

MARSHALL BROWNING HOSPITAL

DUQUOIN, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED JUNE 30, 2013

November 19, 2013

Wisconsin Physicians Service
P.O. Box 8310
Omaha, NE 68108-0310

Re: Provider: Marshall Browning Hospital
Provider Numbers: 14-1331, 14-Z331, 14-8504
Period ended: 6-30-13
Protested amount claimed on submitted cost report.

Dear Sir or Madam:

The cost report for Marshall Browning Hospital, 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 Wisconsin Physicians Service. The expense in question relates to the provider tax assessment in the amount of \$287,071, which we have included as an adjustment to line 5.00 (Administrative and General) 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	\$ 53,615
Worksheet E-2, line 23	52,499
Worksheet E-3, part V, line 34	42,838
Worksheet M-3, line 30	<u>6,123</u>
Total	<u>\$ 154,625</u>

Sincerely,

Edwin Gast, CEO
Marshall Browning Hospital
900 North Washington Street
Duquoin, Illinois 62832
(618)542-2146

Wisconsin Physicians Services
Medicare Part A
PO Box 8310
Omaha, NE 68108-0310

Dear Sir or Madam:

The cost report of Marshall Browning Hospital for the year ended June 30, 2013 includes one Level 2000 error.

20300 Worksheet C, Part I, Line 50, Col. 11 should not be more than 100% or less than .1%.

Marshall Browning Hospital is a rural Illinois Critical Access Hospital. In order to provide the needed services in line 50.00 to the rural area the Hospital incurs cost in excess of the amount it is able to bill for patient volume.

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 11/19/2013 TIME: 14:18
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY MARSHALL BROWNING HOSPITAL (14-1331) (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: 11/19/2013 14:18
 UO2GBxRG2eIz1JsfqXJ:SYQMg6s9J0
 ZAGp:0LIbnnI2Jm1WRkPCNH7U5g5z0
 h1GL0QNVyTOWJGF2

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

 TITLE

 DATE

PI Encryption: 11/19/2013 14:18
 jfSnCrAWy.xRq7vMRt9vu0a0o502n0
 IMe740u6Jm3AJLr6V00nDt4yEN.ue
 yDSA0NrcUIOXSHOY
 PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		-69,164	-260,333	-3,274	-77,830	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		-397,806				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			-1,487			10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		-466,970	-261,820	-3,274	-77,830	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: 900 NORTH WASHINGTON STREET
 2 CITY: DUQUOIN STATE: IL

P.O.BOX:
 ZIP CODE: 62832 COUNTY: PERRY

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			3	
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	MARSHALL BROWNING HOSPITAL	14-1331	99914	1	01/01/2004	N	O	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	MARSHALL BROWNING SWING BED	14-2331	99914		01/01/2004	N	O	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTG									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	MARSHALL BROWNING PHYSICIAN CL	14-8504	99914		05/01/2009	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									21

INPATIENT PPS INFORMATION

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

	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 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 THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)						1 N	2 N 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

	V 1	XVIII 2	XIX 3		
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.) (SEE INSTRUCTIONS)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY) ADDED AS A RESULT OF SECTION 5503. (SEE INSTRUCTIONS)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
		PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED IME FTE COUNT 3	UNWEIGHTED DIRECT GME FTE COUNT 4
					61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
					61.20
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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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))	
64				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)

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR
 FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME.
 ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF
 UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS
 OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER
 OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL.
 ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)).
 (SEE INSTRUCTIONS)

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

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 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))	
66				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)

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

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

INPATIENT PSYCHIATRIC FACILITY PPS

70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? 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
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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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TITLE V AND XIX INPATIENT SERVICES		V	XIX			
		1	2			
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90		
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91		
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92		
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93		
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94		
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95		
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96		
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97		
RURAL PROVIDERS						
		1	2			
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	Y		105		
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.	N		106		
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.	N	N	107		
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	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.	Y	Y	Y	N	109
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.	2			118	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 220,130 PAID LOSSES: SELF INSURANCE:				118.01	
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N			118.02	
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N		N	120	
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			121	
TRANSPLANT CENTER INFORMATION						
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N			125	
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				126	
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				127	
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				128	
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				129	
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				130	
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				131	
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				132	
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				133	
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				134	

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 N	2 140
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.			
141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER: 141
142	STREET:	P.O. BOX:	142
143	CITY:	STATE:	ZIP CODE: 143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	149
DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)			
		TITLE XVIII PART A	TITLE V
		PART B	TITLE XIX
155	HOSPITAL	1	2
156	SUBPROVIDER - IPF	Y	Y
157	SUBPROVIDER - IRF	N	N
158	SUBPROVIDER - (OTHER)	N	N
159	SNF	N	N
160	HHA	N	N
161	CMHC		N
161.10	CORF		
			N 155
			156
			157
			158
			159
			160
			161
			161.10
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
	0	1	2
			ZIP CODE
			3
			CBSA
			4
			FTE/CAMPUS
			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.	120,597	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
170	IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS)	07/01/2012	06/30/2013 170

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N	2	1	
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N	2	3	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	3	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N	Y/N		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	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	
BED COMPLEMENT					
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y/N	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			Y 12 N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	09/20/2013	Y	09/20/2013
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	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- 41 FIRST NAME: DAVID LAST NAME: SCHNAKE TITLE: PARTNER 41
- 42 EMPLOYER: KERBER, ECK & BRAECKEL LLP 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 NO.	COMPONENT	WKST A LINE NO. 1	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS			TOTAL ALL PATIENTS 8	TRIPS 1
						TITLE V 5	TITLE XVIII 6	TITLE XIX 7		
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS) (SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30	25	9,125	40,392.00		1,213	152	1,683	1
2	HMO AND OTHER (SEE INSTRUCTIONS)									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						1,749		1,749	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								31	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		25	9,125	40,392.00		2,962	152	3,463	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	40,392.00		2,962	152	3,463	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
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88					2,417		5,044	26
27	TOTAL (SUM OF LINES 14-26)		25							27
28	OBSERVATION BED DAYS							9	102	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
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---				----- DISCHARGES -----			TOTAL ALL PATIENTS 15
		TOTAL INTERNS & RESIDENTS 9	EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14		
1 HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS) (SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30					369	57	713	1
2 HMO AND OTHER (SEE INSTRUCTIONS)									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)			145.96			369	57	713	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
24.10 HOSPICE (NON-DISTINCT PART)	30								24.10
25 CMHC	99								25
26 RHC	88			10.89					26
27 TOTAL (SUM OF LINES 14-26)				156.85					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
32.01 TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
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 DEPARTMENT					26
27	ADMINISTRATIVE & GENERAL					27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT					30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING					32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY					34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA					36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION					38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY					41
42	SOCIAL SERVICE					42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	5
6	TOTAL (SUM OF LINES 3 THRU 5)	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

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

PROVIDER CCN: 14-1331 MARSHALL BROWNING 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: 2013.11
11/19/2013 14:16

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

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

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

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

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)			0.479607	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)					
2	NET REVENUE FROM MEDICAID			2,337,456	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?			Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?			Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				5
6	MEDICAID CHARGES			4,748,501	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)			2,277,414	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.				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)				19
		UNINSURED	INSURED	TOTAL	
		PATIENTS	PATIENTS		
		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	7,629	638,535	646,164	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	3,659	306,246	309,905	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	3,659	306,246	309,905	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)			1,641,473	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			244,907	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,396,566	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			669,803	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			979,708	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			979,708	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		748,150	748,150	-231,624	1
1.01	00101				525,626	1.01
1.02	00102				34,255	1.02
2	00200		286,764	286,764	-7,814	2
2.01	00201				63,042	2.01
2.02	00202				2,065	2.02
3	00300		34,934	34,934	-34,934	3
4	00400		1,999,498	1,999,498		4
5	00500	998,490	1,166,974	2,165,464		5
6	00600	191,594	128,774	320,368		6
7	00700		234,052	234,052		7
8	00800	23,432	45,010	68,442		8
9	00900	214,957	33,750	248,707		9
10	01000	212,428	140,554	352,982	-169,431	10
11	01100				169,431	11
13	01300	464,636	11,730	476,366		13
14	01400					14
15	01500	222,721	644,270	866,991		15
16	01600	207,604	24,930	232,534		16
17	01700	60,870	4,178	65,048		17
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	856,403	372,125	1,228,528		30
ANCILLARY SERVICE COST CENTERS						
50	05000	239,625	41,463	281,088		50
53	05300	98,714	115,070	213,784		53
54	05400	425,867	484,709	910,576		54
60	06000	425,863	262,857	688,720		60
65	06500	219,648	50,636	270,284		65
66	06600	555,416	41,034	596,450		66
67	06700					67
68	06800					68
69	06900	24,762	7,015	31,777		69
71	07100		649,828	649,828		71
73	07300					73
73.01	07301	33,241	1,862	35,103		73.01
74	07400					74
76.97	07697					76.97
OUTPATIENT SERVICE COST CENTERS						
88	08800	649,757	55,775	705,532		88
91	09100	480,183	1,052,452	1,532,635		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
113	11300		599,746	599,746	-350,616	113
118		6,606,211	9,238,140	15,844,351		118
NONREIMBURSABLE COST CENTERS						
190	19000					190
192	19200	470,741	226,045	696,786		192
192.02	19202	68,190	115,006	183,196		192.02
192.03	19203					192.03
200		7,145,142	9,579,191	16,724,333		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	516,526	17,918	534,444	1
1.01	00101	2008 BLDG & FIXT	525,626		525,626	1.01
1.02	00102	RHC BLDG & FIXT	34,255		34,255	1.02
2	00200	CAP REL COSTS-MVBLE EQUIP	278,950	-70,026	208,924	2
2.01	00201	2008 MVBLE EQUIP	63,042		63,042	2.01
2.02	00202	RHC MVBLE EQUIP	2,065		2,065	2.02
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	1,999,498		1,999,498	4
5	00500	ADMINISTRATIVE & GENERAL	2,165,464	-417,376	1,748,088	5
6	00600	MAINTENANCE & REPAIRS	320,368	-141	320,227	6
7	00700	OPERATION OF PLANT	234,052	-625	233,427	7
8	00800	LAUNDRY & LINEN SERVICE	68,442		68,442	8
9	00900	HOUSEKEEPING	248,707	-157	248,550	9
10	01000	DIETARY	183,551	-578	182,973	10
11	01100	CAFETERIA	169,431	-38,098	131,333	11
13	01300	NURSING ADMINISTRATION	476,366	-1,935	474,431	13
14	01400	CENTRAL SERVICES & SUPPLY				14
15	01500	PHARMACY	866,991	-61,074	805,917	15
16	01600	MEDICAL RECORDS & LIBRARY	232,534	-1,350	231,184	16
17	01700	SOCIAL SERVICE	65,048	-543	64,505	17
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,228,528	-260,953	967,575	30
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	281,088	-2,283	278,805	50
53	05300	ANESTHESIOLOGY	213,784		213,784	53
54	05400	RADIOLOGY-DIAGNOSTIC	910,576	-1,076	909,500	54
60	06000	LABORATORY	688,720	9,201	697,921	60
65	06500	RESPIRATORY THERAPY	270,284	-2,306	267,978	65
66	06600	PHYSICAL THERAPY	596,450	-2,131	594,319	66
67	06700	OCCUPATIONAL THERAPY				67
68	06800	SPEECH PATHOLOGY				68
69	06900	ELECTROCARDIOLOGY	31,777		31,777	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	649,828		649,828	71
73	07300	DRUGS CHARGED TO PATIENTS				73
73.01	07301	CARDIAC REHABILITATION	35,103	1,319	36,422	73.01
74	07400	RENAL DIALYSIS				74
76.97	07697	CARDIAC REHABILITATION				76.97
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC	705,532	-617	704,915	88
91	09100	EMERGENCY	1,532,635	-525,025	1,007,610	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS						
94	09400	HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE	249,130	-249,130		113
118		SUBTOTALS (SUM OF LINES 1-117)	15,844,351	-1,606,986	14,237,365	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
192	19200	PHYSICIANS' PRIVATE OFFICES	696,786	-99,423	597,363	192
192.02	19202	INDEPENDENT LIVING	183,196	-267	182,929	192.02
192.03	19203	MEALS ON WHEELS				192.03
200		TOTAL (SUM OF LINES 118-199)	16,724,333	-1,706,676	15,017,657	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER	
			LINE #				
	1	2	3		4	5	
1 TO RECLASS CAFETERIA COSTS	A	CAFETERIA	11		101,965	67,466	1
500 TOTAL RECLASSIFICATIONS					101,965	67,466	500
CODE LETTER - A							
1 TO RECLASS INTEREST EXP	C	CAP REL COSTS-MVBLE EQUIP	2			33,148	1
2		CAP REL COSTS-BLDG & FIXT	1			159,329	2
3		2008 BLDG & FIXT	1.01			145,488	3
4		2008 MVBLE EQUIP	2.01			12,651	4
500 TOTAL RECLASSIFICATIONS						350,616	500
CODE LETTER - C							
1 TO RECLASS BOND AMORITZATION	D	2008 BLDG & FIXT	1.01			14,118	1
2		CAP REL COSTS-MVBLE EQUIP	2			1,983	2
3		2008 MVBLE EQUIP	2.01			1,228	3
500 TOTAL RECLASSIFICATIONS						17,329	500
CODE LETTER - D							
1 TO RECLASS DEPRECIATION EXPENSE	E	2008 BLDG & FIXT	1.01			355,456	1
2		2008 MVBLE EQUIP	2.01			48,195	2
500 TOTAL RECLASSIFICATIONS						403,651	500
CODE LETTER - E							
1 TO RECLASS DEPRECIATION EXPENSE	F	RHC BLDG & FIXT	1.02			34,255	1
2		RHC MVBLE EQUIP	2.02			2,065	2
500 TOTAL RECLASSIFICATIONS						36,320	500
CODE LETTER - F							
1 TO RECLASS RHC EXP PHYS. CLINIC	G						1
500 TOTAL RECLASSIFICATIONS							500
CODE LETTER - G							
GRAND TOTAL (INCREASES)					101,965	875,382	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		OTHER	WKST A-7	
			LINE #	SALARY		REF.	
	1	6	7	8	9	10	
1 TO RECLASS CAFETERIA COSTS	A	DIETARY	10	101,965	67,466		1
500 TOTAL RECLASSIFICATIONS				101,965	67,466		500
CODE LETTER - A							
1 TO RECLASS INTEREST EXP	C	INTEREST EXPENSE	113		350,616		11 1
2							11 2
3							11 3
4							11 4
500 TOTAL RECLASSIFICATIONS					350,616		500
CODE LETTER - C							
1 TO RECLASS BOND AMORITZATION	D	CAP REL COSTS-BLDG & FIXT	1		17,329		9 1
2							9 2
3							9 3
500 TOTAL RECLASSIFICATIONS					17,329		500
CODE LETTER - D							
1 TO RECLASS DEPRECIATION EXPENSE	E	CAP REL COSTS-BLDG & FIXT	1		355,456		9 1
2		CAP REL COSTS-MVBLE EQUIP	2		48,195		9 2
500 TOTAL RECLASSIFICATIONS					403,651		500
CODE LETTER - E							
1 TO RECLASS DEPRECIATION EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		34,255		9 1
2		CAP REL COSTS-MVBLE EQUIP	2		2,065		9 2
500 TOTAL RECLASSIFICATIONS					36,320		500
CODE LETTER - F							
1 TO RECLASS RHC EXP PHYS. CLINIC	G						1
500 TOTAL RECLASSIFICATIONS							500
CODE LETTER - G							
GRAND TOTAL (DECREASES)				101,965	875,382		

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	3,116					3,116	1
2 LAND IMPROVEMENTS	1,258,140				46,024	1,212,116	2
3 BUILDINGS AND FIXTURES	8,270,626	17,042		17,042	50,465	8,237,203	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT	6,096,434	131,117		131,117	13,500	6,214,051	5
6 MOVABLE EQUIPMENT	4,596,507	417,166		417,166	165,579	4,848,094	6
7 HIT DESIGNATED ASSETS	120,596					120,596	7
8 SUBTOTAL (SUM OF LINES 1-7)	20,345,419	565,325		565,325	275,568	20,635,176	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	20,345,419	565,325		565,325	275,568	20,635,176	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	748,150						748,150 1
1.01 2008 BLDG & FIXT							1.01
1.02 RHC BLDG & FIXT							1.02
2 CAP REL COSTS-MVBLE EQUIP	286,764						286,764 2
2.01 2008 MVBLE EQUIP							2.01
2.02 RHC MVBLE EQUIP							2.02
3 TOTAL (SUM OF LINES 1-2)	1,034,914						1,034,914 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)						(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	9,456,880		9,456,880	0.460514			16,087	16,087 1	
1.01 2008 BLDG & FIXT	6,209,605		6,209,605	0.302385			10,564	10,564 1.01	
1.02 RHC BLDG & FIXT								1.02	
2 CAP REL COSTS-MVBLE EQUIP	4,299,769		4,299,769	0.209383			7,315	7,315 2	
2.01 2008 MVBLE EQUIP	569,200		569,200	0.027718			968	968 2.01	
2.02 RHC MVBLE EQUIP								2.02	
3 TOTAL (SUM OF LINES 1-2)	20,535,454		20,535,454	1.000000			34,934	34,934 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	341,110		177,247			16,087	534,444 1
1.01 2008 BLDG & FIXT	369,574		145,488			10,564	525,626 1.01
1.02 RHC BLDG & FIXT	34,255						34,255 1.02
2 CAP REL COSTS-MVBLE EQUIP	169,228		32,381			7,315	208,924 2
2.01 2008 MVBLE EQUIP	49,423		12,651			968	63,042 2.01
2.02 RHC MVBLE EQUIP	2,065						2,065 2.02
3 TOTAL	965,655		367,767			34,934	1,368,356 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-114	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-767	CAP REL COSTS-MVBLE EQUIP	2	11 2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-524,451			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	-38,098	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-58,737	PHARMACY	15	17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-1,071	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND	A	-69,259	CAP REL COSTS-MVBLE EQUIP	2	9 32
33 MISCELLABEOUS INCOME	B	-51,026	ADMINISTRATIVE & GENERAL	5	33
34					34
35 AHA DUES USED FOR LOBBYING	A	-2,053	ADMINISTRATIVE & GENERAL	5	35
36 IHA DUES USED FOR LOBBYING	A	-9,011	ADMINISTRATIVE & GENERAL	5	36
37 MARKETING	A	-64,849	ADMINISTRATIVE & GENERAL	5	37
38					38
39 DR. HALL SHARED EXPENSES	A	-97,230	PHYSICIANS' PRIVATE OFFICES	192	39
40 DEPRECIATION	A	18,032	CAP REL COSTS-BLDG & FIXT	1	11 40
41 DEPRECIATION	A	-3,366	ADMINISTRATIVE & GENERAL	5	41
42 DEPRECIATION	A	-141	MAINTENANCE & REPAIRS	6	42
43 DEPRECIATION	A	-625	OPERATION OF PLANT	7	43
44 DEPRECIATION	A	-157	HOUSEKEEPING	9	44
45 DEPRECIATION	A	-578	DIETARY	10	45
45.01 DEPRECIATION	A	-1,935	NURSING ADMINISTRATION	13	45.01
45.02 DEPRECIATION	A	-2,337	PHARMACY	15	45.02
45.03 DEPRECIATION	A	-279	MEDICAL RECORDS & LIBRARY	16	45.03
45.04 DEPRECIATION	A	-543	SOCIAL SERVICE	17	45.04
45.05 DEPRECIATION	A	2,152	ADULTS & PEDIATRICS	30	45.05
45.06 DEPRECIATION	A	-2,283	OPERATING ROOM	50	45.06
45.07 DEPRECIATION	A	-1,076	RADIOLOGY-DIAGNOSTIC	54	45.07
45.08 DEPRECIATION	A	1,319	CARDIAC REHABILITATION	73.01	45.08
45.09 DEPRECIATION	A	9,201	LABORATORY	60	45.09
45.10 DEPRECIATION	A	-2,306	RESPIRATORY THERAPY	65	45.10
45.11 DEPRECIATION	A	-2,131	PHYSICAL THERAPY	66	45.11
45.12 DEPRECIATION	A	-574	EMERGENCY	91	45.12
45.13 DEPRECIATION	A	-617	RURAL HEALTH CLINIC	88	45.13
45.14 DEPRECIATION	A	-267	INDEPENDENT LIVING	192.02	45.14
45.15 DEPRECIATION	A	-2,193	PHYSICIANS' PRIVATE OFFICES	192	45.15
45.16 SWAP UNALLOWABLE INTEREST	A	-249,130	INTEREST EXPENSE	113	45.16

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
45.17 HOSPITALIST PHYSICAN FEES	A	-263,105	ADULTS & PEDIATRICS	30	45.17
46					46
47 PROVIDER TAX ASSESSMENT	A	-287,071	ADMINISTRATIVE & GENERAL	5	47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-1,706,676			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-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.	2	3	4	5	6	7	8	9
1	91 EMERGENCY	1,020,333	524,451	495,882				
200	TOTAL	1,020,333	524,451	495,882				
	AGGREGATE							

1
200

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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
10	11	12	13	14	15	16	17	18
1 91	EMERGENCY		AGGREGATE					524,451 1
200	TOTAL							524,451 200

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

WORKSHEET A-8-3
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					4	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					60	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					5	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		18.58				9
10	AHSEA		70.30				10
11	STANDARD TRAVEL ALLOWANCE	35.15	35.15				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					1,306	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					1,306	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					1,306	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					70.29	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					4,217	22
23	TOTAL SALARY EQUIVALENCY					4,217	23

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

WORKSHEET A-8-3
 PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	176	24
25	ASSISTANTS		25
26	SUBTOTAL	176	26
27	STANDARD TRAVEL EXPENSE	25	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	201	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	201	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

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

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

WORKSHEET A-8-3
 PARTS V, VI & VII

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

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					4,217	57
58					201	58
59						59
60						60
61						61
62						62
63					4,418	63
64					1,022	64
65						65

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

WORKSHEET A-8-3
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					124	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		452.75				9
10	AHSEA		74.18				10
11	STANDARD TRAVEL ALLOWANCE	37.09	37.09				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					33,585	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					33,585	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					33,585	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					74.18	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					57,860	22
23	TOTAL SALARY EQUIVALENCY					57,860	23

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

WORKSHEET A-8-3
 PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	4,599	24
25	ASSISTANTS		25
26	SUBTOTAL	4,599	26
27	STANDARD TRAVEL EXPENSE	620	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	5,219	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	5,219	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

STANDARD TRAVEL EXPENSE			
36	THERAPISTS		36
37	ASSISTANTS		37
38	SUBTOTAL		38
39	STANDARD TRAVEL EXPENSE		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS		40
41	ASSISTANTS		41
42	SUBTOTAL		42
43	OPTIONAL TRAVEL EXPENSE		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

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

WORKSHEET A-8-3
 PARTS V, VI & VII

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

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					57,860	57
58					5,219	58
59						59
60						60
61						61
62						62
63					63,079	63
64					24,545	64
65						65

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

WORKSHEET A-8-3
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					4	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					60	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					8	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		20.75				9
10	AHSEA		67.56				10
11	STANDARD TRAVEL ALLOWANCE	33.78	33.78				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					1,402	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					1,402	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					1,402	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					67.57	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					4,054	22
23	TOTAL SALARY EQUIVALENCY					4,054	23

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

WORKSHEET A-8-3
 PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	270	24
25	ASSISTANTS		25
26	SUBTOTAL	270	26
27	STANDARD TRAVEL EXPENSE	40	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	310	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	310	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

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

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

PROVIDER CCN: 14-1331 MARSHALL BROWNING 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: 2013.11
 11/19/2013 14:16

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

WORKSHEET A-8-3
 PARTS V, VI & VII

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

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					4,054	57
58					310	58
59						59
60						60
61						61
62						62
63					4,364	63
64					1,245	64
65						65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP BLDGS + FIXTURES 1.01	CAP REL COSTS- BLDG & FIX 1.02	CAP MOVABLE EQUIPMENT 2	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	534,444	534,444				1
1.01 2008 BLDG & FIXT	525,626		525,626			1.01
1.02 RHC BLDG & FIXT	34,255			34,255		1.02
2 CAP REL COSTS-MVBLE EQUIP	208,924				208,924	2
2.01 2008 MVBLE EQUIP	63,042					2.01
2.02 RHC MVBLE EQUIP	2,065					2.02
4 EMPLOYEE BENEFITS DEPARTMENT	1,999,498					4
5 ADMINISTRATIVE & GENERAL	1,748,088	144,056	14,062		73,523	5
6 MAINTENANCE & REPAIRS	320,227					6
7 OPERATION OF PLANT	233,427	45,826	4,955		1,513	7
8 LAUNDRY & LINEN SERVICE	68,442	17,991			358	8
9 HOUSEKEEPING	248,550	10,261			949	9
10 DIETARY	182,973	21,555			577	10
11 CAFETERIA	131,333	6,403			533	11
13 NURSING ADMINISTRATION	474,431	5,226			1,084	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	805,917		28,853		1,522	15
16 MEDICAL RECORDS & LIBRARY	231,184	11,294			2,155	16
17 SOCIAL SERVICE	64,505	1,108				17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	967,575		295,213		11,424	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	278,805		134,430		6,965	50
53 ANESTHESIOLOGY	213,784					53
54 RADIOLOGY-DIAGNOSTIC	909,500	11,520			68,242	54
60 LABORATORY	697,921	3,236	48,113		5,424	60
65 RESPIRATORY THERAPY	267,978	17,519			10,536	65
66 PHYSICAL THERAPY	594,319	28,841			8,770	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	31,777	513				69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	649,828					71
73 DRUGS CHARGED TO PATIENTS						73
73.01 CARDIAC REHABILITATION	36,422	4,535			4,170	73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	704,915			34,255		88
91 EMERGENCY	1,007,610	19,619			7,127	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	14,237,365	349,503	525,626	34,255	204,872	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,589				190
192 PHYSICIANS' PRIVATE OFFICES	597,363	36,886			3,331	192
192.02 INDEPENDENT LIVING	182,929	142,466			721	192.02
192.03 MEALS ON WHEELS						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	15,017,657	534,444	525,626	34,255	208,924	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAP MOVABLE EQUIPMENT 2.01	CAP MVBLE EQUI 2.02	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 2008 BLDG & FIXT						1.01
1.02 RHC BLDG & FIXT						1.02
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 2008 MVBLE EQUIP	63,042					2.01
2.02 RHC MVBLE EQUIP		2,065				2.02
4 EMPLOYEE BENEFITS DEPARTMENT			1,999,498			4
5 ADMINISTRATIVE & GENERAL	9		279,418	2,259,156	2,259,156	5
6 MAINTENANCE & REPAIRS			53,616	373,843	66,197	6
7 OPERATION OF PLANT				285,721	50,593	7
8 LAUNDRY & LINEN SERVICE			6,557	93,348	16,529	8
9 HOUSEKEEPING			60,154	319,914	56,647	9
10 DIETARY			30,912	236,017	41,792	10
11 CAFETERIA			28,534	166,803	29,536	11
13 NURSING ADMINISTRATION			130,024	610,765	108,149	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	6,867		62,326	905,485	160,335	15
16 MEDICAL RECORDS & LIBRARY			58,096	302,729	53,605	16
17 SOCIAL SERVICE			17,034	82,647	14,634	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	49,691		239,656	1,563,559	276,854	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,607		67,057	488,864	86,564	50
53 ANESTHESIOLOGY			27,624	241,408	42,746	53
54 RADIOLOGY-DIAGNOSTIC			119,175	1,108,437	196,272	54
60 LABORATORY	4,868		119,174	878,736	155,599	60
65 RESPIRATORY THERAPY			61,466	357,499	63,303	65
66 PHYSICAL THERAPY			155,428	787,358	139,418	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY			6,929	39,219	6,945	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS				649,828	115,066	71
73 DRUGS CHARGED TO PATIENTS						73
73.01 CARDIAC REHABILITATION			9,302	54,429	9,638	73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC		2,065	181,828	923,063	163,448	88
91 EMERGENCY			134,374	1,168,730	206,948	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	63,042	2,065	1,848,684	13,897,558	2,060,818	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				5,589	990	190
192 PHYSICIANS' PRIVATE OFFICES			131,732	769,312	136,223	192
192.02 INDEPENDENT LIVING			19,082	345,198	61,125	192.02
192.03 MEALS ON WHEELS						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	63,042	2,065	1,999,498	15,017,657	2,259,156	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 2008 BLDG & FIXT						1.01
1.02 RHC BLDG & FIXT						1.02
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 2008 MVBLE EQUIP						2.01
2.02 RHC MVBLE EQUIP						2.02
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	440,040					6
7 OPERATION OF PLANT		336,314				7
8 LAUNDRY & LINEN SERVICE	7,261	17,549	134,687			8
9 HOUSEKEEPING	10,166	10,009	2,064	398,800		9
10 DIETARY	23,236	21,025	2,933	29,814	354,817	10
11 CAFETERIA	21,784	6,246	2,688	27,503		11
13 NURSING ADMINISTRATION		5,098				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	6,535	7,927		5,171		15
16 MEDICAL RECORDS & LIBRARY	5,083	11,017		6,161		16
17 SOCIAL SERVICE		1,081				17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	198,236	81,104	77,200	188,123	346,428	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	15,249	36,933	12,002	25,193		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	13,797	11,237	4,481	18,042		54
60 LABORATORY	35,581	16,375	625	13,422		60
65 RESPIRATORY THERAPY	31,950	17,089	6,354	17,382		65
66 PHYSICAL THERAPY	9,440	28,132	17,542	15,622		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		500				69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
73.01 CARDIAC REHABILITATION	2,905	4,424		110		73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	11,618			14,742		88
91 EMERGENCY	18,153	19,137	8,798	22,443		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	410,994	294,883	134,687	383,728	346,428	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,452				190
192 PHYSICIANS' PRIVATE OFFICES	4,357	35,979		14,852		192
192.02 INDEPENDENT LIVING	24,689			220		192.02
192.03 MEALS ON WHEELS					8,389	192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	440,040	336,314	134,687	398,800	354,817	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 2008 BLDG & FIXT						1.01
1.02 RHC BLDG & FIXT						1.02
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 2008 MVBLE EQUIP						2.01
2.02 RHC MVBLE EQUIP						2.02
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	254,560					11
13 NURSING ADMINISTRATION	14,853	738,865				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	7,541		1,092,994			15
16 MEDICAL RECORDS & LIBRARY	17,595			396,190		16
17 SOCIAL SERVICE	2,742				101,104	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	56,442	464,534		203,934	101,104	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	10,968	86,504		9,927		50
53 ANESTHESIOLOGY	1,600					53
54 RADIOLOGY-DIAGNOSTIC	20,794			14,014		54
60 LABORATORY	23,079			26,276		60
65 RESPIRATORY THERAPY	11,654			9,343		65
66 PHYSICAL THERAPY	23,994			7,445		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS			1,092,994			73
73.01 CARDIAC REHABILITATION	1,828			146		73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	24,908			21,167		88
91 EMERGENCY	22,394	187,827		74,158		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	240,392	738,865	1,092,994	366,410	101,104	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES	8,455			29,780		192
192.02 INDEPENDENT LIVING	5,713					192.02
192.03 MEALS ON WHEELS						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	254,560	738,865	1,092,994	396,190	101,104	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
1.01 2008 BLDG & FIXT				1.01
1.02 RHC BLDG & FIXT				1.02
2 CAP REL COSTS-MVBLE EQUIP				2
2.01 2008 MVBLE EQUIP				2.01
2.02 RHC MVBLE EQUIP				2.02
4 EMPLOYEE BENEFITS DEPARTMENT				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
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	3,557,518		3,557,518	30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	772,204		772,204	50
53 ANESTHESIOLOGY	285,754		285,754	53
54 RADIOLOGY-DIAGNOSTIC	1,387,074		1,387,074	54
60 LABORATORY	1,149,693		1,149,693	60
65 RESPIRATORY THERAPY	514,574		514,574	65
66 PHYSICAL THERAPY	1,028,951		1,028,951	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	46,664		46,664	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	764,894		764,894	71
73 DRUGS CHARGED TO PATIENTS	1,092,994		1,092,994	73
73.01 CARDIAC REHABILITATION	73,480		73,480	73.01
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION				76.97
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC	1,158,946		1,158,946	88
91 EMERGENCY	1,728,588		1,728,588	91
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
118 SUBTOTALS (SUM OF LINES 1-117)	13,561,334		13,561,334	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,031		12,031	190
192 PHYSICIANS' PRIVATE OFFICES	998,958		998,958	192
192.02 INDEPENDENT LIVING	436,945		436,945	192.02
192.03 MEALS ON WHEELS	8,389		8,389	192.03
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	15,017,657		15,017,657	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP BLDGS + FIXTURES 1.01	CAP REL COSTS- BLDG & FIX 1.02	CAP MOVABLE EQUIPMENT 2	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 2008 BLDG & FIXT						1.01
1.02 RHC BLDG & FIXT						1.02
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 2008 MVBLE EQUIP						2.01
2.02 RHC MVBLE EQUIP						2.02
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL		144,056	14,062		73,523	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		45,826	4,955		1,513	7
8 LAUNDRY & LINEN SERVICE		17,991			358	8
9 HOUSEKEEPING		10,261			949	9
10 DIETARY		21,555			577	10
11 CAFETERIA		6,403			533	11
13 NURSING ADMINISTRATION		5,226			1,084	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY			28,853		1,522	15
16 MEDICAL RECORDS & LIBRARY		11,294			2,155	16
17 SOCIAL SERVICE		1,108				17
INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS			295,213		11,424	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			134,430		6,965	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		11,520			68,242	54
60 LABORATORY		3,236	48,113		5,424	60
65 RESPIRATORY THERAPY		17,519			10,536	65
66 PHYSICAL THERAPY		28,841			8,770	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		513				69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
73.01 CARDIAC REHABILITATION		4,535			4,170	73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC				34,255		88
91 EMERGENCY		19,619			7,127	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		349,503	525,626	34,255	204,872	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,589				190
192 PHYSICIANS' PRIVATE OFFICES		36,886			3,331	192
192.02 INDEPENDENT LIVING		142,466			721	192.02
192.03 MEALS ON WHEELS						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		534,444	525,626	34,255	208,924	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAP MOVABLE EQUIPMENT 2.01	CAP MVBLE EQUI 2.02	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 2008 BLDG & FIXT						1.01
1.02 RHC BLDG & FIXT						1.02
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 2008 MVBLE EQUIP						2.01
2.02 RHC MVBLE EQUIP						2.02
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	9		231,650	231,650		5
6 MAINTENANCE & REPAIRS				6,788	6,788	6
7 OPERATION OF PLANT			52,294	5,188		7
8 LAUNDRY & LINEN SERVICE			18,349	1,695	112	8
9 HOUSEKEEPING			11,210	5,809	157	9
10 DIETARY			22,132	4,285	358	10
11 CAFETERIA			6,936	3,029	336	11
13 NURSING ADMINISTRATION			6,310	11,090		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	6,867		37,242	16,441	101	15
16 MEDICAL RECORDS & LIBRARY			13,449	5,497	78	16
17 SOCIAL SERVICE			1,108	1,501		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	49,691		356,328	28,383	3,058	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,607		143,002	8,876	235	50
53 ANESTHESIOLOGY				4,383		53
54 RADIOLOGY-DIAGNOSTIC			79,762	20,126	213	54
60 LABORATORY	4,868		61,641	15,955	549	60
65 RESPIRATORY THERAPY			28,055	6,491	493	65
66 PHYSICAL THERAPY			37,611	14,296	146	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY			513	712		69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS				11,799		71
73 DRUGS CHARGED TO PATIENTS						73
73.01 CARDIAC REHABILITATION			8,705	988	45	73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC		2,065	36,320	16,760	179	88
91 EMERGENCY			26,746	21,221	280	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	63,042	2,065	1,179,363	211,313	6,340	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			5,589	101		190
192 PHYSICIANS' PRIVATE OFFICES			40,217	13,968	67	192
192.02 INDEPENDENT LIVING			143,187	6,268	381	192.02
192.03 MEALS ON WHEELS						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	63,042	2,065	1,368,356	231,650	6,788	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 2008 BLDG & FIXT						1.01
1.02 RHC BLDG & FIXT						1.02
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 2008 MVBLE EQUIP						2.01
2.02 RHC MVBLE EQUIP						2.02
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	57,482					7
8 LAUNDRY & LINEN SERVICE	2,999	23,155				8
9 HOUSEKEEPING	1,711	355	19,242			9
10 DIETARY	3,594	504	1,439	32,312		10
11 CAFETERIA	1,067	462	1,327		13,157	11
13 NURSING ADMINISTRATION	871				768	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,355		249		390	15
16 MEDICAL RECORDS & LIBRARY	1,883		297		909	16
17 SOCIAL SERVICE	185				142	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	13,861	13,273	9,075	31,548	2,918	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,313	2,063	1,216		567	50
53 ANESTHESIOLOGY					83	53
54 RADIOLOGY-DIAGNOSTIC	1,921	770	871		1,075	54
60 LABORATORY	2,799	107	648		1,193	60
65 RESPIRATORY THERAPY	2,921	1,092	839		602	65
66 PHYSICAL THERAPY	4,808	3,016	754		1,240	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	86					69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
73.01 CARDIAC REHABILITATION	756		5		94	73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC			711		1,287	88
91 EMERGENCY	3,271	1,513	1,083		1,157	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	50,401	23,155	18,514	31,548	12,425	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	932					190
192 PHYSICIANS' PRIVATE OFFICES	6,149		717		437	192
192.02 INDEPENDENT LIVING			11		295	192.02
192.03 MEALS ON WHEELS				764		192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	57,482	23,155	19,242	32,312	13,157	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
	13	15	16	17	24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 2008 BLDG & FIXT						1.01
1.02 RHC BLDG & FIXT						1.02
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 2008 MVBLE EQUIP						2.01
2.02 RHC MVBLE EQUIP						2.02
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	19,039					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		55,778				15
16 MEDICAL RECORDS & LIBRARY			22,113			16
17 SOCIAL SERVICE				2,936		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	11,970		11,383	2,936	484,733	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,229		554		165,055	50
53 ANESTHESIOLOGY					4,466	53
54 RADIOLOGY-DIAGNOSTIC			782		105,520	54
60 LABORATORY			1,467		84,359	60
65 RESPIRATORY THERAPY			521		41,014	65
66 PHYSICAL THERAPY			416		62,287	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY					1,311	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS					11,799	71
73 DRUGS CHARGED TO PATIENTS		55,778			55,778	73
73.01 CARDIAC REHABILITATION			8		10,601	73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC			1,181		56,438	88
91 EMERGENCY	4,840		4,139		64,250	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	19,039	55,778	20,451	2,936	1,147,611	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					6,622	190
192 PHYSICIANS' PRIVATE OFFICES			1,662		63,217	192
192.02 INDEPENDENT LIVING					150,142	192.02
192.03 MEALS ON WHEELS					764	192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	19,039	55,778	22,113	2,936	1,368,356	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	25	26	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
1.01 2008 BLDG & FIXT			1.01
1.02 RHC BLDG & FIXT			1.02
2 CAP REL COSTS-MVBLE EQUIP			2
2.01 2008 MVBLE EQUIP			2.01
2.02 RHC MVBLE EQUIP			2.02
4 EMPLOYEE BENEFITS DEPARTMENT			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
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	484,733		30
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	165,055		50
53 ANESTHESIOLOGY	4,466		53
54 RADIOLOGY-DIAGNOSTIC	105,520		54
60 LABORATORY	84,359		60
65 RESPIRATORY THERAPY	41,014		65
66 PHYSICAL THERAPY	62,287		66
67 OCCUPATIONAL THERAPY			67
68 SPEECH PATHOLOGY			68
69 ELECTROCARDIOLOGY	1,311		69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,799		71
73 DRUGS CHARGED TO PATIENTS	55,778		73
73.01 CARDIAC REHABILITATION	10,601		73.01
74 RENAL DIALYSIS			74
76.97 CARDIAC REHABILITATION			76.97
OUTPATIENT SERVICE COST CENTERS			
88 RURAL HEALTH CLINIC	56,438		88
91 EMERGENCY	64,250		91
92 OBSERVATION BEDS (NON-DISTINCT PART)			92
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
SPECIAL PURPOSE COST CENTERS			
113 INTEREST EXPENSE			113
118 SUBTOTALS (SUM OF LINES 1-117)	1,147,611		118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,622		190
192 PHYSICIANS' PRIVATE OFFICES	63,217		192
192.02 INDEPENDENT LIVING	150,142		192.02
192.03 MEALS ON WHEELS	764		192.03
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)	1,368,356		202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP BLDGS + FIXTURES SQUARE FEET	CAP REL COSTS-BLDG & FIX SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	CAP MOVABLE EQUIPMENT DOLLAR VALUE	
	1	1.01	1.02	2	2.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	78,126					1
1.01 2008 BLDG & FIXT		21,642				1.01
1.02 RHC BLDG & FIXT			4,575			1.02
2 CAP REL COSTS-MVBLE EQUIP				194,145		2
2.01 2008 MVBLE EQUIP					21,344	2.01
2.02 RHC MVBLE EQUIP						2.02
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	21,058	579		68,322	3	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	6,699	204		1,406		7
8 LAUNDRY & LINEN SERVICE	2,630			333		8
9 HOUSEKEEPING	1,500			882		9
10 DIETARY	3,151			536		10
11 CAFETERIA	936			495		11
13 NURSING ADMINISTRATION	764			1,007		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		1,188		1,414	2,325	15
16 MEDICAL RECORDS & LIBRARY	1,651			2,003		16
17 SOCIAL SERVICE	162					17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		12,155		10,616	16,824	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		5,535		6,472	544	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,684			63,415		54
60 LABORATORY	473	1,981		5,040	1,648	60
65 RESPIRATORY THERAPY	2,561			9,791		65
66 PHYSICAL THERAPY	4,216			8,150		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	75					69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
73.01 CARDIAC REHABILITATION	663			3,875		73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC			4,575			88
91 EMERGENCY	2,868			6,623		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	51,091	21,642	4,575	190,380	21,344	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	817					190
192 PHYSICIANS' PRIVATE OFFICES	5,392			3,095		192
192.02 INDEPENDENT LIVING	20,826			670		192.02
192.03 MEALS ON WHEELS						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	534,444	525,626	34,255	208,924	63,042	202
203 UNIT COST MULT-WS B PT I	6.840796	24.287312	7.487432	1.076124	2.953617	203
204 COST TO BE ALLOC PER B PT II						204
205 UNIT COST MULT-WS B PT II						205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP MVBLE EQUI DOLLAR VALUE 2.02	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	MAIN- TENANCE & REPAIRS TIME SPENT 6	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 2008 BLDG & FIXT						1.01
1.02 RHC BLDG & FIXT						1.02
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 2008 MVBLE EQUIP						2.01
2.02 RHC MVBLE EQUIP	2,016					2.02
4 EMPLOYEE BENEFITS DEPARTMENT		7,145,142				4
5 ADMINISTRATIVE & GENERAL		998,490	-2,259,156	12,758,501		5
6 MAINTENANCE & REPAIRS		191,594		373,843	606	6
7 OPERATION OF PLANT				285,721		7
8 LAUNDRY & LINEN SERVICE		23,432		93,348	10	8
9 HOUSEKEEPING		214,957		319,914	14	9
10 DIETARY		110,463		236,017	32	10
11 CAFETERIA		101,965		166,803	30	11
13 NURSING ADMINISTRATION		464,636		610,765		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		222,721		905,485	9	15
16 MEDICAL RECORDS & LIBRARY		207,604		302,729	7	16
17 SOCIAL SERVICE		60,870		82,647		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		856,403		1,563,559	273	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		239,625		488,864	21	50
53 ANESTHESIOLOGY		98,714		241,408		53
54 RADIOLOGY-DIAGNOSTIC		425,867		1,108,437	19	54
60 LABORATORY		425,863		878,736	49	60
65 RESPIRATORY THERAPY		219,648		357,499	44	65
66 PHYSICAL THERAPY		555,416		787,358	13	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		24,762		39,219		69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS				649,828		71
73 DRUGS CHARGED TO PATIENTS						73
73.01 CARDIAC REHABILITATION		33,241		54,429	4	73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	2,016	649,757		923,063	16	88
91 EMERGENCY		480,183		1,168,730	25	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	2,016	6,606,211	-2,259,156	11,638,402	566	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				5,589		190
192 PHYSICIANS' PRIVATE OFFICES		470,741		769,312	6	192
192.02 INDEPENDENT LIVING		68,190		345,198	34	192.02
192.03 MEALS ON WHEELS						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,065	1,999,498		2,259,156	440,040	202
203 UNIT COST MULT-WS B PT I	1.024306	0.279840		0.177071	726.138614	203
204 COST TO BE ALLOC PER B PT II				231,650	6,788	204
205 UNIT COST MULT-WS B PT II				0.018157	11.201320	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA
	OF PLANT	& LINEN	KEEPING		
	SQUARE	SERVICE	TIME	MEALS	MEALS
	FEEET	POUNDS OF	SPENT	SERVED	SERVED
	7	LAUNDRY	9	10	11
		8			
GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT				1
1.01	2008 BLDG & FIXT				1.01
1.02	RHC BLDG & FIXT				1.02
2	CAP REL COSTS-MVBLE EQUIP				2
2.01	2008 MVBLE EQUIP				2.01
2.02	RHC MVBLE EQUIP				2.02
4	EMPLOYEE BENEFITS DEPARTMENT				4
5	ADMINISTRATIVE & GENERAL				5
6	MAINTENANCE & REPAIRS				6
7	OPERATION OF PLANT	50,402			7
8	LAUNDRY & LINEN SERVICE	2,630	4,960		8
9	HOUSEKEEPING	1,500	76	3,625	9
10	DIETARY	3,151	108	271	15,099
11	CAFETERIA	936	99	250	
13	NURSING ADMINISTRATION	764			1,114
14	CENTRAL SERVICES & SUPPLY				65
15	PHARMACY	1,188		47	33
16	MEDICAL RECORDS & LIBRARY	1,651		56	77
17	SOCIAL SERVICE	162			12
INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	12,155	2,843	1,710	14,742
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	5,535	442	229	48
53	ANESTHESIOLOGY				7
54	RADIOLOGY-DIAGNOSTIC	1,684	165	164	91
60	LABORATORY	2,454	23	122	101
65	RESPIRATORY THERAPY	2,561	234	158	51
66	PHYSICAL THERAPY	4,216	646	142	105
67	OCCUPATIONAL THERAPY				
68	SPEECH PATHOLOGY				
69	ELECTROCARDIOLOGY	75			
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				
73	DRUGS CHARGED TO PATIENTS				
73.01	CARDIAC REHABILITATION	663		1	8
74	RENAL DIALYSIS				
76.97	CARDIAC REHABILITATION				
OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC			134	109
91	EMERGENCY	2,868	324	204	98
92	OBSERVATION BEDS (NON-DISTINCT PART)				
OTHER REIMBURSABLE COST CENTERS					
94	HOME PROGRAM DIALYSIS				
SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	44,193	4,960	3,488	14,742
NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	817			
192	PHYSICIANS' PRIVATE OFFICES	5,392		135	37
192.02	INDEPENDENT LIVING			2	25
192.03	MEALS ON WHEELS				357
200	CROSS FOOT ADJUSTMENTS				
201	NEGATIVE COST CENTER				
202	COST TO BE ALLOC PER B PT I	336,314	134,687	398,800	354,817
203	UNIT COST MULT-WS B PT I	6.672632	27.154637	110.013793	23.499371
204	COST TO BE ALLOC PER B PT II	57,482	23,155	19,242	32,312
205	UNIT COST MULT-WS B PT II	1.140471	4.668347	5.308138	2.140009
					254,560
					228.509874
					13,157
					11.810592

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION HOURS SUPE RVED 13	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
1.01 2008 BLDG & FIXT					1.01
1.02 RHC BLDG & FIXT					1.02
2 CAP REL COSTS-MVBLE EQUIP					2
2.01 2008 MVBLE EQUIP					2.01
2.02 RHC MVBLE EQUIP					2.02
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
13 NURSING ADMINISTRATION	74,293				13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY		1,000			15
16 MEDICAL RECORDS & LIBRARY			2,714		16
17 SOCIAL SERVICE				464	17
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	46,709		1,397	464	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	8,698		68		50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC			96		54
60 LABORATORY			180		60
65 RESPIRATORY THERAPY			64		65
66 PHYSICAL THERAPY			51		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS					71
73 DRUGS CHARGED TO PATIENTS		1,000			73
73.01 CARDIAC REHABILITATION			1		73.01
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC			145		88
91 EMERGENCY	18,886		508		91
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	74,293	1,000	2,510	464	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
192 PHYSICIANS' PRIVATE OFFICES			204		192
192.02 INDEPENDENT LIVING					192.02
192.03 MEALS ON WHEELS					192.03
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	738,865	1,092,994	396,190	101,104	202
203 UNIT COST MULT-WS B PT I	9.945284	1,092.994000	145.980103	217.896552	203
204 COST TO BE ALLOC PER B PT II	19,039	55,778	22,113	2,936	204
205 UNIT COST MULT-WS B PT II	0.256269	55.778000	8.147752	6.327586	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	3,557,518		3,557,518		3,557,518	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	772,204		772,204		772,204	50
53 ANESTHESIOLOGY	285,754		285,754		285,754	53
54 RADIOLOGY-DIAGNOSTIC	1,387,074		1,387,074		1,387,074	54
60 LABORATORY	1,149,693		1,149,693		1,149,693	60
65 RESPIRATORY THERAPY	514,574		514,574		514,574	65
66 PHYSICAL THERAPY	1,028,951		1,028,951		1,028,951	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	46,664		46,664		46,664	69
71 MEDICAL SUPPLIES CHARGED TO	764,894		764,894		764,894	71
73 DRUGS CHARGED TO PATIENTS	1,092,994		1,092,994		1,092,994	73
73.01 CARDIAC REHABILITATION	73,480		73,480		73,480	73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC	1,158,946		1,158,946		1,158,946	88
91 EMERGENCY	1,728,588		1,728,588		1,728,588	91
92 OBSERVATION BEDS (NON-DISTI	102,566		102,566		102,566	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	13,663,900		13,663,900		13,663,900	200
201 LESS OBSERVATION BEDS	102,566		102,566		102,566	201
202 TOTAL (SEE INSTRUCTIONS)	13,561,334		13,561,334		13,561,334	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						30
ADULTS & PEDIATRICS	1,132,686		1,132,686			
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	121,488	492,266	613,754	1.258165	1.258165	1.258165 50
53 ANESTHESIOLOGY	89,320	229,293	318,613	0.896869	0.896869	0.896869 53
54 RADIOLOGY-DIAGNOSTIC	1,015,485	6,516,553	7,532,038	0.184157	0.184157	0.184157 54
60 LABORATORY	1,908,568	5,295,041	7,203,609	0.159600	0.159600	0.159600 60
65 RESPIRATORY THERAPY	506,941	438,208	945,149	0.544437	0.544437	0.544437 65
66 PHYSICAL THERAPY	435,873	1,902,947	2,338,820	0.439945	0.439945	0.439945 66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	348,428	448,597	797,025	0.058548	0.058548	0.058548 69
71 MEDICAL SUPPLIES CHARGED TO	1,531,367	768,063	2,299,430	0.332645	0.332645	0.332645 71
73 DRUGS CHARGED TO PATIENTS	1,352,377	653,733	2,006,110	0.544833	0.544833	0.544833 73
73.01 CARDIAC REHABILITATION		186,529	186,529	0.393933	0.393933	0.393933 73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC		529,722	529,722			88
91 EMERGENCY	64,704	1,978,863	2,043,567	0.845868	0.845868	0.845868 91
92 OBSERVATION BEDS (NON-DISTI OTHER REIMBURSABLE COST CENTERS	18,694	310,163	328,857	0.311886	0.311886	0.311886 92
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	8,525,931	19,749,978	28,275,909			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	8,525,931	19,749,978	28,275,909			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1331) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	1.258165		171,740			216,077		50
53 ANESTHESIOLOGY	0.896869		98,020			87,911		53
54 RADIOLOGY-DIAGNOSTIC	0.184157		2,904,568			534,897		54
60 LABORATORY	0.159600		2,569,002			410,013		60
65 RESPIRATORY THERAPY	0.544437		121,412			66,101		65
66 PHYSICAL THERAPY	0.439945		784,754			345,249		66
67 OCCUPATIONAL THERAPY								67
68 SPEECH PATHOLOGY								68
69 ELECTROCARDIOLOGY	0.058548		129,742			7,596		69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.332645		492,261			163,748		71
73 DRUGS CHARGED TO PATIENTS	0.544833		522,846			284,864		73
73.01 CARDIAC REHABILITATION	0.393933		105,641			41,615		73.01
74 RENAL DIALYSIS								74
76.97 CARDIAC REHABILITATION								76.97
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC								88
91 EMERGENCY	0.845868		656,945			555,689		91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.311886		172,651			53,847		92
HOME PROGRAM DIALYSIS								
94 HOME PROGRAM DIALYSIS								94
200 SUBTOTAL (SEE INSTRUCTIONS)			8,729,582			2,767,607		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			8,729,582			2,767,607		202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (14-Z331)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	1.258165							50
53 ANESTHESIOLOGY	0.896869							53
54 RADIOLOGY-DIAGNOSTIC	0.184157							54
60 LABORATORY	0.159600							60
65 RESPIRATORY THERAPY	0.544437							65
66 PHYSICAL THERAPY	0.439945							66
67 OCCUPATIONAL THERAPY								67
68 SPEECH PATHOLOGY								68
69 ELECTROCARDIOLOGY	0.058548							69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.332645							71
73 DRUGS CHARGED TO PATIENTS	0.544833							73
73.01 CARDIAC REHABILITATION	0.393933							73.01
74 RENAL DIALYSIS								74
76.97 CARDIAC REHABILITATION								76.97
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC								88
91 EMERGENCY	0.845868							91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.311886							92
HOME PROGRAM DIALYSIS								
94 HOME PROGRAM DIALYSIS								94
200 SUBTOTAL (SEE INSTRUCTIONS)								200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, ADJUSTMENT COL. 26)	ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 + COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
30 INPAT ROUTINE SERV COST CTRS								30
ADULTS & PEDIATRICS	484,733	240,167	244,566	1,785	137.01	152	20,826	31
31 INTENSIVE CARE UNIT								32
32 CORONARY CARE UNIT								33
33 BURN INTENSIVE CARE UNIT								34
34 SURGICAL INTENSIVE CARE UNIT								35
35 OTHER SPECIAL CARE (SPECIFY)								40
40 SUBPROVIDER - IPF								41
41 SUBPROVIDER - IRF								42
42 SUBPROVIDER I								43
43 NURSERY								44
44 SKILLED NURSING FACILITY								45
45 NURSING FACILITY								200
200 TOTAL (LINES 30-199)	484,733		244,566	1,785		152	20,826	

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 (14-1331) [] 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	165,055	613,754	0.268927	17,711	4,763	50
53	ANESTHESIOLOGY	4,466	318,613	0.014017	11,310	159	53
54	RADIOLOGY-DIAGNOSTIC	105,520	7,532,038	0.014009	133,528	1,871	54
60	LABORATORY	84,359	7,203,609	0.011711	132,283	1,549	60
65	RESPIRATORY THERAPY	41,014	945,149	0.043394	25,583	1,110	65
66	PHYSICAL THERAPY	62,287	2,338,820	0.026632	1,958	52	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	1,311	797,025	0.001645	10,986	18	69
71	MEDICAL SUPPLIES CHARGED TO P	11,799	2,299,430	0.005131	97,308	499	71
73	DRUGS CHARGED TO PATIENTS	55,778	2,006,110	0.027804	56,110	1,560	73
73.01	CARDIAC REHABILITATION	10,601	186,529	0.056833			73.01
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	56,438	529,722	0.106543			88
91	EMERGENCY	64,250	2,043,567	0.031440	30,912	972	91
92	OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	27,699	328,857	0.084228			92
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	690,577	27,143,223		517,689	12,553	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 + COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	1,785		152		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	1,785		152		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK TITLE V HOSPITAL (14-1331) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX IRF NF OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHARGED TO P						71
73 DRUGS CHARGED TO PATIENTS						73
73.01 CARDIAC REHABILITATION						73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC						88
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-1331)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	IRF	[]	NF			[]	OTHER
COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT	INPAT PGM	O/P PGM	O/P PGM			
	CHARGES	COST TO	OF COST TO		PASS-THRU		CHARGES	CHARGES		
	(FROM WKST	CHARGES	CHARGES	PGM	(COL. 8 x		(COL. 9 x			
	C, PT. I,	(COL. 5 +	(COL. 6 +	CHARGES	COL. 10)		COL. 12)			
	COL. 8)	COL. 7)	COL. 7)							
	7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS										
50	OPERATING ROOM	613,754			17,711		50			
53	ANESTHESIOLOGY	318,613			11,310		53			
54	RADIOLOGY-DIAGNOSTIC	7,532,038			133,528		54			
60	LABORATORY	7,203,609			132,283		60			
65	RESPIRATORY THERAPY	945,149			25,583		65			
66	PHYSICAL THERAPY	2,338,820			1,958		66			
67	OCCUPATIONAL THERAPY						67			
68	SPEECH PATHOLOGY						68			
69	ELECTROCARDIOLOGY	797,025			10,986		69			
71	MEDICAL SUPPLIES CHARGED TO	2,299,430			97,308		71			
73	DRUGS CHARGED TO PATIENTS	2,006,110			56,110		73			
73.01	CARDIAC REHABILITATION	186,529					73.01			
74	RENAL DIALYSIS						74			
76.97	CARDIAC REHABILITATION						76.97			
OUTPATIENT SERVICE COST CENTERS										
88	RURAL HEALTH CLINIC	529,722					88			
91	EMERGENCY	2,043,567			30,912		91			
92	OBSERVATION BEDS (NON-DISTIN	328,857					92			
OTHER REIMBURSABLE COST CENTERS										
94	HOME PROGRAM DIALYSIS						94			
200	TOTAL (SUM OF LINES 50-199)	27,143,223			517,689		200			

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1331) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	COST SERVICES SUBJECT TO DED & COINS 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1.258165		66,081		83,141	50
53 ANESTHESIOLOGY	0.896869		39,997		35,872	53
54 RADIOLOGY-DIAGNOSTIC	0.184157		1,215,785		223,895	54
60 LABORATORY	0.159600		721,137		115,093	60
65 RESPIRATORY THERAPY	0.544437		42,004		22,869	65
66 PHYSICAL THERAPY	0.439945		186,672		82,125	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	0.058548		62,798		3,677	69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.332645		274,860		91,431	71
73 DRUGS CHARGED TO PATIENTS	0.544833		83,872		45,696	73
73.01 CARDIAC REHABILITATION	0.393933					73.01
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC						88
91 EMERGENCY	0.845868		741,338		627,074	91
92 OBSERVATION BEDS (NON-DISTINCT)	0.311886		80,840		25,213	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 SUBTOTAL (SEE INSTRUCTIONS)			3,515,384		1,356,086	200
201 LESS PBP CLINIC LAB SERVICES						201
202 NET CHARGES (LINE 200 - LINE 201)			3,515,384		1,356,086	202

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1331) [] 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)	3,565	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,785	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,683	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	875	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)	874	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	16	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)	15	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,213	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)	875	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)	874	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	124.60	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	127.60	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,557,518	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	1,994	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	1,914	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,762,615	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,794,903	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		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)		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)	1,794,903	37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1331) [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,005.55 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,219,732 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) 1,219,732 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					1,009,245 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,228,977 49

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

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

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 879,856 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 878,851 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 1,758,707 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) 102 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,005.55 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 102,566 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	484,733	1,794,903	0.270061	102,566	27,699 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (14-1331) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX-INPT IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,565	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,785	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,683	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	875	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)	874	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	16	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)	15	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	152	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	124.60	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	127.60	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,557,518	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	1,994	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	1,914	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,762,615	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,794,903	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		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)		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)	1,794,903	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (14-1331) SUB (OTHER) PPS
 APPLICABLE TITLE XVIII-PT A IPF TEFRA
 BOXES TITLE XIX-INPT IRF OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,005.55 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 152,844 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) 152,844 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) 182,648 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 335,492 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 20,826 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 12,553 51
 52 TOTAL PROGRAM EXCLUDABLE COST 33,379 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 302,113 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) 102 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 (14-1331) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
30 INPATIENT ROUTINE SERVICE COST CENTERS					
ADULTS & PEDIATRICS		821,736			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1.258165	56,316	70,855		50
53 ANESTHESIOLOGY	0.896869	42,920	38,494		53
54 RADIOLOGY-DIAGNOSTIC	0.184157	554,945	102,197		54
60 LABORATORY	0.159600	842,095	134,398		60
65 RESPIRATORY THERAPY	0.544437	229,924	125,179		65
66 PHYSICAL THERAPY	0.439945	56,201	24,725		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	0.058548	205,710	12,044		69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.332645	661,253	219,963		71
73 DRUGS CHARGED TO PATIENTS	0.544833	486,083	264,834		73
73.01 CARDIAC REHABILITATION	0.393933				73.01
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC					88
91 EMERGENCY	0.845868	19,573	16,556		91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.311886				92
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		3,155,020	1,009,245		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		3,155,020			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z331) [] 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				
ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1.258165	4,750	5,976	50
53 ANESTHESIOLOGY	0.896869	2,900	2,601	53
54 RADIOLOGY-DIAGNOSTIC	0.184157	68,085	12,538	54
60 LABORATORY	0.159600	688,913	109,951	60
65 RESPIRATORY THERAPY	0.544437	192,020	104,543	65
66 PHYSICAL THERAPY	0.439945	356,814	156,979	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.058548	68,252	3,996	69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.332645	597,031	198,599	71
73 DRUGS CHARGED TO PATIENTS	0.544833	692,553	377,326	73
73.01 CARDIAC REHABILITATION	0.393933			73.01
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION				76.97
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC				88
91 EMERGENCY	0.845868			91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.311886			92
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,671,318	972,509	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,671,318		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1331) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2) 3	
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		128,303		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1.258165	17,711	22,283	50
53 ANESTHESIOLOGY	0.896869	11,310	10,144	53
54 RADIOLOGY-DIAGNOSTIC	0.184157	133,528	24,590	54
60 LABORATORY	0.159600	132,283	21,112	60
65 RESPIRATORY THERAPY	0.544437	25,583	13,928	65
66 PHYSICAL THERAPY	0.439945	1,958	861	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.058548	10,986	643	69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.332645	97,308	32,369	71
73 DRUGS CHARGED TO PATIENTS	0.544833	56,110	30,571	73
73.01 CARDIAC REHABILITATION	0.393933			73.01
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION				76.97
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC				88
91 EMERGENCY	0.845868	30,912	26,147	91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.311886			92
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		517,689	182,648	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		517,689		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

CHECK APPLICABLE BOX: HOSPITAL (14-1331) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	2,767,607	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)	2,767,607	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)	2,795,283	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)	37,905	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,235,805	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	1,521,573	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)	1,521,573	30
31	PRIMARY PAYER PAYMENTS	185	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	1,521,388	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)	178,052	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	178,052	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	178,052	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	1,699,440	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	1,699,440	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	8,497	40.01
41	INTERIM PAYMENTS	1,951,276	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	-260,333	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	53,165	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 (14-1331) IPF IRF	[] [] []	SUB (OTHER) SNF SWING BED SNF	INPATIENT		PART B		
					MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1		TOTAL INTERIM PAYMENTS PAID TO PROVIDER				2,005,560		1,951,276	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.	.01	02/19/2013		84,700		NONE	3.01
			.02						3.02
			PROGRAM						3.03
			TO						3.04
			PROVIDER						3.05
			.06						3.06
			.07						3.07
			.08						3.08
			.09						3.09
			.50			NONE		NONE	3.50
			.51						3.51
			PROVIDER						3.52
			TO						3.53
			PROGRAM						3.54
			.55						3.55
			.56						3.56
			.57						3.57
			.58						3.58
			.59						3.59
		SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99			84,700			3.99
4		TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				2,090,260		1,951,276	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	TO	.01				6.01
			PROVIDER						
			PROVIDER	TO	.02		-59,008	-251,836	6.02
			PROGRAM						
7		TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				2,031,252		1,699,440	7
8		NAME OF CONTRACTOR:				CONTRACTOR NUMBER:		NPR DATE:	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL [] IPF [] IRF	[] SUB (OTHER) [] SNF [XX] SWING BED SNF (14-Z331)	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
DESCRIPTION						
1				2,858,677		1
2				NONE		2
3			02/19/2013	237,900		3.01
						3.02
		PROGRAM				3.03
		TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
				NONE		3.50
						3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
				237,900		3.99
4				3,096,577		4
TO BE COMPLETED BY CONTRACTOR						
5						5.01
		PROGRAM				5.02
		TO				5.03
		PROVIDER				5.04
						5.05
						5.06
						5.07
						5.08
						5.09
		PROVIDER				5.50
		TO				5.51
		PROGRAM				5.52
						5.53
						5.54
						5.55
						5.56
						5.57
						5.58
						5.59
						5.99
6						6.01
		PROGRAM				6.02
		TO				6.03
		PROVIDER				6.04
		PROVIDER				6.05
		TO				6.06
		PROGRAM				6.07
						6.08
						6.09
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						6.11
						6.12
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						6.89
						6.90
						6.91
						6.92
						6.93
						6.94
						6.95
						6.96
						6.97
						6.98
						6.99
						7.00
7				2,712,333		7
8						8
NAME OF CONTRACTOR:				CONTRACTOR NUMBER:	NPR DATE:	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1331) [] 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	713	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,213	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,683	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	28,275,909	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	646,164	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	120,597	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	113,048	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	2,261	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)	110,787	10
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	114,061	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	-3,274	32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-Z331)
 APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
 BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A 1	PART B 2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	1,776,294	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)	982,234	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	1,749	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)	2,758,528	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	2,758,528	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	2,758,528	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	46,195	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)	2,712,333	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		17
17.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17.01
18 ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SEE INSTRUCTIONS)	2,712,333	19
19.01 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	13,562	19.01
20 INTERIM PAYMENTS	3,096,577	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS LINES 19.01, 20 AND 21)	-397,806	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	52,499	23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART V

CHECK HOSPITAL (14-1331)
 APPLICABLE BOX: SUB (OTHER)

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

1	INPATIENT SERVICES	2,228,977	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	2,228,977	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	2,251,267	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)	2,251,267	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	284,558	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,966,709	22
23	COINSURANCE	2,312	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,964,397	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	66,855	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	66,855	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	66,855	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	2,031,252	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	2,031,252	30
30.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	10,156	30.01
31	INTERIM PAYMENTS	2,090,260	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS LINES 30.01, 31 AND 32)	-69,164	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	42,838	34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK TITLE V HOSPITAL (14-1331) 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			1
2			2
3		1,356,086	3
4			4
5		1,356,086	5
6			6
7		1,356,086	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9	517,689	3,515,384	9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21		1,356,086	21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29		1,356,086	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31		1,356,086	31
32			32
33			33
34			34
35			35
36		1,356,086	36
37			37
38		1,356,086	38
39			39
40		1,356,086	40
41		1,433,916	41
42		-77,830	42
43			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	553,067			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	4,126,725			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-544,000			6
7	INVENTORY	429,703			7
8	PREPAID EXPENSES	193,725			8
9	OTHER CURRENT ASSETS	37,528			9
10	DUE FROM OTHER FUNDS	1,016,648			10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	5,813,396			11
FIXED ASSETS					
12	LAND	3,114			12
13	LAND IMPROVEMENTS	1,212,116			13
14	ACCUMULATED DEPRECIATION	-643,629			14
15	BUILDINGS	8,237,204			15
16	ACCUMULATED DEPRECIATION	-3,555,516			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	6,214,049			19
20	ACCUMULATED DEPRECIATION	-3,321,187			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	4,748,375			23
24	ACCUMULATED DEPRECIATION	-3,818,493			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS	120,596			27
28	ACCUMULATED DEPRECIATION	-69,259			28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	9,127,370			30
OTHER ASSETS					
31	INVESTMENTS	7,731,334			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	291,086			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	8,022,420			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	22,963,186			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	466,803			37
38	SALARIES, WAGES & FEES PAYABLE	1,078,200			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	382,487			40
41	DEFERRED INCOME	58,775			41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	822,485			43
44	OTHER CURRENT LIABILITIES				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,808,750			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	9,096,888			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	1,767,738			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	10,864,626			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	13,673,376			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	9,289,810			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	9,289,810			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	22,963,186			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		7,477,896							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		1,811,914							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		9,289,810							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 RESTRICTED CONTRIBUTIONS									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)		9,289,810							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 RELEASED FROM RESTRICTION									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		9,289,810							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	1,132,686		1,132,686	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	558,398		558,398	6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	1,691,084		1,691,084	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	1,691,084		1,691,084	18
19 ANCILLARY SERVICES	7,346,439	16,673,292	24,019,731	19
20 OUTPATIENT SERVICES	545,148	5,925,294	6,470,442	20
21 RHC		529,722	529,722	21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
29 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	9,582,671	23,128,308	32,710,979	29

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		16,724,333	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		16,724,333	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	32,710,979	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	16,422,051	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	16,288,928	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	16,724,333	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-435,405	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	50,058	6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	38,098	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	323,697	15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	58,737	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	1,071	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GAIN ON INVESTMENTS - NET)		24
24.01	OTHER (OTHER INCOME)	1,268,174	24.01
24.02	OTHER (OTHER GAINS)	507,484	24.02
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	2,247,319	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,811,914	26
27	OTHER EXPENSES (LOSS ON INVESTMENTS - NET)		27
27.01	OTHER EXPENSES (LOSS ON SWAP HEDGING)		27.01
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	1,811,914	29

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

COMPONENT NO: -

WORKSHEET I-1

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	TOTAL COSTS 1	BASIS 2	STATISTICS 3	FTES PER 2080 HOURS 4	
1 REGISTERED NURSES		HOURS OF SERVICE			1
2 LICENSED PRACTICAL NURSES		HOURS OF SERVICE			2
3 NURSES AIDES		HOURS OF SERVICE			3
4 TECHNICIANS		HOURS OF SERVICE			4
5 SOCIAL WORKERS		HOURS OF SERVICE			5
6 DIETICIANS		HOURS OF SERVICE			6
7 PHYSICIANS		ACCUMULATED COST			7
8 NON-PATIENT CARE SALARY		ACCUMULATED COST			8
9 SUBTOTAL (SUM OF LINES 1-8)					9
10 EMPLOYEE BENEFITS		SALARY			10
11 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			11
12 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME			12
13 MACHINES COSTS & REPAIRS		PERCENTAGE OF TIME			13
14 SUPPLIES		REQUISITIONS			14
15 DRUGS		REQUISITIONS			15
16 OTHER		ACCUMULATED COST			16
17 SUBTOTAL (SUM OF LINES 9-16)					17
18 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			18
19 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME			19
20 EMPLOYEE BENEFITS DEPARTMENT		SALARY			20
21 ADMINISTRATIVE AND GENERAL		ACCUMULATED COST			21
22 MAINT./REPAIRS-OPERATION-HOUSEKEEPING		SQUARE FEET			22
23 MEDICAL EDUCATION PROGRAM COSTS					23
24 CENTRAL SERVICES & SUPPLIES		REQUISITIONS			24
25 PHARMACY		REQUISITIONS			25
26 OTHER ALLOCATED COSTS		ACCUMULATED COST			26
27 SUBTOTAL (SUM OF LINES 17-26)					27
28 LABORATORY		CHARGES			28
29 RESPIRATORY THERAPY		CHARGES			29
30 OTHER ANCILLARY (SPECIFY)		CHARGES			30
30.97 CARDIAC REHABILITATION		CHARGES			30.97
31 TOTAL COSTS (SUM OF LINES 27-30)					31

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2

CHECK APPLICABLE BOX:

RENAL DIALYSIS DEPARTMENT

HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE RNs	SALARY OTHER	EMPLOYEE BENEFITS DEPARTMENT	DRUGS
	BUILDING 1	EQUIPMENT 2				
1 TOTAL RENAL DEPT COSTS MAINTENANCE						1
2 HEMODIALYSIS						2
3 INTERMITTENT PERITONEAL TRAINING						3
4 HEMODIALYSIS						4
5 INTERMITTENT PERITONEAL						5
6 CAPD						6
7 CCPD						7
HOME						
8 HEMODIALYSIS						8
9 INTERMITTENT PERITONEAL						9
10 CAPD						10
11 CCPD						11
OTHER BILLABLE SERVICES						
12 INPATIENT DIALYSIS						12
13 METHOD II HOME PATIENT						13
14 EPO (INCL IN RENAL DEPT)						14
15 ARANESP (INCL IN RENAL DEPT)						15
16 OTHER						16
17 TOTAL (SUM OF LINES 2-16)						17
18 MEDICAL EDUC PGM COSTS						18
19 TOTAL RENAL COSTS (LINES 17+18)						19

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2
 (CONTINUED)

CHECK APPLICABLE BOX:

[XX] RENAL DIALYSIS DEPARTMENT

[] HOME PROGRAM DIALYSIS

	MEDICAL SUPPLIES 7	ROUTINE ANCILLARY SERVICES 8	SUBTOTAL (SUM OF COLS.1-8) 9	OVERHEAD 10	TOTAL (COL.9 + COL.10) 11	
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -
 STATISTICAL BASIS

COMPONENT NO: -

WORKSHEET I-3

CHECK APPLICABLE BOX:

[XX] RENAL DIALYSIS DEPARTMENT

[] HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY RNs (HOURS) 3	OTHER (HOURS) 4	EMPLOYEE BENEFITS DEPARTMENT (SALARY) 5	
	BUILDING (SQUARE FEET) 1	EQUIPMENT (% OF TIME) 2				
1	TOTAL RENAL DEPT COSTS MAINTENANCE					1
2	HEMODIALYSIS					2
3	INTERMITTENT PERITONEAL TRAINING					3
4	HEMODIALYSIS					4
5	INTERMITTENT PERITONEAL					5
6	CAPD					6
7	CCPD					7
8	HOME HEMODIALYSIS					8
9	INTERMITTENT PERITONEAL					9
10	CAPD					10
11	CCPD					11
	OTHER BILLABLE SERVICES					
12	INPT DIAL TRTMNTS					
13	METHOD II HOME PATIENT					13
14	EPO					14
15	ARANESP					15
16	OTHER					16
17	TOTAL STATISTICAL BASIS					17
18	UNIT COST MULTIPLIER (LINE 1 ÷ LINE 17)					18

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

COMPONENT NO: -

WORKSHEET I-4

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	NUMBER OF TOTAL TREATMENTS 1	TOTAL COST (FROM WKST I-2, COL. 11) 2	AVG COST OF PROGRAM TREATMENTS (COL. 2 ÷ COL. 1) 3	NUMBER OF PROGRAM TREATMENTS 4	NUMBER OF PROGRAM TREATMENTS 4.01	NUMBER OF PROGRAM TREATMENTS 4.02	TOTAL PROGRAM EXPENSES (SEE INSTR.) 5	
1 MAINTENANCE - HEMODIALYSIS								1
2 MAINTENANCE - PERITONEAL DIALYSIS								2
3 TRAINING - HEMODIALYSIS								3
4 TRAINING - PERITONEAL DIALYSIS								4
5 TRAINING - CAPD								5
6 TRAINING - CCPD								6
7 HOME PROGRAM - HEMODIALYSIS								7
8 HOME PROGRAM - PERITONEAL DIALYSIS								8
				PATIENT WEEKS	PATIENT WEEKS	PATIENT WEEKS	PATIENT WEEKS	
9 HOME PROGRAM - CAPD								9
10 HOME PROGRAM - CCPD								10
11 TOTALS (SUM OF LINES 1-8, COLS. 1 & 4) (SUM OF LINES 1-10, COLS. 2, 5 & 6)								11
12 TOTAL TREATMENTS (SUM OF LINES 1-8 PLUS (SUM OF LINES 9 AND 10 TIMES 3))								12

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

COMPONENT NO: -

WORKSHEET I-4
 (CONTINUED)

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	AVERAGE PAYMENT RATE (COL. 6 ÷ COL. 4)	AVERAGE PAYMENT RATE (COL. 6.01 ÷ COL. 4.01)	AVERAGE PAYMENT RATE (COL. 6.02 ÷ COL. 4.02)	
1 MAINTENANCE - HEMODIALYSIS	6	6.01	6.02	7	7.01	7.02	1
2 MAINTENANCE - PERITONEAL DIALYSIS							2
3 TRAINING - HEMODIALYSIS							3
4 TRAINING - PERITONEAL DIALYSIS							4
5 TRAINING - CAPD							5
6 TRAINING - CCPD							6
7 HOME PROGRAM - HEMODIALYSIS							7
8 HOME PROGRAM - PERITONEAL DIALYSIS							8
9 HOME PROGRAM - CAPD							9
10 HOME PROGRAM - CCPD							10
11 TOTALS (SUM OF LINES 1-8, COLS. 1 & 4) (SUM OF LINES 1-10, COLS. 2, 5 & 6)							11
12 TOTAL TREATMENTS (SUM OF LINES 1-8 PLUS (SUM OF LINES 9 AND 10 TIMES 3))							12

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

COMPONENT NO: -

WORKSHEET I-5

DESCRIPTION

1	TOTAL EXPENSES RELATED TO CARE OF PROGRAM BENEFICIARIES (SEE INSTRUCTIONS)			1
2	TOTAL PAYMENT DUE (FROM I-4, COL. 6, LINE 11) (SEE INSTRUCTIONS)	1	2	2
2.01	TOTAL PAYMENT DUE (FROM I-4, COL. 6.01, LINE 11) (SEE INSTRUCTIONS)			2.01
2.02	TOTAL PAYMENT DUE (FROM I-4, COL. 6.02, LINE 11) (SEE INSTRUCTIONS)			2.02
2.03	TOTAL PAYMENT DUE (SEE INSTRUCTIONS)			2.03
2.04	OUTLIER PAYMENTS			2.04
3	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3
3.01	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.01
3.02	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.02
3.03	TOTAL DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.03
4	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4
4.01	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.01
4.02	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.02
4.03	TOTAL COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.03
5	BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE, NET OF BAD DEBT RECOVERIES			5
5.01	TRANSITION PERIOD 1 (75-25%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2011 BUT BEFORE 1/1/2012			5.01
5.02	TRANSITION PERIOD 2 (50-50%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2012 BUT BEFORE 1/1/2013			5.02
5.03	TRANSITION PERIOD 3 (25-75%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2013 BUT BEFORE 1/1/2014			5.03
5.04	100% PPS BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2014			5.04
5.05	TOTAL BAD DEBTS (SUM OF LINE 5 THROUGH LINE 5.04)			5.05
6	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			6
7	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			7
8	NET DEDUCTIBLES AND COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			8
9	PROGRAM PAYMENT (SEE INSTRUCTIONS)			9
10	UNRECOVERED FROM MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			10
11	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) (TRANSFER TO WKST E, PART B, LINE 33)			11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE RATE PERCENTAGE

12	TOTAL ALLOWABLE EXPENSES (SEE INSTRUCTIONS)			12
13	TOTAL COMPOSITE COSTS (FROM WKST I-4, COL. 2, LINE 11)			13
14	FACILITY SPECIFIC COMPOSITE COST PERCENTAGE (LINE 13 DIVIDED BY LINE 12)			14

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-133) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT		
1 CAPITAL DRG OTHER THAN OUTLIER		1
2 CAPITAL DRG OUTLIER PAYMENTS		2
3 TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		3
4 NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5 INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6 INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)		8
9 SUM OF LINES 7 AND 8		9
10 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11 DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12 TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)		12

PART II - PAYMENT UNDER REASONABLE COST

1 PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)		1
2 PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)		2
3 TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)		3
4 CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)		4
5 TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1 PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)		1
2 PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		2
3 NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)		3
4 APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)		4
5 CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)		5
6 PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		6
7 ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)		7
8 CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)		8
9 CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)		9
10 CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)		10
11 CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)		11
12 NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)		12
13 CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)		13
14 CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)		14
15 CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)		15
16 CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)		16
17 CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)		17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL	I&R COST &	TOTAL
	NARY CAP- REL COSTS	(COLS.0-4) 2A	POST STEP- DOWN ADJS	
	0	2A	24	25
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
1.01 2008 BLDG & FIXT				1.01
1.02 RHC BLDG & FIXT				1.02
2 CAP REL COSTS-MVBLE EQUIP				2
2.01 2008 MVBLE EQUIP				2.01
2.02 RHC MVBLE EQUIP				2.02
4 EMPLOYEE BENEFITS DEPARTMENT				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
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				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM				50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC				54
60 LABORATORY				60
65 RESPIRATORY THERAPY				65
66 PHYSICAL THERAPY				66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY				69
71 MEDICAL SUPPLIES CHARGED TO PA				71
73 DRUGS CHARGED TO PATIENTS				73
73.01 CARDIAC REHABILITATION				73.01
74 RENAL DIALYSIS				74
76.97 CARDIAC REHABILITATION				76.97
88 RURAL HEALTH CLINIC				88
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY				91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS				92
94 HOME PROGRAM DIALYSIS				94
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
118 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS				118
190 GIFT, FLOWER, COFFEE SHOP & CA				190
192 PHYSICIANS' PRIVATE OFFICES				192
192.02 INDEPENDENT LIVING				192.02
192.03 MEALS ON WHEELS				192.03
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)				202
203 TOTAL STATISTICAL BASIS				203
204 UNIT COST MULTIPLIER				204
204 UNIT COST MULTIPLIER				204

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

RHC I
 COMPONENT NO: 14-8504

WORKSHEET M-1

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	400,622	400,622		400,622		400,622	1
2	PHYSICIAN ASSISTANT							2
3	NURSE PRACTITIONER	52,499	52,499		52,499		52,499	3
4	VISITING NURSE							4
5	OTHER NURSE	64,629	64,629		64,629		64,629	5
6	CLINICAL PSYCHOLOGIST							6
7	CLINICAL SOCIAL WORKER							7
8	LABORATORY TECHNICIAN							8
9	OTHER FACILITY HEALTH CARE STAFF COSTS							9
10	SUBTOTAL (SUM OF LINES 1-9)	517,750	517,750		517,750		517,750	10
COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT							11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13	OTHER COSTS UNDER AGREEMENT							13
14	SUBTOTAL (SUM OF LINES 11-13)							14
OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		7,717	7,717	7,717		7,717	15
16	TRANSPORTATION (HEALTH CARE STAFF)		5,025	5,025	5,025		5,025	16
17	DEPRECIATION-MEDICAL EQUIPMENT					-617	-617	17
18	PROFESSIONAL LIABILITY INSURANCE							18
19	OTHER HEALTH CARE COSTS							19
20	ALLOWABLE GME COSTS							20
21	SUBTOTAL (SUM OF LINES 15-20)		12,742	12,742	12,742	-617	12,125	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	517,750	12,742	530,492	530,492	-617	529,875	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY							23
24	DENTAL							24
25	OPTOMETRY							25
26	ALL OTHER NONREIMBURSABLE COSTS							26
27	NONALLOWABLE GME COSTS							27
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)							28
FACILITY OVERHEAD								
29	FACILITY COSTS		4,242	4,242	4,242		4,242	29
30	ADMINISTRATIVE COSTS	132,007	38,791	170,798	170,798		170,798	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	132,007	43,033	175,040	175,040		175,040	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	649,757	55,775	705,532	705,532	-617	704,915	32

RHC I
 COMPONENT NO: 14-8504

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1 PHYSICIANS	1.40	4,296	4,200	5,880		1
2 PHYSICIAN ASSISTANTS			2,100			2
3 NURSE PRACTITIONERS	0.53	748	2,100	1,113		3
4 SUBTOTAL (SUM OF LINES 1-3)	1.93	5,044		6,993	6,993	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.93	5,044			6,993	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)	529,875	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)	529,875	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)	175,040	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	454,031	15
16 TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	629,071	16
17 ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18 SUBTRACT LINE 17 FROM LINE 16	629,071	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	629,071	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,158,946	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-8504

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)	1,158,946	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	5,613	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,153,333	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	6,993	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	6,993	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	164.93	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. 100-04, CHAPTER 9, \$20.6 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	164.93	164.93	164.93 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1,208	1,209	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	199,235	199,400	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)		398,635	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)		245,667	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)			16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)			16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		298,318	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		298,318	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		25,738	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		43,986	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		298,318	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		3,196	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		301,514	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		301,514	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		1,508	26.01
27	INTERIM PAYMENTS		301,493	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		-1,487	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		6,123	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: 14-8504

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)	517,750	517,750	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000091	0.001100	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	47	570	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	635	1,314	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	682	1,884	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	529,875	529,875	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	629,071	629,071	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001287	0.003556	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	810	2,237	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,492	4,121	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	10	120	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	149.20	34.34	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	6	67	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	895	2,301	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)		5,613	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)		3,196	16

***** 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	67.96		8.52				76.48 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	9.18	27.98	2.89	10.77			50.82 50
53 ANESTHESIOLOGY	13.47	30.76	3.55	12.55			60.33 53
54 RADIOLOGY-DIAGNOSTIC	7.37	38.56	1.77	16.14			63.84 54
60 LABORATORY	11.69	35.66	1.84	10.01			59.20 60
65 RESPIRATORY THERAPY	24.33	12.85	2.71	4.44			44.33 65
66 PHYSICAL THERAPY	2.40	33.55	0.08	7.98			44.01 66
69 ELECTROCARDIOLOGY	25.81	16.28	1.38	7.88			51.35 69
71 MEDICAL SUPPLIES CHARGED TO PAT	28.76	21.41	4.23	11.95			66.35 71
73 DRUGS CHARGED TO PATIENTS	24.23	26.06	2.80	4.18			57.27 73
73.01 CARDIAC REHABILITATION		56.64					56.64 73.01
91 EMERGENCY	0.96	32.15	1.51	36.28			70.90 91
92 OBSERVATION BEDS (NON-DISTINCT		52.50		24.58			77.08 92
200 TOTAL CHARGES	11.62	32.16	1.91	12.95			58.64 200

***** 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		0.77					0.77 50
53 ANESTHESIOLOGY		0.91					0.91 53
54 RADIOLOGY-DIAGNOSTIC		0.90					0.90 54
60 LABORATORY		9.56					9.56 60
65 RESPIRATORY THERAPY		20.32					20.32 65
66 PHYSICAL THERAPY		15.26					15.26 66
69 ELECTROCARDIOLOGY		8.56					8.56 69
71 MEDICAL SUPPLIES CHARGED TO PAT		25.96					25.96 71
73 DRUGS CHARGED TO PATIENTS		34.52					34.52 73
200 TOTAL CHARGES		9.84					9.84 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	534,444	3.56	-534,444	-6.78		1
1.01	2008 BLDG & FIXT	525,626	3.50	-525,626	-6.67		1.01
1.02	RHC BLDG & FIXT	34,255	0.23	-34,255	-0.43		1.02
2	CAP REL COSTS-MVBLE EQUIP	208,924	1.39	-208,924	-2.65		2
2.01	2008 MVBLE EQUIP	63,042	0.42	-63,042	-0.80		2.01
2.02	RHC MVBLE EQUIP	2,065	0.01	-2,065	-0.03		2.02
3	OTHER CAP REL COSTS						3
4	EMPLOYEE BENEFITS DEPARTMENT	1,999,498	13.31	-1,999,498	-25.38		4
5	ADMINISTRATIVE & GENERAL	1,748,088	11.64	-1,748,088	-22.19		5
6	MAINTENANCE & REPAIRS	320,227	2.13	-320,227	-4.07		6
7	OPERATION OF PLANT	233,427	1.55	-233,427	-2.96		7
8	LAUNDRY & LINEN SERVICE	68,442	0.46	-68,442	-0.87		8
9	HOUSEKEEPING	248,550	1.66	-248,550	-3.16		9
10	DIETARY	182,973	1.22	-182,973	-2.32		10
11	CAFETERIA	131,333	0.87	-131,333	-1.67		11
13	NURSING ADMINISTRATION	474,431	3.16	-474,431	-6.02		13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	805,917	5.37	-805,917	-10.23		15
16	MEDICAL RECORDS & LIBRARY	231,184	1.54	-231,184	-2.93		16
17	SOCIAL SERVICE	64,505	0.43	-64,505	-0.82		17
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	967,575	6.44	2,589,943	32.88	3,557,518	23.69
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	278,805	1.86	493,399	6.26	772,204	5.14
53	ANESTHESIOLOGY	213,784	1.42	71,970	0.91	285,754	1.90
54	RADIOLOGY-DIAGNOSTIC	909,500	6.06	477,574	6.06	1,387,074	9.24
60	LABORATORY	697,921	4.65	451,772	5.74	1,149,693	7.66
65	RESPIRATORY THERAPY	267,978	1.78	246,596	3.13	514,574	3.43
66	PHYSICAL THERAPY	594,319	3.96	434,632	5.52	1,028,951	6.85
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	31,777	0.21	14,887	0.19	46,664	0.31
71	MEDICAL SUPPLIES CHARGED TO PAT	649,828	4.33	115,066	1.46	764,894	5.09
73	DRUGS CHARGED TO PATIENTS			1,092,994	13.88	1,092,994	7.28
73.01	CARDIAC REHABILITATION	36,422	0.24	37,058	0.47	73,480	0.49
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
88	RURAL HEALTH CLINIC	704,915	4.69	454,031	5.76	1,158,946	7.72
91	EMERGENCY	1,007,610	6.71	720,978	9.15	1,728,588	11.51
92	OBSERVATION BEDS (NON-DISTINCT						92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
OUTPATIENT SERVICE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CAN			12,031	0.15	12,031	0.08
192	PHYSICIANS' PRIVATE OFFICES	597,363	3.98	401,595	5.10	998,958	6.65
192.02	INDEPENDENT LIVING	182,929	1.22	254,016	3.22	436,945	2.91
192.03	MEALS ON WHEELS			8,389	0.11	8,389	0.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	15,017,657	100.00			15,017,657	100.00

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

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

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

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

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES				Clinic Name Marshall Browning Physician Clinic 14-8504	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	
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 HMAHK 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 Marshall Browning Physician Clinic 14-8504		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		
				ON-SITE	OFF-SITE	TOTAL
16	RHC DENTAL STAFF	1	2	3	4	5
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