

HAMILTON MEMORIAL HOSPITAL

MCLEANSBORO, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED JUNE 30, 2013

October 15, 2013

National Government Services, Inc.
P.O. Box 6474
Indianapolis, IN 46206-6474

Re: Provider: Hamilton Memorial Hospital District
Provider Numbers: 14-1326, 14-Z326, 14-3477
Period ended: 6-30-13
Protested amount claimed on submitted cost report.

Dear Sir or Madam:

The cost report for Hamilton Memorial Hospital District, for the year ended June 30, 2013, claims additional amounts due the provider for an expense paid by the provider, but currently not classified as a reimbursable cost by National Government Services, Inc. The expense in question relate to the SWAP interest in the amount of \$600,732 which we have included as an adjustment to line 1.00 (Cap Rel Cost-Bldg & Fixt) on worksheet A-8. We feel as though the expense should be allowed as a reimbursable cost under Medicare Guidelines.

The calculation of the additional amounts due the provider was calculated by removing the adjustment on worksheet A-8. The protested amounts claimed for the period ended June 30, 2013 are as follows:

Worksheet E, part B, line 44	\$ 135,764
Worksheet E-2, line 23	43,053
Worksheet E-3, part V, line 34	102,610
Worksheet M-3, line 30	<u>10,800</u>
Total	<u>\$ 292,227</u>

Sincerely,

Randall Dauby, CEO
Hamilton Memorial Hospital
611 South Marshall
McLeansboro, IL 62859
(618) 643-2361

National Government Services, Inc.
Cost Reporting Unit
PO Box 6474
Indianapolis, IN 46206-6474

Dear Sir or Madam:

The cost report of Hamilton Memorial Hospital for the fiscal year ended June 30, 2013 includes two Level 2000 Errors.

20300 Worksheet C, Part I, Line 53, Col 11 should not be more than 100% or less than .1%.

The Hospital's anesthesiology cost to charge ratio was 1.270469 as the number of surgeries in 2013 did not generate enough revenue to cover the expense of the CRNA's including allocated overhead. As a rural hospital Hamilton Memorial Hospital qualifies for cost reimbursement for these services. The reimbursement program is designed for rural hospitals with lower surgery volumes.

20300 Worksheet C, Part I, Line 90.01, Col 11 should not be more than 100% or less than .1%.

The Hospital's Norris City, IL hospital-based clinic cost to charge ratio was 3.495628 as the number of visits in 2013 did not generate enough revenue to cover the expense of the facility including allocated overhead. The clinic was in its initial year of operation.

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

- PROVIDER USE ONLY
- 1. ELECTRONICALLY FILED COST REPORT
 - 2. MANUALLY SUBMITTED COST REPORT
 - 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 - 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.
- DATE: 10/08/2013 TIME: 15:07
- CONTRACTOR USE ONLY
- 5. COST REPORT STATUS
 - 6. DATE RECEIVED: _____
 - 7. AS SUBMITTED
 - 8. INITIAL REPORT FOR THIS PROVIDER CCN
 - 9. FINAL REPORT FOR THIS PROVIDER CCN
 - 10. NPR DATE: _____
 - 11. CONTRACTOR'S VENDOR CODE: _____
 - 12. IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED - 0-9.
- 1 - AS SUBMITTED
 - 2 - SETTLED WITHOUT AUDIT
 - 3 - SETTLED WITH AUDIT
 - 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 HAMILTON MEMORIAL HOSPITAL (14-1326) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, 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.

ECR Encryption: 10/08/2013 15:07
 HtfqV7HS06:40fRRsslFjIh5N1ETdC0
 Cw3Ye0SaOp8jCA0G9ULkgn0SPridt1
 R2r500dnvV0oq2P7

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

 TITLE

 DATE

PI Encryption: 10/08/2013 15:07
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 vUuv001gJ05vWWJvOvRZj5smpbt7qQ
 4Zu70q:RIN0EVeGK

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		193,064	-39,885		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF		111,709			5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC			-4,469		10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		304,773	-44,354		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: 611 SOUTH MARSHALL
 2 CITY: MCLEANSBORO STATE: IL

P.O.BOX: 1
 ZIP CODE: 62859 COUNTY: HAMILTON 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	HAMILTON MEMORIAL HOSPITAL	14-1326	99914	1	05/01/2003	N	O	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	HAMILTON MEMORIAL HOSP SWING B	14-2326	99914		05/01/2003	N	O	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	HAMILTON MEMORIAL FAMILY CLINI	14-3477	99914		01/11/2006	N	O	N	15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2012				TO: 06/30/2013				20
21	TYPE OF CONTROL									11 21

INPATIENT PPS INFORMATION

	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID UNPAID DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID UNPAID DAYS 4	MEDICAID ELIGIBLE HMO DAYS 5	OTHER MEDICAID DAYS 6	1	2	
							N	N	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2) (PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.						N	N	22
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
24	IF THIS PROVIDER IS AN IPPS 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 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 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)						N	N	39

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

	V	XVIII	XIX	
	1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?			45
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.			46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.			47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.			48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

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

Y/N	IME AVERAGE	DIRECT GME AVERAGE
N		

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

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

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER
 JULY 1, 2009 AND BEFORE JUNE 30, 2010.

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
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64	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
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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)

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

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

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
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66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				66
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V 1 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)?			1 2 Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?			N 106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			N N 107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			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	Y Y Y 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: 104,454 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.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	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 V	TITLE XIX
	PART A	PART B		
155	HOSPITAL	Y	3	4
156	SUBPROVIDER - IPF	N		N
157	SUBPROVIDER - IRF	N		
158	SUBPROVIDER - (OTHER)	N		
159	SNF	N		
160	HHA	N		
161	CMHC	N		

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? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	165			
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5
HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT						
167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.				Y	167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.				201,279	168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.					169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE	
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1 N	2	1
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	1 N	2	V/I 3
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1 Y	2 A	3 4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N	2	6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y/N	Y 12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15
PS&R REPORT DATA		Y/N	PART A DATE	PART B 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 09/04/2013	3 4 Y 09/04/2013
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.	N		N 18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N 19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N 20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N 21

HOSPITAL AND HEALTH-CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- | | | | |
|-------------------------------|-----------------------------------|----------------|----|
| 41 FIRST NAME: DAVID | LAST NAME: SCHNAKE | TITLE: PARTNER | 41 |
| 42 EMPLOYER: KEB | | | 42 |
| 43 PHONE NUMBER: 618-529-1040 | E-MAIL ADDRESS: DAVIDS@KEBCPA.COM | | 43 |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

LINE	COMPONENT	WKST A LINE NO.	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS							
			NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	TITLE V 5	TITLE XVIII 6	TITLE XIX 7	TOTAL ALL PATIENTS 8	TRIPS 9
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	25	9,125	55,080.00		1,844	186	2,295	1
2	HMO						23			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						745		745	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								84	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		25	9,125	55,080.00		2,589	186	3,124	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)		25	9,125	55,080.00		2,589	186	3,124	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88					1,502		4,563	26
27	TOTAL (SUM OF LINES 14-26)		25							27
28	OBSERVATION BED DAYS							77	599	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCN NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---			DISCHARGES			TOTAL ALL PATIENTS 15
		TOTAL INTERNS & RESIDENTS 9	ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	
1 HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					524	79	716 1
2 HMO						3		2
3 HMO IPF								3
4 HMO IRF								4
5 HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6 HOSPITAL ADULTS & PEDS. SWING BED NF								6
7 TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)								7
8 INTENSIVE CARE UNIT	31							8
9 CORONARY CARE UNIT	32							9
10 BURN INTENSIVE CARE UNIT	33							10
11 SURGICAL INTENSIVE CARE UNIT	34							11
12 OTHER SPECIAL CARE (SPECIFY)	35							12
13 NURSERY	43							13
14 TOTAL (SEE INSTRUCTIONS)			114.38			524	79	716 14
15 CAH VISITS								15
16 SUBPROVIDER - IPF	40							16
17 SUBPROVIDER - IRF	41							17
18 SUBPROVIDER I	42							18
19 SKILLED NURSING FACILITY	44							19
20 NURSING FACILITY	45							20
21 OTHER LONG TERM CARE	46							21
22 HOME HEALTH AGENCY	101							22
23 ASC (DISTINCT PART)	115							23
24 HOSPICE (DISTINCT PART)	116							24
25 CMHC	99							25
26 RHC	88		8.45					26
27 TOTAL (SUM OF LINES 14-26)			122.83					27
28 OBSERVATION BED DAYS								28
29 AMBULANCE TRIPS								29
30 EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								30
31 EMPLOYEE DISCOUNT DAYS-IRF								31
32 LABOR & DELIVERY DAYS (SEE INSTR.)								32
33 LTCH NON-COVERED DAYS								33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	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

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	09/24/1984	2

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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

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

CBSA AT BEGINNING OF COST REPORTING PERIOD	CBSA ON/AFTER OCT 1 OF THE COST REPORTING PERIOD (IF APPLICABLE)
1	2

SNF SERVICES

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

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

	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES
EXPENSES	PERCENTAGE 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 I
 COMPONENT NO: 14-3477

WORKSHEET S-8

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

CHECK APPLICABLE BOX: RHC FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 611 SOUTH MARSHALL 1
 2 CITY: MCLEANSBORO STATE: IL ZIP CODE: 62859 COUNTY: HAMILTON 2
 3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

GRANT AWARD
 1

DATE
 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 10
 IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
11 CLINIC			0800	0500	0800	0500	0800	0500	0800	0500	0800	0500		

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

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. N 13

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED 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)				0.532967	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,651,726	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				571,690	5
6	MEDICAID CHARGES				5,905,739	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				3,147,564	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.				924,148	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)				924,148	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	273,849	8,898	282,747		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	145,952	4,742	150,694		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	689	350	1,039		22
23	COST OF CHARITY CARE	145,263	4,392	149,655		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				1,841,718	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				267,512	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				1,574,206	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				839,000	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				988,655	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				1,912,803	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		1,518,370	1,518,370	1,306,309	1
2	00200		343,814	343,814	179,642	2
3	00300		104,090	104,090	-104,090	3
4	00400		1,185,511	1,185,511		4
5.01	00540		24,673	24,673		5.01
5.02	00550	84,876	14,476	99,352		5.02
5.03	00560	41,720	3,268	44,988		5.03
5.04	00570				152,533	5.04
5.05	00580	224,415	256,128	480,543	-152,533	5.05
5.06	00590	466,220	448,450	914,670	84,583	5.06
7	00700	152,104	564,077	716,181	-2,233	7
8	00800		50,136	50,136		8
9	00900	167,938	20,614	188,552		9
10	01000		72,180	72,180		10
11	01100					11
13	01300	209,131	6,856	215,987		13
14	01400		12,101	12,101	-9,095	14
15	01500	170,430	348,853	519,283	-329,309	15
16	01600	170,592	38,386	208,978		16
17	01700	42,655	615	43,270		17
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,090,157	102,296	1,192,453		30
ANCILLARY SERVICE COST CENTERS						
50	05000	115,509	180,903	296,412	-141,685	50
53	05300	255,192	25,129	280,321	-4,639	53
54	05400	295,687	287,241	582,928	-92,619	54
58	05800				58,739	58
60	06000	326,382	528,002	854,384	-7,200	60
65	06500	105,852	27,226	133,078	-3,981	65
65.50	06501		20,700	20,700		65.50
66	06600	356,115	167,328	523,443		66
67	06700					67
68	06800					68
69	06900		4,896	4,896		69
71	07100				11,097	71
72	07200				86,625	72
73	07300				299,112	73
OUTPATIENT SERVICE COST CENTERS						
88	08800	780,390	170,014	950,404	-37,020	88
90	09000	136,207	127,430	263,637		90
90.01	09001	51,849	10,013	61,862	-2,250	90.01
91	09100	475,918	1,148,104	1,624,022	-15,532	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	11300		1,273,453	1,273,453	-1,273,453	113
117	06950					117
117.02	06952		3,001	3,001	-3,001	117.02
118		5,719,339	9,088,334	14,807,673		118
NONREIMBURSABLE COST CENTERS						
192	19200		116,892	116,892		192
200		5,719,339	9,205,226	14,924,565		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	2,824,679	-614,832	2,209,847	1
2	00200	CAP REL COSTS-MVBLE EQUIP	523,456	-88,790	434,666	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	1,185,511	-28,731	1,156,780	4
5.01	00540	NONPATIENT TELEPHONES	24,673		24,673	5.01
5.02	00550	DATA PROCESSING	99,352		99,352	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	44,988	-1,418	43,570	5.03
5.04	00570	ADMITTING	152,533		152,533	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	328,010		328,010	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	999,253	-166,436	832,817	5.06
7	00700	OPERATION OF PLANT	713,948		713,948	7
8	00800	LAUNDRY & LINEN SERVICE	50,136		50,136	8
9	00900	HOUSEKEEPING	188,552		188,552	9
10	01000	DIETARY	72,180	-325	71,855	10
11	01100	CAFETERIA				11
13	01300	NURSING ADMINISTRATION	215,987		215,987	13
14	01400	CENTRAL SERVICES & SUPPLY	3,006		3,006	14
15	01500	PHARMACY	189,974		189,974	15
16	01600	MEDICAL RECORDS & LIBRARY	208,978	-4,135	204,843	16
17	01700	SOCIAL SERVICE	43,270		43,270	17
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,192,453		1,192,453	30
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	154,727		154,727	50
53	05300	ANESTHESIOLOGY	275,682		275,682	53
54	05400	RADIOLOGY-DIAGNOSTIC	490,309		490,309	54
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	58,739		58,739	58
60	06000	LABORATORY	847,184		847,184	60
65	06500	RESPIRATORY THERAPY	129,097		129,097	65
65.50	06501	SLEEP LAB	20,700		20,700	65.50
66	06600	PHYSICAL THERAPY	523,443	-15,333	508,110	66
67	06700	OCCUPATIONAL THERAPY				67
68	06800	SPEECH PATHOLOGY				68
69	06900	ELECTROCARDIOLOGY	4,896		4,896	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	11,097	-8,127	2,970	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	86,625		86,625	72
73	07300	DRUGS CHARGED TO PATIENTS	299,112	-10,702	288,410	73
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC (RHC)	913,384	-255,020	658,364	88
90	09000	CLINIC	263,637		263,637	90
90.01	09001	NORRIS CITY CLINIC	59,612	-37,506	22,106	90.01
91	09100	EMERGENCY	1,608,490	-646,369	962,121	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
117	06950	OTHER SPECIAL PURPOSE COST CENTERS				117
117.02	06952	SUPPLIES AND EXPENSE				117.02
118		SUBTOTALS (SUM OF LINES 1-117)	14,807,673	-1,877,724	12,929,949	118
NONREIMBURSABLE COST CENTERS						
192	19200	PHYSICIANS' PRIVATE OFFICES	116,892		116,892	192
200		TOTAL (SUM OF LINES 118-199)	14,924,565	-1,877,724	13,046,841	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER	
			LINE #				
	1	2	3		4	5	
1 TO RECLASS INTEREST EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1			1,273,453	1
500 TOTAL RECLASSIFICATIONS						1,273,453	500
1 TO RECLASS RENT EXPENSE	B	CAP REL COSTS-MVBLE EQUIP	2			170,696	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500 TOTAL RECLASSIFICATIONS						170,696	500
1 RECLASS INSURANCE COST	C	OTHER ADMINISTRATIVE AND GENE	5.06			62,288	1
500 TOTAL RECLASSIFICATIONS						62,288	500
1 ADMITTING	D	ADMITTING	5.04		74,730	77,803	1
500 TOTAL RECLASSIFICATIONS					74,730	77,803	500
1 RECLASS SUPPLIES SOLD	E	MEDICAL SUPPLIES CHRGED TO PA	71			97,722	1
2							2
3							3
4							4
5							5
6							6
500 TOTAL RECLASSIFICATIONS						97,722	500
1 RECLASS DRUGS TO PHARMACY	F	DRUGS CHARGED TO PATIENTS	73			270,291	1
500 TOTAL RECLASSIFICATIONS						270,291	500
1 RECLASS SUPPLIES SOLD	G	CENTRAL SERVICES & SUPPLY	14			3,001	1
500 TOTAL RECLASSIFICATIONS						3,001	500
1 RECLASS IV COST	H	DRUGS CHARGED TO PATIENTS	73			28,821	1
2							2
500 TOTAL RECLASSIFICATIONS						28,821	500
1 RECLASS MALPRACTICE	I	OTHER ADMINISTRATIVE AND GENE	5.06			37,002	1
500 TOTAL RECLASSIFICATIONS						37,002	500
1 RECLASS IPL DEVICES	J	IMPL. DEV. CHARGED TO PATIENT	72			86,625	1
500 TOTAL RECLASSIFICATIONS						86,625	500
1 RECLASS MRI COST	K	MAGNETIC RESONANCE IMAGING (M	58			58,739	1
500 TOTAL RECLASSIFICATIONS						58,739	500
CODE LETTER - K							
GRAND TOTAL (INCREASES)					74,730	2,166,441	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 TO RECLASS INTEREST EXPENSE	A	INTEREST EXPENSE	113		1,273,453	11 1
500 TOTAL RECLASSIFICATIONS					1,273,453	500
CODE LETTER - A						
1 TO RECLASS RENT EXPENSE	B	OTHER ADMINISTRATIVE AND GENE	5.06		14,707	10 1
2 OPERATING ROOM			50		69,559	2
3 RESPIRATORY THERAPY			65		1,386	3
4 RADIOLOGY-DIAGNOSTIC			54		33,880	4
5 LABORATORY			60		7,200	5
6 PHARMACY			15		39,481	6
7 OPERATION OF PLANT			7		2,233	7
8 NORRIS CITY CLINIC			90.01		2,250	8
500 TOTAL RECLASSIFICATIONS					170,696	500
CODE LETTER - B						
1 RECLASS INSURANCE COST	C	OTHER CAPITAL RELATED COSTS	3		62,288	1
500 TOTAL RECLASSIFICATIONS					62,288	500
CODE LETTER - C						
1 ADMITTING	D	CASHIERING/ACCOUNTS RECEIVABL	5.05	74,730	77,803	1
500 TOTAL RECLASSIFICATIONS				74,730	77,803	500
CODE LETTER - D						
1 RECLASS SUPPLIES SOLD	E	EMERGENCY	91		15,532	1
2 ANESTHESIOLOGY			53		4,639	2
3 OPERATING ROOM			50		72,126	3
4 RESPIRATORY THERAPY			65		2,595	4
5 RURAL HEALTH CLINIC (RHC)			88		18	5
6 CENTRAL SERVICES & SUPPLY			14		2,812	6
500 TOTAL RECLASSIFICATIONS					97,722	500
CODE LETTER - E						
1 RECLASS DRUGS TO PHARMACY	F	PHARMACY	15		270,291	1
500 TOTAL RECLASSIFICATIONS					270,291	500
CODE LETTER - F						
1 RECLASS SUPPLIES SOLD	G	SUPPLIES AND EXPENSE	117.02		3,001	1
500 TOTAL RECLASSIFICATIONS					3,001	500
CODE LETTER - G						
1 RECLASS IV COST	H	PHARMACY	15		19,537	1
2 CENTRAL SERVICES & SUPPLY			14		9,284	2
500 TOTAL RECLASSIFICATIONS					28,821	500
CODE LETTER - H						
1 RECLASS MALPRACTICE	I	RURAL HEALTH CLINIC (RHC)	88		37,002	1
500 TOTAL RECLASSIFICATIONS					37,002	500
CODE LETTER - I						
1 RECLASS IPL DEVICES	J	MEDICAL SUPPLIES CHRGD TO PA	71		86,625	1
500 TOTAL RECLASSIFICATIONS					86,625	500
CODE LETTER - J						
1 RECLASS MRI COST	K	RADIOLOGY-DIAGNOSTIC	54		58,739	1
500 TOTAL RECLASSIFICATIONS					58,739	500
CODE LETTER - K						
GRAND TOTAL (DECREASES)				74,730	2,166,441	

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	69,760					69,760	1
2 LAND IMPROVEMENTS	601,496					601,496	2
3 BUILDINGS AND FIXTURES	21,532,624	13,300		13,300		21,545,924	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	5,566,542	72,022		72,022		5,638,564	6
7 HIT DESIGNATED ASSETS	209,178	201,279		201,279		410,457	7
8 SUBTOTAL (SUM OF LINES 1-7)	27,979,600	286,601		286,601		28,266,201	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	27,979,600	286,601		286,601		28,266,201	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,518,370						1,518,370 1
2 CAP REL COSTS-MVBLE EQUIP	343,814						343,814 2
3 TOTAL (SUM OF LINES 1-2)	1,862,184						1,862,184 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3		RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
			(COL. 1 - COL. 2)	RATIO (SEE INSTR.)					(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	22,217,180		22,217,180	0.785998		32,856		32,856 1	
2 CAP REL COSTS-MVBLE EQUIP	6,049,021		6,049,021	0.214002		8,946		8,946 2	
3 TOTAL (SUM OF LINES 1-2)	28,266,201		28,266,201	1.000000		41,802		41,802 3	

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,518,370			658,621	32,856		2,209,847 1
2 CAP REL COSTS-MVBLE EQUIP	255,024	170,696			8,946		434,666 2
3 TOTAL	1,773,394	170,696		658,621	41,802		2,644,513 3

ADJUSTMENTS TO EXPENSES

LINE NO.	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8
				COST CENTER	LINE NO.	WKST A-7 REF
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-14,100	CAP REL COSTS-BLDG & FIXT	1	11 1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-1,418	PURCHASING RECEIVING AND STORES	5.03	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)	A	-6,679	OTHER ADMINISTRATIVE AND GENERA	5.06	8
9	PARKING LOT (CHAPTER 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-646,369			10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-325	DIETARY	10	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-8,127	MEDICAL SUPPLIES CHRGD TO PATI	71	16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-10,702	DRUGS CHARGED TO PATIENTS	73	17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4,135	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20	VENDING MACHINES	B	-1,428	OTHER ADMINISTRATIVE AND GENERA	5.06	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 COMMUNITY PROGRAM	B	-83,301	CAP REL COSTS-MVBLE EQUIP	2	9 32
33		B	-14,541	OTHER ADMINISTRATIVE AND GENERA	5.06	33
34						34
35	PORTION OF LOBBYING DUES	A	-5,520	OTHER ADMINISTRATIVE AND GENERA	5.06	35
36	WOMENS WELLNESS	B	-68,037	OTHER ADMINISTRATIVE AND GENERA	5.06	36
37	PHYSICIAN RECRUITMENT	A	2,297	OTHER ADMINISTRATIVE AND GENERA	5.06	37
38	ADVERTISING	A	-46,744	OTHER ADMINISTRATIVE AND GENERA	5.06	38
39	SWAP INTEREST PAYMENTS	A	-600,732	CAP REL COSTS-BLDG & FIXT	1	11 39
40						40
41	VNA THERAPHY SERVICES	A	-15,333	PHYSICAL THERAPY	66	41
42	FUNDRAISING	A	-5,489	CAP REL COSTS-MVBLE EQUIP	2	9 42
43						43
44	NURSING CENTER SERVICES	B	-9,468	OTHER ADMINISTRATIVE AND GENERA	5.06	44
45	OTHER REVENUE RHC	B	-38,660	RURAL HEALTH CLINIC (RHC)	88	45
45.06	FUNDRAISING	A	-16,316	OTHER ADMINISTRATIVE AND GENERA	5.06	45.06
45.09	NON RHC COST	A	-216,360	RURAL HEALTH CLINIC (RHC)	88	45.09
45.10	NON RHC BENEFITS	A	-25,557	EMPLOYEE BENEFITS	4	45.10
45.13	VNA SEVICES BENEFITS	A	-3,174	EMPLOYEE BENEFITS	4	45.13
46	NORRIS CITY CLINIC PHYSICIAN COSTS	A	-31,255	NORRIS CITY CLINIC	90.01	46
47	NORRIS CITY CLINIC PHYSICIAN BENEF	A	-6,251	NORRIS CITY CLINIC	90.01	47
48						48
49						49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-1,877,724			50

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						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 CCN: 14-1326 HAMILTON MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2012.11
 10/08/2013 15:06

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	LINE NO.	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	
2	91	EMERGENCY	AGGREGATE	1,042,531	646,369	396,162					2
200		TOTAL		1,042,531	646,369	396,162					200

PROVIDER CCN: 14-1326 HAMILTON MEMORIAL HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2012.11
 10/08/2013 15:06

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO.		12	13	14	15	16	17	18
2	91 EMERGENCY							646,369
200	TOTAL							646,369 200
	AGGREGATE							

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	NONPATIENT TELEPHONE S 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	2,209,847	2,209,847				1
2 CAP REL COSTS-MVBLE EQUIP	434,666		434,666			2
4 EMPLOYEE BENEFITS	1,156,780			1,156,780		4
5.01 NONPATIENT TELEPHONES	24,673	1,139	224		26,036	5.01
5.02 DATA PROCESSING	99,352			17,994		5.02
5.03 PURCHASING RECEIVING AND STORES	43,570	64,618	12,710	8,845	310	5.03
5.04 ADMITTING	152,533			15,843		5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	328,010	45,261	8,903	31,734		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	832,817	280,647	55,202	98,841	4,649	5.06
7 OPERATION OF PLANT	713,948	202,678	39,866	32,247	620	7
8 LAUNDRY & LINEN SERVICE	50,136	27,214	5,353		155	8
9 HOUSEKEEPING	188,552			35,604		9
10 DIETARY	71,855					10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	215,987	42,699	8,399	44,337	620	13
14 CENTRAL SERVICES & SUPPLY	3,006					14
15 PHARMACY	189,974	33,391	6,568	36,132	620	15
16 MEDICAL RECORDS & LIBRARY	204,843	35,497	6,982	36,167	1,085	16
17 SOCIAL SERVICE	43,270	5,465	1,075	9,043	620	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,192,453	388,361	76,388	231,121	4,802	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	154,727	190,722	37,514	24,489	1,240	50
53 ANESTHESIOLOGY	275,682			54,102		53
54 RADIOLOGY-DIAGNOSTIC	490,309	135,271	26,607	62,687	1,395	54
58 MAGNETIC RESONANCE IMAGING (MRI)	58,739				310	58
60 LABORATORY	847,184	49,104	9,658	69,195	1,240	60
65 RESPIRATORY THERAPY	129,097	19,926	3,919	22,441	620	65
65.50 SLEEP LAB	20,700	10,675	2,100		465	65.50
66 PHYSICAL THERAPY	508,110	127,955	25,168	72,248	1,240	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	4,896					69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	2,970					71
72 IMPL. DEV. CHARGED TO PATIENT	86,625					72
73 DRUGS CHARGED TO PATIENTS	288,410					73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	658,364	212,954	41,887	119,578	2,790	88
90 CLINIC	263,637	66,041	12,990	28,877	620	90
90.01 NORRIS CITY CLINIC	22,106	20,866	4,104	4,358		90.01
91 EMERGENCY	962,121	130,887	25,745	100,897	2,015	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	12,929,949	2,091,371	411,362	1,156,780	25,416	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	116,892	118,476	23,304		620	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	13,046,841	2,209,847	434,666	1,156,780	26,036	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DATA PROCES- SING	PURCHASING , RECEIVIN G AND STOR	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (COLS.0-4) 4A	
	5.02	5.03	5.04	5.05		
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVELE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING	117,346					5.02
5.03 PURCHASING RECEIVING AND STORES		130,053				5.03
5.04 ADMITTING			168,376			5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	95,196			509,104		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	22,150	1,582			1,295,888	5.06
7 OPERATION OF PLANT		4,762			994,121	7
8 LAUNDRY & LINEN SERVICE		239			83,097	8
9 HOUSEKEEPING		1,994			226,150	9
10 DIETARY		336			72,191	10
11 CAFETERIA						11
13 NURSING ADMINISTRATION		292			312,334	13
14 CENTRAL SERVICES & SUPPLY		3,316			6,322	14
15 PHARMACY		28,835			295,520	15
16 MEDICAL RECORDS & LIBRARY		2,358			286,932	16
17 SOCIAL SERVICE		49			59,522	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		10,167	45,518	40,870	1,989,680	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		10,589	3,126	19,904	442,311	50
53 ANESTHESIOLOGY		1,941	1,291	5,971	338,987	53
54 RADIOLOGY-DIAGNOSTIC		1,670	12,682	93,305	823,926	54
58 MAGNETIC RESONANCE IMAGING (MRI)			890	8,058	67,997	58
60 LABORATORY		45,248	26,065	113,732	1,161,426	60
65 RESPIRATORY THERAPY		1,450	19,862	16,944	214,259	65
65.50 SLEEP LAB				2,836	36,776	65.50
66 PHYSICAL THERAPY		1,083	8,934	26,337	771,075	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		252	1,399	8,289	14,836	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			722	498	4,190	71
72 IMPL. DEV. CHARGED TO PATIENT				3,255	89,880	72
73 DRUGS CHARGED TO PATIENTS			45,248	56,016	389,674	73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		2,569	2,639	10,704	1,051,485	88
90 CLINIC		1,299		15,419	388,883	90
90.01 NORRIS CITY CLINIC		1,909		422	53,765	90.01
91 EMERGENCY		8,029		86,544	1,316,238	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	117,346	129,969	168,376	509,104	12,787,465	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		84			259,376	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	117,346	130,053	168,376	509,104	13,046,841	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	OTHER ADMI NISTRATIVE AND GENER 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	1,295,888					5.06
7 OPERATION OF PLANT	109,631	1,103,752				7
8 LAUNDRY & LINEN SERVICE	9,164	18,593	110,854			8
9 HOUSEKEEPING	24,940			251,090		9
10 DIETARY	7,961				80,152	10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	34,444	29,173		1,104		13
14 CENTRAL SERVICES & SUPPLY	697					14
15 PHARMACY	32,590	22,813				15
16 MEDICAL RECORDS & LIBRARY	31,643	24,253				16
17 SOCIAL SERVICE	6,564	3,734				17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	219,422	265,339	60,477	118,838	80,152	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	48,778	130,306	2,461	24,849		50
53 ANESTHESIOLOGY	37,383					53
54 RADIOLOGY-DIAGNOSTIC	90,862	92,420	3,776	11,044		54
58 MAGNETIC RESONANCE IMAGING (MRI)	7,499		1,002			58
60 LABORATORY	128,081	33,549		8,283		60
65 RESPIRATORY THERAPY	23,628	13,614				65
65.50 SLEEP LAB	4,056	7,293				65.50
66 PHYSICAL THERAPY	85,033	87,422	13,626	12,425		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	1,636					69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	462					71
72 IMPL. DEV. CHARGED TO PATIENT	9,912					72
73 DRUGS CHARGED TO PATIENTS	42,973					73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	115,957	145,496	1,151	33,132		88
90 CLINIC	42,886	45,121		5,522		90
90.01 NORRIS CITY CLINIC	5,929	14,256				90.01
91 EMERGENCY	145,153	89,425	28,361	35,893		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	1,267,284	1,022,807	110,854	251,090	80,152	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	28,604	80,945				192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,295,888	1,103,752	110,854	251,090	80,152	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	377,055					13
14 CENTRAL SERVICES & SUPPLY		7,019				14
15 PHARMACY			350,923			15
16 MEDICAL RECORDS & LIBRARY				342,828		16
17 SOCIAL SERVICE					69,820	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	269,423			153,874	17,527	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	18,765					50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC				12,553		54
58 MAGNETIC RESONANCE IMAGING (MRI)				3,333		58
60 LABORATORY				53,079		60
65 RESPIRATORY THERAPY						65
65.50 SLEEP LAB						65.50
66 PHYSICAL THERAPY					6,896	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		797				71
72 IMPL. DEV. CHARGED TO PATIENT		6,222				72
73 DRUGS CHARGED TO PATIENTS			350,923			73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)				31,243	17,240	88
90 CLINIC						90
90.01 NORRIS CITY CLINIC						90.01
91 EMERGENCY	88,867			88,746	28,157	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	377,055	7,019	350,923	342,828	69,820	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	377,055	7,019	350,923	342,828	69,820	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5.01 NONPATIENT TELEPHONES				5.01
5.02 DATA PROCESSING				5.02
5.03 PURCHASING RECEIVING AND STORES				5.03
5.04 ADMITTING				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL				5.06
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	3,174,732		3,174,732	30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	667,470		667,470	50
53 ANESTHESIOLOGY	376,370		376,370	53
54 RADIOLOGY-DIAGNOSTIC	1,034,581		1,034,581	54
58 MAGNETIC RESONANCE IMAGING (MRI)	79,831		79,831	58
60 LABORATORY	1,384,418		1,384,418	60
65 RESPIRATORY THERAPY	251,501		251,501	65
65.50 SLEEP LAB	48,125		48,125	65.50
66 PHYSICAL THERAPY	976,477		976,477	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	16,472		16,472	69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	5,449		5,449	71
72 IMPL. DEV. CHARGED TO PATIENT	106,014		106,014	72
73 DRUGS CHARGED TO PATIENTS	783,570		783,570	73
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	1,395,704		1,395,704	88
90 CLINIC	482,412		482,412	90
90.01 NORRIS CITY CLINIC	73,950		73,950	90.01
91 EMERGENCY	1,820,840		1,820,840	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
117 OTHER SPECIAL PURPOSE COST CENTERS				117
117.02 SUPPLIES AND EXPENSE				117.02
118 SUBTOTALS (SUM OF LINES 1-117)	12,677,916		12,677,916	118
NONREIMBURSABLE COST CENTERS				
192 PHYSICIANS' PRIVATE OFFICES	368,925		368,925	192
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	13,046,841		13,046,841	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	NONPATIENT TELEPHONE S 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES		1,139	224	1,363	1,363	5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES		64,618	12,710	77,328	16	5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE		45,261	8,903	54,164		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL		280,647	55,202	335,849	243	5.06
7 OPERATION OF PLANT		202,678	39,866	242,544	32	7
8 LAUNDRY & LINEN SERVICE		27,214	5,353	32,567	8	8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
13 NURSING ADMINISTRATION		42,699	8,399	51,098	32	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		33,391	6,568	39,959	32	15
16 MEDICAL RECORDS & LIBRARY		35,497	6,982	42,479	57	16
17 SOCIAL SERVICE		5,465	1,075	6,540	32	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		388,361	76,388	464,749	256	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		190,722	37,514	228,236	65	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		135,271	26,607	161,878	73	54
58 MAGNETIC RESONANCE IMAGING (MRI)					16	58
60 LABORATORY		49,104	9,658	58,762	65	60
65 RESPIRATORY THERAPY		19,926	3,919	23,845	32	65
65.50 SLEEP LAB		10,675	2,100	12,775	24	65.50
66 PHYSICAL THERAPY		127,955	25,168	153,123	65	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		212,954	41,887	254,841	146	88
90 CLINIC		66,041	12,990	79,031	32	90
90.01 NORRIS CITY CLINIC		20,866	4,104	24,970		90.01
91 EMERGENCY		130,887	25,745	156,632	105	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)		2,091,371	411,362	2,502,733	1,331	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		118,476	23,304	141,780	32	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		2,209,847	434,666	2,644,513	1,363	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	PURCHASING , RECEIVING AND STORES 5.03	CASHIERING /ACCOUNTS RECEIVABLE 5.05	OTHER ADMINIS- TRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES	77,344					5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE		54,164				5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	941		337,033			5.06
7 OPERATION OF PLANT	2,832		28,512	273,920		7
8 LAUNDRY & LINEN SERVICE	142		2,383	4,614	39,714	8
9 HOUSEKEEPING	1,186		6,486			9
10 DIETARY	200		2,071			10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	173		8,958	7,240		13
14 CENTRAL SERVICES & SUPPLY	1,972		181			14
15 PHARMACY	17,148		8,476	5,662		15
16 MEDICAL RECORDS & LIBRARY	1,402		8,229	6,019		16
17 SOCIAL SERVICE	29		1,707	927		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,046	4,348	57,071	65,848	21,666	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,297	2,117	12,686	32,338	882	50
53 ANESTHESIOLOGY	1,154	635	9,722			53
54 RADIOLOGY-DIAGNOSTIC	993	9,925	23,631	22,936	1,353	54
58 MAGNETIC RESONANCE IMAGING (MRI)		857	1,950		359	58
60 LABORATORY	26,913	12,106	33,311	8,326		60
65 RESPIRATORY THERAPY	862	1,802	6,145	3,379		65
65.50 SLEEP LAB		302	1,055	1,810		65.50
66 PHYSICAL THERAPY	644	2,802	22,115	21,696	4,882	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	150	882	426			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		53	120			71
72 IMPL. DEV. CHARGED TO PATIENT		346	2,578			72
73 DRUGS CHARGED TO PATIENTS		5,959	11,176			73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,528	1,139	30,158	36,108	412	88
90 CLINIC	772	1,640	11,154	11,198		90
90.01 NORRIS CITY CLINIC	1,135	45	1,542	3,538		90.01
91 EMERGENCY	4,775	9,206	37,751	22,193	10,160	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	77,294	54,164	329,594	253,832	39,714	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	50		7,439	20,088		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	77,344	54,164	337,033	273,920	39,714	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	HOUSE-KEEPING 9	DIETARY 10	NURSING ADMINIS-TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	7,672					9
10 DIETARY		2,271				10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	34		67,535			13
14 CENTRAL SERVICES & SUPPLY				2,153		14
15 PHARMACY					71,277	15
16 MEDICAL RECORDS & LIBRARY						16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,631	2,271	48,257			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	759		3,361			50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	337					54
58 MAGNETIC RESONANCE IMAGING (MRI)						58
60 LABORATORY	253					60
65 RESPIRATORY THERAPY						65
65.50 SLEEP LAB						65.50
66 PHYSICAL THERAPY	380					66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS				244		71
72 IMPL. DEV. CHARGED TO PATIENT				1,909		72
73 DRUGS CHARGED TO PATIENTS					71,277	73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,012					88
90 CLINIC	169					90
90.01 NORRIS CITY CLINIC						90.01
91 EMERGENCY	1,097		15,917			91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	7,672	2,271	67,535	2,153	71,277	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	7,672	2,271	67,535	2,153	71,277	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJUS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORES					5.03
5.04 ADMITTING					5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL					5.06
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	58,186				16
17 SOCIAL SERVICE		9,235			17
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	26,115	2,318	702,576	702,576	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM			286,741	286,741	50
53 ANESTHESIOLOGY			11,511	11,511	53
54 RADIOLOGY-DIAGNOSTIC	2,131		223,257	223,257	54
58 MAGNETIC RESONANCE IMAGING (MRI)	566		3,748	3,748	58
60 LABORATORY	9,009		148,745	148,745	60
65 RESPIRATORY THERAPY			36,065	36,065	65
65.50 SLEEP LAB			15,966	15,966	65.50
66 PHYSICAL THERAPY		912	206,619	206,619	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY			1,458	1,458	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			417	417	71
72 IMPL. DEV. CHARGED TO PATIENT			4,833	4,833	72
73 DRUGS CHARGED TO PATIENTS			88,412	88,412	73
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	5,303	2,280	332,927	332,927	88
90 CLINIC			103,996	103,996	90
90.01 NORRIS CITY CLINIC			31,230	31,230	90.01
91 EMERGENCY	15,062	3,725	276,623	276,623	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
117 OTHER SPECIAL PURPOSE COST CENTERS					117
117.02 SUPPLIES AND EXPENSE					117.02
118 SUBTOTALS (SUM OF LINES 1-117)	58,186	9,235	2,475,124	2,475,124	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES			169,389	169,389	192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	58,186	9,235	2,644,513	2,644,513	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCESsing MACHINE TIME	
	1	2	4	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	77,631					1
2 CAP REL COSTS-MVBLE EQUIP		77,631				2
4 EMPLOYEE BENEFITS			5,456,351			4
5.01 NONPATIENT TELEPHONES	40	40		168		5.01
5.02 DATA PROCESSING			84,876		249	5.02
5.03 PURCHASING RECEIVING AND STORES	2,270	2,270	41,720	2		5.03
5.04 ADMITTING			74,730			5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	1,590	1,590	149,685		202	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	9,859	9,859	466,220	30	47	5.06
7 OPERATION OF PLANT	7,120	7,120	152,104	4		7
8 LAUNDRY & LINEN SERVICE	956	956		1		8
9 HOUSEKEEPING			167,938			9
10 DIETARY						10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	1,500	1,500	209,131	4		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,173	1,173	170,430	4		15
16 MEDICAL RECORDS & LIBRARY	1,247	1,247	170,592	7		16
17 SOCIAL SERVICE	192	192	42,655	4		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	13,643	13,643	1,090,157	31		30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,700	6,700	115,509	8		50
53 ANESTHESIOLOGY			255,192			53
54 RADIOLOGY-DIAGNOSTIC	4,752	4,752	295,687	9		54
58 MAGNETIC RESONANCE IMAGING (MRI)				2		58
60 LABORATORY	1,725	1,725	326,382	8		60
65 RESPIRATORY THERAPY	700	700	105,852	4		65
65.50 SLEEP LAB	375	375		3		65.50
66 PHYSICAL THERAPY	4,495	4,495	340,782	8		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	7,481	7,481	564,030	18		88
90 CLINIC	2,320	2,320	136,207	4		90
90.01 NORRIS CITY CLINIC	733	733	20,554			90.01
91 EMERGENCY	4,598	4,598	475,918	13		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	73,469	73,469	5,456,351	164	249	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	4,162	4,162		4		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,209,847	434,666	1,156,780	26,036	117,346	202
203 UNIT COST MULT-WS B PT I	28.466038	5.599129	0.212006	154.976190	471.269076	203
204 COST TO BE ALLOC PER B PT II				1,363		204
205 UNIT COST MULT-WS B PT II				8.113095		205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING , RECEIVING AND STORAGE COSTS SUPPLIES 5.03	ADMITTING INPATIENT CHARGES 5.04	CASHIERING /ACCOUNTS RECEIVABLE GROSS CHARGES 5.05	RECON- CILIATION 5A.06	OTHER ADMI NISTRATIVE AND GENER ACCUM COST 5.06	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES	1,241,016					5.03
5.04 ADMITTING		5,578,243				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE			25,533,579			5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	15,098			-1,295,888	11,750,953	5.06
7 OPERATION OF PLANT	45,437				994,121	7
8 LAUNDRY & LINEN SERVICE	2,279				83,097	8
9 HOUSEKEEPING	19,025				226,150	9
10 DIETARY	3,204				72,191	10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	2,783				312,334	13
14 CENTRAL SERVICES & SUPPLY	31,638				6,322	14
15 PHARMACY	275,149				295,520	15
16 MEDICAL RECORDS & LIBRARY	22,502				286,932	16
17 SOCIAL SERVICE	466				59,522	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	97,014	1,507,945	2,049,742		1,989,680	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	101,046	103,556	998,253		442,311	50
53 ANESTHESIOLOGY	18,524	42,767	299,484		338,987	53
54 RADIOLOGY-DIAGNOSTIC	15,931	420,163	4,679,509		823,926	54
58 MAGNETIC RESONANCE IMAGING (MRI)		29,491	404,150		67,997	58
60 LABORATORY	431,792	863,522	5,704,550		1,161,426	60
65 RESPIRATORY THERAPY	13,837	658,026	849,780		214,259	65
65.50 SLEEP LAB			142,230		36,776	65.50
66 PHYSICAL THERAPY	10,336	295,999	1,320,868		771,075	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	2,405	46,350	415,708		14,836	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		23,936	24,965		4,190	71
72 IMPL. DEV. CHARGED TO PATIENT			163,250		89,880	72
73 DRUGS CHARGED TO PATIENTS		1,499,058	2,809,366		389,674	73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	24,516	87,430	536,822		1,051,485	88
90 CLINIC	12,392		773,312		388,883	90
90.01 NORRIS CITY CLINIC	18,219		21,155		53,765	90.01
91 EMERGENCY	76,620		4,340,435		1,316,238	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	1,240,213	5,578,243	25,533,579	-1,295,888	11,491,577	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	803				259,376	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	130,053	168,376	509,104		1,295,888	202
203 UNIT COST MULT-WS B PT I	0.104796	0.030184	0.019939		0.110279	203
204 COST TO BE ALLOC PER B PT II	77,344		54,164		337,033	204
205 UNIT COST MULT-WS B PT II	0.062323		0.002121		0.028681	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	NURSING ADMINISTRATION HOURS OF SERVICE 13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
7 OPERATION OF PLANT	56,752					7
8 LAUNDRY & LINEN SERVICE	956	20,900				8
9 HOUSEKEEPING			10,913			9
10 DIETARY				11,541		10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	1,500		48		89,318	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,173					15
16 MEDICAL RECORDS & LIBRARY	1,247					16
17 SOCIAL SERVICE	192					17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	13,643	11,402	5,165	11,541	63,822	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,700	464	1,080		4,445	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	4,752	712	480			54
58 MAGNETIC RESONANCE IMAGING (MRI)		189				58
60 LABORATORY	1,725		360			60
65 RESPIRATORY THERAPY	700					65
65.50 SLEEP LAB	375					65.50
66 PHYSICAL THERAPY	4,495	2,569	540			66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	7,481	217	1,440			88
90 CLINIC	2,320		240			90
90.01 NORRIS CITY CLINIC	733					90.01
91 EMERGENCY	4,598	5,347	1,560		21,051	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
117 OTHER SPECIAL PURPOSE COST CENTERS						117
117.02 SUPPLIES AND EXPENSE						117.02
118 SUBTOTALS (SUM OF LINES 1-117)	52,590	20,900	10,913	11,541	89,318	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	4,162					192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,103,752	110,854	251,090	80,152	377,055	202
203 UNIT COST MULT-WS B PT I	19.448689	5.304019	23.008339	6.944979	4.221490	203
204 COST TO BE ALLOC PER B PT II	273,920	39,714	7,672	2,271	67,535	204
205 UNIT COST MULT-WS B PT II	4.826614	1.900191	0.703015	0.196777	0.756119	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY COSTED REQUISITIO 14	PHARMACY COSTED REQUISITIO 15	MEDICAL RECORDS & LIBRARY TIME SPENT 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
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORES					5.03
5.04 ADMITTING					5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL					5.06
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY	97,722				14
15 PHARMACY		299,112			15
16 MEDICAL RECORDS & LIBRARY			55,029		16
17 SOCIAL SERVICE				7,290	17
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS			24,699	1,830	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC			2,015		54
58 MAGNETIC RESONANCE IMAGING (MRI)			535		58
60 LABORATORY			8,520		60
65 RESPIRATORY THERAPY					65
65.50 SLEEP LAB					65.50
66 PHYSICAL THERAPY				720	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	11,097				71
72 IMPL. DEV. CHARGED TO PATIENT	86,625				72
73 DRUGS CHARGED TO PATIENTS		299,112			73
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)			5,015	1,800	88
90 CLINIC					90
90.01 NORRIS CITY CLINIC					90.01
91 EMERGENCY			14,245	2,940	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
117 OTHER SPECIAL PURPOSE COST CENTERS					117
117.02 SUPPLIES AND EXPENSE					117.02
118 SUBTOTALS (SUM OF LINES 1-117)	97,722	299,112	55,029	7,290	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES					192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	7,019	350,923	342,828	69,820	202
203 UNIT COST MULT-WS B PT I	0.071826	1.173216	6.229951	9.577503	203
204 COST TO BE ALLOC PER B PT II	2,153	71,277	58,186	9,235	204
205 UNIT COST MULT-WS B PT II	0.022032	0.238295	1.057370	1.266804	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL	RCE	TOTAL	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS	
	1	2	3	4	5	
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	3,174,732		3,174,732		3,174,732	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	667,470		667,470		667,470	50
53 ANESTHESIOLOGY	376,370		376,370		376,370	53
54 RADIOLOGY-DIAGNOSTIC	1,034,581		1,034,581		1,034,581	54
58 MAGNETIC RESONANCE IMAGING	79,831		79,831		79,831	58
60 LABORATORY	1,384,418		1,384,418		1,384,418	60
65 RESPIRATORY THERAPY	251,501		251,501		251,501	65
65.50 SLEEP LAB	48,125		48,125		48,125	65.50
66 PHYSICAL THERAPY	976,477		976,477		976,477	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	16,472		16,472		16,472	69
71 MEDICAL SUPPLIES CHRGD TO	5,449		5,449		5,449	71
72 IMPL. DEV. CHARGED TO PATIE	106,014		106,014		106,014	72
73 DRUGS CHARGED TO PATIENTS	783,570		783,570		783,570	73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,395,704		1,395,704		1,395,704	88
90 CLINIC	482,412		482,412		482,412	90
90.01 NORRIS CITY CLINIC	73,950		73,950		73,950	90.01
91 EMERGENCY	1,820,840		1,820,840		1,820,840	91
92 OBSERVATION BEDS	520,771		520,771		520,771	92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST						117
117.02 SUPPLIES AND EXPENSE						117.02
200 SUBTOTAL (SEE INSTRUCTIONS)	13,198,687		13,198,687		13,198,687	200
201 LESS OBSERVATION BEDS	520,771		520,771		520,771	201
202 TOTAL (SEE INSTRUCTIONS)	12,677,916		12,677,916		12,677,916	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	1,553,872		1,553,872			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	45,520	689,118	734,638	0.908570	0.908570	0.908570 50
53 ANESTHESIOLOGY	41,997	254,248	296,245	1.270469	1.270469	1.270469 53
54 RADIOLOGY-DIAGNOSTIC	407,940	4,160,235	4,568,175	0.226476	0.226476	0.226476 54
58 MAGNETIC RESONANCE IMAGING	29,491	374,659	404,150	0.197528	0.197528	0.197528 58
60 LABORATORY	863,522	4,841,028	5,704,550	0.242687	0.242687	0.242687 60
65 RESPIRATORY THERAPY	172,226	97,467	269,693	0.932546	0.932546	0.932546 65
65.50 SLEEP LAB		142,230	142,230	0.338360	0.338360	0.338360 65.50
66 PHYSICAL THERAPY	295,999	1,024,869	1,320,868	0.739269	0.739269	0.739269 66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	46,350	369,358	415,708	0.039624	0.039624	0.039624 69
71 MEDICAL SUPPLIES CHRGD TO	596,765	399,537	996,302	0.005469	0.005469	0.005469 71
72 IMPL. DEV. CHARGED TO PATIE		163,250	163,250	0.649397	0.649397	0.649397 72
73 DRUGS CHARGED TO PATIENTS	1,499,058	1,310,308	2,809,366	0.278913	0.278913	0.278913 73
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	87,430	449,392	536,822			88
90 CLINIC		773,312	773,312	0.623826	0.623826	0.623826 90
90.01 NORRIS CITY CLINIC		21,155	21,155	3.495628	3.495628	3.495628 90.01
91 EMERGENCY	3,000	2,578,235	2,581,235	0.705414	0.705414	0.705414 91
92 OBSERVATION BEDS	2,385	493,485	495,870	1.050217	1.050217	1.050217 92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
117 OTHER SPECIAL PURPOSE COST						117
117.02 SUPPLIES AND EXPENSE						117.02
200 SUBTOTAL (SEE INSTRUCTIONS)	5,645,555	18,141,886	23,787,441			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	5,645,555	18,141,886	23,787,441			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1326) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS	
		2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.908570		254,626			231,346		50
53 ANESTHESIOLOGY	1.270469		129,726			164,813		53
54 RADIOLOGY-DIAGNOSTIC	0.226476		1,544,885			349,879		54
58 MAGNETIC RESONANCE IMAGING (MRI)	0.197528		130,737			25,824		58
60 LABORATORY	0.242687		2,367,370			574,530		60
65 RESPIRATORY THERAPY	0.932546		45,126			42,082		65
65.50 SLEEP LAB	0.338360		37,707			12,759		65.50
66 PHYSICAL THERAPY	0.739269		358,606			265,106		66
67 OCCUPATIONAL THERAPY								67
68 SPEECH PATHOLOGY								68
69 ELECTROCARDIOLOGY	0.039624		223,194			8,844		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.005469		126,413			691		71
72 IMPL. DEV. CHARGED TO PATIENT	0.649397		125,376			81,419		72
73 DRUGS CHARGED TO PATIENTS	0.278913		568,204			158,479		73
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
90 CLINIC	0.623826		756,982			472,225		90
90.01 NORRIS CITY CLINIC	3.495628							90.01
91 EMERGENCY	0.705414		1,092,501			770,666		91
92 OBSERVATION BEDS	1.050217		271,473			285,106		92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			8,032,926			3,443,769		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			8,032,926			3,443,769		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	SWING-BED	REDUCED CAP-REL COST	TOTAL PATIENT	PER DIEM	INPAT PGM	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	ADJUSTMENT	(COL.1 MINUS COL.2)	DAYS	(COL.3 ÷ COL.4)	DAYS	(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
30 INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	702,576	145,772	556,804	2,894	192.40	186	35,786	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	702,576		556,804	2,894		186	35,786	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-1326) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	286,741	734,638	0.390316	11,849	4,625	50
53	ANESTHESIOLOGY	11,511	296,245	0.038856	7,481	291	53
54	RADIOLOGY-DIAGNOSTIC	223,257	4,568,175	0.048872	57,045	2,788	54
58	MAGNETIC RESONANCE IMAGING (M	3,748	404,150	0.009274			58
60	LABORATORY	148,745	5,704,550	0.026075	68,300	1,781	60
65	RESPIRATORY THERAPY	36,065	269,693	0.133726	5,767	771	65
65.50	SLEEP LAB	15,966	142,230	0.112255			65.50
66	PHYSICAL THERAPY	206,619	1,320,868	0.156427	2,202	344	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	1,458	415,708	0.003507	2,807	10	69
71	MEDICAL SUPPLIES CHRGED TO PA	417	996,302	0.000419	40,589	17	71
72	IMPL. DEV. CHARGED TO PATIENT	4,833	163,250	0.029605			72
73	DRUGS CHARGED TO PATIENTS	88,412	2,809,366	0.031470	112,565	3,542	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	332,927	536,822	0.620181			88
90	CLINIC	103,996	773,312	0.134481			90
90.01	NORRIS CITY CLINIC	31,230	21,155	1.476247			90.01
91	EMERGENCY	276,623	2,581,235	0.107167			91
92	OBSERVATION BEDS	145,420	495,870	0.293262			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	1,917,968	22,233,569		308,605	14,169	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1326) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.908570		95,571			86,833		50
53 ANESTHESIOLOGY	1.270469		60,878			77,344		53
54 RADIOLOGY-DIAGNOSTIC	0.226476		1,464,466			331,666		54
58 MAGNETIC RESONANCE IMAGING (MRI)	0.197528		138,910			27,439		58
60 LABORATORY	0.242687		1,340,345			325,284		60
65 RESPIRATORY THERAPY	0.932546		19,526			18,209		65
65.50 SLEEP LAB	0.338360							65.50
66 PHYSICAL THERAPY	0.739269		229,994			170,027		66
67 OCCUPATIONAL THERAPY								67
68 SPEECH PATHOLOGY								68
69 ELECTROCARDIOLOGY	0.039624		93,995			3,724		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.005469		187,436			1,025		71
72 IMPL. DEV. CHARGED TO PATIENT	0.649397		6,092			3,956		72
73 DRUGS CHARGED TO PATIENTS	0.278913		440,481			122,856		73
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
90 CLINIC	0.623826							90
90.01 NORRIS CITY CLINIC	3.495628							90.01
91 EMERGENCY	0.705414		1,285,670			906,930		91
92 OBSERVATION BEDS	1.050217		136,117			142,952		92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			5,499,481			2,218,245		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			5,499,481			2,218,245		202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1326) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,723	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,894	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,295	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	373	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)	372	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	42	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)	42	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,844	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)	373	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)	372	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	129.51	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.51	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,174,732	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)	5,439	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	5,565	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	658,700	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,516,032	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,243,001	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,243,001	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.024159	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)	541.61	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,516,032	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[XX]	HOSPITAL (14-1326)	[]	SUB (OTHER)	[]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF			[]	TEFRA
BOXES	[]	TITLE XIX-INPT	[]	IRF			[XX]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

38	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							
	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)						869.39	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)						1,603,155	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)						1,603,155	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)					719,662 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,322,817 49

50	PASS-THROUGH COST ADJUSTMENTS							
	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

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

64	PROGRAM INPATIENT ROUTINE SWING BED COST							
	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)						324,282	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)						323,413	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						647,695	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)						599	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)						869.40	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)						520,771	89

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	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	
90	CAPITAL-RELATED COST	702,576	2,516,032	0.279240	520,771	145,420	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1326) [] SUB (OTHER) [] ICF/MR [XX] PFS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,723	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,894	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,295	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	373	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)	372	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	42	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)	42	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	186	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	129.51	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.51	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,174,732	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)	5,439	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	5,565	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	658,700	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,516,032	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,243,001	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,243,001	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 29)	2.024159	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)	541.61	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,516,032	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1326) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 869.39 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 161,707 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) 161,707 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) 88,500 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 250,207 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 35,786 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 14,169 51
 52 TOTAL PROGRAM EXCLUDABLE COST 49,955 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 200,252 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) 599 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1326) SUB (OTHER) S/B SNF PFS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		1,077,320		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.908570	26,444	24,026	50
53 ANESTHESIOLOGY	1.270469	27,335	34,728	53
54 RADIOLOGY-DIAGNOSTIC	0.226476	286,113	64,798	54
58 MAGNETIC RESONANCE IMAGING (MRI)	0.197528	26,543	5,243	58
60 LABORATORY	0.242687	593,423	144,016	60
65 RESPIRATORY THERAPY	0.932546	117,739	109,797	65
65.50 SLEEP LAB	0.338360			65.50
66 PHYSICAL THERAPY	0.739269	101,878	75,315	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.039624	30,258	1,199	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.005469	287,528	1,572	71
72 IMPL. DEV. CHARGED TO PATIENT	0.649397			72
73 DRUGS CHARGED TO PATIENTS	0.278913	925,653	258,177	73
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
90 CLINIC	0.623826			90
90.01 NORRIS CITY CLINIC	3.495628			90.01
91 EMERGENCY	0.705414	1,122	791	91
92 OBSERVATION BEDS	1.050217			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,424,036	719,662	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,424,036		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z326) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
30 INPATIENT ROUTINE SERVICE COST CENTERS				30
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.908570	4,862	4,417	50
53 ANESTHESIOLOGY	1.270469	3,500	4,447	53
54 RADIOLOGY-DIAGNOSTIC	0.226476	32,421	7,343	54
58 MAGNETIC RESONANCE IMAGING (MRI)	0.197528			58
60 LABORATORY	0.242687	99,742	24,206	60
65 RESPIRATORY THERAPY	0.932546	48,683	45,399	65
65-50 SLEEP LAB	0.338360			65.50
66 PHYSICAL THERAPY	0.739269	158,277	117,009	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.039624	1,180	47	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.005469	104,408	571	71
72 IMPL. DEV. CHARGED TO PATIENT	0.649397			72
73 DRUGS CHARGED TO PATIENTS	0.278913	325,011	90,650	73
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
90 CLINIC	0.623826			90
90.01 NORRIS CITY CLINIC	3.495628			90.01
91 EMERGENCY	0.705414	122	86	91
92 OBSERVATION BEDS	1.050217			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		778,206	294,175	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		778,206		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-1326) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
30 INPATIENT ROUTINE SERVICE COST CENTERS					
ADULTS & PEDIATRICS		97,653			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.908570	11,849	10,766		50
53 ANESTHESIOLOGY	1.270469	7,481	9,504		53
54 RADIOLOGY-DIAGNOSTIC	0.226476	57,045	12,919		54
58 MAGNETIC RESONANCE IMAGING (MRI)	0.197528				58
60 LABORATORY	0.242687	68,300	16,576		60
65 RESPIRATORY THERAPY	0.932546	5,767	5,378		65
65.50 SLEEP LAB	0.338360				65.50
66 PHYSICAL THERAPY	0.739269	2,202	1,628		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	0.039624	2,807	111		69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.005469	40,589	222		71
72 IMPL. DEV. CHARGED TO PATIENT	0.649397				72
73 DRUGS CHARGED TO PATIENTS	0.278913	112,565	31,396		73
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
90 CLINIC	0.623826				90
90.01 NORRIS CITY CLINIC	3.495628				90.01
91 EMERGENCY	0.705414				91
92 OBSERVATION BEDS	1.050217				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		308,605	88,500		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		308,605			202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

CHECK APPLICABLE BOX: HOSPITAL (14-1326) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,443,769	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	3,443,769	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	3,478,207	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 \$2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	24,971	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,128,392	26
27	SUBTOTAL ((LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23) (SEE INSTRUCTIONS)	2,324,844	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	2,324,844	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,324,844	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	202,891	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	202,891	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	202,891	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	2,527,735	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SEQUESTRATION)	-11,439	39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	2,516,296	40
41	INTERIM PAYMENTS	2,556,181	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-39,885	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	135,764	44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[XX] HOSPITAL (14-1326) [] IPF [] IRF	[] SUB (OTHER) [] SNF [] SWING BED SNF	INPATIENT		PART B		
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
DESCRIPTION							
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,788,118		2,645,254	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.			NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.						
		PROGRAM .01	01/03/2013	8,730		NONE	3.01
		TO .02	04/22/2013	3,601			3.02
		PROGRAM .03					3.03
		TO .04					3.04
		PROVIDER .05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE			3.50
		.51			01/03/2013	65,322	3.51
		PROVIDER .52			04/22/2013	23,751	3.52
		TO .53					3.53
		PROGRAM .54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
		.99		12,331		-89,073	3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)						
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			1,800,449		2,556,181	4
TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.						
		PROGRAM .01		NONE		NONE	5.01
		TO .02					5.02
		PROVIDER .03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		PROVIDER .50		NONE		NONE	5.50
		TO .51					5.51
		PROGRAM .52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
		.99					5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT						
		PROGRAM .01		193,064			6.01
		TO .02				-39,885	6.02
		PROVIDER .01					
		TO .02					
		PROGRAM .01					
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			1,993,513		2,516,296	7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-1326 HAMILTON MEMORIAL HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2012.11
10/08/2013 15:06

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1326) [] 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	716	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,844	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	23	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	2,295	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	23,787,441	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	282,747	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	201,279	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	201,279	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	201,279	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 (14-2326)
 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)	654,172	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)	297,117	3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5	PROGRAM DAYS	745	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)	951,289	8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	951,289	10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	951,289	12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	6,442	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)	944,847	15
16	OTHER ADJUSTMENTS (SEQUESTRATION)	-5,413	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)	939,734	19
20	INTERIM PAYMENTS	828,025	20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	111,709	22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	43,053	23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART V

CHECK HOSPITAL (14-1326)
 APPLICABLE BOX: SUB (OTHER)

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

1	INPATIENT SERVICES	2,322,817	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	2,322,817	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	2,346,045	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)	2,346,045	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	407,088	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,938,957	22
23	COINSURANCE	888	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,938,069	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	64,621	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	64,621	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	64,621	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	2,002,690	28
29	OTHER ADJUSTMENTS (SEQUESTRATION)	-9,177	29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,993,513	30
31	INTERIM PAYMENTS	1,800,449	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	193,064	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	102,610	34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK TITLE V HOSPITAL (14-1326) SNF PPS
 APPLICABLE TITLE XIX IPF NF TEFRA
 BOXES: IRF ICF/MR OTHER
 SUB (OTHER)

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

	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
2 MEDICAL AND OTHER SERVICES		2,218,245	2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)		2,218,245	4
5 INPATIENT PRIMARY PAYER PAYMENTS			5
6 OUTPATIENT PRIMARY PAYER PAYMENTS			6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)		2,218,245	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8 ROUTINE SERVICE CHARGES			8
9 ANCILLARY SERVICE CHARGES	308,605	5,499,481	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)		2,218,245	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		2,218,245	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)		2,218,245	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)		2,218,245	36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			37
38 SUBTOTAL (LINE 36 ± LINE 37)		2,218,245	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)		2,218,245	40
41 INTERIM PAYMENTS		2,218,245	41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)			42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

BALANCE SHEET

WORKSHEET G

	ASSETS			
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	3,464,771			1
2 TEMPORARY INVESTMENTS	500,959			2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	5,113,117			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,465,034			6
7 INVENTORY	418,658			7
8 PREPAID EXPENSES	187,883			8
9 OTHER CURRENT ASSETS				9
10 DUE FROM OTHER FUNDS	253,690			10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	8,474,044			11
FIXED ASSETS				
12 LAND	69,760			12
13 LAND IMPROVEMENTS	601,496			13
14 ACCUMULATED DEPRECIATION	-287,480			14
15 BUILDINGS	21,552,244			15
16 ACCUMULATED DEPRECIATION	-6,433,854			16
17 LEASEHOLD IMPROVEMENTS				17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT				19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	5,632,245			23
24 ACCUMULATED DEPRECIATION	-4,444,666			24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS	410,457			27
28 ACCUMULATED DEPRECIATION	-289,548			28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	16,810,654			30
OTHER ASSETS				
31 INVESTMENTS				31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	308,207		100,050	34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	308,207		100,050	35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	25,592,905		100,050	36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	415,580			37
38 SALARIES, WAGES & FEES PAYABLE	509,889			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	17,140,000			40
41 DEFERRED INCOME	284,873			41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS	208,278			43
44 OTHER CURRENT LIABILITIES	109,644			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	18,668,264			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE				47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	3,339,000			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	3,339,000			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	22,007,264			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	3,585,641			52
53 SPECIFIC PURPOSE FUND BALANCE				53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED			100,050	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)	3,585,641		100,050	59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	25,592,905		100,050	60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		1,944,489				101,817			1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		1,641,152							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		3,585,641				101,817			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)		3,585,641				101,817			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)					1,767				12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)						1,767			18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		3,585,641				100,050			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	1,354,997		1,354,997	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	150,563		150,563	6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY				8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	1,505,560		1,505,560	11
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
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	1,505,560		1,505,560	17
18 ANCILLARY SERVICES	3,985,253	16,471,854	20,457,107	18
19 OUTPATIENT SERVICES		1,287,952	1,287,952	19
20 RHC	87,430	449,392	536,822	20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	5,578,243	18,209,198	23,787,441	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		14,924,565	29
30 BAD DEBTS	1,861,879		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		1,861,879	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)		16,786,444	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	23,787,441	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	8,414,614	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	15,372,827	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	16,786,444	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,413,617	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	253,529	6
7	INCOME FROM INVESTMENTS	26,724	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	1,418	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		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	8,127	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	10,702	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	4,135	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	1,428	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS	495,801	23
24	OTHER (OTHER)	473,905	24
24.01	OTHER (GAIN ON SWAP)	1,779,000	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	3,054,769	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,641,152	26
27	OTHER EXPENSES (LOSS ON SWAP CONTRACT)		27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	1,641,152	29

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

RHC I
 COMPONENT NO: 14-3477

WORKSHEET M-1

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1	561,875		561,875		561,875	-203,059	358,816	1
2								2
3	82,315		82,315		82,315	-13,301	69,014	3
4	81,158		81,158		81,158		81,158	4
5								5
6								6
7								7
8								8
9								9
10	725,348		725,348		725,348	-216,360	508,988	10
COSTS UNDER AGREEMENT								
11								11
12								12
13								13
14								14
15								15
16		3,085	3,085		3,085		3,085	16
17								17
18								18
19								19
20								20
21		3,085	3,085		3,085		3,085	21
22	725,348	3,085	728,433		728,433	-216,360	512,073	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26								26
27								27
28								28
FACILITY OVERHEAD								
29								29
30	55,042	166,929	221,971	-37,020	184,951	-38,660	146,291	30
31	55,042	166,929	221,971	-37,020	184,951	-38,660	146,291	31
32	780,390	170,014	950,404	-37,020	913,384	-255,020	658,364	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3477

WORKSHEET M-2

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	1.65	3,324	4,200	6,930	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	0.76	1,239	2,100	1,596	3
4	SUBTOTAL (SUM OF LINES 1-3)	2.41	4,563		8,526	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2.41	4,563		8,526	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)				512,073	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)				512,073	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				146,291	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				737,340	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				883,631	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				883,631	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				883,631	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				1,395,704	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3477

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)	1,395,704	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	7,843	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,387,861	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	8,526	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	8,526	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	162.78	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)	162.78	162.78	162.78	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1,502	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	244,496	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)		14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)		15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	244,496	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)	106,092	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)	310	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	714	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	184,808	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	185,522	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	12,772	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	18,595	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	185,522	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	4,499	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	190,021	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		24
25	OTHER ADJUSTMENTS (SEQUESTRATION)	-909	25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	189,112	26
27	INTERIM PAYMENTS	193,581	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	-4,469	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2	10,800	30

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I
 COMPONENT NO: 14-3477

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	508,988	508,988	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000081	0.001003	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	41	511	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	669	1,656	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	710	2,167	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	512,073	512,073	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	883,631	883,631	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001387	0.004232	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	1,226	3,740	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,936	5,907	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	11	138	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	176.00	42.80	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	10	64	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	1,760	2,739	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)		7,843	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)		4,499	16

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

RHC I
 COMPONENT NO: 14-3477

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		202,378	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50		3.50
	.51	01/03/2013	3.51
	PROVIDER .52	04/22/2013	3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
	.99		3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-8,797	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		193,581	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
	.99		5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)			
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01		6.01
	PROVIDER PROVIDER TO .02	-4,469	6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		189,112	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	8
		NPR DATE:	

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	63.72		6.43				70.15 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	3.60	34.66	1.61	13.01			52.88 50
53 ANESTHESIOLOGY	9.23	43.79	2.53	20.55			76.10 53
54 RADIOLOGY-DIAGNOSTIC	6.26	33.82	1.25	32.06			73.39 54
58 MAGNETIC RESONANCE IMAGING (MRI	6.57	32.35		34.37			73.29 58
60 LABORATORY	10.40	41.50	1.20	23.50			76.60 60
65 RESPIRATORY THERAPY	43.66	16.73	2.14	7.24			69.77 65
65.50 SLEEP LAB		26.51					26.51 65.50
66 PHYSICAL THERAPY	7.71	27.15	0.17	17.41			52.44 66
69 ELECTROCARDIOLOGY	7.28	53.69	0.68	22.61			84.26 69
71 MEDICAL SUPPLIES CHRGED TO PATI	28.86	12.69	4.07	18.81			64.43 71
72 IMPL. DEV. CHARGED TO PATIENT		76.80		3.73			80.53 72
73 DRUGS CHARGED TO PATIENTS	32.95	20.23	4.01	15.68			72.87 73
90 CLINIC		97.89					97.89 90
91 EMERGENCY	0.04	42.32		49.81			92.17 91
92 OBSERVATION BEDS		54.75		27.45			82.20 92
200 TOTAL CHARGES	10.90	36.13	1.39	24.74			73.16 200

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

SWING-BED SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	0.66						0.66 50
53 ANESTHESIOLOGY	1.18						1.18 53
54 RADIOLOGY-DIAGNOSTIC	0.71						0.71 54
60 LABORATORY	1.75						1.75 60
65 RESPIRATORY THERAPY	18.05						18.05 65
66 PHYSICAL THERAPY	11.98						11.98 66
69 ELECTROCARDIOLOGY	0.28						0.28 69
71 MEDICAL SUPPLIES CHRGED TO PATI	10.48						10.48 71
73 DRUGS CHARGED TO PATIENTS	11.57						11.57 73
200 TOTAL CHARGES	3.50						3.50 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1 CAP REL COSTS-BLDG & FIXT	2,209,847	16.94	-2,209,847	-31.73			1
2 CAP REL COSTS-MVBLE EQUIP	434,666	3.33	-434,666	-6.24			2
3 OTHER CAPITAL RELATED COSTS							3
4 EMPLOYEE BENEFITS	1,156,780	8.87	-1,156,780	-16.61			4
5.01 NONPATIENT TELEPHONES	24,673	0.19	-24,673	-0.35			5.01
5.02 DATA PROCESSING	99,352	0.76	-99,352	-1.43			5.02
5.03 PURCHASING RECEIVING AND STORES	43,570	0.33	-43,570	-0.63			5.03
5.04 ADMITTING	152,533	1.17	-152,533	-2.19			5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	328,010	2.51	-328,010	-4.71			5.05
5.06 OTHER ADMINISTRATIVE AND GENERA	832,817	6.38	-832,817	-11.96			5.06
7 OPERATION OF PLANT	713,948	5.47	-713,948	-10.25			7
8 LAUNDRY & LINEN SERVICE	50,136	0.38	-50,136	-0.72			8
9 HOUSEKEEPING	188,552	1.45	-188,552	-2.71			9
10 DIETARY	71,855	0.55	-71,855	-1.03			10
11 CAFETERIA							11
13 NURSING ADMINISTRATION	215,987	1.66	-215,987	-3.10			13
14 CENTRAL SERVICES & SUPPLY	3,006	0.02	-3,006	-0.04			14
15 PHARMACY	189,974	1.46	-189,974	-2.73			15
16 MEDICAL RECORDS & LIBRARY	204,843	1.57	-204,843	-2.94			16
17 SOCIAL SERVICE	43,270	0.33	-43,270	-0.62			17
INPATIENT ROUTINE SERV COST CENTERS							
30 ADULTS & PEDIATRICS	1,192,453	9.14	1,982,279	28.47	3,174,732	24.33	30
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	154,727	1.19	512,743	7.36	667,470	5.12	50
53 ANESTHESIOLOGY	275,682	2.11	100,688	1.45	376,370	2.88	53
54 RADIOLOGY-DIAGNOSTIC	490,309	3.76	544,272	7.82	1,034,581	7.93	54
58 MAGNETIC RESONANCE IMAGING (MRI)	58,739	0.45	21,092	0.30	79,831	0.61	58
60 LABORATORY	847,184	6.49	537,234	7.71	1,384,418	10.61	60
65 RESPIRATORY THERAPY	129,097	0.99	122,404	1.76	251,501	1.93	65
65.50 SLEEP LAB	20,700	0.16	27,425	0.39	48,125	0.37	65.50
66 PHYSICAL THERAPY	508,110	3.89	468,367	6.73	976,477	7.48	66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	4,896	0.04	11,576	0.17	16,472	0.13	69
71 MEDICAL SUPPLIES CHRGD TO PATI	2,970	0.02	2,479	0.04	5,449	0.04	71
72 IMPL. DEV. CHARGED TO PATIENT	86,625	0.66	19,389	0.28	106,014	0.81	72
73 DRUGS CHARGED TO PATIENTS	288,410	2.21	495,160	7.11	783,570	6.01	73
88 RURAL HEALTH CLINIC (RHC)	658,364	5.05	737,340	10.59	1,395,704	10.70	88
90 CLINIC	263,637	2.02	218,775	3.14	482,412	3.70	90
90.01 NORRIS CITY CLINIC	22,106	0.17	51,844	0.74	73,950	0.57	90.01
91 EMERGENCY	962,121	7.37	858,719	12.33	1,820,840	13.96	91
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
OTHER SPECIAL PURPOSE COST CENT							117
117.02 SUPPLIES AND EXPENSE							117.02
NONREIMBURSABLE COST CENTERS							
192 PHYSICIANS' PRIVATE OFFICES	116,892	0.90	252,033	3.62	368,925	2.83	192
200 CROSS FOOT ADJUSTMENTS							200
201 NEGATIVE COST CENTER							201
202 TOTAL	13,046,841	100.00			13,046,841	100.00	202

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

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

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

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

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES		Clinic Name Hamilton Memorial Family Clinic 14-3477		Reporting Period FROM: 7/1/12 TO: 6/30/13		Attachment #1	
Cost Center (OMIT CENTS)	COMPENSATION 1	OTHER 2	TOTAL COL. 1 & 2 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE COL. 3 & 4 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES COL. 5 & 6 7
1 SUPPLEMENTAL COSTS			NONE				
2 Pharmacy			-	-	-	-	-
3 Patient Transportation			-	-	-	-	-
4 Medical Case Management			-	-	-	-	-
5 Health Education			-	-	-	-	-
6 Nutrition Counseling			-	-	-	-	-
7 Others (Specify)			-	-	-	-	-
8			-	-	-	-	-
9			-	-	-	-	-
10			-	-	-	-	-
11			-	-	-	-	-
12 Supplemental Subtotal (sum of lines 2 through 11)	-		-	-	-	-	-
13 DENTAL			-	-	-	-	-
14 NON-ALLOWABLE COST CENTERS			-	-	-	-	-
15 HNVK Case Management			-	-	-	-	-
16 WIC (Women, Infants & Children)			-	-	-	-	-
17 Fundraising & Public Relations			-	-	-	-	-
18 Social Services			-	-	-	-	-
19 Unlicensed Social Workers			-	-	-	-	-
20 Others (Specify)			-	-	-	-	-
21			-	-	-	-	-
22			-	-	-	-	-
23			-	-	-	-	-
24			-	-	-	-	-
25 Non-Allowable Subtotal (sum of lines 15-24)			-	-	-	-	-
26 Totals for schedule C (sum of lines 12, 13 & 25)			-	-	-	-	-

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

RURAL HEALTH CENTER DENTAL STATISTICS		CLINIC NAME Hamilton Memorial Family Clinic 14-3477		REPORTING PERIOD FROM: 7/01/12 TO: 6/30/13			ATTACHMENT #2	
COST CENTER (OMIT CENTS)		COMPENSATION 1	OTHER 2	Col. 1 & 2 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE (COL. 3 & 4) 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES (COL. 5 & 6) 7
1	RHC DENTAL STAFF COST			NONE				
2	Dentists							
3	Dental Hygienist							
4								
5								
6	TOTAL - DENTISTS (Sum on lines 1 through 5)	-	-	-	-	-	-	-
7	Other - Dental Staff							
8								
9								
10								
11	SUBTOTAL - Other Dental Staff (Sum of lines 7-10)	-	-	-	-	-	-	-
12	TOTAL - Dental Staff (Sum of lines 6 and 11)	-	-	-	-	-	-	-
13	Dental Services Under Agreement							
14								
15	TOTAL DENTAL COST (Sum of lines 12 through 14)	-	-	-	-	-	-	-

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

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

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