

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: 09-23-2013 TIME: 15:04
 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 WASHINGTON COUNTY HOSPITAL (14-1308) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 05/01/2012 AND ENDING 04/30/2013, 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, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 5	
1 HOSPITAL		-36,420	-8,749		1,410	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		-91,408				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
10.01 HEALTH CLINIC - RHC II						10.01
10.02 HEALTH CLINIC - RHC III			-35,089			10.02
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		-127,828	-43,838		1,410	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: 705 SOUTH GRAND AVENUE
 2 CITY: NASHVILLE STATE: IL

P.O.BOX: 1
 ZIP CODE: 62263- COUNTY: WASHINGTON 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	1	CCN NUMBER	2	CBSA NUMBER	3	PROV TYPE	4	DATE CERTIFIED	5	PAYMENT SYSTEM (P, T, O, OR N)			
											6	7	8	9
3	HOSPITAL	WASHINGTON COUNTY HOSPITAL	14-1308	99914	1	12/01/2000	N	O	O	3				
4	SUBPROVIDER - IPF													
5	SUBPROVIDER - IRF													
6	SUBPROVIDER - (OTHER)													
7	SWING BEDS - SNF	WASHINGTON COUNTY SWING BED	14-2308	99914		08/18/2000	N	O	O	7				
8	SWING BEDS - NF													
9	HOSPITAL-BASED SNF													
10	HOSPITAL-BASED NF													
11	HOSPITAL-BASED OLTG	WASHINGTON COUNTY EXTENDED CAR	-											
12	HOSPITAL-BASED HHA													
13	SEPARATELY CERTIFIED ASC													
14	HOSPITAL-BASED HOSPICE													
15	HOSPITAL-BASED HEALTH CLINIC - RHC													
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	OKAWVILLE RHC	14-3470	99914		08/01/2005	N	O	N	15.01				
15.02	HOSPITAL-BASED HEALTH CLINIC - RHC III	GRAND STREET RHC	14-3472	99914		08/01/2005	N	O	N	15.02				
16	HOSPITAL-BASED HEALTH CLINIC - FQHC													
17	HOSPITAL-BASED (CMHC)													
18	RENAL DIALYSIS													
19	OTHER													
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 05/01/2012				TO: 04/30/2013							20	
21	TYPE OF CONTROL												21	

INPATIENT PPS INFORMATION

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

		IN-STATE		OUT-OF-STATE		OTHER			
		MEDICAID PAID	MEDICAID UNPAID	MEDICAID PAID	MEDICAID UNPAID	MEDICAID HMO	MEDICAID		
		1	2	3	4	5	6		
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							24	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID 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 IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				2			27	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38	
39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)							1	2

		V	XVIII	XIX
		1	2	3
45	PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	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	N
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR	N	N	N

'N' FOR NO.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

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

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

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

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

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

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

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

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010. ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR
 FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, 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

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66	EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010 ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 69,243 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). 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 N	2	140
-----	--	--------	---	-----

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

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	149

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? N 165
ENTER 'Y' FOR YES OR 'N' FOR NO.

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN
COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

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

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. Y 167

168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),
ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 145,810 168

169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH
(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1 N	2	1	
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	1 N	2	3 2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1 Y	2 A	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N		2 6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 Y	2 07/09/2013	3 Y	4 07/09/2013
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		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.	N	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: MARK	LAST NAME: DALLAS	TITLE: PARTNER	41
42	EMPLOYER: KERBER, ECK & BRAECKEL, LLP			42
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: MARKD@KEBCPA.COM		43

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
	1	2	3	4	5	6
SALARIES						
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200				1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A ADMINISTRATIVE					4
4.01	PHYSICIAN-PART A - TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)					7.01
8	HOME OFFICE PERSONNEL					8
9	SNF	44				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)					10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)					11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE					15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING					16
WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)					17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS					19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A - ADMINISTRATIVE					22
22.01	PHYSICIAN PART A - TEACHING					22.01
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)					25
OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS					26
27	ADMINISTRATIVE & GENERAL					27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT					30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING					32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY					34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA					36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION					38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY					41
42	SOCIAL SERVICE					42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	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)	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	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 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	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 (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	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: 14-1308 WASHINGTON COUNTY HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
09/23/2013 15:04

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
14.02	HOSPITAL-BASED HEALTH CLINIC - RHC III		14.02
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

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

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

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

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

RHC II
COMPONENT NO: 14-3470

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1
2 CITY: STATE: ZIP CODE: COUNTY: 2
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS: GRANT AWARD DATE
1 2
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 4
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) 5
6 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) 6
7 APPALACHIAN REGIONAL COMMISSION 7
8 LOOK-ALIKES 8

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. 1 2 10
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.

FACILITY HOURS OF OPERATIONS(1)

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

11 CLINIC 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
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? 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: CCN NUMBER: 14

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

RHC III
 COMPONENT NO: 14-3472

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 705 SOUTH GRAND AVE 1
 2 CITY: NASHVILLE STATE: IL ZIP CODE: 62263 COUNTY: WASHINGTON 2
 3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

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

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. 1 2
 IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC			0730	1900	0730	1900	0730	1900	0730	1900	0730	1900	0800	1400	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
 N 12
 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: OKAWVILLE RHC CCN NUMBER: 14-3470 14
 14.01 GRAND STREET RHC 14-3472 14.01

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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.603188	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,061,933	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				1,781,103	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				1,074,340	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				12,407	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) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					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) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				12,407	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	109,138	9,925	119,063		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	65,831	5,987	71,818		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	7,544	100	7,644		22
23	COST OF CHARITY CARE	58,287	5,887	64,174		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)			560,093		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			118,399		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			441,694		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			266,425		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			330,599		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			343,006		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100					1
2	00200		270,904	270,904		2
3	00300		520,043	520,043		3
4	00400	71,763	1,676,538	1,748,301		4
5	00500	928,545	1,026,906	1,955,451	8,886	5
6	00600	121,074	373,495	494,569		6
7	00700					7
8	00800		70,819	70,819		8
9	00900	192,595	24,887	217,482		9
10	01000	207,931	121,667	329,598		10
11	01100				-30,554	11
12	01200				30,554	12
13	01300	82,695		82,695		13
14	01400	44,421	92,285	136,706	-84,090	14
15	01500	136,942	687,174	824,116	-657,717	15
16	01600	144,005	26,091	170,096		16
17	01700				5,045	17
19	01900	198,749		198,749	66,000	19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	624,065	42,927	666,992	-5,045	30
46	04600	486,929	22,402	509,331		46
ANCILLARY SERVICE COST CENTERS						
50	05000	183,256	95,229	278,485		50
53	05300		80,045	80,045	-66,000	53
54	05400	202,258	133,486	335,744	43,596	54
57	05700	48,368	115,955	164,323		57
58	05800		70,145	70,145		58
60	06000	342,386	561,524	903,910		60
62.30	06250					62.30
65	06500	31,676	43,312	74,988	-23,882	65
66	06600	621,229	13,030	634,259		66
67.01	06701	22,807	2,794	25,601		67.01
69	06900		9,275	9,275		69
71	07100				107,972	71
73	07300				657,717	73
76	03550					76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88.01	08801					88.01
88.02	08802	987,517	217,355	1,204,872	-52,482	88.02
91	09100	330,513	1,135,018	1,465,531		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
118		6,009,724	7,433,306	13,443,030		118
NONREIMBURSABLE COST CENTERS						
190	19000					190
190.02	19002					190.02
190.03	19003					190.03
190.04	19004	12,189	4,926	17,115		190.04
190.05	19005					190.05
192.01	19201					192.01
192.02	19202					192.02
200		6,021,913	7,438,232	13,460,145		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	270,904		270,904	1
2	00200	520,043	-199,913	320,130	2
3	00300				3
4	00400	1,748,301	-30,300	1,718,001	4
5	00500	1,964,337	-14,155	1,950,182	5
6	00600	494,569		494,569	6
7	00700				7
8	00800	70,819		70,819	8
9	00900	217,482		217,482	9
10	01000	299,044		299,044	10
11	01100	30,554	-5,782	24,772	11
12	01200				12
13	01300	82,695		82,695	13
14	01400	52,616	-1,924	50,692	14
15	01500	166,399		166,399	15
16	01600	170,096	-2,049	168,047	16
17	01700	5,045		5,045	17
19	01900	264,749		264,749	19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	661,947		661,947	30
46	04600	509,331		509,331	46
ANCILLARY SERVICE COST CENTERS					
50	05000	278,485		278,485	50
53	05300	14,045		14,045	53
54	05400	379,340	-5,482	373,858	54
57	05700	164,323		164,323	57
58	05800	70,145		70,145	58
60	06000	903,910	-19,024	884,886	60
62.30	06250				62.30
65	06500	51,106		51,106	65
66	06600	634,259		634,259	66
67.01	06701	25,601		25,601	67.01
69	06900	9,275	-9,275		69
71	07100	107,972		107,972	71
73	07300	657,717		657,717	73
76	03550				76
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
88.01	08801				88.01
88.02	08802	1,152,390	-114,558	1,037,832	88.02
91	09100	1,465,531	-204,022	1,261,509	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
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		13,443,030	-606,484	12,836,546	118
NONREIMBURSABLE COST CENTERS					
190	19000				190
190.02	19002				190.02
190.03	19003				190.03
190.04	19004	17,115		17,115	190.04
190.05	19005				190.05
192.01	19201				192.01
192.02	19202				192.02
200		13,460,145	-606,484	12,853,661	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- COST CENTER 2	INCREASE LINE # 3	-----	
				SALARY 4	OTHER 5
1 RECLASSIFY DRUG COSTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - A	A	DRUGS CHARGED TO PATIENTS	73	657,717	1 500
1 RECLASSIFY MEDICAL SUPPLY COSTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - B	B	MEDICAL SUPPLIES CHRGED TO PA	71	84,090	1 500
1 RECLASSIFY CAFETERIA COSTS 500 TOTAL RECLASSIFICATIONS CODE LETTER - C	C	CAFETERIA	11	19,275	11,279 1 19,275 500
1 RECLASS SOCIAL SERVICE COST 500 TOTAL RECLASSIFICATIONS CODE LETTER - D	D	SOCIAL SERVICE	17	5,045	5,045 1 500
1 RECLASS PROFESSIONAL LIABILITY INSU 500 TOTAL RECLASSIFICATIONS CODE LETTER - E	E	ADMINISTRATIVE & GENERAL	5	52,482	52,482 1 500
1 RECLASSIFY X-RAY DIRECTOR'S SALARY 500 TOTAL RECLASSIFICATIONS CODE LETTER - F	F	RADIOLOGY-DIAGNOSTIC	54	43,596	43,596 1 500
1 RECLASS OXYGEN SUPPLIES 500 TOTAL RECLASSIFICATIONS CODE LETTER - G	G	MEDICAL SUPPLIES CHRGED TO PA	71	23,882	23,882 1 500
1 RECLASSIFY ANESTHESIA PRO FEES 500 TOTAL RECLASSIFICATIONS CODE LETTER - H GRAND TOTAL (INCREASES)	H	NONPHYSICIAN ANESTHETISTS	19	67,916	66,000 1 66,000 500 895,450

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 RECLASSIFY DRUG COSTS	A	PHARMACY	15		657,717	1
500 TOTAL RECLASSIFICATIONS					657,717	500
CODE LETTER - A						
1 RECLASSIFY MEDICAL SUPPLY COSTS	B	CENTRAL SERVICES & SUPPLY	14		84,090	1
500 TOTAL RECLASSIFICATIONS					84,090	500
CODE LETTER - B						
1 RECLASSIFY CAFETERIA COSTS	C	DIETARY	10	19,275	11,279	1
500 TOTAL RECLASSIFICATIONS				19,275	11,279	500
CODE LETTER - C						
1 RECLASS SOCIAL SERVICE COST	D	ADULTS & PEDIATRICS	30	5,045		1
500 TOTAL RECLASSIFICATIONS				5,045		500
CODE LETTER - D						
1 RECLASS PROFESSIONAL LIABILITY INSU	E	RURAL HEALTH CLINIC 3	88.02		52,482	1
500 TOTAL RECLASSIFICATIONS					52,482	500
CODE LETTER - E						
1 RECLASSIFY X-RAY DIRECTOR'S SALARY	F	ADMINISTRATIVE & GENERAL	5	43,596		1
500 TOTAL RECLASSIFICATIONS				43,596		500
CODE LETTER - F						
1 RECLASS OXYGEN SUPPLIES	G	RESPIRATORY THERAPY	65		23,882	1
500 TOTAL RECLASSIFICATIONS					23,882	500
CODE LETTER - G						
1 RECLASSIFY ANESTHESIA PRO FEES	H	ANESTHESIOLOGY	53		66,000	1
500 TOTAL RECLASSIFICATIONS					66,000	500
CODE LETTER - H						
GRAND TOTAL (DECREASES)				67,916	895,450	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND	62,855					62,855	1
2 LAND IMPROVEMENTS	372,843					372,843	2
3 BUILDINGS AND FIXTURES	9,050,027				29,033	9,020,994	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	6,406,876	197,834		197,834	67,843	6,536,867	6
7 HIT DESIGNATED ASSETS	575,134	145,810		145,810		720,944	7
8 SUBTOTAL (SUM OF LINES 1-7)	16,467,735	343,644		343,644	96,876	16,714,503	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	16,467,735	343,644		343,644	96,876	16,714,503	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14)
1 CAP REL COSTS-BLDG & FIXT	270,904						270,904 1
2 CAP REL COSTS-MVBLE EQUIP	520,043						520,043 2
3 TOTAL (SUM OF LINES 1-2)	790,947						790,947 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3		RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
			(SUM OF COLS. 5-7)						
1 CAP REL COSTS-BLDG & FIXT	9,456,692		9,456,692	0.565778					1
2 CAP REL COSTS-MVBLE EQUIP	7,257,811		7,257,811	0.434222					2
3 TOTAL (SUM OF LINES 1-2)	16,714,503		16,714,503	1.000000					3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14)
1 CAP REL COSTS-BLDG & FIXT	270,904						270,904 1
2 CAP REL COSTS-MVBLE EQUIP	320,130						320,130 2
3 TOTAL	591,034						591,034 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)	B	-11,110	ADMINISTRATIVE & GENERAL	5	3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-1,924	CENTRAL SERVICES & SUPPLY	14	4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2	-237,221			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-582	RADIOLOGY-DIAGNOSTIC	54	11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST				
	A-8-1				12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-5,782	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-2,049	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)					
			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST				
	A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND	A	-199,352	CAP REL COSTS-MVBLE EQUIP	2	9 32
33 MISCELLANEOUS REVENUE	B	-4,723	ADMINISTRATIVE & GENERAL	5	33
34					34
35 EDUCATION FEES	B	-100	ADMINISTRATIVE & GENERAL	5	35
36 NONALLOWABLE PUBLIC RELATIONS	A	-9,873	ADMINISTRATIVE & GENERAL	5	36
37 HEALTHLINK ADMIN FEES	A	31,135	ADMINISTRATIVE & GENERAL	5	37
38 LOBBYING PORTION OF DUES	A	-13,279	ADMINISTRATIVE & GENERAL	5	38
39 NON-RHC SERVICES	A	-114,558	RURAL HEALTH CLINIC 3	88.02	39
40 NON-RHC BENEFITS	A	-30,300	EMPLOYEE BENEFITS	4	40
41					41
42 TELEPHONE SERVICE	B	-6,205	ADMINISTRATIVE & GENERAL	5	42
43 NON-RHC DEPRECIATION	A	-561	CAP REL COSTS-MVBLE EQUIP	2	9 43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-606,484			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.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6						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
1	2	3	4	5	6	7	8	9
1 54	RADIOLOGY-DIAGNOSTIC	RADIOLOGY	100	100				1
2 54	RADIOLOGY-DIAGNOSTIC	ULTRASOUND	4,800	4,800				2
3 60	LABORATORY	LABORATORY	19,024	19,024				3
4 69	ELECTROCARDIOLOGY	EKG	9,275	9,275				4
5 91	EMERGENCY	EMERGENCY	1,111,875	204,022	907,853			5
6 54	RADIOLOGY-DIAGNOSTIC	MAMMOGRAPHY						6
200	TOTAL		1,145,074	237,221	907,853			200

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 15:04

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	54	RADIOLOGY-DIAGNOSTIC	RADIOLOGY							100	1
2	54	RADIOLOGY-DIAGNOSTIC	ULTRASOUND							4,800	2
3	60	LABORATORY	LABORATORY							19,024	3
4	69	ELECTROCARDIOLOGY	EKG							9,275	4
5	91	EMERGENCY	EMERGENCY							204,022	5
6	54	RADIOLOGY-DIAGNOSTIC	MAMMOGRAPHY								6
200		TOTAL								237,221	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	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	270,904	270,904				1
2 CAP REL COSTS-MVBLE EQUIP	320,130		320,130			2
4 EMPLOYEE BENEFITS	1,718,001	511	109	1,718,621		4
5 ADMINISTRATIVE & GENERAL	1,950,182	61,656	64,507	260,369	2,336,714	5
6 MAINTENANCE & REPAIRS	494,569	37,086	8,037	35,622	575,314	6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	70,819	3,505	95		74,419	8
9 HOUSEKEEPING	217,482	1,605		56,665	275,752	9
10 DIETARY	299,044	6,576	861	55,506	361,987	10
11 CAFETERIA	24,772	3,230		5,671	33,673	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	82,695	511	103	24,330	107,639	13
14 CENTRAL SERVICES & SUPPLY	50,692	2,940	7,086	13,069	73,787	14
15 PHARMACY	166,399	3,598	14,846	40,291	225,134	15
16 MEDICAL RECORDS & LIBRARY	168,047	3,768	357	42,369	214,541	16
17 SOCIAL SERVICE	5,045	340		1,484	6,869	17
19 NONPHYSICIAN ANESTHETISTS	264,749			58,476	323,225	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	661,947	25,729	15,474	182,127	885,277	30
46 OTHER LONG TERM CARE	509,331	35,322	3,298	143,263	691,214	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	278,485	13,071	15,659	53,917	361,132	50
53 ANESTHESIOLOGY	14,045		400		14,445	53
54 RADIOLOGY-DIAGNOSTIC	373,858	18,108	66,129	72,335	530,430	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	164,323		99,171	14,231	277,725	57
58 MAGNETIC RESONANCE IMAGING (MRI)	70,145				70,145	58
60 LABORATORY	884,886	7,806	11,110	100,736	1,004,538	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	51,106	1,841	986	9,320	63,253	65
66 PHYSICAL THERAPY	634,259	7,632	1,674	182,777	826,342	66
67.01 CARDIAC REHAB	25,601	1,629	655	6,710	34,595	67.01
69 ELECTROCARDIOLOGY		224			224	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	107,972				107,972	71
73 DRUGS CHARGED TO PATIENTS	657,717				657,717	73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3	1,037,832	9,327	404	258,524	1,306,087	88.02
91 EMERGENCY	1,261,509	12,537	6,871	97,243	1,378,160	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
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)	12,836,546	258,552	317,832	1,715,035	12,818,310	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		944			944	190
190.02 UNUSED SPACE						190.02
190.03 NON-REIMBURSEABLE HOME HEALTH						190.03
190.04 OUTPATIENT CLINIC	17,115	11,408	2,298	3,586	34,407	190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01 PHYSICIANS' CLINIC						192.01
192.02 WASHINGTON COUNTY HEALTH CENTER						192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	12,853,661	270,904	320,130	1,718,621	12,853,661	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	2,336,714					5
6 MAINTENANCE & REPAIRS	127,827	703,141				6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	16,535	14,357	105,311			8
9 HOUSEKEEPING	61,268	6,576		343,596		9
10 DIETARY	80,428	26,938		13,568	482,921	10
11 CAFETERIA	7,482	13,232		6,664		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	23,916	2,092		1,053		13
14 CENTRAL SERVICES & SUPPLY	16,394	12,043		6,066		14
15 PHARMACY	50,022	14,737		7,422		15
16 MEDICAL RECORDS & LIBRARY	47,668	15,434		7,773		16
17 SOCIAL SERVICE	1,526	1,394		702		17
19 NONPHYSICIAN ANESTHETISTS	71,816					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	196,696	105,393	18,649	53,081	104,760	30
46 OTHER LONG TERM CARE	153,578	144,692	63,590	72,875	373,839	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	80,238	53,544	3,808	26,968		50
53 ANESTHESIOLOGY	3,209					53
54 RADIOLOGY-DIAGNOSTIC	117,854	74,176	3,558	37,359		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	61,707					57
58 MAGNETIC RESONANCE IMAGING (MRI)	15,585					58
60 LABORATORY	223,194	31,978		16,106		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	14,054	7,543		3,799		65
66 PHYSICAL THERAPY	183,602	31,264	9,140	15,746		66
67.01 CARDIAC REHAB	7,687	6,671		3,360		67.01
69 ELECTROCARDIOLOGY	50	919		463		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	23,990					71
73 DRUGS CHARGED TO PATIENTS	146,136					73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3	290,194	38,205	666	19,242		88.02
91 EMERGENCY	306,203	51,357	5,662	25,866		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
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)	2,328,859	652,545	105,073	318,113	478,599	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	210	3,866		1,947		190
190.02 UNUSED SPACE						190.02
190.03 NON-REIMBURSEABLE HOME HEALTH						190.03
190.04 OUTPATIENT CLINIC	7,645	46,730	238	23,536		190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS					4,322	190.05
192.01 PHYSICIANS' CLINIC						192.01
192.02 WASHINGTON COUNTY HEALTH CENTER						192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,336,714	703,141	105,311	343,596	482,921	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA	NURSING	CENTRAL	PHARMACY	MEDICAL	
	11	ADMINIS- TRATION 13	SERVICES & SUPPLY 14	15	RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	61,051					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		134,700				13
14 CENTRAL SERVICES & SUPPLY	984		109,274			14
15 PHARMACY	1,300		204	298,819		15
16 MEDICAL RECORDS & LIBRARY	2,974		273		288,663	16
17 SOCIAL SERVICE	73					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	9,016	49,350	33,435	168	13,480	30
46 OTHER LONG TERM CARE	12,014	43,274	22,304		16,929	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,489	13,400	12,549	12	23,410	50
53 ANESTHESIOLOGY	734		1,951	132	1,357	53
54 RADIOLOGY-DIAGNOSTIC	3,245		2,077	191	24,541	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	712		468		34,002	57
58 MAGNETIC RESONANCE IMAGING (MRI)					5,198	58
60 LABORATORY	5,690		5,630	162	62,571	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	712	3,700	1,991		3,631	65
66 PHYSICAL THERAPY	7,900		1,660	537	29,851	66
67.01 CARDIAC REHAB	396		1,036		2,175	67.01
69 ELECTROCARDIOLOGY					3,580	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					12,406	71
73 DRUGS CHARGED TO PATIENTS				297,428	30,939	73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3	7,775		3,503	2	10,170	88.02
91 EMERGENCY	4,787	24,976	21,998	187	14,423	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
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)	60,801	134,700	109,079	298,819	288,663	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.02 UNUSED SPACE						190.02
190.03 NON-REIMBURSEABLE HOME HEALTH						190.03
190.04 OUTPATIENT CLINIC	250		195			190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01 PHYSICIANS' CLINIC						192.01
192.02 WASHINGTON COUNTY HEALTH CENTER						192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	61,051	134,700	109,274	298,819	288,663	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	19	24	25	26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY						16
17 SOCIAL SERVICE	10,564					17
19 NONPHYSICIAN ANESTHETISTS		395,041				19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	9,508		1,478,813		1,478,813	30
46 OTHER LONG TERM CARE	1,056		1,595,365		1,595,365	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			577,550		577,550	50
53 ANESTHESIOLOGY		395,041	416,869		416,869	53
54 RADIOLOGY-DIAGNOSTIC			793,431		793,431	54
57 COMPUTED TOMOGRAPHY (CT) SCAN			374,614		374,614	57
58 MAGNETIC RESONANCE IMAGING (MRI)			90,928		90,928	58
60 LABORATORY			1,349,869		1,349,869	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			98,683		98,683	65
66 PHYSICAL THERAPY			1,106,042		1,106,042	66
67.01 CARDIAC REHAB			55,920		55,920	67.01
69 ELECTROCARDIOLOGY			5,236		5,236	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			144,368		144,368	71
73 DRUGS CHARGED TO PATIENTS			1,132,220		1,132,220	73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3			1,675,844		1,675,844	88.02
91 EMERGENCY			1,833,619		1,833,619	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
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)	10,564	395,041	12,729,371		12,729,371	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			6,967		6,967	190
190.02 UNUSED SPACE						190.02
190.03 NON-REIMBURSEABLE HOME HEALTH						190.03
190.04 OUTPATIENT CLINIC			113,001		113,001	190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS			4,322		4,322	190.05
192.01 PHYSICIANS' CLINIC						192.01
192.02 WASHINGTON COUNTY HEALTH CENTER						192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	10,564	395,041	12,853,661		12,853,661	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS & FIXTURES	MOVABLE EQUIPMENT		BENEFITS	
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		511	109	620	620	4
5 ADMINISTRATIVE & GENERAL		61,656	64,507	126,163		95
6 MAINTENANCE & REPAIRS		37,086	8,037	45,123		13
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE		3,505	95	3,600		8
9 HOUSEKEEPING		1,605		1,605		20
10 DIETARY		6,576	861	7,437		20
11 CAFETERIA		3,230		3,230		2
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		511	103	614		9
14 CENTRAL SERVICES & SUPPLY		2,940	7,086	10,026		5
15 PHARMACY		3,598	14,846	18,444		15
16 MEDICAL RECORDS & LIBRARY		3,768	357	4,125		15
17 SOCIAL SERVICE		340		340		1
19 NONPHYSICIAN ANESTHETISTS						21
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		25,729	15,474	41,203		66
46 OTHER LONG TERM CARE		35,322	3,298	38,620		52
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		13,071	15,659	28,730		19
53 ANESTHESIOLOGY			400	400		53
54 RADIOLOGY-DIAGNOSTIC		18,108	66,129	84,237		26
57 COMPUTED TOMOGRAPHY (CT) SCAN			99,171	99,171		5
58 MAGNETIC RESONANCE IMAGING (MRI)						58
60 LABORATORY		7,806	11,110	18,916		36
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		1,841	986	2,827		3
66 PHYSICAL THERAPY		7,632	1,674	9,306		66
67.01 CARDIAC REHAB		1,629	655	2,284		2
69 ELECTROCARDIOLOGY			224	224		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3		9,327	404	9,731		93
91 EMERGENCY		12,537	6,871	19,408		35
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
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)		258,552	317,832	576,384		619
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		944		944		190
190.02 UNUSED SPACE						190.02
190.03 NON-REIMBURSEABLE HOME HEALTH						190.03
190.04 OUTPATIENT CLINIC		11,408	2,298	13,706		1
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01 PHYSICIANS' CLINIC						192.01
192.02 WASHINGTON COUNTY HEALTH CENTER						192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		270,904	320,130	591,034		620

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	126,258					5
6 MAINTENANCE & REPAIRS	6,907	52,043				6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	893	1,063	5,556			8
9 HOUSEKEEPING	3,310	487		5,422		9
10 DIETARY	4,346	1,994		214	14,011	10
11 CAFETERIA	404	979		105		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,292	155		17		13
14 CENTRAL SERVICES & SUPPLY	886	891		96		14
15 PHARMACY	2,703	1,091		117		15
16 MEDICAL RECORDS & LIBRARY	2,576	1,142		123		16
17 SOCIAL SERVICE	82	103		11		17
19 NONPHYSICIAN ANESTHETISTS	3,880					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	10,628	7,801	984	838	3,039	30
46 OTHER LONG TERM CARE	8,298	10,709	3,354	1,149	10,847	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,335	3,963	201	426		50
53 ANESTHESIOLOGY	173					53
54 RADIOLOGY-DIAGNOSTIC	6,368	5,490	188	590		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	3,334					57
58 MAGNETIC RESONANCE IMAGING (MRI)	842					58
60 LABORATORY	12,059	2,367		254		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	759	558		60		65
66 PHYSICAL THERAPY	9,920	2,314	482	248		66
67.01 CARDIAC REHAB	415	494		53		67.01
69 ELECTROCARDIOLOGY	3	68		7		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,296					71
73 DRUGS CHARGED TO PATIENTS	7,896					73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3	15,680	2,828	35	304		88.02
91 EMERGENCY	16,549	3,801	299	408		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
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)	125,834	48,298	5,543	5,020	13,886	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11	286		31		190
190.02 UNUSED SPACE						190.02
190.03 NON-REIMBURSEABLE HOME HEALTH						190.03
190.04 OUTPATIENT CLINIC	413	3,459	13	371		190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS					125	190.05
192.01 PHYSICIANS' CLINIC						192.01
192.02 WASHINGTON COUNTY HEALTH CENTER						192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	126,258	52,043	5,556	5,422	14,011	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA	NURSING	CENTRAL	PHARMACY	MEDICAL	
	11	ADMINIS- TRATION 13	SERVICES & SUPPLY 14	15	RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	4,720					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		2,087				13
14 CENTRAL SERVICES & SUPPLY	76		11,980			14
15 PHARMACY	100		22	22,492		15
16 MEDICAL RECORDS & LIBRARY	230		30		8,241	16
17 SOCIAL SERVICE	6					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	697	765	3,666	13	385	30
46 OTHER LONG TERM CARE	929	670	2,445		484	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	192	208	1,376	1	669	50
53 ANESTHESIOLOGY	57		214	10	39	53
54 RADIOLOGY-DIAGNOSTIC	251		228	14	702	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	55		51		972	57
58 MAGNETIC RESONANCE IMAGING (MRI)					149	58
60 LABORATORY	440		617	12	1,778	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	55	57	218		104	65
66 PHYSICAL THERAPY	611		182	40	853	66
67.01 CARDIAC REHAB	31		114		62	67.01
69 ELECTROCARDIOLOGY					102	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					355	71
73 DRUGS CHARGED TO PATIENTS				22,388	884	73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3	601		384		291	88.02
91 EMERGENCY	370	387	2,412	14	412	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
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)	4,701	2,087	11,959	22,492	8,241	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.02 UNUSED SPACE						190.02
190.03 NON-REIMBURSEABLE HOME HEALTH						190.03
190.04 OUTPATIENT CLINIC	19		21			190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01 PHYSICIANS' CLINIC						192.01
192.02 WASHINGTON COUNTY HEALTH CENTER						192.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,720	2,087	11,980	22,492	8,241	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	17	19	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	543				17
19 NONPHYSICIAN ANESTHETISTS		3,901			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	489		70,574		70,574 30
46 OTHER LONG TERM CARE	54		77,611		77,611 46
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM			40,120		40,120 50
53 ANESTHESIOLOGY			893		893 53
54 RADIOLOGY-DIAGNOSTIC			98,094		98,094 54
57 COMPUTED TOMOGRAPHY (CT) SCAN			103,588		103,588 57
58 MAGNETIC RESONANCE IMAGING (MRI)			991		991 58
60 LABORATORY			36,479		36,479 60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY			4,641		4,641 65
66 PHYSICAL THERAPY			24,022		24,022 66
67.01 CARDIAC REHAB			3,455		3,455 67.01
69 ELECTROCARDIOLOGY			404		404 69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,651		1,651 71
73 DRUGS CHARGED TO PATIENTS			31,168		31,168 73
76 OP GERO PSYCH					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88.01 RURAL HEALTH CLINIC 2					88.01
88.02 RURAL HEALTH CLINIC 3			29,947		29,947 88.02
91 EMERGENCY			44,095		44,095 91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
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)	543		567,733		567,733 118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			1,272		1,272 190
190.02 UNUSED SPACE					190.02
190.03 NON-REIMBURSEABLE HOME HEALTH					190.03
190.04 OUTPATIENT CLINIC			18,003		18,003 190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS			125		125 190.05
192.01 PHYSICIANS' CLINIC					192.01
192.02 WASHINGTON COUNTY HEALTH CENTER					192.02
200 CROSS FOOT ADJUSTMENTS		3,901	3,901		3,901 200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	543	3,901	591,034		591,034 202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	70,030					1
2 CAP REL COSTS-MVBLE EQUIP		320,130				2
4 EMPLOYEE BENEFITS	132	109	5,841,313			4
5 ADMINISTRATIVE & GENERAL	15,938	64,507	884,949	-2,336,714	10,516,947	5
6 MAINTENANCE & REPAIRS	9,587	8,037	121,074		575,314	6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	906	95			74,419	8
9 HOUSEKEEPING	415		192,595		275,752	9
10 DIETARY	1,700	861	188,656		361,987	10
11 CAFETERIA	835		19,275		33,673	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	132	103	82,694		107,639	13
14 CENTRAL SERVICES & SUPPLY	760	7,086	44,421		73,787	14
15 PHARMACY	930	14,846	136,942		225,134	15
16 MEDICAL RECORDS & LIBRARY	974	357	144,005		214,541	16
17 SOCIAL SERVICE	88		5,045		6,869	17
19 NONPHYSICIAN ANESTHETISTS			198,749		323,225	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	6,651	15,474	619,020		885,277	30
46 OTHER LONG TERM CARE	9,131	3,298	486,929		691,214	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,379	15,659	183,256		361,132	50
53 ANESTHESIOLOGY		400			14,445	53
54 RADIOLOGY-DIAGNOSTIC	4,681	66,129	245,854		530,430	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		99,171	48,368		277,725	57
58 MAGNETIC RESONANCE IMAGING (MRI)					70,145	58
60 LABORATORY	2,018	11,110	342,386		1,004,538	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	476	986	31,676		63,253	65
66 PHYSICAL THERAPY	1,973	1,674	621,229		826,342	66
67.01 CARDIAC REHAB	421	655	22,807		34,595	67.01
69 ELECTROCARDIOLOGY	58				224	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					107,972	71
73 DRUGS CHARGED TO PATIENTS					657,717	73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3	2,411	404	878,681		1,306,087	88.02
91 EMERGENCY	3,241	6,871	330,513		1,378,160	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
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)	66,837	317,832	5,829,124	-2,336,714	10,481,596	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	244				944	190
190.02 UNUSED SPACE						190.02
190.03 NON-REIMBURSEABLE HOME HEALTH						190.03
190.04 OUTPATIENT CLINIC	2,949	2,298	12,189		34,407	190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01 PHYSICIANS' CLINIC						192.01
192.02 WASHINGTON COUNTY HEALTH CENTER						192.02

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 15:04

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	270,904	320,130	1,718,621		2,336,714	202
203	UNIT COST MULT-WS B PT I	3.868399	1.000000	0.294218		0.222186	203
204	COST TO BE ALLOC PER B PT II			620		126,258	204
205	UNIT COST MULT-WS B PT II			0.000106		0.012005	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAIN-	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	TENANCE & REPAIRS SQUARE FEET	& LINEN SERVICE POUNDS OF LAUNDRY	KEEPING SQUARE FEET	MEALS SERVED	FTE'S	
	6	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	44,373					6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	906	35,395				8
9 HOUSEKEEPING	415		43,052			9
10 DIETARY	1,700		1,700	41,562		10
11 CAFETERIA	835		835		8,315	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	132		132			13
14 CENTRAL SERVICES & SUPPLY	760		760		134	14
15 PHARMACY	930		930		177	15
16 MEDICAL RECORDS & LIBRARY	974		974		405	16
17 SOCIAL SERVICE	88		88		10	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	6,651	6,268	6,651	9,016	1,228	30
46 OTHER LONG TERM CARE	9,131	21,372	9,131	32,174	1,636	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,379	1,280	3,379		339	50
53 ANESTHESIOLOGY					100	53
54 RADIOLOGY-DIAGNOSTIC	4,681	1,196	4,681		442	54
57 COMPUTED TOMOGRAPHY (CT) SCAN					97	57
58 MAGNETIC RESONANCE IMAGING (MRI)						58
60 LABORATORY	2,018		2,018		775	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	476		476		97	65
66 PHYSICAL THERAPY	1,973	3,072	1,973		1,076	66
67.01 CARDIAC REHAB	421		421		54	67.01
69 ELECTROCARDIOLOGY	58		58			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3	2,411	224	2,411		1,059	88.02
91 EMERGENCY	3,241	1,903	3,241		652	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
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)	41,180	35,315	39,859	41,190	8,281	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	244		244			190
190.02 UNUSED SPACE						190.02
190.03 NON-REIMBURSEABLE HOME HEALTH						190.03
190.04 OUTPATIENT CLINIC	2,949	80	2,949		34	190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS				372		190.05
192.01 PHYSICIANS' CLINIC						192.01
192.02 WASHINGTON COUNTY HEALTH CENTER						192.02

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 15:04

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MAIN- TENANCE & REPAIRS SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	
		6	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	703,141	105,311	343,596	482,921	61,051	202
203	UNIT COST MULT-WS B PT I	15.846145	2.975307	7.980953	11.619292	7.342273	203
204	COST TO BE ALLOC PER B PT II	52,043	5,556	5,422	14,011	4,720	204
205	UNIT COST MULT-WS B PT II	1.172853	0.156971	0.125941	0.337111	0.567649	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS CHARGES 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	63,823					13
14 CENTRAL SERVICES & SUPPLY		79,635				14
15 PHARMACY		149	660,796			15
16 MEDICAL RECORDS & LIBRARY		199		21,103,476		16
17 SOCIAL SERVICE					100	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	23,383	24,366	372	985,522	90	30
46 OTHER LONG TERM CARE	20,504	16,254		1,237,667	10	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,349	9,145	26	1,711,528		50
53 ANESTHESIOLOGY		1,422	293	99,204		53
54 RADIOLOGY-DIAGNOSTIC		1,514	422	1,794,186		54
57 COMPUTED TOMOGRAPHY (CT) SCAN		341		2,485,876		57
58 MAGNETIC RESONANCE IMAGING (MRI)				380,005		58
60 LABORATORY		4,103	359	4,573,973		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,753	1,451		265,443		65
66 PHYSICAL THERAPY		1,210	1,188	2,182,388		66
67.01 CARDIAC REHAB		755		158,979		67.01
69 ELECTROCARDIOLOGY				261,721		69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS				906,985		71
73 DRUGS CHARGED TO PATIENTS			657,717	2,261,974		73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3		2,553	5	743,536		88.02
91 EMERGENCY	11,834	16,031	414	1,054,489		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
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)	63,823	79,493	660,796	21,103,476	100	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.02 UNUSED SPACE						190.02
190.03 NON-REIMBURSEABLE HOME HEALTH						190.03
190.04 OUTPATIENT CLINIC		142				190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS						190.05
192.01 PHYSICIANS' CLINIC						192.01
192.02 WASHINGTON COUNTY HEALTH CENTER						192.02

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 15:04

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS CHARGES 16	SOCIAL SERVICE TIME SPENT 17	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	134,700	109,274	298,819	288,663	10,564	202
203	UNIT COST MULT-WS B PT I	2.110524	1.372186	0.452211	0.013678	105.640000	203
204	COST TO BE ALLOC PER B PT II	2,087	11,980	22,492	8,241	543	204
205	UNIT COST MULT-WS B PT II	0.032700	0.150436	0.034038	0.000391	5.430000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NONPHYSIC. ANESTHET.	ASSIGNED TIME	
		19	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS	100		19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS			30
46 OTHER LONG TERM CARE			46
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
53 ANESTHESIOLOGY	100		53
54 RADIOLOGY-DIAGNOSTIC			54
57 COMPUTED TOMOGRAPHY (CT) SCAN			57
58 MAGNETIC RESONANCE IMAGING (MRI)			58
60 LABORATORY			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY			65
66 PHYSICAL THERAPY			66
67.01 CARDIAC REHAB			67.01
69 ELECTROCARDIOLOGY			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			71
73 DRUGS CHARGED TO PATIENTS			73
76 OP GERO PSYCH			76
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
88.01 RURAL HEALTH CLINIC 2			88.01
88.02 RURAL HEALTH CLINIC 3			88.02
91 EMERGENCY			91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
99.10 CORF			99.10
99.20 OUTPATIENT PHYSICAL THERAPY			99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40 OUTPATIENT SPEECH PATHOLOGY			99.40
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	100		118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
190.02 UNUSED SPACE			190.02
190.03 NON-REIMBURSEABLE HOME HEALTH			190.03
190.04 OUTPATIENT CLINIC			190.04
190.05 NON-REIMBURSEABLE OUTPATIENT MEALS			190.05
192.01 PHYSICIANS' CLINIC			192.01
192.02 WASHINGTON COUNTY HEALTH CENTER			192.02

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
09/23/2013 15:04

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NONPHYSIC. ANESTHET.	
		ASSIGNED TIME	
		19	
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	395,041	202
203	UNIT COST MULT-WS B PT I	3,950.410000	203
204	COST TO BE ALLOC PER B PT II	3,901	204
205	UNIT COST MULT-WS B PT II	39.010000	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	1,478,813		1,478,813		30
46 OTHER LONG TERM CARE	1,595,365		1,595,365		46
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	577,550		577,550		50
53 ANESTHESIOLOGY	416,869		416,869		53
54 RADIOLOGY-DIAGNOSTIC	793,431		793,431		54
57 COMPUTED TOMOGRAPHY (CT) SC	374,614		374,614		57
58 MAGNETIC RESONANCE IMAGING	90,928		90,928		58
60 LABORATORY	1,349,869		1,349,869		60
62.30 BLOOD CLOTTING FOR HEMOPHIL					62.30
65 RESPIRATORY THERAPY	98,683		98,683		65
66 PHYSICAL THERAPY	1,106,042		1,106,042		66
67.01 CARDIAC REHAB	55,920		55,920		67.01
69 ELECTROCARDIOLOGY	5,236		5,236		69
71 MEDICAL SUPPLIES CHRGD TO	144,368		144,368		71
73 DRUGS CHARGED TO PATIENTS	1,132,220		1,132,220		73
76 OP GERO PSYCH					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88.01 RURAL HEALTH CLINIC 2					88.01
88.02 RURAL HEALTH CLINIC 3	1,675,844		1,675,844		88.02
91 EMERGENCY	1,833,619		1,833,619		91
92 OBSERVATION BEDS	17,623		17,623		92
OTHER REIMBURSABLE COST CENTERS					
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)	12,746,994		12,746,994		200
201 LESS OBSERVATION BEDS	17,623		17,623		201
202 TOTAL (SEE INSTRUCTIONS)	12,729,371		12,729,371		202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	959,167		959,167			30
46 OTHER LONG TERM CARE	1,237,667		1,237,667			46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	16,120	1,695,408	1,711,528	0.337447		50
53 ANESTHESIOLOGY	1,008	98,196	99,204	4.202139		53
54 RADIOLOGY-DIAGNOSTIC	65,938	1,728,248	1,794,186	0.442223		54
57 COMPUTED TOMOGRAPHY (CT) SC	48,810	2,437,066	2,485,876	0.150697		57
58 MAGNETIC RESONANCE IMAGING	7,836	372,169	380,005	0.239281		58
60 LABORATORY	330,334	4,243,639	4,573,973	0.295120		60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	166,315	99,128	265,443	0.371767		65
66 PHYSICAL THERAPY	381,897	1,800,491	2,182,388	0.506804		66
67.01 CARDIAC REHAB		158,979	158,979	0.351745		67.01
69 ELECTROCARDIOLOGY	10,034	251,687	261,721	0.020006		69
71 MEDICAL SUPPLIES CHRGD TO	192,675	714,310	906,985	0.159174		71
73 DRUGS CHARGED TO PATIENTS	618,504	1,643,470	2,261,974	0.500545		73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3	401	743,135	743,536			88.02
91 EMERGENCY		1,054,489	1,054,489	1.738870		91
92 OBSERVATION BEDS		26,355	26,355	0.668678		92
OTHER REIMBURSABLE COST CENTERS						
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)	4,036,706	17,066,770	21,103,476			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		17,066,770	21,103,476			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1308) [] 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	PROGRAM CHARGES				PROGRAM COSTS			
		PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS		
	1	2	3	4	5	6	7		
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.337447		704,256			237,649		50	
53 ANESTHESIOLOGY	4.202139		61,742			259,448		53	
54 RADIOLOGY-DIAGNOSTIC	0.442223		490,918			217,095		54	
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.150697		906,663			136,631		57	
58 MAGNETIC RESONANCE IMAGING (MRI)	0.239281		118,293			28,305		58	
60 LABORATORY	0.295120		1,906,006			562,500		60	
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30	
65 RESPIRATORY THERAPY	0.371767		17,244			6,411		65	
66 PHYSICAL THERAPY	0.506804		719,373			364,581		66	
67.01 CARDIAC REHAB	0.351745		127,130			44,717		67.01	
69 ELECTROCARDIOLOGY	0.020006		231,214			4,626		69	
71 MEDICAL SUPPLIES CHRGED TO PATI	0.159174		448,739			71,428		71	
73 DRUGS CHARGED TO PATIENTS	0.500545		1,305,140			653,281		73	
76 OP GERO PSYCH								76	
76.97 CARDIAC REHABILITATION								76.97	
76.98 HYPERBARIC OXYGEN THERAPY								76.98	
76.99 LITHOTRIPSY								76.99	
OUTPATIENT SERVICE COST CENTERS									
88.01 RURAL HEALTH CLINIC 2								88.01	
88.02 RURAL HEALTH CLINIC 3								88.02	
91 EMERGENCY	1.738870		335,504			583,398		91	
92 OBSERVATION BEDS	0.668678		17,290			11,561		92	
OTHER REIMBURSABLE COST CENTERS									
200 SUBTOTAL (SEE INSTRUCTIONS)			7,389,512			3,181,631		200	
201 LESS PBP CLINIC LAB SERVICES								201	
202 NET CHARGES (LINE 200 - LINE 201)			7,389,512			3,181,631		202	

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (14-Z308)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	COST SERVICES DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.337447						50
53 ANESTHESIOLOGY	4.202139						53
54 RADIOLOGY-DIAGNOSTIC	0.442223						54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.150697						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.239281						58
60 LABORATORY	0.295120						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.371767						65
66 PHYSICAL THERAPY	0.506804						66
67.01 CARDIAC REHAB	0.351745						67.01
69 ELECTROCARDIOLOGY	0.020006						69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.159174						71
73 DRUGS CHARGED TO PATIENTS	0.500545						73
76 OP GERO PSYCH							76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88.01 RURAL HEALTH CLINIC 2							88.01
88.02 RURAL HEALTH CLINIC 3							88.02
91 EMERGENCY	1.738870						91
92 OBSERVATION BEDS	0.668678						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)	(COL.3 ÷ COL.4)		(COL.5 x COL.6)
	1	2	3	5	6	7
INPAT ROUTINE SERV COST CTRS						
30 ADULTS & PEDIATRICS	70,574	52,576	17,998	535	33.64	2
31 INTENSIVE CARE UNIT						67
32 CORONARY CARE UNIT						30
33 BURN INTENSIVE CARE UNIT						31
34 SURGICAL INTENSIVE CARE UNIT						32
35 OTHER SPECIAL CARE (SPECIFY)						33
40 SUBPROVIDER - IPF						34
41 SUBPROVIDER - IRF						35
42 SUBPROVIDER I						40
43 NURSERY						41
44 SKILLED NURSING FACILITY						42
45 NURSING FACILITY						43
200 TOTAL (LINES 30-199)	70,574		17,998	535		2
						67
						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-1308) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	40,120	1,711,528	0.023441		50
53 ANESTHESIOLOGY	893	99,204	0.009002		53
54 RADIOLOGY-DIAGNOSTIC	98,094	1,794,186	0.054673		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	103,588	2,485,876	0.041671		57
58 MAGNETIC RESONANCE IMAGING (M	991	380,005	0.002608		58
60 LABORATORY	36,479	4,573,973	0.007975		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	4,641	265,443	0.017484		65
66 PHYSICAL THERAPY	24,022	2,182,388	0.011007		66
67.01 CARDIAC REHAB	3,455	158,979	0.021732		67.01
69 ELECTROCARDIOLOGY	404	261,721	0.001544		69
71 MEDICAL SUPPLIES CHRGED TO PA	1,651	906,985	0.001820		71
73 DRUGS CHARGED TO PATIENTS	31,168	2,261,974	0.013779		73
76 OP GERO PSYCH					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88.01 RURAL HEALTH CLINIC 2					88.01
88.02 RURAL HEALTH CLINIC 3		743,536	0.040276		88.02
91 EMERGENCY	29,947	1,054,489	0.041816		91
92 OBSERVATION BEDS	44,095	26,355	0.125138		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	422,846	18,906,642			200

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
09/23/2013 15:04

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 15:04

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	535		2		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	535		2		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1308) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			HEALTH	MEDICAL	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY	395,041				395,041	53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67.01 CARDIAC REHAB						67.01
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
76 OP GERO PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88.01 RURAL HEALTH CLINIC 2						88.01
88.02 RURAL HEALTH CLINIC 3						88.02
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	395,041				395,041	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1308) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM	INPAT PGM PASS-THRU COSTS	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 ÷ COL. 7)	(COL. 6 ÷ COL. 7)	PGM CHARGES	(COL. 8 x COL. 10)	(COL. 9 x COL. 12)	(COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	1,711,528						50
53 ANESTHESIOLOGY	99,204	3.982108					53
54 RADIOLOGY-DIAGNOSTIC	1,794,186						54
57 COMPUTED TOMOGRAPHY (CT) SCA	2,485,876						57
58 MAGNETIC RESONANCE IMAGING (380,005						58
60 LABORATORY	4,573,973						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	265,443						65
66 PHYSICAL THERAPY	2,182,388						66
67.01 CARDIAC REHAB	158,979						67.01
69 ELECTROCARDIOLOGY	261,721						69
71 MEDICAL SUPPLIES CHRGED TO P	906,985						71
73 DRUGS CHARGED TO PATIENTS	2,261,974						73
76 OP GERO PSYCH							76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88.01 RURAL HEALTH CLINIC 2							88.01
88.02 RURAL HEALTH CLINIC 3	743,536						88.02
91 EMERGENCY	1,054,489						91
92 OBSERVATION BEDS	26,355						92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	18,906,642						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1308) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	----- PROGRAM CHARGES -----				----- PROGRAM COSTS -----		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.337447						50
53 ANESTHESIOLOGY	4.202139						53
54 RADIOLOGY-DIAGNOSTIC	0.442223						54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.150697						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.239281						58
60 LABORATORY	0.295120						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.371767						65
66 PHYSICAL THERAPY	0.506804						66
67.01 CARDIAC REHAB	0.351745						67.01
69 ELECTROCARDIOLOGY	0.020006						69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.159174						71
73 DRUGS CHARGED TO PATIENTS	0.500545						73
76 OP GERO PSYCH							76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88.01 RURAL HEALTH CLINIC 2							88.01
88.02 RURAL HEALTH CLINIC 3							88.02
91 EMERGENCY	1.738870						91
92 OBSERVATION BEDS	0.668678						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1308) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	2,233	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	535	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	510	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,022	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)	511	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	110	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)	55	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	444	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)	893	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)	640	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	131.13	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.00	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,478,813	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)	14,424	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	6,600	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,101,682	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	377,131	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	508,797	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	508,797	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.741221	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)	997.64	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)	377,131	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1308) [] 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) 704.93 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 312,989 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) 312,989 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)					179,744 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					492,733 49

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

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 629,502 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 451,155 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 1,080,657 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 25 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 704.92 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 17,623 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	70,574	377,131	0.187134	17,623	3,298 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1308) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	2,233	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	535	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	510	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,022	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)	511	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	110	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)	55	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	131.13	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.00	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,478,813	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)	14,424	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	6,600	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,101,682	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	377,131	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	508,797	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	508,797	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.741221	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)	997.64	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)	377,131	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1308) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 704.93 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,410 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) 1,410 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,410 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 67 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 67 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 25 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	ROUTINE COST (FROM LINE 27)	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	COST 1			
90 CAPITAL-RELATED COST				90
91 NURSING SCHOOL COST				91
92 ALLIED HEALTH COST				92
93 ALL OTHER MEDICAL EDUCATION				93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-1308) [] SUB (OTHER) [] S/B SNF [] 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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		354,000			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.337447	9,559	3,226		50
53 ANESTHESIOLOGY	4.202139	1,008	4,236		53
54 RADIOLOGY-DIAGNOSTIC	0.442223	29,481	13,037		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.150697	27,898	4,204		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.239281	7,836	1,875		58
60 LABORATORY	0.295120	142,314	42,000		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.371767	29,781	11,072		65
66 PHYSICAL THERAPY	0.506804	18,426	9,338		66
67.01 CARDIAC REHAB	0.351745				67.01
69 ELECTROCARDIOLOGY	0.020006	6,920	138		69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.159174	51,381	8,179		71
73 DRUGS CHARGED TO PATIENTS	0.500545	164,699	82,439		73
76 OP GERO PSYCH					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88.01 RURAL HEALTH CLINIC 2					88.01
88.02 RURAL HEALTH CLINIC 3					88.02
91 EMERGENCY	1.738870				91
92 OBSERVATION BEDS	0.668678				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		489,303	179,744		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		489,303			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z308) [] 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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.337447	6,432	2,170		50
53 ANESTHESIOLOGY	4.202139				53
54 RADIOLOGY-DIAGNOSTIC	0.442223	24,677	10,913		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.150697	9,235	1,392		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.239281				58
60 LABORATORY	0.295120	159,005	46,926		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.371767	49,013	18,221		65
66 PHYSICAL THERAPY	0.506804	341,885	173,269		66
67.01 CARDIAC REHAB	0.351745				67.01
69 ELECTROCARDIOLOGY	0.020006	2,422	48		69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.159174	95,115	15,140		71
73 DRUGS CHARGED TO PATIENTS	0.500545	382,725	191,571		73
76 OP GERO PSYCH					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88.01 RURAL HEALTH CLINIC 2					88.01
88.02 RURAL HEALTH CLINIC 3					88.02
91 EMERGENCY	1.738870				91
92 OBSERVATION BEDS	0.668678				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,070,509	459,650		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,070,509			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-1308) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.337447			50
53 ANESTHESIOLOGY	4.202139			53
54 RADIOLOGY-DIAGNOSTIC	0.442223			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.150697			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.239281			58
60 LABORATORY	0.295120			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.371767			65
66 PHYSICAL THERAPY	0.506804			66
67.01 CARDIAC REHAB	0.351745			67.01
69 ELECTROCARDIOLOGY	0.020006			69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.159174			71
73 DRUGS CHARGED TO PATIENTS	0.500545			73
76 OP GERO PSYCH				76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88.01 RURAL HEALTH CLINIC 2				88.01
88.02 RURAL HEALTH CLINIC 3				88.02
91 EMERGENCY	1.738870			91
92 OBSERVATION BEDS	0.668678			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z308) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.337447			50
53 ANESTHESIOLOGY	4.202139			53
54 RADIOLOGY-DIAGNOSTIC	0.442223			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.150697			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.239281			58
60 LABORATORY	0.295120			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.371767			65
66 PHYSICAL THERAPY	0.506804			66
67.01 CARDIAC REHAB	0.351745			67.01
69 ELECTROCARDIOLOGY	0.020006			69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.159174			71
73 DRUGS CHARGED TO PATIENTS	0.500545			73
76 OP GERO PSYCH				76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88.01 RURAL HEALTH CLINIC 2				88.01
88.02 RURAL HEALTH CLINIC 3				88.02
91 EMERGENCY	1.738870			91
92 OBSERVATION BEDS	0.668678			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-1308) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY		AMOUNT	
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		417,670		2,214,492
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
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 10/17/2012	1,472		NONE
	.02 03/13/2013	586		
PROGRAM	.03			
TO	.04			
PROVIDER	.05			
	.06			
	.07			
	.08			
	.09			
	.50	NONE		
	.51		10/17/2012	14,136
PROVIDER	.52			
TO	.53			
PROGRAM	.54			
	.55			
	.56			
	.57			
	.58			
	.59			
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	2,058		-14,136
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		419,728		2,200,356

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
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	PROGRAM .01				6.01
	TO .02				
	PROVIDER .01				
	PROVIDER .02				
	TO .02	-36,420		-8,749	6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		383,308		2,191,607	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER) INPATIENT
 APPLICABLE [] IPF [] SNF PART A PART B
 BOX: [] IRF [XX] SWING BED SNF (14-Z308)

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,614,797		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		3.01
PROGRAM .01				3.02
TO .02				3.03
PROVIDER .03				3.04
TO .04				3.05
PROVIDER .05				3.06
TO .06				3.07
PROGRAM .07				3.08
TO .08				3.09
PROVIDER .09				3.50
TO .50			NONE	3.51
PROVIDER .51	10/17/2012	9,501		3.52
TO .52	03/13/2013	11,678		3.53
PROGRAM .53				3.54
TO .54				3.55
PROVIDER .55				3.56
TO .56				3.57
PROGRAM .57				3.58
TO .58				3.59
PROVIDER .59				3.99
TO .99				
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-21,179		
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		1,593,618		4
TO BE COMPLETED BY CONTRACTOR				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		5.01
PROGRAM .01				5.02
TO .02				5.03
PROVIDER .03				5.04
TO .04				5.05
PROVIDER .05				5.06
TO .06				5.07
PROGRAM .07				5.08
TO .08				5.09
PROVIDER .09				5.50
TO .50			NONE	5.51
PROVIDER .51				5.52
TO .52				5.53
PROGRAM .53				5.54
TO .54				5.55
PROVIDER .55				5.56
TO .56				5.57
PROGRAM .57				5.58
TO .58				5.59
PROVIDER .59				5.99
TO .99				
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT				6.01
PROGRAM .01				6.02
TO .02				
PROVIDER .03				
TO .04				
PROVIDER .05				
TO .06				
PROGRAM .07				
TO .08				
PROVIDER .09				
TO .50				
PROVIDER .51				
TO .52				
PROGRAM .53				
TO .54				
PROVIDER .55				
TO .56				
PROGRAM .57				
TO .58				
PROVIDER .59				
TO .99				
SUBTOTAL (SUM OF LINES 6.01-6.99)				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,502,210		7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

PROVIDER CCN: 14-1308 WASHINGTON COUNTY HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
09/23/2013 15:04

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1308) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

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	152	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	444	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	510	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	21,103,476	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	119,063	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	145,810	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	145,810	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	145,810	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-Z308)
 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)	1,091,464	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)	464,247	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	1,533	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)	1,555,711	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	1,555,711	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	1,555,711	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	53,501	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)	1,502,210	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)	1,502,210	19
20 INTERIM PAYMENTS	1,593,618	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	-91,408	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 (14-1308)
APPLICABLE BOX: [] SUB (OTHER)

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

1	INPATIENT SERVICES	492,733	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	492,733	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	497,660	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 AND 17)	497,660	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	116,664	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	380,996	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	380,996	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	2,312	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	2,312	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	2,312	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	383,308	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	383,308	30
31	INTERIM PAYMENTS	419,728	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	-36,420	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-1308) [] SNF [] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [XX] OTHER
 [] SUB (OTHER)

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES	1,410	1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	1,410	4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	1,410	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES		9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)		15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	1,410	21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21	1,410	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	1,410	31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	1,410	36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)	1,410	38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	1,410	40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	1,410	42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	925,548			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	3,020,844			4
5	OTHER RECEIVABLES	47,096			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,300,219			6
7	INVENTORY	288,668			7
8	PREPAID EXPENSES	97,822			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	3,079,759			11
FIXED ASSETS					
12	LAND	62,855			12
13	LAND IMPROVEMENTS	372,843			13
14	ACCUMULATED DEPRECIATION	-358,157			14
15	BUILDINGS	9,020,993			15
16	ACCUMULATED DEPRECIATION	-6,551,570			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	6,571,812			23
24	ACCUMULATED DEPRECIATION	-6,117,236			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS	720,944			27
28	ACCUMULATED DEPRECIATION	-199,352			28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	3,523,132			30
OTHER ASSETS					
31	INVESTMENTS	1,240,850			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	1,240,850			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	7,843,741			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	344,584			37
38	SALARIES, WAGES & FEES PAYABLE	650,239			38
39	PAYROLL TAXES PAYABLE	51,864			39
40	NOTES & LOANS PAYABLE (SHORT TERM)	157,770			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	350,377			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,554,834			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	1,730,000			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	1,730,000			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	3,284,834			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	4,558,907			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)	4,558,907			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	7,843,741			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		4,471,417							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		87,490							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		4,558,907							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)		4,558,907							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)		4,558,907							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	412,255		412,255	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	450,370		450,370	6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE	1,241,782		1,241,782	9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	2,104,407		2,104,407	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,104,407		2,104,407	18
19 ANCILLARY SERVICES	1,830,418	15,059,658	16,890,076	19
20 OUTPATIENT SERVICES		1,080,844	1,080,844	20
20 RHC				20
20.01 RHC II				20.01
20.02 RHC III		743,135	743,135	20.02
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
		1,017,301	1,017,301	
		470,333	470,333	
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	3,934,825	18,371,271	22,306,096	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		13,460,145	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34 DEDUCT (SPECIFY)			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		13,460,145	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	22,306,096	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	9,357,903	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	12,948,193	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	13,460,145	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-511,952	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	12,163	6
7	INCOME FROM INVESTMENTS	16,200	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	1,924	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	5,782	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	582	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	1,928	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	2,049	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	18,923	22
23	GOVERNMENTAL APPROPRIATIONS	351,315	23
24	OTHER (RENTAL INCOME)		24
24.01	OTHER (GRANT INCOME)	184,835	24.01
24.02	OTHER (OTHER OPERATING REVENUE)	5,741	24.02
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	601,442	25
26	TOTAL (LINE 5 PLUS LINE 25)	89,490	26
27	OTHER EXPENSES (SCHOLARSHIPS)	2,000	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	2,000	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	87,490	29

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
46 OTHER LONG TERM CARE					46
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (MR					58
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67.01 CARDIAC REHAB					67.01
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
73 DRUGS CHARGED TO PATIENTS					73
76 OP GERO PSYCH					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88.01 RURAL HEALTH CLINIC 2					88.01
88.02 RURAL HEALTH CLINIC 3					88.02
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
190.02 UNUSED SPACE					190.02
190.03 NON-REIMBURSEABLE HOME HEALTH					190.03
190.04 OUTPATIENT CLINIC					190.04
190.05 NON-REIMBURSEABLE OUTPATIENT M					190.05
192.01 PHYSICIANS' CLINIC					192.01
192.02 WASHINGTON COUNTY HEALTH CENTE					192.02
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

RHC I
 COMPONENT NO: -

WORKSHEET M-1

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

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7
FACILITY HEALTH CARE STAFF COSTS							
1 PHYSICIAN							1
2 PHYSICIAN ASSISTANT							2
3 NURSE PRACTITIONER							3
4 VISITING NURSE							4
5 OTHER NURSE							5
6 CLINICAL PSYCHOLOGIST							6
7 CLINICAL SOCIAL WORKER							7
8 LABORATORY TECHNICIAN							8
9 OTHER FACILITY HEALTH CARE STAFF COSTS							9
10 SUBTOTAL (SUM OF LINES 1-9)							10
COSTS UNDER AGREEMENT							
11 PHYSICIAN SERVICES UNDER AGREEMENT							11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13 OTHER COSTS UNDER AGREEMENT							13
14 SUBTOTAL (SUM OF LINES 11-13)							14
OTHER HEALTH CARE COSTS							
15 MEDICAL SUPPLIES							15
16 TRANSPORTATION (HEALTH CARE STAFF)							16
17 DEPRECIATION-MEDICAL EQUIPMENT							17
18 PROFESSIONAL LIABILITY INSURANCE							18
19 OTHER HEALTH CARE COSTS							19
20 ALLOWABLE GME COSTS							20
21 SUBTOTAL (SUM OF LINES 15-20)							21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)							22
COSTS OTHER THAN RHC/FQHC SERVICES							
23 PHARMACY							23
24 DENTAL							24
25 OPTOMETRY							25
26 ALL OTHER NONREIMBURSABLE COSTS							26
27 NONALLOWABLE GME COSTS							27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)							28
FACILITY OVERHEAD							
29 FACILITY COSTS							29
30 ADMINISTRATIVE COSTS							30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)							31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)							32

RHC I
 COMPONENT NO: -

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS					1
2	PHYSICIAN ASSISTANTS					2
3	NURSE PRACTITIONERS					3
4	SUBTOTAL (SUM OF LINES 1-3)					4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)					8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)					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)					12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)					13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)					14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)					15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)					16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16					18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)					19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)					20

RHC II
 COMPONENT NO: 14-3470

WORKSHEET M-1

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

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7
FACILITY HEALTH CARE STAFF COSTS							
1 PHYSICIAN							1
2 PHYSICIAN ASSISTANT							2
3 NURSE PRACTITIONER							3
4 VISITING NURSE							4
5 OTHER NURSE							5
6 CLINICAL PSYCHOLOGIST							6
7 CLINICAL SOCIAL WORKER							7
8 LABORATORY TECHNICIAN							8
9 OTHER FACILITY HEALTH CARE STAFF COSTS							9
10 SUBTOTAL (SUM OF LINES 1-9)							10
COSTS UNDER AGREEMENT							
11 PHYSICIAN SERVICES UNDER AGREEMENT							11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13 OTHER COSTS UNDER AGREEMENT							13
14 SUBTOTAL (SUM OF LINES 11-13)							14
OTHER HEALTH CARE COSTS							
15 MEDICAL SUPPLIES							15
16 TRANSPORTATION (HEALTH CARE STAFF)							16
17 DEPRECIATION-MEDICAL EQUIPMENT							17
18 PROFESSIONAL LIABILITY INSURANCE							18
19 OTHER HEALTH CARE COSTS							19
20 ALLOWABLE GME COSTS							20
21 SUBTOTAL (SUM OF LINES 15-20)							21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)							22
COSTS OTHER THAN RHC/FQHC SERVICES							
23 PHARMACY							23
24 DENTAL							24
25 OPTOMETRY							25
26 ALL OTHER NONREIMBURSABLE COSTS							26
27 NONALLOWABLE GME COSTS							27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)							28
FACILITY OVERHEAD							
29 FACILITY COSTS							29
30 ADMINISTRATIVE COSTS							30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)							31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)							32

RHC II
 COMPONENT NO: 14-3470

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS		4,200			1
2	PHYSICIAN ASSISTANTS		2,100			2
3	NURSE PRACTITIONERS		2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)					4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)					8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)					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)					12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)					13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)					14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)					15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)					16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16					18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)					19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)					20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES
 RHC II COMPONENT NO: 14-3470

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

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	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)	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%)	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	16.05
17	PRIMARY PAYOR PAYMENTS	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	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)	26
27	INTERIM PAYMENTS	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)	28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2	30

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC II
 COMPONENT NO: 14-3470

WORKSHEET M-4

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

	PNEUMOCOCCAL	SEASONAL
	1	INFLUENZA
		2

1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 / LINE 11)	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	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
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)	16

RHC III
 COMPONENT NO: 14-3472

WORKSHEET M-1

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

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	987,517		987,517		987,517	-108,835	878,682	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE								5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9)	987,517		987,517		987,517	-108,835	878,682	10
COSTS UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT		140,340	140,340		140,340		140,340	11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT		6,075	6,075		6,075	-1,995	4,080	13
14 SUBTOTAL (SUM OF LINES 11-13)		146,415	146,415		146,415	-1,995	144,420	14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		5,904	5,904		5,904	-446	5,458	15
16 TRANSPORTATION (HEALTH CARE STAFF)		1,740	1,740		1,740	-522	1,218	16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE		52,482	52,482	-52,482				18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		60,126	60,126	-52,482	7,644	-968	6,676	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	987,517	206,541	1,194,058	-52,482	1,141,576	-111,798	1,029,778	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY		4	4		4		4	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)		4	4		4		4	28
FACILITY OVERHEAD								
29 FACILITY COSTS		4,754	4,754		4,754	-2,760	1,994	29
30 ADMINISTRATIVE COSTS		6,056	6,056		6,056		6,056	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		10,810	10,810		10,810	-2,760	8,050	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	987,517	217,355	1,204,872	-52,482	1,152,390	-114,558	1,037,832	32

RHC III
 COMPONENT NO: 14-3472

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	1.77	4,280	4,200	7,434	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	1.24	2,624	2,100	2,604	3
4	SUBTOTAL (SUM OF LINES 1-3)	3.01	6,904		10,038	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	3.01	6,904		10,038	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				1,029,778	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)				4	11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				1,029,782	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				0.999996	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				8,050	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				638,012	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				646,062	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				646,062	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				646,059	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				1,675,837	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES
 RHC III COMPONENT NO: 14-3472

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)	1,675,837	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	14,960	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,660,877	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	10,038	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	10,038	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	165.46	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)	197.53	197.53	8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	165.46	165.46	165.46 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1,996	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	330,258	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)	330,258	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)	241,751	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%)	243,132	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	243,132	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)	26,343	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	43,082	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	243,132	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	8,317	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	251,449	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	7,402	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	7,402	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	258,851	26
27	INTERIM PAYMENTS	293,940	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	-35,089	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.

RHC III
 COMPONENT NO: 14-3472

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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)	878,682	878,682	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000641	0.003072	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	563	2,699	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	2,002	3,929	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	2,565	6,628	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,029,778	1,029,778	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	646,062	646,062	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.002491	0.006436	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	1,609	4,158	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	4,174	10,786	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	24	115	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	173.92	93.79	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	16	59	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	2,783	5,534	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)		14,960	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)		8,317	16

