HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT WORKSHEET S
CERTIFICATION AND SETTLEMENT SUMMARY PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY
1. [X] ELECTRONICALLY FILED COST REPORT DATE: 03-27-2012 TIME: 10:31_____
2. [ ] MANUALLY SUBMITTED COST REPORT
3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [F] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY IROQUOIS MEMORIAL HOSPITAL (14-0167) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2010 AND ENDING 09/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-85,007	-3,212			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-5,953			10
10.01	HEALTH CLINIC - RHC II			1,436			10.01
10.02	HEALTH CLINIC - RHC III			510			10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-85,007	-7,219			200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 200 FAIRMAN AVENUE P.O.BOX: 1
2 CITY: WATSEKA STATE: IL ZIP CODE: 60970 COUNTY: IROQUOIS 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	IROQUOIS MEMORIAL HOSPITAL	14-0167	00014	1	07/01/1996	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	IROQUOIS MEMORIAL HOSPITAL	14-U167	00014		12/31/2006	N	P	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	IROQUOIS RESIDENT HOME	14-6049	00014		08/18/2003	N	P	N	9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	IROQUOIS HOME HEALTH	14-7586	00014		09/30/1994	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE	IROQUOIS MEMORIAL HOSPICE	14-1616	00014		11/04/2004				14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	GILMAN CLINIC	14-3424	00014		09/04/1996	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	MILFORD CLINIC	14-3425	00014		10/09/1996	N	O	N	15.01
15.02	HOSPITAL-BASED HEALTH CLINIC - RHC III	KENTLAND CLINIC	15-3979	00015		10/29/1996	N	O	N	15.02
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 10/01/2010		TO: 09/30/2011						20
21	TYPE OF CONTROL			2						21

INPATIENT PPS INFORMATION — 1 2

22 DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILTY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO. — Y N 22

23 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO. — 3 N 23

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	859		40				24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25

26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.	2	26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.	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.	1	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: 10/01/2010 ENDING: 09/30/2011	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.		37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING: ENDING:	38

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2 PART I (CONT)

		1	2	3	
TEACHING HOSPITALS					
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60

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

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

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

		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				64

ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)

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

		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2
PART I (CONT)

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

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

INPATIENT PSYCHIATRIC FACILITY PPS

70 IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO. — N — 70

71 IF LINE 70 YES: — 71
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.

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: — 76
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.

LONG TERM CARE HOSPITAL PPS

80 IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO. — N — 80

TEFRA PROVIDERS

85 IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO. — N — 85

86 DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO. — N — 86

		V	XIX	
TITLE V AND XIX INPATIENT SERVICES		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)?	N	105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.		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.		107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N	108

		PHY-SICAL	OCCUP-ATIONAL	SPEECH	RESPI-RATORY	
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.	N	N	N	N	109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2 PART I (CONT)

	MISCELLANEOUS COST REPORTING INFORMATION	1	2	
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.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.	5,000,000		119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	Y	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE	
	PROVIDER ORGANIZATION AND OPERATION	1	2	
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1

		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N			3

		Y/N	TYPE	DATE	
	FINANCIAL DATA AND REPORTS	1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	01/26/2012	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5

		Y/N	Y/N	
	APPROVED EDUCATIONAL ACTIVITIES	1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11

		Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	N	14

BED COMPLEMENT

15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
	PS&R REPORT DATA	1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	01/13/2012	Y	01/13/2012	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE WORKSHEET S-2
PART II

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

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

	CAPITAL RELATED COST	
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	27
	INTEREST EXPENSE	
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	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.	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	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.	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.	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.	35

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

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	33	12,045			1,795	680	2,769	1
2	HMO						126			2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						44		44	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		33	12,045			1,839	680	2,813	7
8	INTENSIVE CARE UNIT	31	16	5,840			1,137	9	1,645	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						210	256	13
14	TOTAL (SEE INSTRUCTIONS)		49	17,885			2,976	899	4,714	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	35	12,775			2,108		9,395	19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					3,067		3,906	22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116	1	365					50	24
25	CMHC	99								25
26	RHC	88					997		4,224	26
26.01	RHC II	88.01					1,507		3,754	26.01
26.02	RHC III	88.02					3,771		10,682	26.02
27	TOTAL (SUM OF LINES 14-26)		85							27
28	OBSERVATION BED DAYS							115	615	28
29	AMBULANCE TRIPS						1,232			29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES --- TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					924	234	1,485	1
2	HMO						34			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)			276.30			924	234	1,485	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		29.84						19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101		7.09						22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116		12.37						24
25	CMHC	99								25
26	RHC	88		6.85						26
26.01	RHC II	88.01		4.80						26.01
26.02	RHC III	88.02		14.78						26.02
27	TOTAL (SUM OF LINES 14-26)			352.03						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART II & III

PART II - WAGE DATA

		WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	16,620,465		16,620,465	732,231.00	22.70	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A							4
4.01	PHYSICIANS-PART A - DIRECT TEACHING							4.01
5	PHYSICIAN-PART B		1,005,932		1,005,932	5,200.00	193.45	5
6	NON-PHYSICIAN-PART B		1,017,454		1,017,454	42,266.00	24.07	6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44	1,022,225		1,022,225	62,071.00	16.47	9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		3,116,880		3,116,880	131,051.00	23.78	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		824,274		824,274	9,241.00	89.20	11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN-PART A							15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		2,009,970		2,009,970			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		791,637		791,637			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A							22
23	PHYSICIAN PART B		81,756		81,756			23
24	WAGE-RELATED COSTS (RHC/FQHC)		180,795		180,795			24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		143,721		143,721	8,476.00	16.96	26
27	ADMINISTRATIVE & GENERAL		1,104,980		1,104,980	62,993.00	17.54	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		204,052		204,052	707.00	288.62	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		226,060		226,060	13,517.00	16.72	30
31	LAUNDRY & LINEN SERVICE		44,506		44,506	4,588.00	9.70	31
32	HOUSEKEEPING		269,152		269,152	27,520.00	9.78	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		363,235	-175,172	188,063	17,601.00	10.68	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)		9,345		9,345	143.00	65.35	35
36	CAFETERIA			175,172	175,172	16,398.00	10.68	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		630,526		630,526	18,703.00	33.71	38
39	CENTRAL SERVICES AND SUPPLY		39,364		39,364	2,988.00	13.17	39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		449,997		449,997	27,268.00	16.50	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	14,810,476	14,810,476	685,615.00	21.60	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	4,139,105	4,139,105	193,122.00	21.43	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	10,671,371	10,671,371	492,493.00	21.67	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	824,274	824,274	9,241.00	89.20	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	2,009,970	2,009,970		18.84%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	13,505,615	13,505,615	501,734.00	26.92	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,484,938	3,484,938	200,902.00	17.35	7

HOSPITAL WAGE RELATED COSTS WORKSHEET S-3
PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	QUALIFIED AND NON-QUALIFIED PENSION PLAN COST		3
4	PRIOR YEAR PENSION SERVICE COST		4
	PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5	401K/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	1,631,206	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	127,223	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	1,123,040	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	124,437	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	58,252	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	3,064,158	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

	COMPONENT 0	CONTRACT LABOR 1	BENEFIT COST 2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	833,619		1
2	HOSPITAL	833,619		2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II			14.01
14.02	HOSPITAL-BASED HEALTH CLINIC - RHC III			14.02
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA HHA NO.: 14-7586 WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA COUNTY:

	DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1	HOME HEALTH AIDE HOURS		2,929		187	3,116	1
2	UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION		203.00	20.00	73.00	296.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00

		------- NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT) ------- STAFF 1	CONTRACT 2	TOTAL 3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	0.29		0.29	3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL	1.00		1.00	5
6	DIRECT NURSING SERVICE	3.00		3.00	6
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE	0.90		0.90	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE	0.20		0.20	10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE	0.10		0.10	12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE	0.10		0.10	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE	1.50		1.50	16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	3	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).	99914	20
20.01		16580	20.01
20.02		19180	20.02

PPS ACTIVITY

		FULL EPISODES WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (COLS. 1-4) 5	
21	SKILLED NURSING VISITS	1,055	40	91	2	1,188	21
22	SKILLED NURSING VISIT CHARGES	160,624	6,090	13,855	305	180,874	22
23	PHYSICAL THERAPY VISITS	858		11	3	872	23
24	PHYSICAL THERAPY VISIT CHARGES	130,631		1,675	457	132,763	24
25	OCCUPATIONAL THERAPY VISITS	159		5		164	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	24,208		761		24,969	26
27	SPEECH PATHOLOGY VISITS	7				7	27
28	SPEECH PATHOLOGY VISIT CHARGES	1,066				1,066	28
29	MEDICAL SOCIAL SERVICE VISITS	2				2	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	378				378	30
31	HOME HEALTH AIDE VISITS	827		7		834	31
32	HOME HEALTH AIDE VISIT CHARGES	78,151		661		78,812	32
33	TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	2,908	40	114	5	3,067	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	395,058	6,090	16,952	762	418,862	35
36	TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	205		45	1	251	36
37	TOTAL NUMBER OF OUTLIER EPISODES		1			1	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	7,351		788		8,139	38

PROSPECTIVE PAYMENT FOR SNF WORKSHEET S-7
STATISTICAL DATA

		Y/N 1	DATE 2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	12/31/2006	2

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4	
3	RUX	29		29	3
4	RUL	16		16	4
5	RVX				5
6	RVL	24		24	6
7	RHX	139	15	154	7
8	RHL	171		171	8
9	RMX	35		35	9
10	RML	18		18	10
11	RLX				11
12	RUC	10		10	12
13	RUB	3		3	13
14	RUA	32		32	14
15	RVC				15
16	RVB	50		50	16
17	RVA	155		155	17
18	RHC	189	3	192	18
19	RHB	250	19	269	19
20	RHA	581		581	20
21	RMC	22		22	21
22	RMB	44		44	22
23	RMA	123		123	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	16		16	28
29	HE2	13		13	29
30	HE1	100		100	30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1	3		3	34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1	4		4	38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1	16		16	44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	6		6	48
49	CC2				49
50	CC1	4	1	5	50
51	CB2				51
52	CB1	2		2	52
53	CA2				53
54	CA1	52		52	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 WORKSHEET S-7
STATISTICAL DATA

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4	
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	1	6	7	76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL	2,108	44	2,152	200

	SNF SERVICES	CBSA AT BEGINNING OF COST REPORTING PERIOD 1	CBSA ON/AFTER OF THE COST REPORTING PERIOD (IF APPLICABLE) 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).	00014	00014	201

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

		EXPENSES 1	PERCENTAGE 2	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 3	
202	STAFFING	1,022,225	59.27%	Y	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)	1,724,696			207

RHC I WORKSHEET S-8

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

COMPONENT NO: 14-3424

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 508 E CRESENT
2 CITY: GILMAN STATE: IL ZIP CODE: 60938 COUNTY: IROQUOIS
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN

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

		1	2
10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N	10

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION (0)	SUNDAY FROM (1)	SUNDAY TO (2)	MONDAY FROM (3)	MONDAY TO (4)	TUESDAY FROM (5)	TUESDAY TO (6)	WEDNESDAY FROM (7)	WEDNESDAY TO (8)	THURSDAY FROM (9)	THURSDAY TO (10)	FRIDAY FROM (11)	FRIDAY TO (12)	SATURDAY FROM (13)	SATURDAY TO (14)	
11	CLINIC			0900	1700	0830	1700	0830	1700	0900	1700	0830	1700			11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

		1	2
12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N	12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.	N	13
14	PROVIDER NAME: CCN NUMBER:		14

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

RHC II WORKSHEET S-8

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

COMPONENT NO: 14-3425

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 207 N AXTEL 1
2 CITY: MILFORD STATE: IL ZIP CODE: 60983 COUNTY: IROQUOIS 2
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

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

		1	2	
10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N		10

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
11	CLINIC			0900	1700	0830	1700	0830	1700	0900	1700	0830	1700			11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

		1	2	
12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.	N		13
14	PROVIDER NAME: CCN NUMBER:			14

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

RHC III WORKSHEET S-8

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

COMPONENT NO: 15-3979

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 303 N SEVENTH
2 CITY: KENTLAND STATE: IN ZIP CODE: 47951 COUNTY: NEWTON
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN

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

		1	2	
10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N		10

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
11	CLINIC			0700	1900	0700	1900	0700	1900	0700	1900	0700	1900			11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

		1	2	
12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.	N		13
14	PROVIDER NAME: CCN NUMBER:			14

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

HOSPICE IDENTIFICATION DATA HOSPICE NO.: 14-1616 WORKSHEET S-9
PARTS I & II

PART I - ENROLLMENT DAYS

		UNDUPLICATED DAYS						
		TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURSING FACILITY 3	TITLE XIX NURSING FACILITY 4	ALL OTHER 5	TOTAL (SUM OF COLS. 1, 2 & 5) 6	
1	CONTINUOUS HOME CARE					1	1	1
2	ROUTINE HOME CARE	2,010	196	6,894	402	857	3,063	2
3	INPATIENT RESPITE CARE	68					68	3
4	GENERAL INPATIENT CARE	4					4	4
5	TOTAL HOSPICE DAYS	2,082	196	6,894	402	858	3,136	5

PART II - CENSUS DATA

		TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURSING FACILITY 3	TITLE XIX NURSING FACILITY 4	ALL OTHER 5	TOTAL (SUM OF COLS. 1, 2 & 5) 6	
6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	132	4	100	3	10	146	6
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE							7
8	AVERAGE LENGTH OF STAY (LINE 5/LINE 6)	15.77	49.00	68.94	134.00	85.80	21.48	8
9	UNDUPLICATED CENSUS COUNT	194	1	201		5	200	9

NOTE: PARTS I & II, COLUMNS 1 AND 2 ALSO INCLUDE THE DAYS REPORTED IN COLUMN 3 AND 4.

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA WORKSHEET S-10

	UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION		
1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)	0.420191	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	2,327,351	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	7,849,560	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	3,298,314	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)	970,963	8
	STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)		
9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)		12
	OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)		
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)		16
	UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)		
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)	970,963	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	477,348	140,970	618,318	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	200,577	59,234	259,811	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE	200,577	59,234	259,811	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 LENGHTH OF STAY LIMIT (SEE INSTRUCTIONS)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)	2,257,829	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	202,480	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	2,055,349	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	863,639	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	1,123,450	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	2,094,413	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	CAP REL COSTS-BLDG & FIXT		1,833,552	1,833,552	-605,660	1
2	00200	CAP REL COSTS-MVBLE EQUIP				1,030,401	2
3	00300	OTHER CAPITAL RELATED COSTS					3
4	00400	EMPLOYEE BENEFITS	143,721	1,831,019	1,974,740	212,401	4
5.01	00540	ADMISSIONS	291,327	225,040	516,367	-1,054	5.01
5.02	00550	PURCHASING, RECEIVING, AND STORES	102,348	109,886	212,234	-80,780	5.02
5.03	00560	DATA PROCESSING	271,510	316,833	588,343	21,263	5.03
5.04	00570	COMMUNICATIONS		235,321	235,321	28,096	5.04
5.05	00580	BUSINESS OFFICE	163,438	113,045	276,483		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	276,357	2,401,360	2,677,717	52,159	5.06
7	00700	OPERATION OF PLANT	226,060	730,382	956,442	44,920	7
8	00800	LAUNDRY & LINEN SERVICE	44,506	12,614	57,120		8
9	00900	HOUSEKEEPING	269,152	59,253	328,405		9
10	01000	DIETARY	363,235	303,145	666,380	-321,366	10
11	01100	CAFETERIA				321,366	11
13	01300	NURSING ADMINISTRATION	630,526	129,249	759,775	-883	13
14	01400	CENTRAL SERVICES & SUPPLY	39,364	19,190	58,554		14
16	01600	MEDICAL RECORDS & LIBRARY	449,997	249,330	699,327	-1,860	16
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	1,317,699	358,846	1,676,545	-348,839	30
31	03100	INTENSIVE CARE UNIT	908,253	279,420	1,187,673	-29,935	31
43	04300	NURSERY		177	177	191,491	43
44	04400	SKILLED NURSING FACILITY	1,022,225	245,022	1,267,247	-35,137	44
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	741,858	1,474,163	2,216,021	-1,098,773	50
52	05200	DELIVERY ROOM & LABOR ROOM				116,078	52
53	05300	ANESTHESIOLOGY		333,123	333,123	-15,759	53
54	05400	RADIOLOGY-DIAGNOSTIC	762,036	1,471,437	2,233,473	-11,398	54
60	06000	LABORATORY	639,036	1,159,356	1,798,392	-5,671	60
65	06500	RESPIRATORY THERAPY	366,252	118,001	484,253	-37,769	65
66	06600	PHYSICAL THERAPY	603,151	290,794	893,945	-15,541	66
69	06900	ELECTROCARDIOLOGY	96,335	59,664	155,999	-444	69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS				693,464	71
72	07200	IMPL. DEV. CHARGED TO PATIENT				890,447	72
73	07300	DRUGS CHARGED TO PATIENTS	485,848	1,391,579	1,877,427	-44,329	73
		OUTPATIENT SERVICE COST CENTERS					
88	08800	RURAL HEALTH CLINIC (RHC)	313,393	139,262	452,655	-35,611	88
88.01	08801	RHC II	279,898	137,444	417,342	-40,399	88.01
88.02	08802	RHC III	872,163	336,928	1,209,091	-76,082	88.02
90	09000	CLINIC	1,073,890	-43,085	1,030,805	-79,759	90
91	09100	EMERGENCY	750,007	641,900	1,391,907	-23,974	91
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
95	09500	AMBULANCE SERVICES	666,478	210,522	877,000	-39,972	95
101	10100	HOME HEALTH AGENCY	381,916	117,777	499,693	-10,356	101
		SPECIAL PURPOSE COST CENTERS					
113	11300	INTEREST EXPENSE		350,738	350,738	-350,738	113
116	11600	HOSPICE	613,620	488,202	1,101,822	-137,255	116
118		SUBTOTALS (SUM OF LINES 1-117)	15,165,599	18,130,489	33,296,088	152,742	118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,915	2,915	7,403	190
194	07950	IROQUOIS WOMEN'S HEALTH	1,049,744	793,854	1,843,598	-63,971	194
194.01	07951	OTHER NON-REIMBURSABLE COSTS	151,830	219,023	370,853	-96,174	194.01
194.02	07952	DURABLE MEDICAL EQUIPMENT SALES/RENT	253,292	486,043	739,335		194.02
194.03	07953	WELLNESS					194.03
194.04	07954	RENTED SPACE					194.04
200		TOTAL (SUM OF LINES 118-199)	16,620,465	19,632,324	36,252,789		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
		GENERAL SERVICE COST CENTERS				
1	00100	CAP REL COSTS-BLDG & FIXT	1,227,892	-30,631	1,197,261	1
2	00200	CAP REL COSTS-MVBLE EQUIP	1,030,401	-8,514	1,021,887	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	2,187,141	-98,788	2,088,353	4
5.01	00540	ADMISSIONS	515,313	-33,085	482,228	5.01
5.02	00550	PURCHASING, RECEIVING, AND STORES	131,454		131,454	5.02
5.03	00560	DATA PROCESSING	609,606		609,606	5.03
5.04	00570	COMMUNICATIONS	263,417		263,417	5.04
5.05	00580	BUSINESS OFFICE	276,483		276,483	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	2,729,876	-869,285	1,860,591	5.06
7	00700	OPERATION OF PLANT	1,001,362	-12,785	988,577	7
8	00800	LAUNDRY & LINEN SERVICE	57,120	-127	56,993	8
9	00900	HOUSEKEEPING	328,405	-1,496	326,909	9
10	01000	DIETARY	345,014		345,014	10
11	01100	CAFETERIA	321,366	-139,480	181,886	11
13	01300	NURSING ADMINISTRATION	758,892	-645	758,247	13
14	01400	CENTRAL SERVICES & SUPPLY	58,554	-783	57,771	14
16	01600	MEDICAL RECORDS & LIBRARY	697,467	-5,350	692,117	16
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	1,327,706	-34,577	1,293,129	30
31	03100	INTENSIVE CARE UNIT	1,157,738	-5,625	1,152,113	31
43	04300	NURSERY	191,668		191,668	43
44	04400	SKILLED NURSING FACILITY	1,232,110	-501	1,231,609	44
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	1,117,248	-14,963	1,102,285	50
52	05200	DELIVERY ROOM & LABOR ROOM	116,078		116,078	52
53	05300	ANESTHESIOLOGY	317,364	-313,282	4,082	53
54	05400	RADIOLOGY-DIAGNOSTIC	2,222,075	-54,689	2,167,386	54
60	06000	LABORATORY	1,792,721	-359	1,792,362	60
65	06500	RESPIRATORY THERAPY	446,484	-13,500	432,984	65
66	06600	PHYSICAL THERAPY	878,404	-20,354	858,050	66
69	06900	ELECTROCARDIOLOGY	155,555	-46,144	109,411	69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	693,464	-422	693,042	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	890,447		890,447	72
73	07300	DRUGS CHARGED TO PATIENTS	1,833,098		1,833,098	73
		OUTPATIENT SERVICE COST CENTERS				
88	08800	RURAL HEALTH CLINIC (RHC)	417,044		417,044	88
88.01	08801	RHC II	376,943		376,943	88.01
88.02	08802	RHC III	1,133,009		1,133,009	88.02
90	09000	CLINIC	951,046	-667,739	283,307	90
91	09100	EMERGENCY	1,367,933	-502,285	865,648	91
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
95	09500	AMBULANCE SERVICES	837,028	-80,415	756,613	95
101	10100	HOME HEALTH AGENCY	489,337		489,337	101
		SPECIAL PURPOSE COST CENTERS				
113	11300	INTEREST EXPENSE				113
116	11600	HOSPICE	964,567	-31,033	933,534	116
118		SUBTOTALS (SUM OF LINES 1-117)	33,448,830	-2,986,857	30,461,973	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,318	-192	10,126	190
194	07950	IROQUOIS WOMEN'S HEALTH	1,779,627		1,779,627	194
194.01	07951	OTHER NON-REIMBURSABLE COSTS	274,679	-1,397	273,282	194.01
194.02	07952	DURABLE MEDICAL EQUIPMENT SALES/RENT	739,335		739,335	194.02
194.03	07953	WELLNESS				194.03
194.04	07954	RENTED SPACE				194.04
200		TOTAL (SUM OF LINES 118-199)	36,252,789	-2,988,446	33,264,343	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5	
1	RECLASS MOV EQ DEPR	A	CAP REL COSTS-MVBLE EQUIP	2		924,606	1
500	TOTAL RECLASSIFICATIONS					924,606	500
	CODE LETTER - A						
1	R/C ADVERTISING	B	OTHER ADMINISTRATIVE AND GENE	5.06		129,351	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	TOTAL RECLASSIFICATIONS					129,351	500
	CODE LETTER - B						
1	R/C MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHRGED TO PA	71		1,435,526	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
500	TOTAL RECLASSIFICATIONS					1,435,526	500
	CODE LETTER - C						
1	RECLASS DRUGS CHARGED	D	MEDICAL SUPPLIES CHRGED TO PA	71		148,385	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9			CLINIC	90		526	9
10							10
11							11
12							12
13							13
500	TOTAL RECLASSIFICATIONS					148,911	500
	CODE LETTER - D						
1	RECLASS TELEPHONE	E	COMMUNICATIONS	5.04		28,096	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	TOTAL RECLASSIFICATIONS					28,096	500
	CODE LETTER - E						
1	RECLASS INTEREST EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		273,667	1
2			CAP REL COSTS-MVBLE EQUIP	2		76,070	2
3			OTHER ADMINISTRATIVE AND GENE	5.06		1,001	3
500	TOTAL RECLASSIFICATIONS					350,738	500
	CODE LETTER - F						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS CAFETERIA	G	CAFETERIA	11	175,172	146,194	1
500	TOTAL RECLASSIFICATIONS				175,172	146,194	500
	CODE LETTER - G						
1	RECLASS NURSERY COST	H	NURSERY	43	157,517	33,974	1
2			DELIVERY ROOM & LABOR ROOM	52	95,484	20,594	2
500	TOTAL RECLASSIFICATIONS				253,001	54,568	500
	CODE LETTER - H						
1	RECLASS OPERATION OF PLANT COST	I	OPERATION OF PLANT	7		44,920	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	TOTAL RECLASSIFICATIONS					44,920	500
	CODE LETTER - I						
1	RECLASS TRANSPORTATION	J	OTHER ADMINISTRATIVE AND GENE	5.06		21,017	1
2							2
500	TOTAL RECLASSIFICATIONS					21,017	500
	CODE LETTER - J						
1	RECLASS IT COST	K	DATA PROCESSING	5.03		27,289	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
500	TOTAL RECLASSIFICATIONS					27,289	500
	CODE LETTER - K						
1	RECLASS GIFT SHOP	L	GIFT, FLOWER, COFFEE SHOP & C	190		7,403	1
500	TOTAL RECLASSIFICATIONS					7,403	500
	CODE LETTER - L						
1	RECLASS SHELDON CLINIC	M	OTHER NON-REIMBURSABLE COSTS	194.01		10,331	1
2							2
500	TOTAL RECLASSIFICATIONS					10,331	500
	CODE LETTER - M						
1	RECLASS OTHER CAP RELATED COST	N	OTHER CAPITAL RELATED COSTS	3		82,707	1
500	TOTAL RECLASSIFICATIONS					82,707	500
	CODE LETTER - N						
1	RECLASS EMPLOYEE BENEFITS	O	EMPLOYEE BENEFITS	4		212,401	1
2							2
3							3
4							4
5							5
500	TOTAL RECLASSIFICATIONS					212,401	500
	CODE LETTER - O						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	INCREASE LINE #	INCREASE SALARY	INCREASE OTHER	
		1	2	3	4	5	
1	RECLASS IMPL MED SUPPLIES	P	IMPL. DEV. CHARGED TO PATIENT	72		890,447	1
500	TOTAL RECLASSIFICATIONS					890,447	500
	CODE LETTER - P						
	GRAND TOTAL (INCREASES)				428,173	4,514,505	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	RECLASS MOV EQ DEPR	A	CAP REL COSTS-BLDG & FIXT	1		924,606	9 1
500	TOTAL RECLASSIFICATIONS					924,606	500
	CODE LETTER - A						
1	R/C ADVERTISING	B	CLINIC	90		4,409	1
2			RURAL HEALTH CLINIC (RHC)	88		4,308	2
3			RHC II	88.01		2,862	3
4			RHC III	88.02		1,421	4
5			HOME HEALTH AGENCY	101		583	5
6			HOSPICE	116		1,847	6
7			IROQUOIS WOMEN'S HEALTH	194		7,525	7
8			OTHER NON-REIMBURSABLE COSTS	194.01		106,396	8
500	TOTAL RECLASSIFICATIONS					129,351	500
	CODE LETTER - B						
1	R/C MEDICAL SUPPLIES	C	PURCHASING, RECEIVING, AND ST	5.02		78,612	1
2			ADULTS & PEDIATRICS	30		39,448	2
3			INTENSIVE CARE UNIT	31		28,638	3
4			SKILLED NURSING FACILITY	44		21,977	4
5			OPERATING ROOM	50		1,097,847	5
6			ANESTHESIOLOGY	53		15,759	6
7			RESPIRATORY THERAPY	65		37,759	7
8			PHYSICAL THERAPY	66		4,494	8
9			ELECTROCARDIOLOGY	69		444	9
10			DRUGS CHARGED TO PATIENTS	73		44,329	10
11			CLINIC	90		8,240	11
12			EMERGENCY	91		21,945	12
13			AMBULANCE SERVICES	95		10,343	13
14			HOME HEALTH AGENCY	101		7,468	14
15			HOSPICE	116		11,519	15
16			IROQUOIS WOMEN'S HEALTH	194		6,704	16
500	TOTAL RECLASSIFICATIONS					1,435,526	500
	CODE LETTER - C						
1	RECLASS DRUGS CHARGED	D	ADULTS & PEDIATRICS	30		1,145	1
2			INTENSIVE CARE UNIT	31		669	2
3			SKILLED NURSING FACILITY	44		11,171	3
4			OPERATING ROOM	50		579	4
5			RADIOLOGY-DIAGNOSTIC	54		7,594	5
6			LABORATORY	60		2,849	6
7			RESPIRATORY THERAPY	65		10	7
8			PHYSICAL THERAPY	66		641	8
9							9
10			EMERGENCY	91		1,717	10
11			AMBULANCE SERVICES	95		940	11
12			HOME HEALTH AGENCY	101		2	12
13			HOSPICE	116		121,594	13
500	TOTAL RECLASSIFICATIONS					148,911	500
	CODE LETTER - D						
1	RECLASS TELEPHONE	E	PURCHASING, RECEIVING, AND ST	5.02		626	1
2			DATA PROCESSING	5.03		6,026	2
3			OTHER ADMINISTRATIVE AND GENE	5.06		3,631	3
4			NURSING ADMINISTRATION	13		883	4
5			MEDICAL RECORDS & LIBRARY	16		20	5
6			OPERATING ROOM	50		347	6
7			RADIOLOGY-DIAGNOSTIC	54		973	7
8			CLINIC	90		8,381	8
9			AMBULANCE SERVICES	95		7,209	9
500	TOTAL RECLASSIFICATIONS					28,096	500
	CODE LETTER - E						
1	RECLASS INTEREST EXPENSE	F	INTEREST EXPENSE	113		350,738	11 1
2							11 2
3							3
500	TOTAL RECLASSIFICATIONS					350,738	500
	CODE LETTER - F						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1		6	7	8	9	10
1	RECLASS CAFETERIA	G	DIETARY	10	175,172	146,194	1
500	TOTAL RECLASSIFICATIONS				175,172	146,194	500
	CODE LETTER - G						
1	RECLASS NURSERY COST	H	ADULTS & PEDIATRICS	30	253,001	54,568	1
2							2
500	TOTAL RECLASSIFICATIONS				253,001	54,568	500
	CODE LETTER - H						
1	RECLASS OPERATION OF PLANT COST	I	OTHER ADMINISTRATIVE AND GENE	5.06		840	1
2			PHYSICAL THERAPY	66		10,406	2
3			RURAL HEALTH CLINIC (RHC)	88		5,852	3
4			RHC II	88.01		6,737	4
5			RHC III	88.02		2,122	5
6			AMBULANCE SERVICES	95		5,112	6
7			HOME HEALTH AGENCY	101		2,242	7
8			HOSPICE	116		2,233	8
9			IROQUOIS WOMEN'S HEALTH	194		9,376	9
500	TOTAL RECLASSIFICATIONS					44,920	500
	CODE LETTER - I						
1	RECLASS TRANSPORTATION	J	AMBULANCE SERVICES	95		16,368	1
2			IROQUOIS WOMEN'S HEALTH	194		4,649	2
500	TOTAL RECLASSIFICATIONS					21,017	500
	CODE LETTER - J						
1	RECLASS IT COST	K	ADMISSIONS	5.01		1,054	1
2			PURCHASING, RECEIVING, AND ST	5.02		1,542	2
3			OTHER ADMINISTRATIVE AND GENE	5.06		2,001	3
4			MEDICAL RECORDS & LIBRARY	16		1,840	4
5			ADULTS & PEDIATRICS	30		677	5
6			INTENSIVE CARE UNIT	31		628	6
7			SKILLED NURSING FACILITY	44		1,989	7
8			RADIOLOGY-DIAGNOSTIC	54		2,831	8
9			LABORATORY	60		2,822	9
10			RURAL HEALTH CLINIC (RHC)	88		5,855	10
11			RHC II	88.01		825	11
12			EMERGENCY	91		312	12
13			HOME HEALTH AGENCY	101		61	13
14			HOSPICE	116		62	14
15			IROQUOIS WOMEN'S HEALTH	194		4,681	15
16			OTHER NON-REIMBURSABLE COSTS	194.01		109	16
500	TOTAL RECLASSIFICATIONS					27,289	500
	CODE LETTER - K						
1	RECLASS GIFT SHOP	L	OTHER ADMINISTRATIVE AND GENE	5.06		7,403	1
500	TOTAL RECLASSIFICATIONS					7,403	500
	CODE LETTER - L						
1	RECLASS SHELDON CLINIC	M	CAP REL COSTS-BLDG & FIXT	1		7,703	9 1
2			OTHER ADMINISTRATIVE AND GENE	5.06		2,628	2
500	TOTAL RECLASSIFICATIONS					10,331	500
	CODE LETTER - M						
1	RECLASS OTHER CAP RELATED COST	N	OTHER ADMINISTRATIVE AND GENE	5.06		82,707	14 1
500	TOTAL RECLASSIFICATIONS					82,707	500
	CODE LETTER - N						
1	RECLASS EMPLOYEE BENEFITS	O	RURAL HEALTH CLINIC (RHC)	88		19,596	1
2			RHC II	88.01		29,975	2
3			RHC III	88.02		72,539	3
4			CLINIC	90		59,255	4
5			IROQUOIS WOMEN'S HEALTH	194		31,036	5
500	TOTAL RECLASSIFICATIONS					212,401	500
	CODE LETTER - O						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	RECLASS IMPL MED SUPPLIES	P	MEDICAL SUPPLIES CHRGED TO PA	71		890,447	1
500	TOTAL RECLASSIFICATIONS					890,447	500
	CODE LETTER - P						
	GRAND TOTAL (DECREASES)				428,173	4,514,505	

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 PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	249,035	18,500		18,500		267,535		1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	22,883,021	516,818		516,818		23,399,839		3
4	BUILDING IMPROVEMENTS	477,850					477,850		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	12,920,765	746,959		746,959	271,081	13,396,643		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	36,530,671	1,282,277		1,282,277	271,081	37,541,867		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	36,530,671	1,282,277		1,282,277	271,081	37,541,867		10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	1,833,552						1,833,552	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (SUM OF LINES 1-2)	1,833,552						1,833,552	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	ALLOCATION OF OTHER CAPITAL INSURANCE 5	TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT	23,877,689		23,877,689	0.640593			52,982	52,982	1
2	CAP REL COSTS-MVBLE EQUIP	13,396,643		13,396,643	0.359407			29,725	29,725	2
3	TOTAL (SUM OF LINES 1-2)	37,274,332		37,274,332	1.000000			82,707	82,707	3

	DESCRIPTION	SUMMARY OF CAPITAL 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	901,243		243,036			52,982	1,197,261	1
2	CAP REL COSTS-MVBLE EQUIP	924,606		67,556			29,725	1,021,887	2
3	TOTAL	1,825,849		310,592			82,707	2,219,148	3

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: COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-30,631	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-8,514	CAP REL COSTS-MVBLE EQUIP	2	11	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)	B	-112	OTHER ADMINISTRATIVE AND GENERA	5.06		3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-1,629	OTHER ADMINISTRATIVE AND GENERA	5.06		4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-12,785	OPERATION OF PLANT	7		8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,583,602				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	B	-127	LAUNDRY & LINEN SERVICE	8		13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-139,480	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-422	MEDICAL SUPPLIES CHRGED TO PATI	71		16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-5,350	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	CNA CLASS REVENUE	B	-645	NURSING ADMINISTRATION	13		33
34	OTHER REVENUE SPORTS MEDICINE	B	-8,540	PHYSICAL THERAPY	66		34
35	OTHER REVENUE WELLNESS	B	-6,762	PHYSICAL THERAPY	66		35
36	AMBULANCE TOWNSHIP INCOME	B	-59,557	AMBULANCE SERVICES	95		36
37	RENTAL INCOME	B	-1,950	OPERATING ROOM	50		37
38	RENTAL INCOME	B	-67,188	CLINIC	90		38
39	RENTAL INCOME	B	-4,950	PHYSICAL THERAPY	66		39
40	COLLECTION FEES REVENUE	B	-33,085	ADMISSIONS	5.01		40
41	OTHER REVENUE HSKP	B	-1,496	HOUSEKEEPING	9		41
42	OTHER REVENUE CENTRAL SUPPLY	B	-783	CENTRAL SERVICES & SUPPLY	14		42
43	OTHER REVENUE REHAB	B	-102	PHYSICAL THERAPY	66		43
44	OTHER REVENUE EMS	B	-20,255	AMBULANCE SERVICES	95		44
45	MISC INCOME A&G	B	-5,192	OTHER ADMINISTRATIVE AND GENERA	5.06		45
46	MISC INCOME AUXILLIARY	B	-29,438	OTHER ADMINISTRATIVE AND GENERA	5.06		46
47	MISC INCOME MED STAFF	B	-18,300	OTHER ADMINISTRATIVE AND GENERA	5.06		47
48	MISC INCOME EMPL COMMITTEE	B	-4,376	OTHER ADMINISTRATIVE AND GENERA	5.06		48
49	PHYSICIAN BENEFIT OFFSET	A	-93,962	EMPLOYEE BENEFITS	4		49
49.01	PHYSICIAN BENEFIT OFFSET	A	-2,634	EMPLOYEE BENEFITS	4		49.01
49.02	PHYSICIAN BENEFIT OFFSET	A	-2,192	EMPLOYEE BENEFITS	4		49.02
49.03	DONATION EXPENSE	A	-825	OTHER ADMINISTRATIVE AND GENERA	5.06		49.03
49.04	ALCOHOL EXPENSE	A	-1,085	OTHER ADMINISTRATIVE AND GENERA	5.06		49.04
49.05	ALCOHOL EXPENSE	A	-423	RADIOLOGY-DIAGNOSTIC	54		49.05
49.06	ALCOHOL EXPENSE	A	-192	GIFT, FLOWER, COFFEE SHOP & CAN	190		49.06
49.07	ALCOHOL EXPENSE	A	-1,397	OTHER NON-REIMBURSABLE COSTS	194.01		49.07
49.08	ADVERTISING EXPENSE	A	-115,075	OTHER ADMINISTRATIVE AND GENERA	5.06		49.08
49.09	PHYSICIAN RECRUITMENT	A	-4,191	OTHER ADMINISTRATIVE AND GENERA	5.06		49.09
49.10	LOBBYING EXPENSE	A	-14,018	OTHER ADMINISTRATIVE AND GENERA	5.06		49.10
49.11	LOBBYING EXPENSE	A	-501	SKILLED NURSING FACILITY	44		49.11
49.12	PROVIDER TAX EXPENSE	A	-674,355	OTHER ADMINISTRATIVE AND GENERA	5.06		49.12

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
49.13	AMB CABLE COST	A	-603	AMBULANCE SERVICES	95		49.13
49.14	A&G CABLE TV COST	A	-689	OTHER ADMINISTRATIVE AND GENERA	5.06		49.14
49.15	HOSPICE PRO FEE	A	-31,033	HOSPICE	116		49.15
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-2,988,446				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) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.						5

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA-TION INCL FRINGES	PROFES-SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD-JUSTED RCE LIMIT	5 PERCENT OF UNAD-JUSTED RCE LIMIT	
	1	2		3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS	AGGREGATE	34,577	34,577						1
2	31	INTENSIVE CARE UNIT	AGGREGATE	5,625	5,625						2
3	50	OPERATING ROOM	AGGREGATE	13,013	13,013						3
4	53	ANESTHESIOLOGY	AGGREGATE	313,282	313,282						4
5	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE	54,266	54,266						5
6	60	LABORATORY	AGGREGATE	359	359						6
7	65	RESPIRATORY THERAPY	AGGREGATE	13,500	13,500						7
8	69	ELECTROCARDIOLOGY	AGGREGATE	46,144	46,144						8
9	90	CLINIC	AGGREGATE	600,551	600,551						9
10	91	EMERGENCY	AGGREGATE	502,285	502,285						10
200		TOTAL		1,583,602	1,583,602						200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18	
1	30	ADULTS & PEDIATRICS	AGGREGATE							34,577	1
2	31	INTENSIVE CARE UNIT	AGGREGATE							5,625	2
3	50	OPERATING ROOM	AGGREGATE							13,013	3
4	53	ANESTHESIOLOGY	AGGREGATE							313,282	4
5	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE			12,883				54,266	5
6	60	LABORATORY	AGGREGATE							359	6
7	65	RESPIRATORY THERAPY	AGGREGATE							13,500	7
8	69	ELECTROCARDIOLOGY	AGGREGATE							46,144	8
9	90	CLINIC	AGGREGATE			37,619				600,551	9
10	91	EMERGENCY	AGGREGATE			69,285				502,285	10
200		TOTAL				119,787				1,583,602	200

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	ADMITTING	
		0	1	2	4	5.01	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	1,197,261	1,197,261				1
2	CAP REL COSTS-MVBLE EQUIP	1,021,887		1,021,887			2
4	EMPLOYEE BENEFITS	2,088,353	4,873		2,093,226		4
5.01	ADMISSIONS	482,228	7,703		38,377	528,308	5.01
5.02	PURCHASING, RECEIVING, AND STORES	131,454	13,256		13,482		5.02
5.03	DATA PROCESSING	609,606	4,943	84,080	35,766		5.03
5.04	COMMUNICATIONS	263,417	1,583	3,988			5.04
5.05	BUSINESS OFFICE	276,483	11,337	1,258	21,530		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,860,591	62,788	3,084	36,405		5.06
7	OPERATION OF PLANT	988,577	118,564	12,788	29,779		7
8	LAUNDRY & LINEN SERVICE	56,993	20,428		5,863		8
9	HOUSEKEEPING	326,909	5,916	94	35,456		9
10	DIETARY	345,014	28,140	823	24,774		10
11	CAFETERIA	181,886	9,197		23,076		11
13	NURSING ADMINISTRATION	758,247	13,053	246	83,060		13
14	CENTRAL SERVICES & SUPPLY	57,771	13,309	12,867	5,185		14
16	MEDICAL RECORDS & LIBRARY	692,117	12,770	6,408	59,279		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,293,129	108,642	30,512	140,252	24,273	30
31	INTENSIVE CARE UNIT	1,152,113	47,392	13,372	119,645	16,319	31
43	NURSERY	191,668	4,961	4,507	20,750	2,522	43
44	SKILLED NURSING FACILITY	1,231,609	86,586	9,541	134,659	13,580	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,102,285	144,653	121,757	96,011	67,413	50
52	DELIVERY ROOM & LABOR ROOM	116,078	1,981		12,578	1,577	52
53	ANESTHESIOLOGY	4,082	973	25,259		2,759	53
54	RADIOLOGY-DIAGNOSTIC	2,167,386	45,137	466,227	98,323	117,413	54
60	LABORATORY	1,792,362	29,192	41,240	84,181	82,892	60
65	RESPIRATORY THERAPY	432,984	25,699	35,060	48,247	8,691	65
66	PHYSICAL THERAPY	858,050	109,332	22,586	79,454	22,701	66
69	ELECTROCARDIOLOGY	109,411	5,306		12,690	10,791	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	693,042				11,226	71
72	IMPL. DEV. CHARGED TO PATIENT	890,447				24,651	72
73	DRUGS CHARGED TO PATIENTS	1,833,098	16,555	7,790	64,001	63,771	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	417,044	22,993	5,272	41,284		88
88.01	RHC II	376,943	7,959	4,740	36,871		88.01
88.02	RHC III	1,133,009	37,249	15,882	114,891		88.02
90	CLINIC	283,307	24,656	3,791	67,968	1,898	90
91	EMERGENCY	865,648	26,725	21,026	98,799	33,749	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	756,613	1,831	62,653	87,796	22,082	95
101	HOME HEALTH AGENCY	489,337	11,267	482	50,310		101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	933,534	11,337	701	80,833		116
118	SUBTOTALS (SUM OF LINES 1-117)	30,461,973	1,098,286	1,018,034	1,901,575	528,308	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,126	8,118				190
194	IROQUOIS WOMEN'S HEALTH	1,779,627	41,564	3,678	138,284		194
194.01	OTHER NON-REIMBURSABLE COSTS	273,282	49,293	175	20,001		194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT	739,335			33,366		194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	33,264,343	1,197,261	1,021,887	2,093,226	528,308	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	PURCHASING RECEIVING AND STORES 5.02	DATA PROCESSING 5.03	COMMUNICATIONS 5.04	BUSINESS OFFICE 5.05	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES	158,192					5.02
5.03	DATA PROCESSING	163	734,558				5.03
5.04	COMMUNICATIONS			268,988			5.04
5.05	BUSINESS OFFICE	285	11,908		322,801		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	471	10,555	13,035		1,986,929	5.06
7	OPERATION OF PLANT	2,125	14,567	3,555		1,169,955	7
8	LAUNDRY & LINEN SERVICE	268	4,944	1,185		89,681	8
9	HOUSEKEEPING	1,727	29,658	2,370		402,130	9
10	DIETARY	1,096	18,968	5,925		424,740	10
11	CAFETERIA	1,021	17,672	2,370		235,222	11
13	NURSING ADMINISTRATION	290	20,156	13,035		888,087	13
14	CENTRAL SERVICES & SUPPLY	863	3,220	1,185		94,400	14
16	MEDICAL RECORDS & LIBRARY	652	29,386	16,590		817,202	16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	3,361	48,371	16,590	14,831	1,679,961	30
31	INTENSIVE CARE UNIT	2,521	38,103	11,850	9,971	1,411,286	31
43	NURSERY		6,183	1,185	1,541	233,317	43
44	SKILLED NURSING FACILITY	2,775	66,893	10,665	8,298	1,564,606	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,647	27,938	14,220	41,189	1,617,113	50
52	DELIVERY ROOM & LABOR ROOM		3,747	1,185	963	138,109	52
53	ANESTHESIOLOGY	828		1,185	1,686	36,772	53
54	RADIOLOGY-DIAGNOSTIC	37,131	36,122	17,775	71,746	3,057,260	54
60	LABORATORY	24,192	37,199	14,220	50,647	2,156,125	60
65	RESPIRATORY THERAPY	2,275	18,630	5,925	5,310	582,821	65
66	PHYSICAL THERAPY	550	32,309	16,590	13,870	1,155,442	66
69	ELECTROCARDIOLOGY	96	3,814		6,593	148,701	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	19,120		1,185	6,859	731,432	71
72	IMPL. DEV. CHARGED TO PATIENT	42,558			15,062	972,718	72
73	DRUGS CHARGED TO PATIENTS	420	19,229	4,740	38,964	2,048,568	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	349	11,519	2,370		500,831	88
88.01	RHC II	312	9,489	3,555		439,869	88.01
88.02	RHC III	878	28,128	2,370		1,332,407	88.02
90	CLINIC	735	31,669	3,555	1,159	418,738	90
91	EMERGENCY	2,145	32,027	10,665	20,620	1,111,404	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	856	48,700	5,925	13,492	999,948	95
101	HOME HEALTH AGENCY	531	15,894	5,925		573,746	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	4,444	27,727	8,295		1,066,871	116
118	SUBTOTALS (SUM OF LINES 1-117)	156,685	704,725	219,225	322,801	30,086,391	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14		2,370		20,628	190
194	IROQUOIS WOMEN'S HEALTH	752	20,453	47,393		2,031,751	194
194.01	OTHER NON-REIMBURSABLE COSTS	741	9,380			352,872	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT					772,701	194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	158,192	734,558	268,988	322,801	33,264,343	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	OTHER ADMINISTRATIVE AND GENER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.06	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,986,929					5.06
7	OPERATION OF PLANT	74,323	1,244,278				7
8	LAUNDRY & LINEN SERVICE	5,697	26,145	121,523			8
9	HOUSEKEEPING	25,546	7,572	4,491	439,739		9
10	DIETARY	26,982	36,015	1,001	13,082	501,820	10
11	CAFETERIA	14,943	11,771		4,276		11
13	NURSING ADMINISTRATION	56,417	16,706		6,068		13
14	CENTRAL SERVICES & SUPPLY	5,997	17,034	40	6,188		14
16	MEDICAL RECORDS & LIBRARY	51,914	16,343		5,937		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	106,721	139,044	19,212	50,508	92,580	30
31	INTENSIVE CARE UNIT	89,653	60,654	15,023	22,033	80,692	31
43	NURSERY	14,822	6,350	186	2,306		43
44	SKILLED NURSING FACILITY	99,393	110,817	44,322	40,254	282,886	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	102,729	185,131	16,081	67,250		50
52	DELIVERY ROOM & LABOR ROOM	8,774	2,535		921		52
53	ANESTHESIOLOGY	2,336	1,245		452		53
54	RADIOLOGY-DIAGNOSTIC	194,213	57,768	5,481	20,984		54
60	LABORATORY	136,970	37,361	133	13,572		60
65	RESPIRATORY THERAPY	37,024	32,891		11,948		65
66	PHYSICAL THERAPY	73,401	139,927	4,397	50,829		66
69	ELECTROCARDIOLOGY	9,446	6,791		2,467		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	46,465					71
72	IMPL. DEV. CHARGED TO PATIENT	61,793					72
73	DRUGS CHARGED TO PATIENTS	130,137	21,188		7,696		73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	31,816	29,427		10,690		88
88.01	RHC II	27,943	10,186		3,700		88.01
88.02	RHC III	84,642	47,672		17,317		88.02
90	CLINIC	26,601	31,555	650	11,462	1,363	90
91	EMERGENCY	70,603	34,204	9,900	12,425	2,843	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	63,523	2,343	563	851		95
101	HOME HEALTH AGENCY	36,448	14,419		5,238		101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	67,774	14,510		5,271		116
118	SUBTOTALS (SUM OF LINES 1-117)	1,785,046	1,117,604	121,480	393,725	460,364	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,310	10,390		3,774		190
194	IROQUOIS WOMEN'S HEALTH	129,069	53,196		19,323		194
194.01	OTHER NON-REIMBURSABLE COSTS	22,417	63,088	43	22,917	41,456	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT	49,087					194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,986,929	1,244,278	121,523	439,739	501,820	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		11	13	14	16	24	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	266,212					11
13	NURSING ADMINISTRATION	8,566	975,844				13
14	CENTRAL SERVICES & SUPPLY	1,372		125,031			14
16	MEDICAL RECORDS & LIBRARY	12,492			903,888		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	20,563	184,842	8,408	37,991	2,339,830	30
31	INTENSIVE CARE UNIT	16,199	145,604	16	25,541	1,866,701	31
43	NURSERY	2,630	23,626		3,948	287,185	43
44	SKILLED NURSING FACILITY	28,433			21,255	2,191,966	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	11,873	106,761	78,889	105,512	2,291,339	50
52	DELIVERY ROOM & LABOR ROOM	1,591	14,319		2,468	168,717	52
53	ANESTHESIOLOGY				4,319	45,124	53
54	RADIOLOGY-DIAGNOSTIC	15,351		3,347	183,732	3,538,136	54
60	LABORATORY	15,808			129,739	2,489,708	60
65	RESPIRATORY THERAPY	7,918	71,192	271	13,602	757,667	65
66	PHYSICAL THERAPY	13,731			35,531	1,473,258	66
69	ELECTROCARDIOLOGY	1,620			16,890	185,915	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS				17,571	795,468	71
72	IMPL. DEV. CHARGED TO PATIENT				38,582	1,073,093	72
73	DRUGS CHARGED TO PATIENTS	8,176			99,811	2,315,576	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	4,898		773	5,018	583,453	88
88.01	RHC II	4,031		677	6,127	492,533	88.01
88.02	RHC III	11,958		3,331	15,070	1,512,397	88.02
90	CLINIC	13,464	121,018	1,012	2,970	628,833	90
91	EMERGENCY	13,616	122,385	2,335	52,822	1,432,537	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	20,706	186,097		34,562	1,308,593	95
101	HOME HEALTH AGENCY	6,756			6,811	643,418	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	11,787			20,956	1,187,169	116
118	SUBTOTALS (SUM OF LINES 1-117)	253,539	975,844	99,059	880,828	29,608,616	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					36,102	190
194	IROQUOIS WOMEN'S HEALTH	8,690		25,972	23,060	2,291,061	194
194.01	OTHER NON-REIMBURSABLE COSTS	3,983				506,776	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT					821,788	194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	266,212	975,844	125,031	903,888	33,264,343	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT			1
2	CAP REL COSTS-MVBLE EQUIP			2
4	EMPLOYEE BENEFITS			4
5.01	ADMISSIONS			5.01
5.02	PURCHASING, RECEIVING, AND STORES			5.02
5.03	DATA PROCESSING			5.03
5.04	COMMUNICATIONS			5.04
5.05	BUSINESS OFFICE			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			5.06
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
13	NURSING ADMINISTRATION			13
14	CENTRAL SERVICES & SUPPLY			14
16	MEDICAL RECORDS & LIBRARY			16
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS		2,339,830	30
31	INTENSIVE CARE UNIT		1,866,701	31
43	NURSERY		287,185	43
44	SKILLED NURSING FACILITY		2,191,966	44
	ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM		2,291,339	50
52	DELIVERY ROOM & LABOR ROOM		168,717	52
53	ANESTHESIOLOGY		45,124	53
54	RADIOLOGY-DIAGNOSTIC		3,538,136	54
60	LABORATORY		2,489,708	60
65	RESPIRATORY THERAPY		757,667	65
66	PHYSICAL THERAPY		1,473,258	66
69	ELECTROCARDIOLOGY		185,915	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		795,468	71
72	IMPL. DEV. CHARGED TO PATIENT		1,073,093	72
73	DRUGS CHARGED TO PATIENTS		2,315,576	73
	OUTPATIENT SERVICE COST CENTERS			
88	RURAL HEALTH CLINIC (RHC)		583,453	88
88.01	RHC II		492,533	88.01
88.02	RHC III		1,512,397	88.02
90	CLINIC		628,833	90
91	EMERGENCY		1,432,537	91
92	OBSERVATION BEDS			92
	OTHER REIMBURSABLE COST CENTERS			
95	AMBULANCE SERVICES		1,308,593	95
101	HOME HEALTH AGENCY		643,418	101
	SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE			113
116	HOSPICE		1,187,169	116
118	SUBTOTALS (SUM OF LINES 1-117)		29,608,616	118
	NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		36,102	190
194	IROQUOIS WOMEN'S HEALTH		2,291,061	194
194.01	OTHER NON-REIMBURSABLE COSTS		506,776	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT		821,788	194.02
194.03	WELLNESS			194.03
194.04	RENTED SPACE			194.04
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	TOTAL (SUM OF LINES 118-201)		33,264,343	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS	438	4,873		5,311	5,311	4
5.01	ADMISSIONS	1,247	7,703		8,950	97	5.01
5.02	PURCHASING, RECEIVING, AND STORES	512	13,256		13,768	34	5.02
5.03	DATA PROCESSING	448	4,943	84,080	89,471	91	5.03
5.04	COMMUNICATIONS		1,583	3,988	5,571		5.04
5.05	BUSINESS OFFICE	10,853	11,337	1,258	23,448	55	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	5,855	62,788	3,084	71,727	92	5.06
7	OPERATION OF PLANT	600	118,564	12,788	131,952	76	7
8	LAUNDRY & LINEN SERVICE		20,428		20,428	15	8
9	HOUSEKEEPING		5,916	94	6,010	90	9
10	DIETARY	1,536	28,140	823	30,499	63	10
11	CAFETERIA	1,430	9,197		10,627	59	11
13	NURSING ADMINISTRATION	1,346	13,053	246	14,645	211	13
14	CENTRAL SERVICES & SUPPLY		13,309	12,867	26,176	13	14
16	MEDICAL RECORDS & LIBRARY	2,740	12,770	6,408	21,918	150	16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	15,391	108,642	30,512	154,545	359	30
31	INTENSIVE CARE UNIT	14,143	47,392	13,372	74,907	303	31
43	NURSERY	7,100	4,961	4,507	16,568	53	43
44	SKILLED NURSING FACILITY	1,422	86,586	9,541	97,549	341	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	9,638	144,653	121,757	276,048	243	50
52	DELIVERY ROOM & LABOR ROOM	4,303	1,981		6,284	32	52
53	ANESTHESIOLOGY		973	25,259	26,232		53
54	RADIOLOGY-DIAGNOSTIC	177,304	45,137	466,227	688,668	249	54
60	LABORATORY	13,433	29,192	41,240	83,865	213	60
65	RESPIRATORY THERAPY	15,605	25,699	35,060	76,364	122	65
66	PHYSICAL THERAPY	1,845	109,332	22,586	133,763	201	66
69	ELECTROCARDIOLOGY	785	5,306		6,091	32	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS	545	16,555	7,790	24,890	162	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	1,120	22,993	5,272	29,385	105	88
88.01	RHC II	798	7,959	4,740	13,497	93	88.01
88.02	RHC III	1,739	37,249	15,882	54,870	291	88.02
90	CLINIC	7,975	24,656	3,791	36,422	172	90
91	EMERGENCY	11,100	26,725	21,026	58,851	251	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	26,159	1,831	62,653	90,643	223	95
101	HOME HEALTH AGENCY	1,078	11,267	482	12,827	128	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	88,304	11,337	701	100,342	205	116
118	SUBTOTALS (SUM OF LINES 1-117)	426,792	1,098,286	1,018,034	2,543,112	4,824	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		8,118		8,118		190
194	IROQUOIS WOMEN'S HEALTH	1,907	41,564	3,678	47,149	351	194
194.01	OTHER NON-REIMBURSABLE COSTS		49,293	175	49,468	51	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT					85	194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	428,699	1,197,261	1,021,887	2,647,847	5,311	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	ADMITTING	PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	
		5.01	5.02	5.03	5.04	5.05	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMISSIONS	9,047					5.01
5.02	PURCHASING, RECEIVING, AND STORES		13,802				5.02
5.03	DATA PROCESSING		14	89,576			5.03
5.04	COMMUNICATIONS				5,571		5.04
5.05	BUSINESS OFFICE		25	1,452		24,980	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		41	1,287	270		5.06
7	OPERATION OF PLANT		185	1,776	74		7
8	LAUNDRY & LINEN SERVICE		23	603	25		8
9	HOUSEKEEPING		151	3,617	49		9
10	DIETARY		96	2,313	123		10
11	CAFETERIA		89	2,155	49		11
13	NURSING ADMINISTRATION		25	2,458	270		13
14	CENTRAL SERVICES & SUPPLY		75	393	25		14
16	MEDICAL RECORDS & LIBRARY		57	3,584	344		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	416	293	5,899	344	1,147	30
31	INTENSIVE CARE UNIT	280	220	4,646	245	771	31
43	NURSERY	43		754	25	119	43
44	SKILLED NURSING FACILITY	233	242	8,156	221	642	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,156	144	3,407	295	3,185	50
52	DELIVERY ROOM & LABOR ROOM	27		457	25	74	52
53	ANESTHESIOLOGY	47	72		25	130	53
54	RADIOLOGY-DIAGNOSTIC	2,002	3,240	4,405	368	5,567	54
60	LABORATORY	1,421	2,111	4,536	295	3,916	60
65	RESPIRATORY THERAPY	149	198	2,272	123	411	65
66	PHYSICAL THERAPY	389	48	3,940	344	1,073	66
69	ELECTROCARDIOLOGY	185	8	465		510	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	192	1,668		25	530	71
72	IMPL. DEV. CHARGED TO PATIENT	423	3,714			1,165	72
73	DRUGS CHARGED TO PATIENTS	1,093	37	2,345	98	3,013	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)		30	1,405	49		88
88.01	RHC II		27	1,157	74		88.01
88.02	RHC III		77	3,430	49		88.02
90	CLINIC	33	64	3,862	74	90	90
91	EMERGENCY	579	187	3,906	221	1,594	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	379	75	5,939	123	1,043	95
101	HOME HEALTH AGENCY		46	1,938	123		101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE		388	3,381	172		116
118	SUBTOTALS (SUM OF LINES 1-117)	9,047	13,670	85,938	4,547	24,980	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1		49		190
194	IROQUOIS WOMEN'S HEALTH		66	2,494	975		194
194.01	OTHER NON-REIMBURSABLE COSTS		65	1,144			194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT						194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	9,047	13,802	89,576	5,571	24,980	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	OTHER ADMINISTRATIVE AND GENER 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	73,417					5.06
7	OPERATION OF PLANT	2,746	136,809				7
8	LAUNDRY & LINEN SERVICE	210	2,875	24,179			8
9	HOUSEKEEPING	944	833	894	12,588		9
10	DIETARY	997	3,960	199	374	38,624	10
11	CAFETERIA	552	1,294		122		11
13	NURSING ADMINISTRATION	2,084	1,837		174		13
14	CENTRAL SERVICES & SUPPLY	222	1,873	8	177		14
16	MEDICAL RECORDS & LIBRARY	1,918	1,797		170		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	3,943	15,288	3,823	1,446	7,126	30
31	INTENSIVE CARE UNIT	3,312	6,669	2,989	631	6,211	31
43	NURSERY	548	698	37	66		43
44	SKILLED NURSING FACILITY	3,672	12,184	8,816	1,152	21,772	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,795	20,352	3,200	1,925		50
52	DELIVERY ROOM & LABOR ROOM	324	279		26		52
53	ANESTHESIOLOGY	86	137		13		53
54	RADIOLOGY-DIAGNOSTIC	7,185	6,352	1,091	601		54
60	LABORATORY	5,060	4,108	27	389		60
65	RESPIRATORY THERAPY	1,368	3,616		342		65
66	PHYSICAL THERAPY	2,712	15,385	875	1,455		66
69	ELECTROCARDIOLOGY	349	747		71		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,717					71
72	IMPL. DEV. CHARGED TO PATIENT	2,283					72
73	DRUGS CHARGED TO PATIENTS	4,808	2,330		220		73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	1,175	3,236		306		88
88.01	RHC II	1,032	1,120		106		88.01
88.02	RHC III	3,127	5,242		496		88.02
90	CLINIC	983	3,470	129	328	105	90
91	EMERGENCY	2,608	3,761	1,970	356	219	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	2,347	258	112	24		95
101	HOME HEALTH AGENCY	1,347	1,585		150		101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	2,504	1,595		151		116
118	SUBTOTALS (SUM OF LINES 1-117)	65,958	122,881	24,170	11,271	35,433	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48	1,142		108		190
194	IROQUOIS WOMEN'S HEALTH	4,769	5,849		553		194
194.01	OTHER NON-REIMBURSABLE COSTS	828	6,937	9	656	3,191	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT	1,814					194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	73,417	136,809	24,179	12,588	38,624	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		11	13	14	16	24	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	14,947					11
13	NURSING ADMINISTRATION	481	22,185				13
14	CENTRAL SERVICES & SUPPLY	77		29,039			14
16	MEDICAL RECORDS & LIBRARY	701			30,639		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,155	4,202	1,953	1,289	203,228	30
31	INTENSIVE CARE UNIT	910	3,310	4	866	106,274	31
43	NURSERY	148	537		134	19,730	43
44	SKILLED NURSING FACILITY	1,594			721	157,295	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	667	2,427	18,322	3,579	338,745	50
52	DELIVERY ROOM & LABOR ROOM	89	326		84	8,027	52
53	ANESTHESIOLOGY				146	26,888	53
54	RADIOLOGY-DIAGNOSTIC	862		777	6,213	727,580	54
60	LABORATORY	888			4,400	111,229	60
65	RESPIRATORY THERAPY	445	1,618	63	461	87,552	65
66	PHYSICAL THERAPY	771			1,205	162,161	66
69	ELECTROCARDIOLOGY	91			573	9,122	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS				596	4,728	71
72	IMPL. DEV. CHARGED TO PATIENT				1,309	8,894	72
73	DRUGS CHARGED TO PATIENTS	459			3,385	42,840	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	275		180	170	36,316	88
88.01	RHC II	226		157	208	17,697	88.01
88.02	RHC III	671		774	511	69,538	88.02
90	CLINIC	756	2,751	235	101	49,575	90
91	EMERGENCY	765	2,782	542	1,792	80,384	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	1,163	4,232		1,172	107,733	95
101	HOME HEALTH AGENCY	379			231	18,754	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	662			711	110,111	116
118	SUBTOTALS (SUM OF LINES 1-117)	14,235	22,185	23,007	29,857	2,504,401	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					9,466	190
194	IROQUOIS WOMEN'S HEALTH	488		6,032	782	69,508	194
194.01	OTHER NON-REIMBURSABLE COSTS	224				62,573	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT					1,899	194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	14,947	22,185	29,039	30,639	2,647,847	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT			1
2	CAP REL COSTS-MVBLE EQUIP			2
4	EMPLOYEE BENEFITS			4
5.01	ADMISSIONS			5.01
5.02	PURCHASING, RECEIVING, AND STORES			5.02
5.03	DATA PROCESSING			5.03
5.04	COMMUNICATIONS			5.04
5.05	BUSINESS OFFICE			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			5.06
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
13	NURSING ADMINISTRATION			13
14	CENTRAL SERVICES & SUPPLY			14
16	MEDICAL RECORDS & LIBRARY			16
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS		203,228	30
31	INTENSIVE CARE UNIT		106,274	31
43	NURSERY		19,730	43
44	SKILLED NURSING FACILITY		157,295	44
	ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM		338,745	50
52	DELIVERY ROOM & LABOR ROOM		8,027	52
53	ANESTHESIOLOGY		26,888	53
54	RADIOLOGY-DIAGNOSTIC		727,580	54
60	LABORATORY		111,229	60
65	RESPIRATORY THERAPY		87,552	65
66	PHYSICAL THERAPY		162,161	66
69	ELECTROCARDIOLOGY		9,122	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		4,728	71
72	IMPL. DEV. CHARGED TO PATIENT		8,894	72
73	DRUGS CHARGED TO PATIENTS		42,840	73
	OUTPATIENT SERVICE COST CENTERS			
88	RURAL HEALTH CLINIC (RHC)		36,316	88
88.01	RHC II		17,697	88.01
88.02	RHC III		69,538	88.02
90	CLINIC		49,575	90
91	EMERGENCY		80,384	91
92	OBSERVATION BEDS			92
	OTHER REIMBURSABLE COST CENTERS			
95	AMBULANCE SERVICES		107,733	95
101	HOME HEALTH AGENCY		18,754	101
	SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE			113
116	HOSPICE		110,111	116
118	SUBTOTALS (SUM OF LINES 1-117)		2,504,401	118
	NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		9,466	190
194	IROQUOIS WOMEN'S HEALTH		69,508	194
194.01	OTHER NON-REIMBURSABLE COSTS		62,573	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT		1,899	194.02
194.03	WELLNESS			194.03
194.04	RENTED SPACE			194.04
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	TOTAL (SUM OF LINES 118-201)		2,647,847	202

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS GROSS SAL	ADMITTING GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	
		1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	135,384					1
2	CAP REL COSTS-MVBLE EQUIP		915,140				2
4	EMPLOYEE BENEFITS	551		15,890,156			4
5.01	ADMISSIONS	871		291,327	67,092,855		5.01
5.02	PURCHASING, RECEIVING, AND STORES	1,499		102,348		3,017,434	5.02
5.03	DATA PROCESSING	559	75,297	271,510		3,109	5.03
5.04	COMMUNICATIONS	179	3,571				5.04
5.05	BUSINESS OFFICE	1,282	1,127	163,438		5,430	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	7,100	2,762	276,357		8,981	5.06
7	OPERATION OF PLANT	13,407	11,452	226,060		40,529	7
8	LAUNDRY & LINEN SERVICE	2,310		44,506		5,116	8
9	HOUSEKEEPING	669	84	269,152		32,934	9
10	DIETARY	3,182	737	188,063		20,905	10
11	CAFETERIA	1,040		175,172		19,476	11
13	NURSING ADMINISTRATION	1,476	220	630,526		5,532	13
14	CENTRAL SERVICES & SUPPLY	1,505	11,523	39,364		16,467	14
16	MEDICAL RECORDS & LIBRARY	1,444	5,739	449,997		12,445	16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	12,285	27,325	1,064,698	3,082,714	64,108	30
31	INTENSIVE CARE UNIT	5,359	11,975	908,253	2,072,487	48,089	31
43	NURSERY	561	4,036	157,517	320,331		43
44	SKILLED NURSING FACILITY	9,791	8,544	1,022,225	1,724,696	52,926	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	16,357	109,038	728,845	8,561,473	31,419	50
52	DELIVERY ROOM & LABOR ROOM	224		95,484	200,234		52
53	ANESTHESIOLOGY	110	22,620		350,435	15,795	53
54	RADIOLOGY-DIAGNOSTIC	5,104	417,524	746,393	14,909,005	708,252	54
60	LABORATORY	3,301	36,932	639,036	10,527,348	461,444	60
65	RESPIRATORY THERAPY	2,906	31,398	366,252	1,103,739	43,392	65
66	PHYSICAL THERAPY	12,363	20,227	603,151	2,883,071	10,498	66
69	ELECTROCARDIOLOGY	600		96,335	1,370,458	1,835	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS				1,425,766	364,702	71
72	IMPL. DEV. CHARGED TO PATIENT				3,130,645	811,757	72
73	DRUGS CHARGED TO PATIENTS	1,872	6,976	485,848	8,098,939	8,019	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	2,600	4,721	313,393		6,666	88
88.01	RHC II	900	4,245	279,898		5,952	88.01
88.02	RHC III	4,212	14,223	872,163		16,750	88.02
90	CLINIC	2,788	3,395	515,958	240,998	14,016	90
91	EMERGENCY	3,022	18,830	750,007	4,286,094	40,922	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	207	56,108	666,478	2,804,422	16,333	95
101	HOME HEALTH AGENCY	1,274	432	381,916		10,123	101
	SPECIAL PURPOSE COST CENTERS						
116	HOSPICE	1,282	628	613,620		84,766	116
118	SUBTOTALS (SUM OF LINES 1-117)	124,192	911,689	14,435,290	67,092,855	2,988,688	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918				273	190
194	IROQUOIS WOMEN'S HEALTH	4,700	3,294	1,049,744		14,341	194
194.01	OTHER NON-REIMBURSABLE COSTS	5,574	157	151,830		14,132	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT			253,292			194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,197,261	1,021,887	2,093,226	528,308	158,192	202
203	UNIT COST MULT-WS B PT I	8.843445	1.116646	0.131731	0.007874	0.052426	203
204	COST TO BE ALLOC PER B PT II			5,311	9,047	13,802	204
205	UNIT COST MULT-WS B PT II			0.000334	0.000135	0.004574	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	DATA PROCESSING TIME SPENT 5.03	COMMUNICATIONS # OF PHONES 5.04	BUSINESS OFFICE GROSS CHARGES 5.05	RECON-CILIATION 5A.06	OTHER ADMINISTRATIVE AND GENER ACCUM COST 5.06	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING	681,606					5.03
5.04	COMMUNICATIONS		227				5.04
5.05	BUSINESS OFFICE	11,050		67,092,855			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,794	11		-1,986,929	31,277,414	5.06
7	OPERATION OF PLANT	13,517	3			1,169,955	7
8	LAUNDRY & LINEN SERVICE	4,588	1			89,681	8
9	HOUSEKEEPING	27,520	2			402,130	9
10	DIETARY	17,601	5			424,740	10
11	CAFETERIA	16,398	2			235,222	11
13	NURSING ADMINISTRATION	18,703	11			888,087	13
14	CENTRAL SERVICES & SUPPLY	2,988	1			94,400	14
16	MEDICAL RECORDS & LIBRARY	27,268	14			817,202	16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	44,884	14	3,082,714		1,679,961	30
31	INTENSIVE CARE UNIT	35,356	10	2,072,487		1,411,286	31
43	NURSERY	5,737	1	320,331		233,317	43
44	SKILLED NURSING FACILITY	62,071	9	1,724,696		1,564,606	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	25,924	12	8,561,473		1,617,113	50
52	DELIVERY ROOM & LABOR ROOM	3,477	1	200,234		138,109	52
53	ANESTHESIOLOGY		1	350,435		36,772	53
54	RADIOLOGY-DIAGNOSTIC	33,518	15	14,909,005		3,057,260	54
60	LABORATORY	34,517	12	10,527,348		2,156,125	60
65	RESPIRATORY THERAPY	17,287	5	1,103,739		582,821	65
66	PHYSICAL THERAPY	29,980	14	2,883,071		1,155,442	66
69	ELECTROCARDIOLOGY	3,539		1,370,458		148,701	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		1	1,425,766		731,432	71
72	IMPL. DEV. CHARGED TO PATIENT			3,130,645		972,718	72
73	DRUGS CHARGED TO PATIENTS	17,843	4	8,098,939		2,048,568	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	10,689	2			500,831	88
88.01	RHC II	8,805	3			439,869	88.01
88.02	RHC III	26,100	2			1,332,407	88.02
90	CLINIC	29,386	3	240,998		418,738	90
91	EMERGENCY	29,718	9	4,286,094		1,111,404	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	45,189	5	2,804,422		999,948	95
101	HOME HEALTH AGENCY	14,748	5			573,746	101
	SPECIAL PURPOSE COST CENTERS						
116	HOSPICE	25,728	7			1,066,871	116
118	SUBTOTALS (SUM OF LINES 1-117)	653,923	185	67,092,855	-1,986,929	28,099,462	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		2			20,628	190
194	IROQUOIS WOMEN'S HEALTH	18,979	40			2,031,751	194
194.01	OTHER NON-REIMBURSABLE COSTS	8,704				352,872	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT					772,701	194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	734,558	268,988	322,801		1,986,929	202
203	UNIT COST MULT-WS B PT I	1.077687	1,184.969163	0.004811		0.063526	203
204	COST TO BE ALLOC PER B PT II	89,576	5,571	24,980		73,417	204
205	UNIT COST MULT-WS B PT II	0.131419	24.541850	0.000372		0.002347	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS	SQUARE FEET	MEALS	FTE'S	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
7	OPERATION OF PLANT	109,936					7
8	LAUNDRY & LINEN SERVICE	2,310	383,025				8
9	HOUSEKEEPING	669	14,155	106,957			9
10	DIETARY	3,182	3,155	3,182	47,488		10
11	CAFETERIA	1,040		1,040		27,938	11
13	NURSING ADMINISTRATION	1,476		1,476		899	13
14	CENTRAL SERVICES & SUPPLY	1,505	125	1,505		144	14
16	MEDICAL RECORDS & LIBRARY	1,444		1,444		1,311	16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	12,285	60,555	12,285	8,761	2,158	30
31	INTENSIVE CARE UNIT	5,359	47,350	5,359	7,636	1,700	31
43	NURSERY	561	585	561		276	43
44	SKILLED NURSING FACILITY	9,791	139,695	9,791	26,770	2,984	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	16,357	50,685	16,357		1,246	50
52	DELIVERY ROOM & LABOR ROOM	224		224		167	52
53	ANESTHESIOLOGY	110		110			53
54	RADIOLOGY-DIAGNOSTIC	5,104	17,275	5,104		1,611	54
60	LABORATORY	3,301	420	3,301		1,659	60
65	RESPIRATORY THERAPY	2,906		2,906		831	65
66	PHYSICAL THERAPY	12,363	13,860	12,363		1,441	66
69	ELECTROCARDIOLOGY	600		600		170	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS	1,872		1,872		858	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	2,600		2,600		514	88
88.01	RHC II	900		900		423	88.01
88.02	RHC III	4,212		4,212		1,255	88.02
90	CLINIC	2,788	2,050	2,788	129	1,413	90
91	EMERGENCY	3,022	31,205	3,022	269	1,429	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	207	1,775	207		2,173	95
101	HOME HEALTH AGENCY	1,274		1,274		709	101
	SPECIAL PURPOSE COST CENTERS						
116	HOSPICE	1,282		1,282		1,237	116
118	SUBTOTALS (SUM OF LINES 1-117)	98,744	382,890	95,765	43,565	26,608	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918		918			190
194	IROQUOIS WOMEN'S HEALTH	4,700		4,700		912	194
194.01	OTHER NON-REIMBURSABLE COSTS	5,574	135	5,574	3,923	418	194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT						194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,244,278	121,523	439,739	501,820	266,212	202
203	UNIT COST MULT-WS B PT I	11.318203	0.317272	4.111363	10.567301	9.528671	203
204	COST TO BE ALLOC PER B PT II	136,809	24,179	12,588	38,624	14,947	204
205	UNIT COST MULT-WS B PT II	1.244442	0.063126	0.117692	0.813342	0.535006	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINIS-TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY CSS CSTED REQ' 14	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
	GENERAL SERVICE COST CENTERS				
1	CAP REL COSTS-BLDG & FIXT				1
2	CAP REL COSTS-MVBLE EQUIP				2
4	EMPLOYEE BENEFITS				4
5.01	ADMISSIONS				5.01
5.02	PURCHASING, RECEIVING, AND STORES				5.02
5.03	DATA PROCESSING				5.03
5.04	COMMUNICATIONS				5.04
5.05	BUSINESS OFFICE				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL				5.06
7	OPERATION OF PLANT				7
8	LAUNDRY & LINEN SERVICE				8
9	HOUSEKEEPING				9
10	DIETARY				10
11	CAFETERIA				11
13	NURSING ADMINISTRATION	236,958			13
14	CENTRAL SERVICES & SUPPLY		15,689		14
16	MEDICAL RECORDS & LIBRARY			73,344,165	16
	INPATIENT ROUTINE SERV COST CENTERS				
30	ADULTS & PEDIATRICS	44,884	1,055	3,082,714	30
31	INTENSIVE CARE UNIT	35,356	2	2,072,487	31
43	NURSERY	5,737		320,331	43
44	SKILLED NURSING FACILITY			1,724,696	44
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	25,924	9,899	8,561,473	50
52	DELIVERY ROOM & LABOR ROOM	3,477		200,234	52
53	ANESTHESIOLOGY			350,435	53
54	RADIOLOGY-DIAGNOSTIC		420	14,909,005	54
60	LABORATORY			10,527,348	60
65	RESPIRATORY THERAPY	17,287	34	1,103,739	65
66	PHYSICAL THERAPY			2,883,071	66
69	ELECTROCARDIOLOGY			1,370,458	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			1,425,766	71
72	IMPL. DEV. CHARGED TO PATIENT			3,130,645	72
73	DRUGS CHARGED TO PATIENTS			8,098,939	73
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC (RHC)		97	407,178	88
88.01	RHC II		85	497,138	88.01
88.02	RHC III		418	1,222,790	88.02
90	CLINIC	29,386	127	240,998	90
91	EMERGENCY	29,718	293	4,286,094	91
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES	45,189		2,804,422	95
101	HOME HEALTH AGENCY			552,665	101
	SPECIAL PURPOSE COST CENTERS				
116	HOSPICE			1,700,410	116
118	SUBTOTALS (SUM OF LINES 1-117)	236,958	12,430	71,473,036	118
	NONREIMBURSABLE COST CENTERS				
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
194	IROQUOIS WOMEN'S HEALTH		3,259	1,871,129	194
194.01	OTHER NON-REIMBURSABLE COSTS				194.01
194.02	DURABLE MEDICAL EQUIPMENT SALES/RENT				194.02
194.03	WELLNESS				194.03
194.04	RENTED SPACE				194.04
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	COST TO BE ALLOC PER B PT I	975,844	125,031	903,888	202
203	UNIT COST MULT-WS B PT I	4.118215	7.969342	0.012324	203
204	COST TO BE ALLOC PER B PT II	22,185	29,039	30,639	204
205	UNIT COST MULT-WS B PT II	0.093624	1.850915	0.000418	205

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,339,830		2,339,830		2,339,830	30
31	INTENSIVE CARE UNIT	1,866,701		1,866,701		1,866,701	31
43	NURSERY	287,185		287,185		287,185	43
44	SKILLED NURSING FACILITY	2,191,966		2,191,966		2,191,966	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,291,339		2,291,339		2,291,339	50
52	DELIVERY ROOM & LABOR ROOM	168,717		168,717		168,717	52
53	ANESTHESIOLOGY	45,124		45,124		45,124	53
54	RADIOLOGY-DIAGNOSTIC	3,538,136		3,538,136		3,538,136	54
60	LABORATORY	2,489,708		2,489,708		2,489,708	60
65	RESPIRATORY THERAPY	757,667		757,667		757,667	65
66	PHYSICAL THERAPY	1,473,258		1,473,258		1,473,258	66
69	ELECTROCARDIOLOGY	185,915		185,915		185,915	69
71	MEDICAL SUPPLIES CHRGED TO	795,468		795,468		795,468	71
72	IMPL. DEV. CHARGED TO PATIE	1,073,093		1,073,093		1,073,093	72
73	DRUGS CHARGED TO PATIENTS	2,315,576		2,315,576		2,315,576	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	583,453		583,453		583,453	88
88.01	RHC II	492,533		492,533		492,533	88.01
88.02	RHC III	1,512,397		1,512,397		1,512,397	88.02
90	CLINIC	628,833		628,833		628,833	90
91	EMERGENCY	1,432,537		1,432,537		1,432,537	91
92	OBSERVATION BEDS	423,735		423,735		423,735	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	1,308,593		1,308,593		1,308,593	95
101	HOME HEALTH AGENCY	643,418		643,418		643,418	101
113	INTEREST EXPENSE						113
116	HOSPICE	1,187,169		1,187,169		1,187,169	116
200	SUBTOTAL (SEE INSTRUCTIONS)	30,032,351		30,032,351		30,032,351	200
201	LESS OBSERVATION BEDS	423,735		423,735		423,735	201
202	TOTAL (SEE INSTRUCTIONS)	29,608,616		29,608,616		29,608,616	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES INPATIENT	CHARGES OUTPATIENT	CHARGES TOTAL (COLS. 6 + 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,944,392		1,944,392				30
31	INTENSIVE CARE UNIT	2,072,487		2,072,487				31
43	NURSERY	320,331		320,331				43
44	SKILLED NURSING FACILITY	1,724,696		1,724,696				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,560,501	6,000,972	8,561,473	0.267634	0.267634	0.267634	50
52	DELIVERY ROOM & LABOR ROOM	171,431	28,803	200,234	0.842599	0.842599	0.842599	52
53	ANESTHESIOLOGY	137,318	213,117	350,435	0.128766	0.128766	0.128766	53
54	RADIOLOGY-DIAGNOSTIC	2,154,127	12,754,878	14,909,005	0.237315	0.237315	0.237315	54
60	LABORATORY	1,610,013	8,917,335	10,527,348	0.236499	0.236499	0.236499	60
65	RESPIRATORY THERAPY	451,228	652,511	1,103,739	0.686455	0.686455	0.686455	65
66	PHYSICAL THERAPY	669,854	2,213,217	2,883,071	0.511003	0.511003	0.511003	66
69	ELECTROCARDIOLOGY	429,459	940,999	1,370,458	0.135659	0.135659	0.135659	69
71	MEDICAL SUPPLIES CHRGED TO	756,273	669,493	1,425,766	0.557923	0.557923	0.557923	71
72	IMPL. DEV. CHARGED TO PATIE	1,190,744	1,939,901	3,130,645	0.342771	0.342771	0.342771	72
73	DRUGS CHARGED TO PATIENTS	3,596,319	4,502,620	8,098,939	0.285911	0.285911	0.285911	73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)		407,178	407,178				88
88.01	RHC II		497,138	497,138				88.01
88.02	RHC III		1,222,790	1,222,790				88.02
90	CLINIC	1,369	239,629	240,998	2.609287	2.609287	2.609287	90
91	EMERGENCY	734,662	3,551,432	4,286,094	0.334229	0.334229	0.334229	91
92	OBSERVATION BEDS	196,411	941,911	1,138,322	0.372245	0.372245	0.372245	92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		2,804,422	2,804,422	0.466618	0.466618	0.466618	95
101	HOME HEALTH AGENCY		552,665	552,665				101
113	INTEREST EXPENSE							113
116	HOSPICE		1,700,410	1,700,410				116
200	SUBTOTAL (SEE INSTRUCTIONS)	20,721,615	50,751,421	71,473,036				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	20,721,615	50,751,421	71,473,036				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	203,228	716	202,512	3,384	59.84	1,795	107,413	30
31	INTENSIVE CARE UNIT	106,274		106,274	1,645	64.60	1,137	73,450	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	19,730		19,730	256	77.07			43
44	SKILLED NURSING FACILITY	157,295		157,295	9,395	16.74	2,108	35,288	44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	486,527		485,811	14,680		5,040	216,151	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0167)	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF			

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	338,745	8,561,473	0.039566	1,078,421	42,669	50
52	DELIVERY ROOM & LABOR ROOM	8,027	200,234	0.040088			52
53	ANESTHESIOLOGY	26,888	350,435	0.076727	67,387	5,170	53
54	RADIOLOGY-DIAGNOSTIC	727,580	14,909,005	0.048801	1,429,693	69,770	54
60	LABORATORY	111,229	10,527,348	0.010566	1,476,037	15,596	60
65	RESPIRATORY THERAPY	87,552	1,103,739	0.079323	291,356	23,111	65
66	PHYSICAL THERAPY	162,161	2,883,071	0.056246	125,252	7,045	66
69	ELECTROCARDIOLOGY	9,122	1,370,458	0.006656	425,933	2,835	69
71	MEDICAL SUPPLIES CHRGED TO PA	4,728	1,425,766	0.003316	554,278	1,838	71
72	IMPL. DEV. CHARGED TO PATIENT	8,894	3,130,645	0.002841	833,622	2,368	72
73	DRUGS CHARGED TO PATIENTS	42,840	8,098,939	0.005290	2,102,696	11,123	73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	36,316	407,178	0.089189			88
88.01	RHC II	17,697	497,138	0.035598			88.01
88.02	RHC III	69,538	1,222,790	0.056868			88.02
90	CLINIC	49,575	240,998	0.205707			90
91	EMERGENCY	80,384	4,286,094	0.018755	549,442	10,305	91
92	OBSERVATION BEDS	36,934	1,138,322	0.032446	155,004	5,029	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	1,818,210	60,353,633	60,353,633	9,089,121	196,859	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D
PART III

CHECK APPLICABLE BOXES
[ ] TITLE V
[XX] TITLE XVIII-PT A
[ ] 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 APPLICABLE BOXES
[ ] TITLE V
[XX] TITLE XVIII-PT A
[ ] 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	3,384		1,795		30
31	INTENSIVE CARE UNIT	1,645		1,137		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	256				43
44	SKILLED NURSING FACILITY	9,395		2,108		44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	14,680		5,040		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

CHECK	[ ] TITLE V	[XX]	HOSPITAL (14-0167)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (SUM OF LINES 50-199)							200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS — WORKSHEET D PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX] HOSPITAL (14-0167)	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS
	[XX] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] TITLE XIX	[ ] IRF	[ ] NF		

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	8,561,473			1,078,421		2,467,894		50
52	DELIVERY ROOM & LABOR ROOM	200,234							52
53	ANESTHESIOLOGY	350,435			67,387		120,647		53
54	RADIOLOGY-DIAGNOSTIC	14,909,005			1,429,693		6,092,663		54
60	LABORATORY	10,527,348			1,476,037		282,081		60
65	RESPIRATORY THERAPY	1,103,739			291,356		266,307		65
66	PHYSICAL THERAPY	2,883,071			125,252				66
69	ELECTROCARDIOLOGY	1,370,458			425,933		450,939		69
71	MEDICAL SUPPLIES CHRGED TO P	1,425,766			554,278		317,735		71
72	IMPL. DEV. CHARGED TO PATIEN	3,130,645			833,622		1,379,930		72
73	DRUGS CHARGED TO PATIENTS	8,098,939			2,102,696		2,289,485		73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)	407,178							88
88.01	RHC II	497,138							88.01
88.02	RHC III	1,222,790							88.02
90	CLINIC	240,998					14,550		90
91	EMERGENCY	4,286,094			549,442		977,430		91
92	OBSERVATION BEDS	1,138,322			155,004		670,333		92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
200	TOTAL (SUM OF LINES 50-199)	60,353,633			9,089,121		15,329,994		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0167)	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.267634	2,467,894			660,492			50
52	DELIVERY ROOM & LABOR ROOM	0.842599							52
53	ANESTHESIOLOGY	0.128766	120,647			15,535			53
54	RADIOLOGY-DIAGNOSTIC	0.237315	6,092,663			1,445,880			54
60	LABORATORY	0.236499	282,081			66,712			60
65	RESPIRATORY THERAPY	0.686455	266,307			182,808			65
66	PHYSICAL THERAPY	0.511003							66
69	ELECTROCARDIOLOGY	0.135659	450,939			61,174			69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.557923	317,735			177,272			71
72	IMPL. DEV. CHARGED TO PATIENT	0.342771	1,379,930			473,000			72
73	DRUGS CHARGED TO PATIENTS	0.285911	2,289,485	3,565		654,589	1,019		73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	2.609287	14,550			37,965			90
91	EMERGENCY	0.334229	977,430			326,685			91
92	OBSERVATION BEDS	0.372245	670,333			249,528			92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.466618							95
200	SUBTOTAL (SEE INSTRUCTIONS)		15,329,994	3,565		4,351,640	1,019		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)		15,329,994	3,565		4,351,640	1,019		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-U167)
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.267634							50
52	DELIVERY ROOM & LABOR ROOM	0.842599							52
53	ANESTHESIOLOGY	0.128766							53
54	RADIOLOGY-DIAGNOSTIC	0.237315							54
60	LABORATORY	0.236499							60
65	RESPIRATORY THERAPY	0.686455							65
66	PHYSICAL THERAPY	0.511003							66
69	ELECTROCARDIOLOGY	0.135659							69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.557923							71
72	IMPL. DEV. CHARGED TO PATIENT	0.342771							72
73	DRUGS CHARGED TO PATIENTS	0.285911							73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	2.609287							90
91	EMERGENCY	0.334229							91
92	OBSERVATION BEDS	0.372245							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.466618							95
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[XX]	SNF (14-6049)			[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (SUM OF LINES 50-199)							200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS — WORKSHEET D PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS
	[XX] TITLE XVIII-PT A	[ ] IPF	[XX] SNF (14-6049)		[ ] TEFRA
	[ ] TITLE XIX	[ ] IRF	[ ] NF		

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	8,561,473							50
52	DELIVERY ROOM & LABOR ROOM	200,234							52
53	ANESTHESIOLOGY	350,435							53
54	RADIOLOGY-DIAGNOSTIC	14,909,005			20,932				54
60	LABORATORY	10,527,348			63,243				60
65	RESPIRATORY THERAPY	1,103,739			9,863				65
66	PHYSICAL THERAPY	2,883,071			458,275				66
69	ELECTROCARDIOLOGY	1,370,458			3,147				69
71	MEDICAL SUPPLIES CHRGED TO P	1,425,766			7,473				71
72	IMPL. DEV. CHARGED TO PATIEN	3,130,645							72
73	DRUGS CHARGED TO PATIENTS	8,098,939			85,987				73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)	407,178							88
88.01	RHC II	497,138							88.01
88.02	RHC III	1,222,790							88.02
90	CLINIC	240,998							90
91	EMERGENCY	4,286,094							91
92	OBSERVATION BEDS	1,138,322							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
200	TOTAL (SUM OF LINES 50-199)	60,353,633			648,920				200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[XX]	SNF (14-6049)	[ ]	S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.267634							50
52	DELIVERY ROOM & LABOR ROOM	0.842599							52
53	ANESTHESIOLOGY	0.128766							53
54	RADIOLOGY-DIAGNOSTIC	0.237315							54
60	LABORATORY	0.236499							60
65	RESPIRATORY THERAPY	0.686455							65
66	PHYSICAL THERAPY	0.511003							66
69	ELECTROCARDIOLOGY	0.135659							69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.557923							71
72	IMPL. DEV. CHARGED TO PATIENT	0.342771							72
73	DRUGS CHARGED TO PATIENTS	0.285911							73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	2.609287							90
91	EMERGENCY	0.334229							91
92	OBSERVATION BEDS	0.372245							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.466618							95
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 APPLICABLE BOXES [ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	203,228	716	202,512	3,384	59.84	680	40,691	30
31	INTENSIVE CARE UNIT	106,274		106,274	1,645	64.60	9	581	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	19,730		19,730	256	77.07	210	16,185	43
44	SKILLED NURSING FACILITY	157,295		157,295	9,395	16.74			44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	486,527		485,811	14,680		899	57,457	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS — WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0167)	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[ ] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	338,745	8,561,473	0.039566			50
52	DELIVERY ROOM & LABOR ROOM	8,027	200,234	0.040088			52
53	ANESTHESIOLOGY	26,888	350,435	0.076727			53
54	RADIOLOGY-DIAGNOSTIC	727,580	14,909,005	0.048801			54
60	LABORATORY	111,229	10,527,348	0.010566			60
65	RESPIRATORY THERAPY	87,552	1,103,739	0.079323			65
66	PHYSICAL THERAPY	162,161	2,883,071	0.056246			66
69	ELECTROCARDIOLOGY	9,122	1,370,458	0.006656			69
71	MEDICAL SUPPLIES CHRGED TO PA	4,728	1,425,766	0.003316			71
72	IMPL. DEV. CHARGED TO PATIENT	8,894	3,130,645	0.002841			72
73	DRUGS CHARGED TO PATIENTS	42,840	8,098,939	0.005290			73
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	36,316	407,178	0.089189			88
88.01	RHC II	17,697	497,138	0.035598			88.01
88.02	RHC III	69,538	1,222,790	0.056868			88.02
90	CLINIC	49,575	240,998	0.205707			90
91	EMERGENCY	80,384	4,286,094	0.018755			91
92	OBSERVATION BEDS	36,934	1,138,322	0.032446			92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	1,818,210	60,353,633	60,353,633			200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D
PART III

CHECK APPLICABLE BOXES
[ ] TITLE V
[ ] TITLE XVIII-PT A
[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 APPLICABLE BOXES
[ ] TITLE V
[ ] TITLE XVIII-PT A
[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	3,384		680		30
31	INTENSIVE CARE UNIT	1,645		9		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	256		210		43
44	SKILLED NURSING FACILITY	9,395				44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	14,680		899		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0167)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
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 (14-0167)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	8,561,473							50
52	DELIVERY ROOM & LABOR ROOM	200,234							52
53	ANESTHESIOLOGY	350,435							53
54	RADIOLOGY-DIAGNOSTIC	14,909,005							54
60	LABORATORY	10,527,348							60
65	RESPIRATORY THERAPY	1,103,739							65
66	PHYSICAL THERAPY	2,883,071							66
69	ELECTROCARDIOLOGY	1,370,458							69
71	MEDICAL SUPPLIES CHRGED TO P	1,425,766							71
72	IMPL. DEV. CHARGED TO PATIEN	3,130,645							72
73	DRUGS CHARGED TO PATIENTS	8,098,939							73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)	407,178							88
88.01	RHC II	497,138							88.01
88.02	RHC III	1,222,790							88.02
90	CLINIC	240,998							90
91	EMERGENCY	4,286,094							91
92	OBSERVATION BEDS	1,138,322							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	2,804,422							95
200	TOTAL (SUM OF LINES 50-199)	60,353,633							200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0167)	[ ]	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	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.267634							50
52	DELIVERY ROOM & LABOR ROOM	0.842599							52
53	ANESTHESIOLOGY	0.128766							53
54	RADIOLOGY-DIAGNOSTIC	0.237315							54
60	LABORATORY	0.236499							60
65	RESPIRATORY THERAPY	0.686455							65
66	PHYSICAL THERAPY	0.511003							66
69	ELECTROCARDIOLOGY	0.135659							69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.557923							71
72	IMPL. DEV. CHARGED TO PATIENT	0.342771							72
73	DRUGS CHARGED TO PATIENTS	0.285911							73
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	2.609287							90
91	EMERGENCY	0.334229							91
92	OBSERVATION BEDS	0.372245							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.466618							95
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0167)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	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)	3,428	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,384	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,384	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	11	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)	33	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,795	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)	11	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)	33	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	184.15	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	188.27	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,339,830	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	2,026	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	6,213	23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	8,239	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,331,591	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,163,892	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,163,892	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.077499	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)	639.45	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,331,591	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK APPLICABLE BOXES [ ] TITLE V-INPT [XX] TITLE XVIII-PT A [ ] TITLE XIX-INPT
[XX] HOSPITAL (14-0167) [ ] IPF [ ] IRF
[ ] SUB (OTHER)
[XX] PPS [ ] TEFRA [ ] 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)	689.00	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,236,755	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)	1,236,755	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	1,866,701	1,645	1,134.77	1,137	1,290,233	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)					2,744,964	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					5,271,952	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					180,863	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					196,859	51
52	TOTAL PROGRAM EXCLUDABLE COST					377,722	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					4,894,230	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)					2,026	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)					6,213	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					8,239	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)	615	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	689.00	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	423,735	89

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
90	CAPITAL-RELATED COST	203,228	2,331,591	0.087163	423,735	36,934	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[XX]	SNF (14-6049)			[ ] 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)	9,395	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,395	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,395	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,108	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		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,191,966	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)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,191,966	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,724,696	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,724,696	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.270929	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)	183.58	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,191,966	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PARTS III & IV

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[XX]	SNF (14-6049)			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	2,191,966	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	233.31	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	491,817	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	491,817	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	491,817	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	290,056	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	781,873	86

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0167)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,428	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,384	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,384	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	11	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)	33	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	680	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)	256	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	210	16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	184.15	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	188.27	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,339,830	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	2,026	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	6,213	23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	8,239	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,331,591	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,163,892	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,163,892	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.077499	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)	639.45	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,331,591	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK APPLICABLE BOXES [ ] TITLE V-INPT [XX] HOSPITAL (14-0167) [ ] SUB (OTHER) [XX] PPS
[ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA
[XX] TITLE XIX-INPT [ ] IRF [ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	689.00	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	468,520	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)	468,520	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)	287,185	256	1,121.82	210	235,582	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	1,866,701	1,645	1,134.77	9	10,213	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					714,315	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					57,457	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					57,457	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					656,858	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (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)	615	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

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

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0167)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		1,130,736		30
31	INTENSIVE CARE UNIT		1,347,729		31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.267634	1,078,421	288,622	50
52	DELIVERY ROOM & LABOR ROOM	0.842599			52
53	ANESTHESIOLOGY	0.128766	67,387	8,677	53
54	RADIOLOGY-DIAGNOSTIC	0.237315	1,429,693	339,288	54
60	LABORATORY	0.236499	1,476,037	349,081	60
65	RESPIRATORY THERAPY	0.686455	291,356	200,003	65
66	PHYSICAL THERAPY	0.511003	125,252	64,004	66
69	ELECTROCARDIOLOGY	0.135659	425,933	57,782	69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.557923	554,278	309,244	71
72	IMPL. DEV. CHARGED TO PATIENT	0.342771	833,622	285,741	72
73	DRUGS CHARGED TO PATIENTS	0.285911	2,102,696	601,184	73
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC (RHC)				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	2.609287			90
91	EMERGENCY	0.334229	549,442	183,639	91
92	OBSERVATION BEDS	0.372245	155,004	57,699	92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		9,089,121	2,744,964	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		9,089,121		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ] TITLE V	[ ] HOSPITAL	[ ] SUB (OTHER)	[XX] S/B SNF (14-U167)	[XX] PPS
APPLICABLE	[XX] 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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.267634			50
52	DELIVERY ROOM & LABOR ROOM	0.842599			52
53	ANESTHESIOLOGY	0.128766			53
54	RADIOLOGY-DIAGNOSTIC	0.237315			54
60	LABORATORY	0.236499	2,165	512	60
65	RESPIRATORY THERAPY	0.686455			65
66	PHYSICAL THERAPY	0.511003	8,714	4,453	66
69	ELECTROCARDIOLOGY	0.135659			69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.557923	151	84	71
72	IMPL. DEV. CHARGED TO PATIENT	0.342771			72
73	DRUGS CHARGED TO PATIENTS	0.285911	4,312	1,233	73
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC (RHC)				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	2.609287			90
91	EMERGENCY	0.334229			91
92	OBSERVATION BEDS	0.372245			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		15,342	6,282	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		15,342		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[XX]	SNF (14-6049)	[ ]	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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.267634			50
52	DELIVERY ROOM & LABOR ROOM	0.842599			52
53	ANESTHESIOLOGY	0.128766			53
54	RADIOLOGY-DIAGNOSTIC	0.237315	20,932	4,967	54
60	LABORATORY	0.236499	63,243	14,957	60
65	RESPIRATORY THERAPY	0.686455	9,863	6,771	65
66	PHYSICAL THERAPY	0.511003	458,275	234,180	66
69	ELECTROCARDIOLOGY	0.135659	3,147	427	69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.557923	7,473	4,169	71
72	IMPL. DEV. CHARGED TO PATIENT	0.342771			72
73	DRUGS CHARGED TO PATIENTS	0.285911	85,987	24,585	73
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC (RHC)				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	2.609287			90
91	EMERGENCY	0.334229			91
92	OBSERVATION BEDS	0.372245			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		648,920	290,056	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		648,920		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0167)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.267634			50
52	DELIVERY ROOM & LABOR ROOM	0.842599			52
53	ANESTHESIOLOGY	0.128766			53
54	RADIOLOGY-DIAGNOSTIC	0.237315			54
60	LABORATORY	0.236499			60
65	RESPIRATORY THERAPY	0.686455			65
66	PHYSICAL THERAPY	0.511003			66
69	ELECTROCARDIOLOGY	0.135659			69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.557923			71
72	IMPL. DEV. CHARGED TO PATIENT	0.342771			72
73	DRUGS CHARGED TO PATIENTS	0.285911			73
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC (RHC)				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	2.609287			90
91	EMERGENCY	0.334229			91
92	OBSERVATION BEDS	0.372245			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0167)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	5,205,536	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	23,913	2
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	47.19	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0298	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1925	31
32	SUM OF LINES 30 AND 31	0.2223	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0755	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	393,018	34
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	5,622,467	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	6,633,710	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	6,633,710	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	418,568	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0167)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	7,052,278	59
60	PRIMARY PAYER PAYMENTS	3,858	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	7,048,420	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	724,220	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	1,132	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	97,696	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	68,387	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	90,545	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	6,391,455	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.96	LOW VOLUME PAYMENT ADJUSTMENT - 1	277,776	70.96
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	6,669,231	71
72	INTERIM PAYMENTS	6,754,238	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-85,007	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2	90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2	91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)	94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)	95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)	96

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-0167) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	1,019	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	4,351,640	2
3	PPS PAYMENTS	4,426,950	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	26,058	4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)	0.805	5
6	LINE 2 TIMES LINE 5	3,503,070	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)	1,019	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	3,565	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)	3,565	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)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	3,565	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)	2,546	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)	1,019	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)	4,453,008	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	995,435	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	3,458,592	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)	3,458,592	30
31	PRIMARY PAYER PAYMENTS	148	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	3,458,444	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)	159,662	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	111,763	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	150,875	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	3,570,207	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	3,570,207	40
41	INTERIM PAYMENTS	3,573,419	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-3,212	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART B

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [XX] SNF (14-6049)

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (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)		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)	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)		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)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		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)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		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)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED WORKSHEET E-1 PART I

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-0167) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				6,483,801		3,558,896	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	04/22/2011	56,782	04/22/2011	4,967	3.01
		.02	09/23/2011	213,655	09/23/2011	9,556	3.02
	PROGRAM	.03					3.03
	TO	.04					3.04
	PROVIDER	.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER	.52					3.52
	TO	.53					3.53
	PROGRAM	.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		270,437		14,523	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)				6,754,238		3,573,419	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
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02		-6,754,238		-3,212	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)						3,570,207	7

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED WORKSHEET E-1 PART I

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [XX] SWING BED SNF (14-U167)

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	INPATIENT PART B MM/DD/YYYY 3	INPATIENT PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				14,229			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		NONE		NONE	3.01
		.02					3.02
	PROGRAM TO PROVIDER	.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER TO PROGRAM	.52					3.52
		.53					3.53
		.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					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)				14,229			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 TO PROVIDER	.01		NONE		NONE	5.01
		.02					5.02
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER TO PROGRAM	.50		NONE		NONE	5.50
		.51					5.51
		.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				14,229			7

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED WORKSHEET E-1 PART I

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] SNF (14-6049) [ ] SWING BED SNF

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	INPATIENT PART B MM/DD/YYYY 3	INPATIENT PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				740,819			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		NONE		NONE	3.01
		.02					3.02
	PROGRAM TO PROVIDER	.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER TO PROGRAM	.52					3.52
		.53					3.53
		.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					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)				740,819			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 TO PROVIDER	.01		NONE		NONE	5.01
		.02					5.02
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER TO PROGRAM	.50		NONE		NONE	5.50
		.51					5.51
		.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				740,819			7

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT WORKSHEET E-1
PART II

CHECK APPLICABLE BOX [XX] HOSPITAL (14-0167) [ ] CAH

	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,485	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,932	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	126	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	4,414	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	71,473,036	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	618,318	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS WORKSHEET E-2

CHECK APPLICABLE BOXES
[ ] TITLE V
[XX] TITLE XVIII
[ ] TITLE XIX
[XX] SWING BED - SNF (14-U167)
[ ] SWING BED - NF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	19,594		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)			3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			4
5	PROGRAM DAYS	44		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)	19,594		8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	19,594		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)			11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	19,594		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	5,365		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)	14,229		15
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			16
17	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			17
18	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			18
19	TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	14,229		19
20	INTERIM PAYMENTS	14,229		20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)			22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VI

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

	PROSPECTIVE PAYMENT AMOUNT		
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	872,935	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (SUM OF LINES 1-3)	872,935	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	MEDICAL AND OTHER SERVICES		5
6	DEDUCTIBLES		6
7	COINSURANCE	132,116	7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		9
10	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	740,819	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	740,819	15
16	INTERIM PAYMENTS	740,819	16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)		18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0167)	[ ]	SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
BOXES:			[ ]	IRF	[ ]	ICF/MR	[ ]	OTHER
			[ ]	SUB (OTHER)				

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

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

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	683,374				1
2	TEMPORARY INVESTMENTS	371,634				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	6,438,253				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,550,000				6
7	INVENTORY	1,412,037				7
8	PREPAID EXPENSES	977,468				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	8,332,766				11
	FIXED ASSETS					
12	LAND	249,035				12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	23,296,839				15
16	ACCUMULATED DEPRECIATION	-12,598,785				16
17	LEASEHOLD IMPROVEMENTS	477,850				17
18	ACCUMULATED AMORTIZATION	-402,781				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	13,267,720				23
24	ACCUMULATED DEPRECIATION	-10,735,820				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	13,554,058				30
	OTHER ASSETS					
31	INVESTMENTS	1,805,767				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	5,966,247				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	7,772,014				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	29,658,838				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	922,436				37
38	SALARIES, WAGES & FEES PAYABLE	2,123,101				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)	1,049,002				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	700,000				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	4,794,539				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	5,145,435				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	5,145,435				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	9,939,974				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	19,718,864				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)	19,718,864				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	29,658,838				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD	19,627,808								1
2	NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)	91,056								2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	19,718,864								3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5										5
6										6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	19,718,864								11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13										13
14										14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	19,718,864								19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	1,881,524		1,881,524	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	62,868		62,868	5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	1,724,696		1,724,696	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	3,669,088		3,669,088	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	2,072,487		2,072,487	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	2,072,487		2,072,487	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	5,741,575		5,741,575	17
18	ANCILLARY SERVICES	13,727,267	38,833,846	52,561,113	18
19	OUTPATIENT SERVICES	862,442	4,802,972	5,665,414	19
20	RHC		407,178	407,178	20
20.01	RHC II		497,138	497,138	20.01
20.02	RHC III		1,222,790	1,222,790	20.02
21	FQHC				21
22	HOME HEALTH AGENCY		552,665	552,665	22
23	AMBULANCE		2,804,422	2,804,422	23
25	ASC				25
26	HOSPICE		1,700,410	1,700,410	26
27	IROQUOIS WOMENS HEALTH		1,871,129	1,871,129	27
27.01	NURSERY	320,331		320,331	27.01
27.02	DME		913,022	913,022	27.02
27.03	PROFESSIONAL FEES	178,350	1,099,190	1,277,540	27.03
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	20,829,965	54,704,762	75,534,727	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		36,252,789	29
30	ADD (SPECIFY)			30
31	PROVISION FOR BAD DEBTS	2,302,832		31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)		2,302,832	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)		38,555,621	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	75,534,727	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	38,546,572	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	36,988,155	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	38,555,621	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,567,466	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,152,626	6
7	INCOME FROM INVESTMENTS	39,437	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	1,629	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	127	13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	139,480	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	422	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	5,350	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 (OTHER)	319,451	24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,658,522	25
26	TOTAL (LINE 5 PLUS LINE 25)	91,056	26
27	OTHER EXPENSES (LOSS ON SALE OF ASSET)		27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	91,056	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS HHA NO.: 14-7586 WORKSHEET H

		SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR-TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (SEE INSTRUCTIONS)							4
5	ADMINISTRATIVE AND GENERAL	42,180	3,399			12,475	58,054	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE	222,844	17,962				240,806	6
7	PHYSICAL THERAPY	59,286	4,778		56,020		120,084	7
8	OCCUPATIONAL THERAPY	13,178	1,062		10,611		24,851	8
9	SPEECH PATHOLOGY	6,587	533		417		7,537	9
10	MEDICAL SOCIAL SERVICES	6,585	531				7,116	10
11	HOME HEALTH AIDE	31,256	2,519				33,775	11
12	SUPPLIES (SEE INSTRUCTIONS)					7,468	7,468	12
13	DRUGS					2	2	13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
24	TOTAL (SUM OF LINES 1-23)	381,916	30,784		67,048	19,945	499,693	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS HHA NO.: 14-7586 WORKSHEET H (CONTINUED)

		RECLASS-IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (SEE INSTRUCTIONS)					4
5	ADMINISTRATIVE AND GENERAL	-2,886	55,168		55,168	5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		240,806		240,806	6
7	PHYSICAL THERAPY		120,084		120,084	7
8	OCCUPATIONAL THERAPY		24,851		24,851	8
9	SPEECH PATHOLOGY		7,537		7,537	9
10	MEDICAL SOCIAL SERVICES		7,116		7,116	10
11	HOME HEALTH AIDE		33,775		33,775	11
12	SUPPLIES (SEE INSTRUCTIONS)	-7,468				12
13	DRUGS	-2				13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
24	TOTAL (SUM OF LINES 1-23)	-10,356	489,337		489,337	24

COST ALLOCATION - HHA GENERAL SERVICE COST HHA NO.: 14-7586 WORKSHEET H-1 PART I

		NET EXPENSES FOR COST ALLOCATION 0	CAP REL COSTS BLDG & FIXTURES 1	CAP REL COSTS MVBL EQUIPMENT 2	PLANT OPERATN & MAINT 3	TRANSPORT-ATION 4	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	GENERAL SERVICE COST CENTER									
1	CAPITAL RELATED-BLDGS & FIXT									1
2	CAPITAL RELATED-MOVABLE EQUIP									2
3	PLANT OPERATION & MAINTENANCE									3
4	TRANSPORTATION (SEE INSTR.)									4
5	ADMINISTRATIVE AND GENERAL	55,168					55,168	55,168		5
	HHA REIMBURSABLE SERVICES									
6	SKILLED NURSING CARE	240,806					240,806	30,597	271,403	6
7	PHYSICAL THERAPY	120,084					120,084	15,259	135,343	7
8	OCCUPATIONAL THERAPY	24,851					24,851	3,158	28,009	8
9	SPEECH PATHOLOGY	7,537					7,537	958	8,495	9
10	MEDICAL SOCIAL SERVICES	7,116					7,116	904	8,020	10
11	HOME HEALTH AIDE	33,775					33,775	4,292	38,067	11
12	SUPPLIES (SEE INSTRUCTIONS)									12
13	DRUGS									13
14	DME									14
	HHA NONREIMBURSABLE SERVICES									
15	HOME DIALYSIS AIDE SERVICES									15
16	RESPIRATORY THERAPY									16
17	PRIVATE DUTY NURSING									17
18	CLINIC									18
19	HEALTH PROMOTION ACTIVITIES									19
20	DAY CARE PROGRAM									20
21	HOME DELIVERED MEALS PROGRAM									21
22	HOMEMAKER SERVICE									22
23	ALL OTHERS									23
24	TOTAL (SUM OF LINES 1-23)	489,337					489,337		489,337	24

COST ALLOCATION - HHA STATISTICAL BASIS HHA NO.: 14-7586 WORKSHEET H-1
PART II

		CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT-ATION (MILEAGE) 4	RECONCIL-IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXT							1
2	CAPITAL RELATED-MOVABLE EQUIP							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (SEE INSTR.)							4
5	ADMINISTRATIVE AND GENERAL					-55,168	434,169	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						240,806	6
7	PHYSICAL THERAPY						120,084	7
8	OCCUPATIONAL THERAPY						24,851	8
9	SPEECH PATHOLOGY						7,537	9
10	MEDICAL SOCIAL SERVICES						7,116	10
11	HOME HEALTH AIDE						33,775	11
12	SUPPLIES (SEE INSTRUCTIONS)							12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (SUM OF LINES 1-23)					-55,168	434,169	24
25	COST TO BE ALLOC (PER W/S H)						55,168	25
26	UNIT COST MULTIPLIER						0.127066	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7586 WORKSHEET H-2
PART I

	HHA COST CENTER	HHA TRIAL BALANCE 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS 4	ADMITTING 5.01	PURCHASING RECEIVING AND STORES 5.02	DATA PROCESSING 5.03	
1	ADMINISTRATIVE AND GENERAL		11,267	482		5,556		531	15,894	1
2	SKILLED NURSING CARE	271,403				29,356				2
3	PHYSICAL THERAPY	135,343				7,810				3
4	OCCUPATIONAL THERAPY	28,009				1,736				4
5	SPEECH PATHOLOGY	8,495				868				5
6	MEDICAL SOCIAL SERVICES	8,020				867				6
7	HOME HEALTH AIDE	38,067				4,117				7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	489,337	11,267	482		50,310		531	15,894	20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7586 WORKSHEET H-2
PART I

	HHA COST CENTER	COMMUNICATIONS	BUSINESS OFFICE	SUBTOTAL (COLS.0-4)	OTHER ADMINISTRATIVE AND GENER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.04	5.05	4A	5.06	7	8	9	10	
1	ADMINISTRATIVE AND GENERAL	5,925		39,655	2,519	14,419		5,238		1
2	SKILLED NURSING CARE			300,759	19,105					2
3	PHYSICAL THERAPY			143,153	9,094					3
4	OCCUPATIONAL THERAPY			29,745	1,890					4
5	SPEECH PATHOLOGY			9,363	595					5
6	MEDICAL SOCIAL SERVICES			8,887	565					6
7	HOME HEALTH AIDE			42,184	2,680					7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	5,925		573,746	36,448	14,419		5,238		20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7586 WORKSHEET H-2
PART I

	HHA COST CENTER	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SUBTOTAL (SUM OF COL.4A-23)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (SUM OF COL.4A-23)	ALLOCATED HHA A&G (SEE PT.2)	
		11	13	14	16	24	25	26	27	
1	ADMINISTRATIVE AND GENERAL	6,756			6,811	75,398		75,398		1
2	SKILLED NURSING CARE					319,864		319,864	42,458	2
3	PHYSICAL THERAPY					152,247		152,247	20,209	3
4	OCCUPATIONAL THERAPY					31,635		31,635	4,199	4
5	SPEECH PATHOLOGY					9,958		9,958	1,322	5
6	MEDICAL SOCIAL SERVICES					9,452		9,452	1,255	6
7	HOME HEALTH AIDE					44,864		44,864	5,955	7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	6,756			6,811	643,418		643,418	75,398	20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.								0.132738	21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7586 WORKSHEET H-2
PART I

	HHA COST CENTER	TOTAL HHA COSTS 28	
1	ADMINISTRATIVE AND GENERAL		1
2	SKILLED NURSING CARE	362,322	2
3	PHYSICAL THERAPY	172,456	3
4	OCCUPATIONAL THERAPY	35,834	4
5	SPEECH PATHOLOGY	11,280	5
6	MEDICAL SOCIAL SERVICES	10,707	6
7	HOME HEALTH AIDE	50,819	7
8	SUPPLIES		8
9	DRUGS		9
10	DME		10
11	HOME DIALYSIS AIDE SERVICES		11
12	RESPIRATORY THERAPY		12
13	PRIVATE DUTY NURSING		13
14	CLINIC		14
15	HEALTH PROMOTION ACTIVITIES		15
16	DAY CARE PROGRAM		16
17	HOME DELIVERED MEALS PROGRAM		17
18	HOMEMAKER SERVICE		18
19	ALL OTHERS		19
20	TOTAL (SUM OF LINES 1-19)	643,418	20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7586 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SAL	ADMITTING GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	DATA PROCESSING TIME SPENT	COMMUNICATIONS # OF PHONES	
		1	2	3	4	5.01	5.02	5.03	5.04	
1	ADMINISTRATIVE AND GENERAL	1,274	432		42,180		10,123	14,748	5	1
2	SKILLED NURSING CARE				222,844					2
3	PHYSICAL THERAPY				59,286					3
4	OCCUPATIONAL THERAPY				13,178					4
5	SPEECH PATHOLOGY				6,587					5
6	MEDICAL SOCIAL SERVICES				6,585					6
7	HOME HEALTH AIDE				31,256					7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTAL (SUM OF LINES 1-19)	1,274	432		381,916		10,123	14,748	5	20
21	TOTAL COST TO BE ALLOCATED	11,267	482		50,310		531	15,894	5,925	21
22	UNIT COST MULTIPLIER	8.843799						1.077705		22
22	UNIT COST MULTIPLIER		1.115741		0.131731		0.052455		1,185.000000	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7586 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	BUSINESS OFFICE GROSS CHARGES 5.05	RECON-CILIATION 4A.06	OTHER ADMINISTRATIVE AND GENER ACCUM COST 5.06	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS 8	HOUSE-KEEPING SQUARE FEET 9	DIETARY MEALS 10	CAFETERIA FTE'S 11	
1	ADMINISTRATIVE AND GENERAL			39,655	1,274		1,274		709	1
2	SKILLED NURSING CARE			300,759						2
3	PHYSICAL THERAPY			143,153						3
4	OCCUPATIONAL THERAPY			29,745						4
5	SPEECH PATHOLOGY			9,363						5
6	MEDICAL SOCIAL SERVICES			8,887						6
7	HOME HEALTH AIDE			42,184						7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTAL (SUM OF LINES 1-19)			573,746	1,274		1,274		709	20
21	TOTAL COST TO BE ALLOCATED			36,448	14,419		5,238		6,756	21
22	UNIT COST MULTIPLIER			0.063526						22
22	UNIT COST MULTIPLIER				11.317896		4.111460		9.528914	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7586 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	NURSING ADMINIS-TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY CSS CSTED REQ' 14	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
1	ADMINISTRATIVE AND GENERAL			552,665	1
2	SKILLED NURSING CARE				2
3	PHYSICAL THERAPY				3
4	OCCUPATIONAL THERAPY				4
5	SPEECH PATHOLOGY				5
6	MEDICAL SOCIAL SERVICES				6
7	HOME HEALTH AIDE				7
8	SUPPLIES				8
9	DRUGS				9
10	DME				10
11	HOME DIALYSIS AIDE SERVICES				11
12	RESPIRATORY THERAPY				12
13	PRIVATE DUTY NURSING				13
14	CLINIC				14
15	HEALTH PROMOTION ACTIVITIES				15
16	DAY CARE PROGRAM				16
17	HOME DELIVERED MEALS PROGRAM				17
18	HOMEMAKER SERVICE				18
19	ALL OTHERS				19
19.50	TELEMEDICINE				19.50
20	TOTAL (SUM OF LINES 1-19)			552,665	20
21	TOTAL COST TO BE ALLOCATED			6,811	21
22	UNIT COST MULTIPLIER			0.012324	22
22	UNIT COST MULTIPLIER				22

APPORTIONMENT OF PATIENT SERVICE COSTS HHA NO.: 14-7586 WORKSHEET H-3
PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

	COST PER VISIT COMPUTATION PATIENT SERVICES	FROM WKST H-2, PART I, COL 28, LINE	FACILITY COSTS (FROM WKST H-2, PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS COLS. 1+2) 3	TOTAL VISITS 4	AVERAGE COST PER VISIT (COL.3 ÷ COL.4) 5	
1	SKILLED NURSING CARE	2	362,322		362,322	1,569	230.93	1
2	PHYSICAL THERAPY	3	172,456		172,456	1,209	142.64	2
3	OCCUPATIONAL THERAPY	4	35,834		35,834	229	156.48	3
4	SPEECH PATHOLOGY	5	11,280		11,280	9	1,253.33	4
5	MEDICAL SOCIAL SERVICES	6	10,707		10,707	3	3,569.00	5
6	HOME HEALTH AIDE	7	50,819		50,819	887	57.29	6
7	TOTAL (SUM OF LINES 1-6)		643,418		643,418	3,906		7

PATIENT SERVICES

8	SKILLED NURSING CARE	8
8.01	SKILLED NURSING CARE	8.01
8.02	SKILLED NURSING CARE	8.02
9	PHYSICAL THERAPY	9
9.01	PHYSICAL THERAPY	9.01
9.02	PHYSICAL THERAPY	9.02
10	OCCUPATIONAL THERAPY	10
10.01	OCCUPATIONAL THERAPY	10.01
10.02	OCCUPATIONAL THERAPY	10.02
11	SPEECH PATHOLOGY	11
11.01	SPEECH PATHOLOGY	11.01
11.02	SPEECH PATHOLOGY	11.02
12	MEDICAL SOCIAL SERVICES	12
12.01	MEDICAL SOCIAL SERVICES	12.01
12.02	MEDICAL SOCIAL SERVICES	12.02
13	HOME HEALTH AIDE	13
13.01	HOME HEALTH AIDE	13.01
13.02	HOME HEALTH AIDE	13.02
14	TOTAL (SUM OF LINES 8-13)	14

	SUPPLIES AND DRUGS COST COMPUTATIONS OTHER PATIENT SERVICES	FROM WKST H-2, PART I, COL 28, LINE	FACILITY COSTS (FROM WKST H-2, PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS COLS. 1+2) 3	TOTAL CHARGES (FROM HHA RECORD) 4	RATIO (COL.3 ÷ COL.4) 5	
15	COST OF MEDICAL SUPPLIES	8		5,783	5,783	10,365	0.557935	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS HHA NO.: 14-7586 WORKSHEET H-3
PARTS I & II
(CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS		COST OF SERVICES		
		PART B		PART B	
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	TOTAL PROGRAM COST (SUM OF COLS.9-10)
	6	7	9	10	12	
1 SKILLED NURSING CARE	632	556	145,948	128,397	274,345	1
2 PHYSICAL THERAPY	507	365	72,318	52,064	124,382	2
3 OCCUPATIONAL THERAPY	83	81	12,988	12,675	25,663	3
4 SPEECH PATHOLOGY	5	2	6,267	2,507	8,774	4
5 MEDICAL SOCIAL SERVICES		2		7,138	7,138	5
6 HOME HEALTH AIDE	288	546	16,500	31,280	47,780	6
7 TOTAL (SUM OF LINES 1-6)	1,515	1,552	254,021	234,061	488,082	7

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		
		PART A	PART B NOT SUBJ TO DEDUCTIBLES & COINSUR	PART B SUBJECT TO DEDUCTIBLES & COINSUR
	1	2	3	4	
8 SKILLED NURSING CARE	99914	613	510		8
8.01 SKILLED NURSING CARE	16580	12	25		8.01
8.02 SKILLED NURSING CARE	19180	7	21		8.02
9 PHYSICAL THERAPY	99914	481	342		9
9.01 PHYSICAL THERAPY	16580	22	23		9.01
9.02 PHYSICAL THERAPY	19180	4			9.02
10 OCCUPATIONAL THERAPY	99914	79	79		10
10.01 OCCUPATIONAL THERAPY	16580	4	2		10.01
10.02 OCCUPATIONAL THERAPY	19180				10.02
11 SPEECH PATHOLOGY	99914	5	2		11
11.01 SPEECH PATHOLOGY	16580				11.01
11.02 SPEECH PATHOLOGY	19180				11.02
12 MEDICAL SOCIAL SERVICES	99914		2		12
12.01 MEDICAL SOCIAL SERVICES	16580				12.01
12.02 MEDICAL SOCIAL SERVICES	19180				12.02
13 HOME HEALTH AIDE	99914	266	543		13
13.01 HOME HEALTH AIDE	16580	14	3		13.01
13.02 HOME HEALTH AIDE	19180	8			13.02
14 TOTAL (SUM OF LINES 8-13)		1,515	1,552		14

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES			
		PART B			PART B		
OTHER PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
	6	7	8	9	10	11	
15 COST OF MEDICAL SUPPLIES	2,509	5,630		1,400	3,141		15
16 COST OF DRUGS							16

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

	FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
		1	2	3	4	
1 PHYSICAL THERAPY	66	0.511003			COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY	67				COL 2, LINE 3	2
3 SPEECH PATHOLOGY	68				COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHRGED TO PAT	71	0.557923	10,365	5,783	COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	73	0.285911			COL 2, LINE 16	5

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT HHA NO.: 14-7586 WORKSHEET H-4
PARTS I & II

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

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10	TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	250,139	212,344	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS		1,497	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	6,185	7,873	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES		174	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS		947	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22	SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	256,324	222,835	22
23	EXCESS REASONABLE COST (FROM LINE 8)			23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	256,324	222,835	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26	NET COST (LINE 24 MINUS LINE 25)	256,324	222,835	26
27	REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	256,324	222,835	29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31	SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	256,324	222,835	31
32	INTERIM PAYMENTS (SEE INSTRUCTIONS)	256,324	222,835	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7586

WORKSHEET H-5

	DESCRIPTION			PART A MO/DAY/YR 1	PART A AMOUNT 2	PART B MO/DAY/YR 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				256,324		222,835	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		NONE		NONE	3.01
			.02					3.02
		PROGRAM	.03					3.03
		TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.50		NONE		NONE	3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)				256,324		222,835	4
	TO BE COMPLETED BY INTERMEDIARY							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE		NONE	5.01
		TO	.02					5.02
		PROVIDER	.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER	.50		NONE		NONE	5.50
		TO	.51					5.51
		PROGRAM	.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO PROVIDER	.01					6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				256,324		222,835	7

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

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS HOSPICE NO.: 14-1616 WORKSHEET K

		SALARIES (FROM WKST K-1) 1	EMPLOYEE BENEFITS (FROM WKST K-2) 2	TRANS-PORTATION (SEE INSTR.) 3	CONTRACTED SERVICES (FROM WKST K-3) 4	OTHER 5	TOTAL (COLS. 1-5) 6	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED COSTS-BLDG AND FIXT.							1
2	CAPITAL RELATED COSTS-MOVABLE EQUIP.							2
3	PLANT OPERATION AND MAINTENANCE					2,234	2,234	3
4	TRANSPORTATION - STAFF							4
5	VOLUNTEER SERVICE COORDINATION							5
6	ADMINISTRATIVE AND GENERAL	102,911	6,904		26,130	153,778	289,723	6
	INPATIENT CARE SERVICE							
7	INPATIENT - GENERAL CARE							7
8	INPATIENT - RESPITE CARE							8
	VISITING SERVICES							
9	PHYSICIAN SERVICES							9
10	NURSING CARE	449,350	30,151		79,461	185,425	744,387	10
11	NURSING CARE-CONTINUOUS HOME CARE							11
12	PHYSICAL THERAPY							12
13	OCCUPATIONAL THERAPY							13
14	SPEECH/LANGUAGE PATHOLOGY							14
15	MEDICAL SOCIAL SERVICES							15
16	SPIRITUAL COUNSELING							16
17	DIETARY COUNSELING							17
18	COUNSELING - OTHER							18
19	HOME HEALTH AIDE AND HOMEMAKER							19
20	HH AIDE & HOMEMAKER-CONT. HOME CARE							20
21	OTHER	61,359	4,119				65,478	21
	OTHER HOSPICE SERVICE COSTS							
22	DRUGS, BIOLOGICAL & INFUSION THERAPY							22
23	ANALGESICS							23
24	SEDATIVES/HYPNOTICS							24
25	OTHER - SPECIFY							25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN							26
27	PATIENT TRANSPORTATION							27
28	IMAGING SERVICES							28
29	LABS AND DIAGNOSTICS							29
30	MEDICAL SUPPLIES							30
31	OUTPATIENT SERVICES (INCLUDING E/R DEPT.)							31
32	RADIATION THERAPY							32
33	CHEMOTHERAPY							33
34	OTHER							34
	HOSPICE NONREIMBURSABLE SERVICE							
35	BEREAVEMENT PROGRAM COSTS							35
36	VOLUNTEER PROGRAM COSTS							36
37	FUNDRAISING							37
38	OTHER PROGRAM COSTS							38
39	TOTAL (SUM OF LINES 1-38)	613,620	41,174		105,591	341,437	1,101,822	39

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS HOSPICE NO.: 14-1616 WORKSHEET K (CONTINUED)

		RECLASSIFI-CATION 7	SUBTOTAL (COL.6 ± COL.7) 8	ADJUST-MENTS 9	TOTAL (COL.8 ± COL.9) 10	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED COSTS-BLDG AND FIXT.					1
2	CAPITAL RELATED COSTS-MOVABLE EQUIP.					2
3	PLANT OPERATION AND MAINTENANCE	-2,234				3
4	TRANSPORTATION - STAFF					4
5	VOLUNTEER SERVICE COORDINATION					5
6	ADMINISTRATIVE AND GENERAL	-1,910	287,813	-31,033	256,780	6
	INPATIENT CARE SERVICE					
7	INPATIENT - GENERAL CARE					7
8	INPATIENT - RESPITE CARE					8
	VISITING SERVICES					
9	PHYSICIAN SERVICES					9
10	NURSING CARE	-133,111	611,276		611,276	10
11	NURSING CARE-CONTINUOUS HOME CARE					11
12	PHYSICAL THERAPY					12
13	OCCUPATIONAL THERAPY					13
14	SPEECH/LANGUAGE PATHOLOGY					14
15	MEDICAL SOCIAL SERVICES					15
16	SPIRITUAL COUNSELING					16
17	DIETARY COUNSELING					17
18	COUNSELING - OTHER					18
19	HOME HEALTH AIDE AND HOMEMAKER					19
20	HH AIDE & HOMEMAKER-CONT. HOME CARE					20
21	OTHER		65,478		65,478	21
	OTHER HOSPICE SERVICE COSTS					
22	DRUGS, BIOLOGICAL & INFUSION THERAPY					22
23	ANALGESICS					23
24	SEDATIVES/HYPNOTICS					24
25	OTHER - SPECIFY					25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN					26
27	PATIENT TRANSPORTATION					27
28	IMAGING SERVICES					28
29	LABS AND DIAGNOSTICS					29
30	MEDICAL SUPPLIES					30
31	OUTPATIENT SERVICES (INCLUDING E/R DEPT.)					31
32	RADIATION THERAPY					32
33	CHEMOTHERAPY					33
34	OTHER					34
	HOSPICE NONREIMBURSABLE SERVICE					
35	BEREAVEMENT PROGRAM COSTS					35
36	VOLUNTEER PROGRAM COSTS					36
37	FUNDRAISING					37
38	OTHER PROGRAM COSTS					38
39	TOTAL (SUM OF LINES 1-38)	-274,510	964,567	-62,066	933,534	39

HOSPICE COMPENSATION ANALYSIS - SALARIES AND WAGES HOSPICE NO.: 14-1616 WORKSHEET K-1

		ADMINI-STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER-VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9	
	GENERAL SERVICE COST CENTER										
1	CAP REL COSTS-BLDG AND FIXT.										1
2	CAP REL COSTS-MOVABLE EQUIP.										2
3	PLANT OPERATION & MAINT.										3
4	TRANSPORTATION - STAFF										4
5	VOLUNTEER SERVICE COORD.										5
6	ADMINISTRATIVE AND GENERAL	102,911								102,911	6
	INPATIENT CARE SERVICE										
7	INPATIENT - GENERAL CARE										7
8	INPATIENT - RESPITE CARE										8
	VISITING SERVICES										
9	PHYSICIAN SERVICES										9
10	NURSING CARE	449,350								449,350	10
11	NURSING CARE-CONT.HOME CARE										11
12	PHYSICAL THERAPY										12
13	OCCUPATIONAL THERAPY										13
14	SPEECH/LANGUAGE PATHOLOGY										14
15	MEDICAL SOCIAL SERVICES										15
16	SPIRITUAL COUNSELING										16
17	DIETARY COUNSELING										17
18	COUNSELING - OTHER										18
19	HH AIDE AND HOMEMAKER										19
20	HH AIDE & HMKR-CONT.HME CARE										20
21	OTHER	61,359								61,359	21
	OTHER HOSPICE SERVICE COSTS										
22	DRUGS, BIOL. & INFUS. THER.										22
23	ANALGESICS										23
24	SEDATIVES / HYPNOTICS										24
25	OTHER - SPECIFY										25
26	DURABLE MED. EQUIP./OXYGEN										26
27	PATIENT TRANSPORTATION										27
28	IMAGING SERVICES										28
29	LABS AND DIAGNOSTICS										29
30	MEDICAL SUPPLIES										30
31	OUTPAT.SERV.(INCL.E/R DEPT.)										31
32	RADIATION THERAPY										32
33	CHEMOTHERAPY										33
34	OTHER										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	BEREAVEMENT PROGRAM COSTS										35
36	VOLUNTEER PROGRAM COSTS										36
37	FUNDRAISING										37
38	OTHER PROGRAM COSTS										38
39	TOTAL (SUM OF LINES 1-38)	613,620								613,620	39

HOSPICE COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED) HOSPICE NO.: 14-1616 WORKSHEET K-2

		ADMINI-STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER-VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9	
	GENERAL SERVICE COST CENTER										
1	CAP REL COSTS-BLDG AND FIXT.										1
2	CAP REL COSTS-MOVABLE EQUIP.										2
3	PLANT OPERATION & MAINT.										3
4	TRANSPORTATION - STAFF										4
5	VOLUNTEER SERVICE COORD.										5
6	ADMINISTRATIVE AND GENERAL	6,904								6,904	6
	INPATIENT CARE SERVICE										
7	INPATIENT - GENERAL CARE										7
8	INPATIENT - RESPITE CARE										8
	VISITING SERVICES										
9	PHYSICIAN SERVICES										9
10	NURSING CARE					30,151				30,151	10
11	NURSING CARE-CONT.HOME CARE										11
12	PHYSICAL THERAPY										12
13	OCCUPATIONAL THERAPY										13
14	SPEECH/LANGUAGE PATHOLOGY										14
15	MEDICAL SOCIAL SERVICES										15
16	SPIRITUAL COUNSELING										16
17	DIETARY COUNSELING										17
18	COUNSELING - OTHER										18
19	HH AIDE AND HOMEMAKER										19
20	HH AIDE & HMKR-CONT.HME CARE										20
21	OTHER								4,119	4,119	21
	OTHER HOSPICE SERVICE COSTS										
22	DRUGS, BIOL. & INFUS. THER.										22
23	ANALGESICS										23
24	SEDATIVES / HYPNOTICS										24
25	OTHER - SPECIFY										25
26	DURABLE MED. EQUIP./OXYGEN										26
27	PATIENT TRANSPORTATION										27
28	IMAGING SERVICES										28
29	LABS AND DIAGNOSTICS										29
30	MEDICAL SUPPLIES										30
31	OUTPAT.SERV.(INCL.E/R DEPT.)										31
32	RADIATION THERAPY										32
33	CHEMOTHERAPY										33
34	OTHER										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	BEREAVEMENT PROGRAM COSTS										35
36	VOLUNTEER PROGRAM COSTS										36
37	FUNDRAISING										37
38	OTHER PROGRAM COSTS										38
39	TOTAL (SUM OF LINES 1-38)	6,904				30,151			4,119	41,174	39

HOSPICE COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES HOSPICE NO.: 14-1616 WORKSHEET K-3

		ADMINI-STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER-VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9	
	GENERAL SERVICE COST CENTER										
1	CAP REL COSTS-BLDG AND FIXT.										1
2	CAP REL COSTS-MOVABLE EQUIP.										2
3	PLANT OPERATION & MAINT.										3
4	TRANSPORTATION - STAFF										4
5	VOLUNTEER SERVICE COORD.										5
6	ADMINISTRATIVE AND GENERAL								26,130	26,130	6
	INPATIENT CARE SERVICE										
7	INPATIENT - GENERAL CARE										7
8	INPATIENT - RESPITE CARE										8
	VISITING SERVICES										
9	PHYSICIAN SERVICES										9
10	NURSING CARE					79,461				79,461	10
11	NURSING CARE-CONT.HOME CARE										11
12	PHYSICAL THERAPY										12
13	OCCUPATIONAL THERAPY										13
14	SPEECH/LANGUAGE PATHOLOGY										14
15	MEDICAL SOCIAL SERVICES										15
16	SPIRITUAL COUNSELING										16
17	DIETARY COUNSELING										17
18	COUNSELING - OTHER										18
19	HH AIDE AND HOMEMAKER										19
20	HH AIDE & HMKR-CONT.HME CARE										20
21	OTHER										21
	OTHER HOSPICE SERVICE COSTS										
22	DRUGS, BIOL. & INFUS. THER.										22
23	ANALGESICS										23
24	SEDATIVES / HYPNOTICS										24
25	OTHER - SPECIFY										25
26	DURABLE MED. EQUIP./OXYGEN										26
27	PATIENT TRANSPORTATION										27
28	IMAGING SERVICES										28
29	LABS AND DIAGNOSTICS										29
30	MEDICAL SUPPLIES										30
31	OUTPAT.SERV.(INCL.E/R DEPT.)										31
32	RADIATION THERAPY										32
33	CHEMOTHERAPY										33
34	OTHER										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	BEREAVEMENT PROGRAM COSTS										35
36	VOLUNTEER PROGRAM COSTS										36
37	FUNDRAISING										37
38	OTHER PROGRAM COSTS										38
39	TOTAL (SUM OF LINES 1-38)					79,461			26,130	105,591	39

COST ALLOCATION - HOSPICE GENERAL SERVICE COST HOSPICE NO.: 14-1616 WORKSHEET K-4
PART I

		NET EXPENSES FOR COST ALLOCATION 0	CAP REL COSTS BLDG & FIXTURES 1	CAP REL COSTS MVBL EQUIPMENT 2	PLANT OPERATN & MAINT 3	TRANSPO-RTATION 4	VOLUNTEER SERV. CO-ORDINATOR 5	SUBTOTAL (COLS.0-5) 5A	ADMIN & GENERAL 6	TOTAL (COL.5 ± COL.6) 7	
	GENERAL SERVICE COST CENTER										
1	CAP REL COSTS-BLDG AND FIXT.										1
2	CAP REL COSTS-MOVABLE EQUIP.										2
3	PLANT OPERATION & MAINT.										3
4	TRANSPORTATION - STAFF										4
5	VOLUNTEER SERVICE COORD.										5
6	ADMINISTRATIVE AND GENERAL	256,780						256,780	256,780		6
	INPATIENT CARE SERVICE										
7	INPATIENT - GENERAL CARE										7
8	INPATIENT - RESPITE CARE										8
	VISITING SERVICES										
9	PHYSICIAN SERVICES										9
10	NURSING CARE	611,276						611,276	231,936	843,212	10
11	NURSING CARE-CONTINUOUS HOME										11
12	PHYSICAL THERAPY										12
13	OCCUPATIONAL THERAPY										13
14	SPEECH/LANGUAGE PATHOLOGY										14
15	MEDICAL SOCIAL SERVICES										15
16	SPIRITUAL COUNSELING										16
17	DIETARY COUNSELING										17
18	COUNSELING - OTHER										18
19	HH AIDE AND HOMEMAKER										19
20	HH AIDE & HMKR-CONT. HOME CA										20
21	OTHER	65,478						65,478	24,844	90,322	21
	OTHER HOSPICE SERVICE COSTS										
22	DRUGS, BIOL. & INFUS. THER.										22
23	ANALGESICS										23
24	SEDATIVES / HYPNOTICS										24
25	OTHER - SPECIFY										25
26	DURABLE MED. EQUIP./OXYGEN										26
27	PATIENT TRANSPORTATION										27
28	IMAGING SERVICES										28
29	LABS AND DIAGNOSTICS										29
30	MEDICAL SUPPLIES										30
31	OUTPAT.SERV.(INCL.E/R DEPT.)										31
32	RADIATION THERAPY										32
33	CHEMOTHERAPY										33
34	OTHER										34
	HOSPICE NONREIMBURSABLE SERV.										
35	BEREAVEMENT PROGRAM COSTS										35
36	VOLUNTEER PROGRAM COSTS										36
37	FUNDRAISING										37
38	OTHER PROGRAM COSTS										38
39	TOTAL (SUM OF LINES 1-38)	933,534						933,534		933,534	39

COST ALLOCATION - HOSPICE STATISTICAL BASIS HOSPICE NO.: 14-1616 WORKSHEET K-4 PART II

		CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPO-RTATION (MILEAGE) 4	VOLUNTEER SERV. CO-ORDINATOR (HOURS) 5	RECONCIL-IATION 6A	ADMIN & GENERAL (ACCUM COST) 6	
	GENERAL SERVICE COST CENTER								
1	CAP REL COSTS-BLDG AND FIXT.								1
2	CAP REL COSTS-MOVABLE EQUIP.								2
3	PLANT OPERATION & MAINT.								3
4	TRANSPORTATION - STAFF								4
5	VOLUNTEER SERVICE COORD.								5
6	ADMINISTRATIVE AND GENERAL						-256,780	676,754	6
	INPATIENT CARE SERVICE								
7	INPATIENT - GENERAL CARE								7
8	INPATIENT - RESPITE CARE								8
	VISITING SERVICES								
9	PHYSICIAN SERVICES								9
10	NURSING CARE							611,276	10
11	NURSING CARE-CONTINUOUS HOME								11
12	PHYSICAL THERAPY								12
13	OCCUPATIONAL THERAPY								13
14	SPEECH/LANGUAGE PATHOLOGY								14
15	MEDICAL SOCIAL SERVICES								15
16	SPIRITUAL COUNSELING								16
17	DIETARY COUNSELING								17
18	COUNSELING - OTHER								18
19	HH AIDE AND HOMEMAKER								19
20	HH AIDE & HMKR-CONT. HOME CA								20
21	OTHER							65,478	21
	OTHER HOSPICE SERVICE COSTS								
22	DRUGS, BIOL. & INFUS. THER.								22
23	ANALGESICS								23
24	SEDATIVES / HYPNOTICS								24
25	OTHER - SPECIFY								25
26	DURABLE MED. EQUIP./OXYGEN								26
27	PATIENT TRANSPORTATION								27
28	IMAGING SERVICES								28
29	LABS AND DIAGNOSTICS								29
30	MEDICAL SUPPLIES								30
31	OUTPAT.SERV.(INCL.E/R DEPT.)								31
32	RADIATION THERAPY								32
33	CHEMOTHERAPY								33
34	OTHER								34
	HOSPICE NONREIMBURSABLE SERVICE								
35	BEREAVEMENT PROGRAM COSTS								35
36	VOLUNTEER PROGRAM COSTS								36
37	FUNDRAISING								37
38	OTHER PROGRAM COSTS								38
39	COST TO BE ALLOCATED							256,780	39
40	UNIT COST MULTIPLIER							0.379429	40

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS HOSPICE NO.: 14-1616 WORKSHEET K-5
PART I

	HOSPICE COST CENTER	HOSPICE TRIAL BALANCE 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS 4	ADMITTING 5.01	PURCHASING RECEIVING AND STORES 5.02	DATA PROCESSING 5.03	
1	ADMINISTRATIVE AND GENERAL		11,337	701		13,557		4,444	27,727	1
2	INPATIENT - GENERAL CARE									2
3	INPATIENT - RESPITE CARE									3
4	PHYSICIAN SERVICES									4
5	NURSING CARE	843,212				59,193				5
6	NURSING CARE-CONTINUOUS HOM									6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH/LANGUAGE PATHOLOGY									9
10	MEDICAL SOCIAL SERV. - DIRE									10
11	SPIRITUAL COUNSELING									11
12	DIETARY COUNSELING									12
13	COUNSELING - OTHER									13
14	HOME HLTH AIDE & HOMEMAKERS									14
15	HH AIDE & HMKR-CONT. HOME C									15
16	OTHER	90,322				8,083				16
17	DRUGS,BIOLOGICALS & INFUSIO									17
18	ANALGESICS									18
19	SEDATIVES / HYPNOTICS									19
20	OTHER - SPECIFY									20
21	DURABLE MED. EQUIP./OXYGEN									21
22	PATIENT TRANSPORTATION									22
23	IMAGING SERVICES									23
24	LABS AND DIAGNOSTICS									24
25	MEDICAL SUPPLIES									25
26	OUTPAT. SERV.(INCL.E/R DEPT									26
27	RADIATION THERAPY									27
28	CHEMOTHERAPY									28
29	OTHER									29
30	BEREAVEMENT PROGRAM COSTS									30
31	VOLUNTEER PROGRAM COSTS									31
32	FUNDRAISING									32
33	OTHER PROGRAM COSTS									33
34	TOTALS (SUM OF LINES 1-33)	933,534	11,337	701		80,833		4,444	27,727	34
35	UNIT COST MULTIPLIER									35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS HOSPICE NO.: 14-1616 WORKSHEET K-5
PART I

	HOSPICE COST CENTER	COMMUNICATIONS	BUSINESS OFFICE	SUBTOTAL	OTHER ADMINISTRATIVE AND GENER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.04	5.05	4A	5.06	7	8	9	10	
1	ADMINISTRATIVE AND GENERAL	8,295		66,061	4,197	14,510		5,271		1
2	INPATIENT - GENERAL CARE									2
3	INPATIENT - RESPITE CARE									3
4	PHYSICIAN SERVICES									4
5	NURSING CARE			902,405	57,326					5
6	NURSING CARE-CONTINUOUS HOM									6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH/LANGUAGE PATHOLOGY									9
10	MEDICAL SOCIAL SERV. - DIRE									10
11	SPIRITUAL COUNSELING									11
12	DIETARY COUNSELING									12
13	COUNSELING - OTHER									13
14	HOME HLTH AIDE & HOMEMAKERS									14
15	HH AIDE & HMKR-CONT. HOME C									15
16	OTHER			98,405	6,251					16
17	DRUGS,BIOLOGICALS & INFUSIO									17
18	ANALGESICS									18
19	SEDATIVES / HYPNOTICS									19
20	OTHER - SPECIFY									20
21	DURABLE MED. EQUIP./OXYGEN									21
22	PATIENT TRANSPORTATION									22
23	IMAGING SERVICES									23
24	LABS AND DIAGNOSTICS									24
25	MEDICAL SUPPLIES									25
26	OUTPAT. SERV.(INCL.E/R DEPT									26
27	RADIATION THERAPY									27
28	CHEMOTHERAPY									28
29	OTHER									29
30	BEREAVEMENT PROGRAM COSTS									30
31	VOLUNTEER PROGRAM COSTS									31
32	FUNDRAISING									32
33	OTHER PROGRAM COSTS									33
34	TOTALS (SUM OF LINES 1-33)	8,295		1,066,871	67,774	14,510		5,271		34
35	UNIT COST MULTIPLIER									35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS HOSPICE NO.: 14-1616 WORKSHEET K-5
PART I

	HOSPICE COST CENTER	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SUBTOTAL (COLS. 4A-23)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (COLS. 24 ± 25)	ALLOC HOSP A&G (SEE PART II)	
		11	13	14	16	24	25	26	27	
1	ADMINISTRATIVE AND GENERAL	11,787			20,956	122,782		122,782		1
2	INPATIENT - GENERAL CARE									2
3	INPATIENT - RESPITE CARE									3
4	PHYSICIAN SERVICES									4
5	NURSING CARE					959,731		959,731	110,709	5
6	NURSING CARE-CONTINUOUS HOM									6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH/LANGUAGE PATHOLOGY									9
10	MEDICAL SOCIAL SERV. - DIRE									10
11	SPIRITUAL COUNSELING									11
12	DIETARY COUNSELING									12
13	COUNSELING - OTHER									13
14	HOME HLTH AIDE & HOMEMAKERS									14
15	HH AIDE & HMKR-CONT. HOME C									15
16	OTHER					104,656		104,656	12,073	16
17	DRUGS,BIOLOGICALS & INFUSIO									17
18	ANALGESICS									18
19	SEDATIVES / HYPNOTICS									19
20	OTHER - SPECIFY									20
21	DURABLE MED. EQUIP./OXYGEN									21
22	PATIENT TRANSPORTATION									22
23	IMAGING SERVICES									23
24	LABS AND DIAGNOSTICS									24
25	MEDICAL SUPPLIES									25
26	OUTPAT. SERV.(INCL.E/R DEPT									26
27	RADIATION THERAPY									27
28	CHEMOTHERAPY									28
29	OTHER									29
30	BEREAVEMENT PROGRAM COSTS									30
31	VOLUNTEER PROGRAM COSTS									31
32	FUNDRAISING									32
33	OTHER PROGRAM COSTS									33
34	TOTALS (SUM OF LINES 1-33)	11,787			20,956	1,187,169		1,187,169		34
35	UNIT COST MULTIPLIER								0.115355	35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS HOSPICE NO.: 14-1616 WORKSHEET K-5
PART I

	HOSPICE COST CENTER	TOTAL HOSP COSTS (COL 26 ± 27) 28	
1	ADMINISTRATIVE AND GENERAL		1
2	INPATIENT - GENERAL CARE		2
3	INPATIENT - RESPITE CARE		3
4	PHYSICIAN SERVICES		4
5	NURSING CARE	1,070,440	5
6	NURSING CARE-CONTINUOUS HOM		6
7	PHYSICAL THERAPY		7
8	OCCUPATIONAL THERAPY		8
9	SPEECH/LANGUAGE PATHOLOGY		9
10	MEDICAL SOCIAL SERV. - DIRE		10
11	SPIRITUAL COUNSELING		11
12	DIETARY COUNSELING		12
13	COUNSELING - OTHER		13
14	HOME HLTH AIDE & HOMEMAKERS		14
15	HH AIDE & HMKR-CONT. HOME C		15
16	OTHER	116,729	16
17	DRUGS,BIOLOGICALS & INFUSIO		17
18	ANALGESICS		18
19	SEDATIVES / HYPNOTICS		19
20	OTHER - SPECIFY		20
21	DURABLE MED. EQUIP./OXYGEN		21
22	PATIENT TRANSPORTATION		22
23	IMAGING SERVICES		23
24	LABS AND DIAGNOSTICS		24
25	MEDICAL SUPPLIES		25
26	OUTPAT. SERV.(INCL.E/R DEPT		26
27	RADIATION THERAPY		27
28	CHEMOTHERAPY		28
29	OTHER		29
30	BEREAVEMENT PROGRAM COSTS		30
31	VOLUNTEER PROGRAM COSTS		31
32	FUNDRAISING		32
33	OTHER PROGRAM COSTS		33
34	TOTALS (SUM OF LINES 1-33)	1,187,169	34
35	UNIT COST MULTIPLIER		35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS HOSPICE NO.: 14-1616 WORKSHEET K-5
STATISTICAL BASIS PART II

	HOSPICE COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW 2	OTHER CAP REL COSTS NOT USED 3	EMPLOYEE BENEFITS GROSS SAL 4	ADMITTING GROSS CHARGES 5.01	PURCHASING RECEIVING AND STORES COST REQ'S 5.02	DATA PROCESSING TIME SPENT 5.03	COMMUNICATIONS # OF PHONES 5.04	
1	ADMINISTRATIVE AND GENERAL	1,282	628		102,911		84,766	25,728	7	1
2	INPATIENT - GENERAL CARE									2
3	INPATIENT - RESPITE CARE									3
4	PHYSICIAN SERVICES									4
5	NURSING CARE				449,350					5
6	NURSING CARE-CONTINUOUS HOM									6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH/LANGUAGE PATHOLOGY									9
10	MEDICAL SOCIAL SERV. - DIRE									10
11	SPIRITUAL COUNSELING									11
12	DIETARY COUNSELING									12
13	COUNSELING - OTHER									13
14	HOME HLTH AIDE & HOMEMAKERS									14
15	HH AIDE & HMKR-CONT. HOME C									15
16	OTHER				61,359					16
17	DRUGS,BIOLOGICALS & INFUSIO									17
18	ANALGESICS									18
19	SEDATIVES / HYPNOTICS									19
20	OTHER - SPECIFY									20
21	DURABLE MED. EQUIP./OXYGEN									21
22	PATIENT TRANSPORTATION									22
23	IMAGING SERVICES									23
24	LABS AND DIAGNOSTICS									24
25	MEDICAL SUPPLIES									25
26	OUTPAT. SERV.(INCL.E/R DEPT									26
27	RADIATION THERAPY									27
28	CHEMOTHERAPY									28
29	OTHER									29
30	BEREAVEMENT PROGRAM COSTS									30
31	VOLUNTEER PROGRAM COSTS									31
32	FUNDRAISING									32
33	OTHER PROGRAM COSTS									33
34	TOTALS (SUM OF LINES 1-33)	1,282	628		613,620		84,766	25,728	7	34
35	TOTAL COST TO BE ALLOCATED	11,337	701		80,833		4,444	27,727	8,295	35
36	UNIT COST MULTIPLIER	8.843214	1.116242		0.131731		0.052427	1.0776971	185.00000	36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS HOSPICE NO.: 14-1616 WORKSHEET K-5
STATISTICAL BASIS PART II

	HOSPICE COST CENTER	BUSINESS OFFICE	RECON-CILIATION	OTHER ADMINISTRATIVE AND GENER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		GROSS CHARGES		ACCUM COST	SQUARE FEET	POUNDS	SQUARE FEET	MEALS	FTE'S	
		5.05	4A.06	5.06	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL			66,061	1,282		1,282		1,237	1
2	INPATIENT - GENERAL CARE									2
3	INPATIENT - RESPITE CARE									3
4	PHYSICIAN SERVICES									4
5	NURSING CARE			902,405						5
6	NURSING CARE-CONTINUOUS HOM									6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH/LANGUAGE PATHOLOGY									9
10	MEDICAL SOCIAL SERV. - DIRE									10
11	SPIRITUAL COUNSELING									11
12	DIETARY COUNSELING									12
13	COUNSELING - OTHER									13
14	HOME HLTH AIDE & HOMEMAKERS									14
15	HH AIDE & HMKR-CONT. HOME C									15
16	OTHER			98,405						16
17	DRUGS,BIOLOGICALS & INFUSIO									17
18	ANALGESICS									18
19	SEDATIVES / HYPNOTICS									19
20	OTHER - SPECIFY									20
21	DURABLE MED. EQUIP./OXYGEN									21
22	PATIENT TRANSPORTATION									22
23	IMAGING SERVICES									23
24	LABS AND DIAGNOSTICS									24
25	MEDICAL SUPPLIES									25
26	OUTPAT. SERV.(INCL.E/R DEPT									26
27	RADIATION THERAPY									27
28	CHEMOTHERAPY									28
29	OTHER									29
30	BEREAVEMENT PROGRAM COSTS									30
31	VOLUNTEER PROGRAM COSTS									31
32	FUNDRAISING									32
33	OTHER PROGRAM COSTS									33
34	TOTALS (SUM OF LINES 1-33)			1,066,871	1,282		1,282		1,237	34
35	TOTAL COST TO BE ALLOCATED			67,774	14,510		5,271		11,787	35
36	UNIT COST MULTIPLIER			0.063526	11.318253		4.111544		9.528698	36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS HOSPICE NO.: 14-1616 WORKSHEET K-5
STATISTICAL BASIS PART II

	HOSPICE COST CENTER	NURSING ADMINIS-TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY CSS CSTED REQ' 14	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
1	ADMINISTRATIVE AND GENERAL		1,700,410		1
2	INPATIENT - GENERAL CARE				2
3	INPATIENT - RESPITE CARE				3
4	PHYSICIAN SERVICES				4
5	NURSING CARE				5
6	NURSING CARE-CONTINUOUS HOM				6
7	PHYSICAL THERAPY				7
8	OCCUPATIONAL THERAPY				8
9	SPEECH/LANGUAGE PATHOLOGY				9
10	MEDICAL SOCIAL SERV. - DIRE				10
11	SPIRITUAL COUNSELING				11
12	DIETARY COUNSELING				12
13	COUNSELING - OTHER				13
14	HOME HLTH AIDE & HOMEMAKERS				14
15	HH AIDE & HMKR-CONT. HOME C				15
16	OTHER				16
17	DRUGS,BIOLOGICALS & INFUSIO				17
18	ANALGESICS				18
19	SEDATIVES / HYPNOTICS				19
20	OTHER - SPECIFY				20
21	DURABLE MED. EQUIP./OXYGEN				21
22	PATIENT TRANSPORTATION				22
23	IMAGING SERVICES				23
24	LABS AND DIAGNOSTICS				24
25	MEDICAL SUPPLIES				25
26	OUTPAT. SERV.(INCL.E/R DEPT				26
27	RADIATION THERAPY				27
28	CHEMOTHERAPY				28
29	OTHER				29
30	BEREAVEMENT PROGRAM COSTS				30
31	VOLUNTEER PROGRAM COSTS				31
32	FUNDRAISING				32
33	OTHER PROGRAM COSTS				33
34	TOTALS (SUM OF LINES 1-33)		1,700,410		34
35	TOTAL COST TO BE ALLOCATED		20,956		35
36	UNIT COST MULTIPLIER		0.012324		36

APPORTIONMENT OF HOSPICE SHARED SERVICES HOSPICE NO.: 14-1616 WORKSHEET K-5
PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

		WKST C, PART I, COL. 9, LINE 0	COST TO CHARGE RATIO 1	TOTAL HOSPICE CHARGES (PROVIDER RECORDS) 2	HOSPICE SHARED ANCILLARY COSTS (COL.1 x 2) 3	
	ANCILLARY SERVICE COST CENTERS					
1	PHYSICAL THERAPY	66	0.511003			1
2	OCCUPATIONAL THERAPY	67				2
3	SPEECH/LANGUAGE PATHOLOGY	68				3
4	DRUGS, BIOLOGICALS AND INFUSION	73	0.285911			4
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96				5
6	LABS AND DIAGNOSTICS	60	0.236499			6
7	MEDICAL SUPPLIES	71	0.557923			7
8	OUTPATIENT SERVICES (INCL. E/R DEPT)	93				8
9	RADIATION THERAPY	55				9
10	OTHER ANCILLARY (SPECIFY)	76				10
11	TOTALS (SUM OF LINES 1-10)					11

CALCULATION OF HOSPICE PER DIEM COST HOSPICE NO.: 14-1616 WORKSHEET K-6

	COMPUTATION OF PER DIEM COST	TITLE XVIII 1	TITLE XIX 2	OTHER 3	TOTAL 4	
1	TOTAL COST (SEE INSTRUCTIONS)				1,187,169	1
2	TOTAL UNDUPLICATED DAYS (WKST S-9, COL. 6, LINE 5)				3,136	2
3	AVERAGE COST PER DIEM (LINE 1 DIVIDED BY LINE 2)				378.56	3
4	UNDUPLICATED MEDICARE DAYS (WKST S-9, COL. 1, LINE 5)	2,082				4
5	AGGREGATE MEDICARE COST (LINE 3 TIMES LINE 4)	788,162				5
6	UNDUPLICATED MEDICAID DAYS (WKST S-9, COL. 2, LINE 5)		196			6
7	AGGREGATE MEDICAID COST (LINE 3 TIMES LINE 6)		74,198			7
8	UNDUPLICATED SNF DAYS (WKST S-9, COL. 3, LINE 5)	6,894				8
9	AGGREGATE SNF COST (LINE 3 TIMES LINE 8)	2,609,793				9
10	UNDUPLICATED NF DAYS (WKST S-9, COL. 4, LINE 5)		402			10
11	AGGREGATE NF COST (LINE 3 TIMES LINE 10)		152,181			11
12	OTHER UNDUPLICATED DAYS (WKST S-9, COL. 5, LINE 5)			858		12
13	AGGREGATE COST FOR OTHER DAYS (LINE 3 TIMES LINE 12)			324,804		13

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

CHECK	[ ]	TITLE V	[XX]	HOSPITAL ((14-016)	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD
BOXES	[ ]	TITLE XIX				

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	416,793	1
2	CAPITAL DRG OUTLIER PAYMENTS	1,775	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	12.09	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 REPORTED ON WORKSHEET S-3, PART I (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)	418,568	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

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

CHECK APPLICABLE BOXES	[ ]	TITLE V	[XX]	HOSPITAL ((14-016)	[XX]	PPS	
	[ ]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD	
	[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 REPORTED ON WORKSHEET S-3, PART I (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	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STO						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENER						5.06
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
16	MEDICAL RECORDS & LIBRARY						16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY						60
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHRGED TO PAT						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
88	RURAL HEALTH CLINIC (RHC)						88
88.01	RHC II						88.01
88.02	RHC III						88.02
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
101	HOME HEALTH AGENCY						101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE						116
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CA						190
194	IROQUOIS WOMEN'S HEALTH						194
194.01	OTHER NON-REIMBURSABLE COSTS						194.01
194.02	DURABLE MEDICAL EQUIPMENT SALE						194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINE 118 AND LINES 190-201)						202
203	TOTAL STATISTICAL BASIS						203
204	UNIT COST MULTIPLIER						204
204	UNIT COST MULTIPLIER						204

RHC I WORKSHEET M-1

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

COMPONENT NO: 14-3424

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	115,200		115,200		115,200		115,200	1
2	PHYSICIAN ASSISTANT	82,194		82,194		82,194		82,194	2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE	80,304		80,304		80,304		80,304	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)	277,698		277,698		277,698		277,698	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		3,715	3,715		3,715		3,715	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		9,397	9,397		9,397		9,397	18
19	OTHER HEALTH CARE COSTS		5,955	5,955		5,955		5,955	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		19,067	19,067		19,067		19,067	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	277,698	19,067	296,765		296,765		296,765	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		7,164	7,164	-5,852	1,312		1,312	29
30	ADMINISTRATIVE COSTS	35,695	113,031	148,726	-29,759	118,967		118,967	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	35,695	120,195	155,890	-35,611	120,279		120,279	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	313,393	139,262	452,655	-35,611	417,044		417,044	32

RHC I WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3424

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.50	1,435	4,200	2,100		1
2	PHYSICIAN ASSISTANTS	1.16	2,789	2,100	2,436		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	1.66	4,224		4,536	4,536	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.66	4,224			4,536	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)	296,765	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)	296,765	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)	120,279	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	166,409	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	286,688	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	286,688	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	286,688	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	583,453	20

RHC I WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3424

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	583,453	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	6,781	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	576,672	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	4,536	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,536	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	127.13	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	127.13	127.13	127.13	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	249	748		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	31,655	95,093		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)	31,655	95,093		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		62,994		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		310		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		468		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		62,566		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	25,324	63,034		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		16,418		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		13,296		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		88,358		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		4,680		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		93,038		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		3,878		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		3,878		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		96,916		26
27	INTERIM PAYMENTS		102,869		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		-5,953		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

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

RHC I WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST COMPONENT NO: 14-3424

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	277,698	277,698	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000704	0.004399	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	195	1,222	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	753	1,279	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	948	2,501	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	296,765	296,765	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	286,688	286,688	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.003194	0.008428	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	916	2,416	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,864	4,917	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	16	100	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	116.50	49.17	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	14	62	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	1,631	3,049	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)		6,781	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		4,680	16

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

RHC I COMPONENT NO: 14-3424

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				105,417	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE	3.01
			.02			3.02
		PROGRAM	.03			3.03
		TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50	04/11/2011	2,548	3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		-2,548	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				102,869	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE	5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER	.50		NONE	5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99			5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO PROVIDER	.01			6.01
		PROVIDER TO PROGRAM	.02		-5,953	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				96,916	7

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

RHC II WORKSHEET M-1

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

COMPONENT NO: 14-3425

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	76,800		76,800		76,800		76,800	1
2	PHYSICIAN ASSISTANT	100,792		100,792		100,792		100,792	2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE	73,283		73,283		73,283		73,283	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)	250,875		250,875		250,875		250,875	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		2,877	2,877		2,877		2,877	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		6,265	6,265		6,265		6,265	18
19	OTHER HEALTH CARE COSTS		6,244	6,244		6,244		6,244	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		15,386	15,386		15,386		15,386	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	250,875	15,386	266,261		266,261		266,261	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		4,055	4,055	-2,123	1,932		1,932	29
30	ADMINISTRATIVE COSTS	29,023	118,003	147,026	-38,276	108,750		108,750	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	29,023	122,058	151,081	-40,399	110,682		110,682	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	279,898	137,444	417,342	-40,399	376,943		376,943	32

RHC II WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3425

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.34	1,481	4,200	1,428		1
2	PHYSICIAN ASSISTANTS	0.71	2,273	2,100	1,491		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	1.05	3,754		2,919	3,754	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.05	3,754			3,754	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)	266,261	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)	266,261	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)	110,682	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	115,590	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	226,272	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	226,272	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	226,272	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	492,533	20

RHC II WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3425

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	492,533	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	7,549	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	484,984	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	3,754	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	3,754	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	129.19	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	129.19	129.19	129.19	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	377	1,130		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	48,705	145,985		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)	48,705	145,985		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		100,496		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		1,422		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		2,066		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		99,689		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	38,964	101,755		16.05
17	PRIMARY PAYOR PAYMENTS		89		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		19,308		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		22,659		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		140,630		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		5,370		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		146,000		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		7,894		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		7,894		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		153,894		26
27	INTERIM PAYMENTS		152,458		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		1,436		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

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

RHC II WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST COMPONENT NO: 14-3425

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	250,875	250,875	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000792	0.006441	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	199	1,616	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	706	1,560	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	905	3,176	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	266,261	266,261	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	226,272	226,272	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.003399	0.011928	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	769	2,699	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,674	5,875	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	15	122	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	111.60	48.16	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	11	86	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	1,228	4,142	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		7,549	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)		5,370	16

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

RHC II COMPONENT NO: 14-3425

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				148,350	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01	04/22/2011	4,108	3.01
			.02			3.02
		PROGRAM	.03			3.03
		TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50		NONE	3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		4,108	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				152,458	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE	5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER	.50		NONE	5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99			5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO PROVIDER	.01		1,436	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				153,894	7

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

RHC III WORKSHEET M-1

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

COMPONENT NO: 15-3979

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	256,000		256,000		256,000		256,000	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	384,677		384,677		384,677		384,677	3
4	VISITING NURSE								4
5	OTHER NURSE	157,858		157,858		157,858		157,858	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)	798,535		798,535		798,535		798,535	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		9,424	9,424		9,424		9,424	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		18,552	18,552		18,552		18,552	18
19	OTHER HEALTH CARE COSTS		14,356	14,356		14,356		14,356	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		42,332	42,332		42,332		42,332	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	798,535	42,332	840,867		840,867		840,867	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
	FACILITY OVERHEAD								
29	FACILITY COSTS		14,638	14,638	-6,737	7,901		7,901	29
30	ADMINISTRATIVE COSTS	73,628	279,958	353,586	-69,345	284,241		284,241	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	73,628	294,596	368,224	-76,082	292,142		292,142	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	872,163	336,928	1,209,091	-76,082	1,133,009		1,133,009	32

RHC III WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 15-3979

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.73	3,340	4,200	3,066		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	2.51	7,342	2,100	5,271		3
4	SUBTOTAL (SUM OF LINES 1-3)	3.24	10,682		8,337	10,682	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	3.24	10,682			10,682	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)	840,867	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)	840,867	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)	292,142	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	379,388	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	671,530	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	671,530	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	671,530	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,512,397	20

RHC III WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 15-3979

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	1,512,397	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	13,445	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,498,952	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	10,682	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	10,682	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	140.33	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	140.33	140.33	140.33	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	943	2,828		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	132,331	396,853		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)	132,331	396,853		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		310,659		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		3,640		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		4,650		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		273,630		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	105,865	278,280		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		50,165		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		72,334		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		384,145		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		6,238		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		390,383		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		10,558		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		10,558		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		400,941		26
27	INTERIM PAYMENTS		400,431		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		510		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

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

RHC III WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST COMPONENT NO: 15-3979

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	798,535	798,535	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000419	0.003924	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	335	3,133	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	1,129	2,878	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,464	6,011	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	840,867	840,867	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	671,530	671,530	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001741	0.007149	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	1,169	4,801	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	2,633	10,812	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	24	225	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	109.71	48.05	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	10	107	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	1,097	5,141	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)		13,445	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)		6,238	16

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

RHC III COMPONENT NO: 15-3979

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				437,656	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE	3.01
			.02			3.02
		PROGRAM	.03			3.03
		TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50	04/22/2011	37,225	3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		-37,225	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				400,431	4
		TO BE COMPLETED BY INTERMEDIARY				
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE	5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER	.50		NONE	5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99			5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO PROVIDER	.01		510	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				400,941	7

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