTRAL SERVICES & SUPPLY		1	2,358	863,077	14
15 PHARMACY		2	4,326	5,119	391,277
16 MEDICAL RECORDS & LIBRARY		9			15
17 SOCIAL SERVICE					16
19 NONPHYSICIAN ANESTHETISTS					17
20 NURSING SCHOOL					19
21 I&R SRVCES-SALARY & FRINGES APPRVD					20
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					21
23 PARAMED ED PRGM-(SPECIFY)					22
INPATIENT ROUTINE SERV COST CENTERS					23
30 ADULTS & PEDIATRICS	17,413	31	63,604	15,790	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		6	12,548	247,000	50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC		8	15,653	58,705	54
60 LABORATORY		11	23,062	400,511	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		6	12,527	9,192	65
66 PHYSICAL THERAPY		6		5,633	66
69 ELECTROCARDIOLOGY				67	69
70 ELECTROENCEPHALOGRAPHY				100	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				80,115	71
73 DRUGS CHARGED TO PATIENTS					391,277
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES					73
76.97 CARDIAC REHABILITATION					76
76.98 HYPERBARIC OXYGEN THERAPY					76.97
76.99 LITHOTRIPSY					76.98
OUTPATIENT SERVICE COST CENTERS					76.99
88 RURAL HEALTH CLINIC (RHC)		26		12,793	88
90 CLINIC					90
91 EMERGENCY		11	22,031	23,241	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		11	23,157	4,811	95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	59,265	133	179,266	863,077	391,277
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					118
192 PHYSICIANS' PRIVATE OFFICES		1			190
200 CROSS FOOT ADJUSTMENTS					192
201 NEGATIVE COST CENTER					200
202 COST TO BE ALLOC PER B PT I	450,983	329,932	548,153	91,029	361,602
203 UNIT COST MULT-WS B PT I	7.609601	2,462.179104	3.057763	0.105470	0.924159
204 COST TO BE ALLOC PER B PT II	30,130	21,687	18,306	10,695	30,205
205 UNIT COST MULT-WS B PT II	0.508394	161.843284	0.102116	0.012392	0.077196

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

MEDICAL
 RECORDS &
 LIBRARY
 TIME
 SPENT
 16

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY TIME SPENT	
GENERAL SERVICE COST CENTERS		
1 CAP REL COSTS-BLDG & FIXT		1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT		1.01
2 CAP REL COSTS-MVBLE EQUIP		2
4 EMPLOYEE BENEFITS		4
5 ADMINISTRATIVE & GENERAL		5
6 MAINTENANCE & REPAIRS		6
7 OPERATION OF PLANT		7
7.01 RHC UTILITY EXPENSE		7.01
8 LAUNDRY & LINEN SERVICE		8
9 HOUSEKEEPING		9
10 DIETARY		10
11 CAFETERIA		11
12 MAINTENANCE OF PERSONNEL		12
13 NURSING ADMINISTRATION		13
14 CENTRAL SERVICES & SUPPLY		14
15 PHARMACY		15
16 MEDICAL RECORDS & LIBRARY	9,737	16
17 SOCIAL SERVICE		17
19 NONPHYSICIAN ANESTHETISTS		19
20 NURSING SCHOOL		20
21 I&R SRVCES-SALARY & FRINGES APPRVD		21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23 PARAMED ED PRGM-(SPECIFY)		23
30 INPATIENT ROUTINE SERV COST CENTERS		
ADULTS & PEDIATRICS	1,661	30
ANCILLARY SERVICE COST CENTERS		
50 OPERATING ROOM	335	50
53 ANESTHESIOLOGY		53
54 RADIOLOGY-DIAGNOSTIC	2,690	54
60 LABORATORY	2,605	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65 RESPIRATORY THERAPY	65	65
66 PHYSICAL THERAPY	240	66
69 ELECTROCARDIOLOGY	80	69
70 ELECTROENCEPHALOGRAPHY	19	70
71 MEDICAL SUPPLIES CHRGED TO PATIENTS		71
73 DRUGS CHARGED TO PATIENTS		73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	23	76
76.97 CARDIAC REHABILITATION		76.97
76.98 HYPERBARIC OXYGEN THERAPY		76.98
76.99 LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS		
88 RURAL HEALTH CLINIC (RHC)		88
90 CLINIC		90
91 EMERGENCY	1,787	91
92 OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS		
95 AMBULANCE SERVICES	232	95
99.10 CORF		99.10
99.20 OUTPATIENT PHYSICAL THERAPY		99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40 OUTPATIENT SPEECH PATHOLOGY		99.40
SPECIAL PURPOSE COST CENTERS		
118 SUBTOTALS (SUM OF LINES 1-117)	9,737	118
NONREIMBURSABLE COST CENTERS		
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192 PHYSICIANS' PRIVATE OFFICES		192
200 CROSS FOOT ADJUSTMENTS		200
201 NEGATIVE COST CENTER		201
202 COST TO BE ALLOC PER B PT I	661,713	202
203 UNIT COST MULT-WS B PT I	67.958611	203
204 COST TO BE ALLOC PER B PT II	74,879	204
205 UNIT COST MULT-WS B PT II	7.690151	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL	RCE	TOTAL
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS
	1	2	3	4	5
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	2,762,330		2,762,330		30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1,140,110		1,140,110		50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	2,079,513		2,079,513		54
60 LABORATORY	2,135,139		2,135,139		60
62.30 BLOOD CLOTTING FOR HEMOPHIL					62.30
65 RESPIRATORY THERAPY	463,336		463,336		65
66 PHYSICAL THERAPY	691,627		691,627		66
69 ELECTROCARDIOLOGY	99,178		99,178		69
70 ELECTROENCEPHALOGRAPHY	41,018		41,018		70
71 MEDICAL SUPPLIES CHRGED TO	399,547		399,547		71
73 DRUGS CHARGED TO PATIENTS	887,429		887,429		73
76 PSYCHIATRIC/PSYCHOLOGICAL S	657,924		657,924		76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	3,549,939		3,549,939		88
90 CLINIC	79,257		79,257		90
91 EMERGENCY	1,911,132		1,911,132		91
92 OBSERVATION BEDS	41,703		41,703		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	1,025,261		1,025,261		95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THE					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	17,964,443		17,964,443		200
201 LESS OBSERVATION BEDS	41,703		41,703		201
202 TOTAL (SEE INSTRUCTIONS)	17,922,740		17,922,740		202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES		TOTAL (COLS. 6 + 7) 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7				
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,474,930		2,474,930			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	419,856	1,775,173	2,195,029	0.519405		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	897,852	7,946,183	8,844,035	0.235132		54
60 LABORATORY	1,618,714	6,851,824	8,470,538	0.252067		60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	329,185	157,108	486,293	0.952792		65
66 PHYSICAL THERAPY	164,650	1,583,103	1,747,753	0.395724		66
69 ELECTROCARDIOLOGY	64,092	526,568	590,660	0.167910		69
70 ELECTROENCEPHALOGRAPHY	1,522	375,693	377,215	0.108739		70
71 MEDICAL SUPPLIES CHRGED TO	1,415,688	1,382,787	2,798,475	0.142773		71
73 DRUGS CHARGED TO PATIENTS	3,028,272	2,163,824	5,192,096	0.170919		73
76 PSYCHIATRIC/PSYCHOLOGICAL S		996,205	996,205	0.660430		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		2,342,705	2,342,705			88
90 CLINIC		80,167	80,167	0.988649		90
91 EMERGENCY	146,826	3,428,543	3,575,369	0.534527		91
92 OBSERVATION BEDS	364	91,433	91,797	0.454296		92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		1,098,155	1,098,155	0.933621		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	10,561,951	30,799,471	41,361,422			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		30,799,471	41,361,422			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1351) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.519405		891,675			463,140		50
53 ANESTHESIOLOGY								53
54 RADIOLOGY-DIAGNOSTIC	0.235132		3,285,049			772,420		54
60 LABORATORY	0.252067		3,492,042			880,229		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.952792		84,989			80,977		65
66 PHYSICAL THERAPY	0.395724		577,793			228,647		66
69 ELECTROCARDIOLOGY	0.167910		281,506			47,268		69
70 ELECTROENCEPHALOGRAPHY	0.108739		160,928			17,499		70
71 MEDICAL SUPPLIES CHRGED TO PATI	0.142773		511,475			73,025		71
73 DRUGS CHARGED TO PATIENTS	0.170919		910,424			155,609		73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.660430		921,157			608,360		76
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
90 CLINIC	0.988649		35,864			35,457		90
91 EMERGENCY	0.534527		1,153,080			616,352		91
92 OBSERVATION BEDS	0.454296		42,401			19,263		92
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	0.933621							95
200 SUBTOTAL (SEE INSTRUCTIONS)			12,348,383			3,998,246		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			12,348,383			3,998,246		202

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1351) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TBFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,245	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,803	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,803	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		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)	73	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	7	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,623	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)	362	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)	73	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	118.00	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	118.00	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,762,330	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)	826	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	284,276	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,478,054	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,474,930	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,474,930	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	1.001262	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	650.78	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,478,054	37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1351) [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 651.61 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,709,173 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) 1,709,173 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					1,281,432 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,990,605 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 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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 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 INSTRU 235,883 64
 (TITLE XVIII ONLY)
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU 47,568 65
 (TITLE XVIII ONLY)
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 283,451 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 67
 (LINE 12 x LINE 19)
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 68
 (LINE 13 x LINE 20)
 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) 64 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 651.61 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 41,703 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	209,870	2,478,054	0.084691	41,703	3,532 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2011 TO 02/29/2012

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

VERSION: 2011.10
 06/21/2012 13:48

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-1351) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEPRA
 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		1,691,835		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.519405	365,073	189,621	50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.235132	470,661	110,667	54
60 LABORATORY	0.252067	1,035,964	261,132	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.952792	218,759	208,432	65
66 PHYSICAL THERAPY	0.395724	104,941	41,528	66
69 ELECTROCARDIOLOGY	0.167910	58,139	9,762	69
70 ELECTROENCEPHALOGRAPHY	0.108739	1,011	110	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.142773	929,505	132,708	71
73 DRUGS CHARGED TO PATIENTS	0.170919	1,909,408	326,354	73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.660430			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
90 CLINIC	0.988649			90
91 EMERGENCY	0.534527	2,017	1,078	91
92 OBSERVATION BEDS	0.454296	89	40	92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		5,095,567	1,281,432	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		5,095,567		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z351) [] 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
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.519405	1,756	912	50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.235132	40,743	9,580	54
60 LABORATORY	0.252067	101,527	25,592	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.952792	31,920	30,413	65
66 PHYSICAL THERAPY	0.395724	42,438	16,794	66
69 ELECTROCARDIOLOGY	0.167910	1,657	278	69
70 ELECTROENCEPHALOGRAPHY	0.108739	511	56	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.142773	109,877	15,687	71
73 DRUGS CHARGED TO PATIENTS	0.170919	318,987	54,521	73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.660430			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
90 CLINIC	0.988649			90
91 EMERGENCY	0.534527			91
92 OBSERVATION BEDS	0.454296			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		649,416	153,833	200
201 LESS BPB CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		649,416		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

CHECK APPLICABLE BOX: HOSPITAL (14-1351) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,998,246	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	3,998,246	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	4,038,228	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	43,146	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,768,654	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	2,226,428	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	2,226,428	30
31	PRIMARY PAYER PAYMENTS	703	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,225,725	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	416,085	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	416,085	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	416,085	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	2,641,810	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	2,641,810	40
41	INTERIM PAYMENTS	3,020,583	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-378,773	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-1351) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,639,818		3,020,213	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.					
		NONE	02/17/2012	370	3.01
					3.02
					3.03
					3.04
					3.05
					3.06
					3.07
					3.08
					3.09
	02/17/2012	13,246		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)		-13,246		370	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)		2,626,572		3,020,583	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.					
					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					
					6.01
					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					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-Z351)	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT		
DESCRIPTION	1	2	3	4	5	6	7	8	9	10		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER								422,845			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.								NONE		NONE	3.01	
											3.02	
				PROGRAM							3.03	
				TO							3.04	
				PROVIDER							3.05	
											3.06	
											3.07	
											3.08	
											3.09	
						08/26/2011		2,597		NONE	3.50	
						02/17/2012		2,517			3.51	
				PROVIDER							3.52	
				TO							3.53	
				PROGRAM							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)								-5,114			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)								417,731			4	
TO BE COMPLETED BY CONTRACTOR												
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				PROGRAM							5.01	
				TO							5.02	
				PROVIDER							5.03	
											5.04	
											5.05	
											5.06	
											5.07	
											5.08	
											5.09	
				PROVIDER							5.50	
				TO							5.51	
				PROGRAM							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				PROGRAM							6.01	
				TO							6.02	
				PROVIDER							6.03	
				PROVIDER							6.04	
				TO							6.05	
				PROGRAM							6.06	
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)											7	
8 NAME OF CONTRACTOR:								CONTRACTOR NUMBER:			DATE:	

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
PERIOD FROM 03/01/2011 TO 02/29/2012

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

VERSION: 2011.10
06/21/2012 13:48

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK HOSPITAL (14-1351) 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	1,072	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,623	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,739	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	41,361,422	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	589,930	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
PERIOD FROM 03/01/2011 TO 02/29/2012

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

VERSION: 2011.10
06/21/2012 13:48

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-Z351)
APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	286,286	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)	155,371	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	435	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)	441,657	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	441,657	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	441,657	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	15,731	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)	425,926	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)	425,926	19
20 INTERIM PAYMENTS	417,731	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	8,195	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 [XX] HOSPITAL (14-1351)
 APPLICABLE BOX: [] SUB (OTHER)

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

1	INPATIENT SERVICES	2,990,605	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	2,990,605	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	3,020,511	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)	3,020,511	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	415,085	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	2,605,426	22
23	COINSURANCE	6,195	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	2,599,231	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	92,634	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	92,634	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	92,634	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	2,691,865	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	2,691,865	30
31	INTERIM PAYMENTS	2,626,572	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	65,293	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1,957,857			1
2	TEMPORARY INVESTMENTS	2,604,280			2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	3,867,364			4
5	OTHER RECEIVABLES	59,241			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	187,264			7
8	PREPAID EXPENSES	193,974			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	8,869,980			11
FIXED ASSETS					
12	LAND	132,111			12
13	LAND IMPROVEMENTS	345,852			13
14	ACCUMULATED DEPRECIATION	-250,530			14
15	BUILDINGS	12,306,190			15
16	ACCUMULATED DEPRECIATION	-6,926,530			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	7,596,513			19
20	ACCUMULATED DEPRECIATION	-5,178,859			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT				23
24	ACCUMULATED DEPRECIATION				24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	8,024,747			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	5,478,514			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	5,478,514			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	22,373,241			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,396,456			37
38	SALARIES, WAGES & FEES PAYABLE	591,065			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	220,440			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,207,961			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	4,823,091			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	4,823,091			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	7,031,052			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	15,342,189			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)	15,342,189			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	22,373,241			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		15,331,563							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		10,626							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		15,342,189							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)		15,342,189							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)		15,342,189							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	2,598,766		2,598,766	1
2 SUBPROVIDER IPF				2
3 SUBPROVIDER IRF				3
5 SWING BED - SNF				5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	2,598,766		2,598,766	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT				11
12 CORONARY CARE UNIT				12
13 BURN INTENSIVE CARE UNIT				13
14 SURGICAL INTENSIVE CARE UNIT				14
15 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,598,766		2,598,766	17
18 ANCILLARY SERVICES	8,396,586		8,396,586	18
19 OUTPATIENT SERVICES		30,090,784	30,090,784	19
20 RHC		2,702,951	2,702,951	20
20.01 RHC II				20.01
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE		1,098,155	1,098,155	23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	10,995,352	33,891,890	44,887,242	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		19,760,989	29
30 PROVISION FOR BAD DEBTS	2,201,591		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		2,201,591	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)		21,962,580	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	44,887,242	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	23,523,795	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	21,363,447	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	21,962,580	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-599,133	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	43,206	6
7	INCOME FROM INVESTMENTS	83,167	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	110,934	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	6,200	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (TAX REVENUE)	206,037	24
24.01	OTHER (RENTAL INCOME)	44,937	24.01
24.02	OTHER (MISCELLANEOUS INCOME)	115,278	24.02
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	609,759	25
26	TOTAL (LINE 5 PLUS LINE 25)	10,626	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)	10,626	29

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

RHC I
 COMPONENT NO: 14-3458

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	1,005,526		1,005,526		1,005,526	-41,348	964,178	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	217,667		217,667		217,667		217,667	3
4 VISITING NURSE								4
5 OTHER NURSE	362,551		362,551		362,551		362,551	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	7,274		7,274		7,274		7,274	9
10 SUBTOTAL (SUM OF LINES 1-9)	1,593,018		1,593,018		1,593,018	-41,348	1,551,670	10
COSTS UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT		62,731	62,731		62,731		62,731	11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13)		62,731	62,731		62,731		62,731	14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		38,139	38,139		38,139		38,139	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE		21,849	21,849		21,849		21,849	18
19 OTHER HEALTH CARE COSTS		49,400	49,400		49,400		49,400	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		109,388	109,388		109,388		109,388	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,593,018	172,119	1,765,137		1,765,137	-41,348	1,723,789	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	318,543		318,543		318,543		318,543	29
30 ADMINISTRATIVE COSTS								30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	318,543		318,543		318,543		318,543	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,911,561	172,119	2,083,680		2,083,680	-41,348	2,042,332	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3458

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	2.70	13,118	4,200	11,340	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	2.66	10,528	2,100	5,586	3
4	SUBTOTAL (SUM OF LINES 1-3)	5.36	23,646		16,926	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	5.36	23,646			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		2			9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				1,723,789	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)				1,723,789	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)				318,543	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				1,507,607	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				1,826,150	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				1,826,150	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				1,826,150	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				3,549,939	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3458

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)	3,549,939	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	15,980	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	3,533,959	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	23,646	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)	2	5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	23,648	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	149.44	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)	149.44	149.44	149.44	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	6,347			10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	948,496			11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)				15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	948,496			16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)				16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		706,918		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		706,918		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		64,848		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)				19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		706,918		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		15,980		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		722,898		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		39,558		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		762,456		26
27	INTERIM PAYMENTS		726,974		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		35,482		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: 14-3458

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,551,670	1,551,670	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000111	0.001183	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	172	1,836	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	1,020	4,732	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,192	6,568	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,723,789	1,723,789	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,826,150	1,826,150	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.000691	0.003810	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	1,262	6,958	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	2,454	13,526	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	17	182	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	144.35	74.32	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	17	182	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	2,454	13,526	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)		15,980	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)		15,980	16

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

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		708,623	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 08/26/2011	18,351	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	18,351	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		726,974	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		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		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 .01		6.01
	TO .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____