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: 11-13-2012 TIME: 10:51_____
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 KIRBY HOSPITAL (14-1301) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2011 AND ENDING 06/30/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		230,135	511,173			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		211,234				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-396			10
10.01	HEALTH CLINIC - RHC II			127,744			10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		441,369	638,521			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: 1000 MEDICAL CENTER DR — P.O.BOX: — 1
2 CITY: MONTICELLO — STATE: IL — ZIP CODE: 61856 — COUNTY: PIATT — 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	KIRBY HOSPITAL	14-1301	16580	1	08/08/1999	N	O	N	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	KIRBY HOSPITAL-SWING BED	14-Z301	16580		08/08/1999	N	O	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	ATWOOD RURAL HEALTH CLINIC	14-3438	16580		11/17/1997	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	KIRBY MEDICAL GROUP RURAL HEA	14-3495	16580		11/20/2008	N	O	N	15.01
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2011	TO: 06/30/2012							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.	N	N	22
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	2	N	23

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			2				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

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

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

		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 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60

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

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)				
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS				
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63

		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, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				64

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

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

		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

TITLE V AND XIX INPATIENT SERVICES	V 1	XIX 2	
90 DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91 IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93 DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94 DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95 IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96 DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97 IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97

RURAL PROVIDERS	1	2	
105 DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	Y		105
106 IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.	Y		106
107 COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.	N	N	107
108 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		108

	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	Y	N	109

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

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	2	118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 128,526 PAID LOSSES: SELF INSURANCE:		118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

		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, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	149

	DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE V 3	TITLE XIX 4	
155	HOSPITAL	Y	Y			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 0	COUNTY 1	STATE 2	ZIP CODE 3	CBSA 4	FTE/CAMPUS 5

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	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		169

(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.

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

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

		Y/N 1	Y/N 2	
	APPROVED EDUCATIONAL ACTIVITIES			
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 Y/N 1	PART A DATE 2	PART B Y/N 3	PART B DATE 4	
	PS&R REPORT DATA					
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	11/09/2012	Y	11/09/2012	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.	Y	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
	INTEREST EXPENSE		
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	N	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31
	PURCHASED SERVICES		
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
	PROVIDER-BASED PHYSICIANS		
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	35

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: DAVE	LAST NAME: HARMS	TITLE: CFO		41
42	EMPLOYER: KIRBY MEDICAL CENTER				42
43	PHONE NUMBER: 217-762-1504	E-MAIL ADDRESS: DHARMS@KIRBYHEALTH.ORG			43

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	16	5,856	13,128.00		380	33	678	1
2	HMO									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						354		477	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								96	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		16	5,856	13,128.00		734	33	1,251	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)		16	5,856	13,128.00		734	33	1,251	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88							5,147	26
26.01	RHC II	88.01							13,351	26.01
27	TOTAL (SUM OF LINES 14-26)		16							27
28	OBSERVATION BED DAYS								126	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 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	DISCHARGES --- TITLE V	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					121	10	187	1
2	HMO									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)			136.21			121	10	187	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88		20.09						26
26.01	RHC II	88.01		5.79						26.01
27	TOTAL (SUM OF LINES 14-26)			162.09						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	9,998,369					1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		2,138,015	25,929				10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)							17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS							26
27	ADMINISTRATIVE & GENERAL		2,267,565	-115,319				27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS		215,490					29
30	OPERATION OF PLANT							30
31	LAUNDRY & LINEN SERVICE		60,632					31
32	HOUSEKEEPING		321,271					32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		214,068	-174,025				34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA			174,025				36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION			115,319				38
39	CENTRAL SERVICES AND SUPPLY		104,757					39
40	PHARMACY		34,668					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		438,089					41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	9,998,369		9,998,369	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2,138,015	25,929	2,163,944	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	7,860,354	-25,929	7,834,425	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)				4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)				5
6	TOTAL (SUM OF LINES 3 THRU 5)	7,860,354	-25,929	7,834,425	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,656,540		3,656,540	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

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

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

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.	N		2

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

PROSPECTIVE PAYMENT FOR SNF — 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				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				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).			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				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)				207

RHC I WORKSHEET S-8

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

COMPONENT NO: 14-3438

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 108 S. MAIN STREET
2 CITY: ATWOOD STATE: IL ZIP CODE: 61913 COUNTY: DOUGLASS
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? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N	

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			0800	1700	0800	1700	0800	1700	0800	1700	0800	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: 14-3495

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 1111 N. STATE STREET	1
2	CITY: MONTICELLO STATE: IL ZIP CODE: 61856 COUNTY: PIATT	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? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N		10

FACILITY HOURS OF OPERATIONS(1)

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

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

		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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA — WORKSHEET S-10

	UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION		
1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)	0.769028	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	1,484,636	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	3,436,443	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	2,642,721	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	1,158,085	8
	STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)		
9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12
	OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)		
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16
	UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)		
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)	1,158,085	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 FACILITY	630,779		630,779	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	485,087		485,087	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	485,087		485,087	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)	1,421,163	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	182,177	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	1,238,986	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	952,815	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	1,437,902	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	2,595,987	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		1,692,879	1,692,879	1,042,733	1
2	00200	CAP REL COSTS-MVBLE EQUIP		745,292	745,292	182,921	2
3	00300	OTHER CAPITAL RELATED COSTS					3
4	00400	EMPLOYEE BENEFITS		35,007	35,007	28,068	4
5	00500	ADMINISTRATIVE & GENERAL	2,267,565	5,254,783	7,522,348	-1,334,199	5
6	00600	MAINTENANCE & REPAIRS	215,490	234,544	450,034		6
7	00700	OPERATION OF PLANT		498,232	498,232	-63,038	7
8	00800	LAUNDRY & LINEN SERVICE	60,632	120,532	181,164		8
9	00900	HOUSEKEEPING	321,271	204,112	525,383		9
10	01000	DIETARY	214,068	294,458	508,526	-413,401	10
11	01100	CAFETERIA				413,401	11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION				143,515	13
14	01400	CENTRAL SERVICES & SUPPLY	104,757	123,550	228,307	-118,478	14
15	01500	PHARMACY	34,668	483,209	517,877	-337,063	15
16	01600	MEDICAL RECORDS & LIBRARY	438,089	257,720	695,809		16
17	01700	SOCIAL SERVICE					17
19	01900	NONPHYSICIAN ANESTHETISTS					19
20	02000	NURSING SCHOOL					20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	02300	PARAMED ED PRGM-(SPECIFY)					23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	1,159,213	550,335	1,709,548	-304	30
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	271,882	454,819	726,701	304	50
53	05300	ANESTHESIOLOGY	59,736	8,909	68,645		53
54	05400	RADIOLOGY-DIAGNOSTIC	541,658	596,250	1,137,908		54
56.10	03630	ULTRASOUND		33,306	33,306		56.10
60	06000	LABORATORY	509,320	951,443	1,460,763	-9,798	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
66	06600	PHYSICAL THERAPY	475,115	245,486	720,601		66
67	06700	OCCUPATIONAL THERAPY	140,960	34,535	175,495		67
68	06800	SPEECH PATHOLOGY		29,420	29,420		68
69	06900	ELECTROCARDIOLOGY	19,650	5,552	25,202	31,948	69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS				118,478	71
73	07300	DRUGS CHARGED TO PATIENTS				337,063	73
76.97	07697	CARDIAC REHABILITATION					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
88	08800	RURAL HEALTH CLINIC (RHC)	306,943	179,487	486,430		88
88.01	08801	RHC II	1,538,921	947,058	2,485,979		88.01
91	09100	EMERGENCY	1,026,280	1,451,721	2,478,001	-54,731	91
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
95	09500	AMBULANCE SERVICES	292,151	227,747	519,898	32,581	95
99.10	09910	CORF					99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY					99.40
		SPECIAL PURPOSE COST CENTERS					
118		SUBTOTALS (SUM OF LINES 1-117)	9,998,369	15,660,386	25,658,755		118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
200		TOTAL (SUM OF LINES 118-199)	9,998,369	15,660,386	25,658,755		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
		GENERAL SERVICE COST CENTERS				
1	00100	CAP REL COSTS-BLDG & FIXT	2,735,612	-319,342	2,416,270	1
2	00200	CAP REL COSTS-MVBLE EQUIP	928,213	172,404	1,100,617	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	63,075		63,075	4
5	00500	ADMINISTRATIVE & GENERAL	6,188,149	-1,262,901	4,925,248	5
6	00600	MAINTENANCE & REPAIRS	450,034		450,034	6
7	00700	OPERATION OF PLANT	435,194	10,643	445,837	7
8	00800	LAUNDRY & LINEN SERVICE	181,164	-57,124	124,040	8
9	00900	HOUSEKEEPING	525,383		525,383	9
10	01000	DIETARY	95,125		95,125	10
11	01100	CAFETERIA	413,401	-70,546	342,855	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	143,515		143,515	13
14	01400	CENTRAL SERVICES & SUPPLY	109,829		109,829	14
15	01500	PHARMACY	180,814		180,814	15
16	01600	MEDICAL RECORDS & LIBRARY	695,809	-395	695,414	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	1,709,244	-13,500	1,695,744	30
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	727,005	-94,717	632,288	50
53	05300	ANESTHESIOLOGY	68,645		68,645	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,137,908	-148,609	989,299	54
56.10	03630	ULTRASOUND	33,306		33,306	56.10
60	06000	LABORATORY	1,450,965		1,450,965	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	06600	PHYSICAL THERAPY	720,601	-10,281	710,320	66
67	06700	OCCUPATIONAL THERAPY	175,495		175,495	67
68	06800	SPEECH PATHOLOGY	29,420		29,420	68
69	06900	ELECTROCARDIOLOGY	57,150	-21,313	35,837	69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	118,478		118,478	71
73	07300	DRUGS CHARGED TO PATIENTS	337,063		337,063	73
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
88	08800	RURAL HEALTH CLINIC (RHC)	486,430		486,430	88
88.01	08801	RHC II	2,485,979	7,095	2,493,074	88.01
91	09100	EMERGENCY	2,423,270	-932,579	1,490,691	91
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
95	09500	AMBULANCE SERVICES	552,479	-241	552,238	95
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
		SPECIAL PURPOSE COST CENTERS				
118		SUBTOTALS (SUM OF LINES 1-117)	25,658,755	-2,741,406	22,917,349	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
200		TOTAL (SUM OF LINES 118-199)	25,658,755	-2,741,406	22,917,349	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASSIFY MEDICAL SUPPLY EXPENSE	A	MEDICAL SUPPLIES CHRGED TO PA	71		60,246	1
2	RECLASSIFY MEDICAL SUPPLY EXPENSE	A	MEDICAL SUPPLIES CHRGED TO PA	71		58,232	2
500	TOTAL RECLASSIFICATIONS					118,478	500
	CODE LETTER - A						
1	RECLASSIFY DRUG COSTS	B	DRUGS CHARGED TO PATIENTS	73		130,276	1
2	RECLASSIFY DRUG COSTS	B	DRUGS CHARGED TO PATIENTS	73		206,787	2
500	TOTAL RECLASSIFICATIONS					337,063	500
	CODE LETTER - B						
1	RECLASSIFY PROPERTY INS	C	CAP REL COSTS-BLDG & FIXT	1		36,534	1
2	RECLASSIFY PROPERTY INS	C	CAP REL COSTS-MVBLE EQUIP	2		26,504	2
500	TOTAL RECLASSIFICATIONS					63,038	500
	CODE LETTER - C						
1	RECLASSIFY EMPLOYEE INS	D	EMPLOYEE BENEFITS	4		28,068	1
500	TOTAL RECLASSIFICATIONS					28,068	500
	CODE LETTER - D						
1	RECLASSIFY INTEREST EXPENSE	E	CAP REL COSTS-BLDG & FIXT	1		1,006,199	1
2	RECLASSIFY INTEREST EXPENSE	E	CAP REL COSTS-MVBLE EQUIP	2		156,417	2
500	TOTAL RECLASSIFICATIONS					1,162,616	500
	CODE LETTER - E						
1	RECLASSIFY DIETARY COSTS	F	CAFETERIA	11	174,025	239,376	1
500	TOTAL RECLASSIFICATIONS				174,025	239,376	500
	CODE LETTER - F						
1	RECLASSIFY CNO COSTS	G	NURSING ADMINISTRATION	13	115,319	28,196	1
2	RECLASSIFY CNO COSTS	G	OPERATING ROOM	50	244	60	2
500	TOTAL RECLASSIFICATIONS				115,563	28,256	500
	CODE LETTER - G						
1	RECLASSIFY EKG COSTS	H	ELECTROCARDIOLOGY	69	24,784	7,164	1
2	RECLASSIFY EKG COSTS	H					2
500	TOTAL RECLASSIFICATIONS				24,784	7,164	500
	CODE LETTER - H						
1	AMB PERSONNEL COSTS FR ER TO AMB	I	AMBULANCE SERVICES	95	25,929	6,652	1
500	TOTAL RECLASSIFICATIONS				25,929	6,652	500
	CODE LETTER - I						
	GRAND TOTAL (INCREASES)				340,301	1,990,711	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RECLASSIFY MEDICAL SUPPLY EXPENSE	A	CENTRAL SERVICES & SUPPLY	14		60,246		1
2	RECLASSIFY MEDICAL SUPPLY EXPENSE	A	CENTRAL SERVICES & SUPPLY	14		58,232		2
500	TOTAL RECLASSIFICATIONS					118,478		500
	CODE LETTER - A							
1	RECLASSIFY DRUG COSTS	B	PHARMACY	15		130,276		1
2	RECLASSIFY DRUG COSTS	B	PHARMACY	15		206,787		2
500	TOTAL RECLASSIFICATIONS					337,063		500
	CODE LETTER - B							
1	RECLASSIFY PROPERTY INS	C	OPERATION OF PLANT	7		36,534	12	1
2	RECLASSIFY PROPERTY INS	C	OPERATION OF PLANT	7		26,504	12	2
500	TOTAL RECLASSIFICATIONS					63,038		500
	CODE LETTER - C							
1	RECLASSIFY EMPLOYEE INS	D	ADMINISTRATIVE & GENERAL	5		28,068		1
500	TOTAL RECLASSIFICATIONS					28,068		500
	CODE LETTER - D							
1	RECLASSIFY INTEREST EXPENSE	E	ADMINISTRATIVE & GENERAL	5		1,006,199	11	1
2	RECLASSIFY INTEREST EXPENSE	E	ADMINISTRATIVE & GENERAL	5		156,417	11	2
500	TOTAL RECLASSIFICATIONS					1,162,616		500
	CODE LETTER - E							
1	RECLASSIFY DIETARY COSTS	F	DIETARY	10	174,025	239,376		1
500	TOTAL RECLASSIFICATIONS				174,025	239,376		500
	CODE LETTER - F							
1	RECLASSIFY CNO COSTS	G	ADMINISTRATIVE & GENERAL	5	115,319	28,196		1
2	RECLASSIFY CNO COSTS	G	ADULTS & PEDIATRICS	30	244	60		2
500	TOTAL RECLASSIFICATIONS				115,563	28,256		500
	CODE LETTER - G							
1	RECLASSIFY EKG COSTS	H	LABORATORY	60	7,448	2,350		1
2	RECLASSIFY EKG COSTS	H	EMERGENCY	91	17,336	4,814		2
500	TOTAL RECLASSIFICATIONS				24,784	7,164		500
	CODE LETTER - H							
1	AMB PERSONNEL COSTS FR ER TO AMB	I	EMERGENCY	91	25,929	6,652		1
500	TOTAL RECLASSIFICATIONS				25,929	6,652		500
	CODE LETTER - I							
	GRAND TOTAL (DECREASES)				340,301	1,990,711		

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	504,612	4,049,850		4,049,850		4,554,462		1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	30,037,523	2,177,232		2,177,232	5,601,069	26,613,686		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	5,238,947	3,034,622		3,034,622	1,060,653	7,212,916		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	35,781,082	9,261,704		9,261,704	6,661,722	38,381,064		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	35,781,082	9,261,704		9,261,704	6,661,722	38,381,064		10

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

SUMMARY OF CAPITAL

	DESCRIPTION	DEPRECIATION 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	1,692,879						1,692,879	1
2	CAP REL COSTS-MVBLE EQUIP	745,292						745,292	2
3	TOTAL (SUM OF LINES 1-2)	2,438,171						2,438,171	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS — ALLOCATION OF OTHER CAPITAL

	DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT	31,168,148		31,168,148	0.812071					1
2	CAP REL COSTS-MVBLE EQUIP	7,212,916		7,212,916	0.187929					2
3	TOTAL (SUM OF LINES 1-2)	38,381,064		38,381,064	1.000000					3

SUMMARY OF CAPITAL

	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	1,692,879		956,242	36,534		-269,385	2,416,270	1
2	CAP REL COSTS-MVBLE EQUIP	745,292		327,487	26,504		1,334	1,100,617	2
3	TOTAL	2,438,171		1,283,729	63,038		-268,051	3,516,887	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	-49,957	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	171,070	CAP REL COSTS-MVBLE EQUIP	2	11	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,210,718				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	-57,124	LAUNDRY & LINEN SERVICE	8		13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-70,546	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-395	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES	A	10,440	CAP REL COSTS-BLDG & FIXT	1	14	26
27	DEPRECIATION--MOVABLE EQUIPMENT	A	1,334	CAP REL COSTS-MVBLE EQUIP	2	14	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	MISC INCOME	B	-4,374	ADMINISTRATIVE & GENERAL	5		33
33.01	ACCELERATED DEPRECIATION	A	-279,825	CAP REL COSTS-BLDG & FIXT	1	14	33.01
34	NET BAD DEBT EXPENSE	A	-684,134	ADMINISTRATIVE & GENERAL	5		34
35	MISC INCOME-AMBULANCE	B	-241	AMBULANCE SERVICES	95		35
36	CANCER CLINIC INCOME	B	-16,879	ADMINISTRATIVE & GENERAL	5		36
37	PHASE 3 CARDIAC REHAB INCOME	B	-12,232	PHYSICAL THERAPY	66		37
38							38
39	PUBLIC RELATIONS COSTS-UNALLOWABLE	A	-407,891	ADMINISTRATIVE & GENERAL	5		39
40	LOBBYING PORTION OF IHA-AHA DUES	A	-5,800	ADMINISTRATIVE & GENERAL	5		40
41	TRUST BLDG DEP-PT	A	1,951	PHYSICAL THERAPY	66		41
42	TRUST BLDG DEP-RHC II	A	7,095	RHC II	88.01		42
43	TRUST BLDG DEP-ADMIN	A	5,852	ADMINISTRATIVE & GENERAL	5		43
44	TRUST BLDG DEP-PLANT OP	A	10,643	OPERATION OF PLANT	7		44
45							45
46	PROPERTY TAXES	A	-17,735	ADMINISTRATIVE & GENERAL	5		46
47	MEDICAID ASSESSEMENT FEES	A	-117,492	ADMINISTRATIVE & GENERAL	5		47
48	KEY EMPLOYEES-LIFE INSURANCE	A	-14,448	ADMINISTRATIVE & GENERAL	5		48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-2,741,406				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	LINE NO.
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	50	OPERATING ROOM	SLEEP LAB PHYS	94,717	94,717						1
2	69	ELECTROCARDIOLOGY	DR. M	21,313	21,313						2
3	91	EMERGENCY	ER PHYS & PHYS	1,467,958	932,579	535,379					3
4	88	RURAL HEALTH CLINIC (RHC	RHC I PHYS & PH	306,943		306,943					4
5	88.01	RHC II	RHC II PHYS & P	1,461,110		1,461,110					5
6	30	ADULTS & PEDIATRICS	HOSPITALISTS	13,500	13,500						6
7	54	RADIOLOGY-DIAGNOSTIC	RADIOLOGISTS	148,609	148,609						7
200		TOTAL		3,514,150	1,210,718	2,303,432					200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUST-MENT	
	10	11		12	13	14	15	16	17	18	
1	50	OPERATING ROOM	SLEEP LAB PHYS							94,717	1
2	69	ELECTROCARDIOLOGY	DR. M							21,313	2
3	91	EMERGENCY	ER PHYS & PHYS							932,579	3
4	88	RURAL HEALTH CLINIC (RHC	RHC I PHYS & PH								4
5	88.01	RHC II	RHC II PHYS & P								5
6	30	ADULTS & PEDIATRICS	HOSPITALISTS							13,500	6
7	54	RADIOLOGY-DIAGNOSTIC	RADIOLOGISTS							148,609	7
200		TOTAL								1,210,718	200

REASONABLE COST DETERMINATION FOR THERAPY SERVICES — WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 — PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	113	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		451.75				9
10	AHSEA		66.10				10
11	STANDARD TRAVEL ALLOWANCE	33.05	33.05				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	29,861	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	29,861	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	29,861	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	66.10	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	51,558	22
23	TOTAL SALARY EQUIVALENCY	51,558	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES — WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 — PARTS III & IV

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	3,735	24
25	ASSISTANTS		25
26	SUBTOTAL	3,735	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	3,735	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	3,735	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 PARTS V,VI & VII

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

PART V - OVERTIME COMPUTATION

		THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	51,558	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	3,735	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	55,293	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	29,420	64
65	EXCESS OVER LIMITATION		65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	2,416,270	2,416,270				1
2	CAP REL COSTS-MVBLE EQUIP	1,100,617		1,100,617			2
4	EMPLOYEE BENEFITS	63,075	5,936		69,011		4
5	ADMINISTRATIVE & GENERAL	4,925,248	193,046	230,342	14,858	5,363,494	5
6	MAINTENANCE & REPAIRS	450,034	14,923	6,711	1,487	473,155	6
7	OPERATION OF PLANT	445,837	455,182			901,019	7
8	LAUNDRY & LINEN SERVICE	124,040	21,559	10,588	418	156,605	8
9	HOUSEKEEPING	525,383	38,955	159	2,217	566,714	9
10	DIETARY	95,125	76,633		276	172,034	10
11	CAFETERIA	342,855	36,358		1,201	380,414	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	143,515	5,070		796	149,381	13
14	CENTRAL SERVICES & SUPPLY	109,829	51,570		723	162,122	14
15	PHARMACY	180,814	36,482		239	217,535	15
16	MEDICAL RECORDS & LIBRARY	695,414	58,948	11,754	3,024	769,140	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,695,744	329,864	82,732	7,999	2,116,339	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	632,288	264,897	84,273	1,878	983,336	50
53	ANESTHESIOLOGY	68,645			412	69,057	53
54	RADIOLOGY-DIAGNOSTIC	989,299	130,800	594,378	3,739	1,718,216	54
56.10	ULTRASOUND	33,306	4,370			37,676	56.10
60	LABORATORY	1,450,965	54,084	15,564	3,464	1,524,077	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY	710,320	120,783	11,988	3,279	846,370	66
67	OCCUPATIONAL THERAPY	175,495	8,327		973	184,795	67
68	SPEECH PATHOLOGY	29,420	4,246			33,666	68
69	ELECTROCARDIOLOGY	35,837	453	7,757	307	44,354	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	118,478	660			119,138	71
73	DRUGS CHARGED TO PATIENTS	337,063				337,063	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	486,430	25,517		2,119	514,066	88
88.01	RHC II	2,493,074	229,693	7,513	10,622	2,740,902	88.01
91	EMERGENCY	1,490,691	207,103	36,858	6,785	1,741,437	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	552,238	26,795		2,195	581,228	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	22,917,349	2,402,254	1,100,617	69,011	22,903,333	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		14,016			14,016	190
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	22,917,349	2,416,270	1,100,617	69,011	22,917,349	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	
		5	6	7	8	9	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	5,363,494					5
6	MAINTENANCE & REPAIRS	144,570	617,725				6
7	OPERATION OF PLANT	275,302	126,211	1,302,532			7
8	LAUNDRY & LINEN SERVICE	47,850	5,978	16,311	226,744		8
9	HOUSEKEEPING	173,157	10,801	29,473	46,010	826,155	9
10	DIETARY	52,564	21,248	57,978		38,114	10
11	CAFETERIA	116,234	10,081	27,508		18,083	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	45,643	1,406	3,836		2,522	13
14	CENTRAL SERVICES & SUPPLY	49,536	14,299	39,016		25,648	14
15	PHARMACY	66,467	10,116	27,601		18,144	15
16	MEDICAL RECORDS & LIBRARY	235,007	16,345	44,599		29,318	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	646,637	91,463	249,565	116,261	164,057	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	300,453	73,449	200,414	21,859	131,747	50
53	ANESTHESIOLOGY	21,100					53
54	RADIOLOGY-DIAGNOSTIC	524,992	37,342	101,891		66,981	54
56.10	ULTRASOUND	11,512	126	343		226	56.10
60	LABORATORY	465,674	14,996	40,919		26,899	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY	258,604	33,490	91,381		60,071	66
67	OCCUPATIONAL THERAPY	56,463	2,309	6,300		4,141	67
68	SPEECH PATHOLOGY	10,286	1,177	3,212		2,112	68
69	ELECTROCARDIOLOGY	13,552	126	343		226	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	36,402	183	499		328	71
73	DRUGS CHARGED TO PATIENTS	102,988					73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	157,070	14,150				88
88.01	RHC II	837,470	63,688	173,779		114,238	88.01
91	EMERGENCY	532,087	57,425	156,688	38,873	103,003	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	177,591	7,430	20,272	3,741	13,326	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	5,359,211	613,839	1,291,928	226,744	819,184	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,283	3,886	10,604		6,971	190
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	5,363,494	617,725	1,302,532	226,744	826,155	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY	341,938					10
11	CAFETERIA		552,320				11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION			202,788			13
14	CENTRAL SERVICES & SUPPLY		14,515		305,136		14
15	PHARMACY		4,823		3,572	348,258	15
16	MEDICAL RECORDS & LIBRARY		54,324		2,269		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	337,255	112,099	148,555	4,407		30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		19,905	13,520	50,024		50
53	ANESTHESIOLOGY		946	1,281	410		53
54	RADIOLOGY-DIAGNOSTIC		44,868		9,154		54
56.10	ULTRASOUND				89		56.10
60	LABORATORY		50,495		6,581		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY		34,325		4,163		66
67	OCCUPATIONAL THERAPY		8,132				67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY				242		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS				61,759		71
73	DRUGS CHARGED TO PATIENTS					348,258	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)				20,824		88
88.01	RHC II		104,819		130,418		88.01
91	EMERGENCY		69,075	39,432	6,534		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES		33,994		4,690		95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	337,255	552,320	202,788	305,136	348,258	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,683					190
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	341,938	552,320	202,788	305,136	348,258	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY	1,151,002				16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	204,017	4,190,655		4,190,655	30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	93,955	1,888,662		1,888,662	50
53	ANESTHESIOLOGY		92,794		92,794	53
54	RADIOLOGY-DIAGNOSTIC	145,372	2,648,816		2,648,816	54
56.10	ULTRASOUND	33,039	83,011		83,011	56.10
60	LABORATORY		2,129,641		2,129,641	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
66	PHYSICAL THERAPY	217,233	1,545,637		1,545,637	66
67	OCCUPATIONAL THERAPY		262,140		262,140	67
68	SPEECH PATHOLOGY		50,453		50,453	68
69	ELECTROCARDIOLOGY		58,843		58,843	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		218,309		218,309	71
73	DRUGS CHARGED TO PATIENTS		788,309		788,309	73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC (RHC)		706,110		706,110	88
88.01	RHC II		4,165,314		4,165,314	88.01
91	EMERGENCY	445,616	3,190,170		3,190,170	91
92	OBSERVATION BEDS					92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES	11,770	854,042		854,042	95
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	1,151,002	22,872,906		22,872,906	118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		44,443		44,443	190
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	1,151,002	22,917,349		22,917,349	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		5,936		5,936	5,936	4
5	ADMINISTRATIVE & GENERAL		193,046	230,342	423,388	1,277	5
6	MAINTENANCE & REPAIRS		14,923	6,711	21,634	128	6
7	OPERATION OF PLANT		455,182		455,182		7
8	LAUNDRY & LINEN SERVICE		21,559	10,588	32,147	36	8
9	HOUSEKEEPING		38,955	159	39,114	191	9
10	DIETARY		76,633		76,633	24	10
11	CAFETERIA		36,358		36,358	103	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		5,070		5,070	68	13
14	CENTRAL SERVICES & SUPPLY		51,570		51,570	62	14
15	PHARMACY		36,482		36,482	21	15
16	MEDICAL RECORDS & LIBRARY		58,948	11,754	70,702	260	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		329,864	82,732	412,596	688	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		264,897	84,273	349,170	162	50
53	ANESTHESIOLOGY					35	53
54	RADIOLOGY-DIAGNOSTIC		130,800	594,378	725,178	322	54
56.10	ULTRASOUND		4,370		4,370		56.10
60	LABORATORY		54,084	15,564	69,648	298	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY		120,783	11,988	132,771	282	66
67	OCCUPATIONAL THERAPY		8,327		8,327	84	67
68	SPEECH PATHOLOGY		4,246		4,246		68
69	ELECTROCARDIOLOGY		453	7,757	8,210	26	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		660		660		71
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)		25,517		25,517	182	88
88.01	RHC II		229,693	7,513	237,206	914	88.01
91	EMERGENCY		207,103	36,858	243,961	584	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES		26,795		26,795	189	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)		2,402,254	1,100,617	3,502,871	5,936	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		14,016		14,016		190
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		2,416,270	1,100,617	3,516,887	5,936	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	
		5	6	7	8	9	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	424,665					5
6	MAINTENANCE & REPAIRS	11,447	33,209				6
7	OPERATION OF PLANT	21,797	6,784	483,763			7
8	LAUNDRY & LINEN SERVICE	3,789	321	6,058	42,351		8
9	HOUSEKEEPING	13,710	581	10,946	8,594	73,136	9
10	DIETARY	4,162	1,142	21,533		3,374	10
11	CAFETERIA	9,203	542	10,216		1,601	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	3,614	76	1,425		223	13
14	CENTRAL SERVICES & SUPPLY	3,922	769	14,491		2,271	14
15	PHARMACY	5,263	544	10,251		1,606	15
16	MEDICAL RECORDS & LIBRARY	18,607	879	16,564		2,595	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	51,198	4,917	92,692	21,714	14,523	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	23,789	3,949	74,434	4,083	11,663	50
53	ANESTHESIOLOGY	1,671					53
54	RADIOLOGY-DIAGNOSTIC	41,567	2,008	37,842		5,930	54
56.10	ULTRASOUND	911	7	127		20	56.10
60	LABORATORY	36,870	806	15,197		2,381	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY	20,475	1,800	33,939		5,318	66
67	OCCUPATIONAL THERAPY	4,471	124	2,340		367	67
68	SPEECH PATHOLOGY	814	63	1,193		187	68
69	ELECTROCARDIOLOGY	1,073	7	127		20	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	2,882	10	185		29	71
73	DRUGS CHARGED TO PATIENTS	8,154					73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	12,436	761				88
88.01	RHC II	66,311	3,424	64,542		10,113	88.01
91	EMERGENCY	42,129	3,087	58,194	7,261	9,118	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	14,061	399	7,529	699	1,180	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	424,326	33,000	479,825	42,351	72,519	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	209	3,938		617	190
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	424,665	33,209	483,763	42,351	73,136	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY	106,868					10
11	CAFETERIA		58,023				11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION			10,476			13
14	CENTRAL SERVICES & SUPPLY		1,525		74,610		14
15	PHARMACY		507		873	55,547	15
16	MEDICAL RECORDS & LIBRARY		5,707		555		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	105,405	11,775	7,675	1,077		30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		2,091	698	12,232		50
53	ANESTHESIOLOGY		99	66	100		53
54	RADIOLOGY-DIAGNOSTIC		4,714		2,238		54
56.10	ULTRASOUND				22		56.10
60	LABORATORY		5,305		1,609		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY		3,606		1,018		66
67	OCCUPATIONAL THERAPY		854				67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY				59		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS				15,101		71
73	DRUGS CHARGED TO PATIENTS					55,547	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)				5,092		88
88.01	RHC II		11,012		31,889		88.01
91	EMERGENCY		7,257	2,037	1,598		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES		3,571		1,147		95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	105,405	58,023	10,476	74,610	55,547	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,463					190
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	106,868	58,023	10,476	74,610	55,547	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY	115,869				16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	20,538	744,798		744,798	30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	9,458	491,729		491,729	50
53	ANESTHESIOLOGY		1,971		1,971	53
54	RADIOLOGY-DIAGNOSTIC	14,634	834,433		834,433	54
56.10	ULTRASOUND	3,326	8,783		8,783	56.10
60	LABORATORY		132,114		132,114	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
66	PHYSICAL THERAPY	21,868	221,077		221,077	66
67	OCCUPATIONAL THERAPY		16,567		16,567	67
68	SPEECH PATHOLOGY		6,503		6,503	68
69	ELECTROCARDIOLOGY		9,522		9,522	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		18,867		18,867	71
73	DRUGS CHARGED TO PATIENTS		63,701		63,701	73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC (RHC)		43,988		43,988	88
88.01	RHC II		425,411		425,411	88.01
91	EMERGENCY	44,860	420,086		420,086	91
92	OBSERVATION BEDS					92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES	1,185	56,755		56,755	95
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	115,869	3,496,305		3,496,305	118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		20,582		20,582	190
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	115,869	3,516,887		3,516,887	202

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	58,615					1
2	CAP REL COSTS-MVBLE EQUIP		422,955				2
4	EMPLOYEE BENEFITS	144		9,998,369			4
5	ADMINISTRATIVE & GENERAL	4,683	88,518	2,152,246	-5,363,494	17,553,855	5
6	MAINTENANCE & REPAIRS	362	2,579	215,490		473,155	6
7	OPERATION OF PLANT	11,042				901,019	7
8	LAUNDRY & LINEN SERVICE	523	4,069	60,632		156,605	8
9	HOUSEKEEPING	945	61	321,271		566,714	9
10	DIETARY	1,859		40,043		172,034	10
11	CAFETERIA	882		174,025		380,414	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	123		115,319		149,381	13
14	CENTRAL SERVICES & SUPPLY	1,251		104,757		162,122	14
15	PHARMACY	885		34,668		217,535	15
16	MEDICAL RECORDS & LIBRARY	1,430	4,517	438,089		769,140	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	8,002	31,793	1,158,969		2,116,339	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6,426	32,385	272,126		983,336	50
53	ANESTHESIOLOGY			59,736		69,057	53
54	RADIOLOGY-DIAGNOSTIC	3,173	228,413	541,658		1,718,216	54
56.10	ULTRASOUND	106				37,676	56.10
60	LABORATORY	1,312	5,981	501,872		1,524,077	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY	2,930	4,607	475,115		846,370	66
67	OCCUPATIONAL THERAPY	202		140,960		184,795	67
68	SPEECH PATHOLOGY	103				33,666	68
69	ELECTROCARDIOLOGY	11	2,981	44,434		44,354	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	16				119,138	71
73	DRUGS CHARGED TO PATIENTS					337,063	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	619		306,943		514,066	88
88.01	RHC II	5,572	2,887	1,538,921		2,740,902	88.01
91	EMERGENCY	5,024	14,164	983,015		1,741,437	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	650		318,080		581,228	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	58,275	422,955	9,998,369	-5,363,494	17,539,839	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	340				14,016	190
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	2,416,270	1,100,617	69,011		5,363,494	202
203	UNIT COST MULT-WS B PT I	41.222725	2.602208	0.006902		0.305545	203
204	COST TO BE ALLOC PER B PT II			5,936		424,665	204
205	UNIT COST MULT-WS B PT II			0.000594		0.024192	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	
		6	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	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS	54,044					6
7	OPERATION OF PLANT	11,042	41,764				7
8	LAUNDRY & LINEN SERVICE	523	523	83,463			8
9	HOUSEKEEPING	945	945	16,936	40,296		9
10	DIETARY	1,859	1,859		1,859	2,994	10
11	CAFETERIA	882	882		882		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	123	123		123		13
14	CENTRAL SERVICES & SUPPLY	1,251	1,251		1,251		14
15	PHARMACY	885	885		885		15
16	MEDICAL RECORDS & LIBRARY	1,430	1,430		1,430		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	8,002	8,002	42,795	8,002	2,953	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6,426	6,426	8,046	6,426		50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	3,267	3,267		3,267		54
56.10	ULTRASOUND	11	11		11		56.10
60	LABORATORY	1,312	1,312		1,312		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY	2,930	2,930		2,930		66
67	OCCUPATIONAL THERAPY	202	202		202		67
68	SPEECH PATHOLOGY	103	103		103		68
69	ELECTROCARDIOLOGY	11	11		11		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	16	16		16		71
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	1,238					88
88.01	RHC II	5,572	5,572		5,572		88.01
91	EMERGENCY	5,024	5,024	14,309	5,024		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	650	650	1,377	650		95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	53,704	41,424	83,463	39,956	2,953	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	340	340		340	41	190
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	617,725	1,302,532	226,744	826,155	341,938	202
203	UNIT COST MULT-WS B PT I	11.430038	31.187913	2.716701	20.502159	114.207749	203
204	COST TO BE ALLOC PER B PT II	33,209	483,763	42,351	73,136	106,868	204
205	UNIT COST MULT-WS B PT II	0.614481	11.583254	0.507422	1.814969	35.694055	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	CAFETERIA TOTAL FTES 11	NURSING ADMINIS-TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	11,682					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		46,706				13
14	CENTRAL SERVICES & SUPPLY	307		782,403			14
15	PHARMACY	102		9,158	100		15
16	MEDICAL RECORDS & LIBRARY	1,149		5,819		5,574	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,371	34,215	11,299		988	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	421	3,114	128,267		455	50
53	ANESTHESIOLOGY	20	295	1,051			53
54	RADIOLOGY-DIAGNOSTIC	949		23,471		704	54
56.10	ULTRASOUND			229		160	56.10
60	LABORATORY	1,068		16,875			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY	726		10,675		1,052	66
67	OCCUPATIONAL THERAPY	172					67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY			621			69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			158,356			71
73	DRUGS CHARGED TO PATIENTS				100		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)			53,395			88
88.01	RHC II	2,217		334,408			88.01
91	EMERGENCY	1,461	9,082	16,754		2,158	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	719		12,025		57	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	11,682	46,706	782,403	100	5,574	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	552,320	202,788	305,136	348,258	1,151,002	202
203	UNIT COST MULT-WS B PT I	47.279575	4.341798	0.389999	3,482.580000	206.494797	203
204	COST TO BE ALLOC PER B PT II	58,023	10,476	74,610	55,547	115,869	204
205	UNIT COST MULT-WS B PT II	4.966872	0.224297	0.095360	555.470000	20.787406	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	
	GENERAL SERVICE COST CENTERS	
1	CAP REL COSTS-BLDG & FIXT	1
2	CAP REL COSTS-MVBLE EQUIP	2
4	EMPLOYEE BENEFITS	4
5	ADMINISTRATIVE & GENERAL	5
6	MAINTENANCE & REPAIRS	6
7	OPERATION OF PLANT	7
8	LAUNDRY & LINEN SERVICE	8
9	HOUSEKEEPING	9
10	DIETARY	10
11	CAFETERIA	11
12	MAINTENANCE OF PERSONNEL	12
13	NURSING ADMINISTRATION	13
14	CENTRAL SERVICES & SUPPLY	14
15	PHARMACY	15
16	MEDICAL RECORDS & LIBRARY	16
17	SOCIAL SERVICE	17
19	NONPHYSICIAN ANESTHETISTS	19
20	NURSING SCHOOL	20
21	I&R SRVCES-SALARY & FRINGES APPRVD	21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
	INPATIENT ROUTINE SERV COST CENTERS	
30	ADULTS & PEDIATRICS	30
	ANCILLARY SERVICE COST CENTERS	
50	OPERATING ROOM	50
53	ANESTHESIOLOGY	53
54	RADIOLOGY-DIAGNOSTIC	54
56.10	ULTRASOUND	56.10
60	LABORATORY	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
66	PHYSICAL THERAPY	66
67	OCCUPATIONAL THERAPY	67
68	SPEECH PATHOLOGY	68
69	ELECTROCARDIOLOGY	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	71
73	DRUGS CHARGED TO PATIENTS	73
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
	OUTPATIENT SERVICE COST CENTERS	
88	RURAL HEALTH CLINIC (RHC)	88
88.01	RHC II	88.01
91	EMERGENCY	91
92	OBSERVATION BEDS	92
	OTHER REIMBURSABLE COST CENTERS	
95	AMBULANCE SERVICES	95
99.10	CORF	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	99.40
	SPECIAL PURPOSE COST CENTERS	
118	SUBTOTALS (SUM OF LINES 1-117)	118
	NONREIMBURSABLE COST CENTERS	
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190
200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	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	4,190,655		4,190,655			30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,888,662		1,888,662			50
53	ANESTHESIOLOGY	92,794		92,794			53
54	RADIOLOGY-DIAGNOSTIC	2,648,816		2,648,816			54
56.10	ULTRASOUND	83,011		83,011			56.10
60	LABORATORY	2,129,641		2,129,641			60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
66	PHYSICAL THERAPY	1,545,637		1,545,637			66
67	OCCUPATIONAL THERAPY	262,140		262,140			67
68	SPEECH PATHOLOGY	50,453		50,453			68
69	ELECTROCARDIOLOGY	58,843		58,843			69
71	MEDICAL SUPPLIES CHRGED TO	218,309		218,309			71
73	DRUGS CHARGED TO PATIENTS	788,309		788,309			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	706,110		706,110			88
88.01	RHC II	4,165,314		4,165,314			88.01
91	EMERGENCY	3,190,170		3,190,170			91
92	OBSERVATION BEDS	411,015		411,015			92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	854,042		854,042			95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THE						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	23,283,921		23,283,921			200
201	LESS OBSERVATION BEDS	411,015		411,015			201
202	TOTAL (SEE INSTRUCTIONS)	22,872,906		22,872,906			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	1,463,289		1,463,289				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	8,142	1,487,114	1,495,256	1.263103			50
53	ANESTHESIOLOGY	1,539	91,840	93,379	0.993735			53
54	RADIOLOGY-DIAGNOSTIC	90,804	5,147,752	5,238,556	0.505639			54
56.10	ULTRASOUND	17,078	515,292	532,370	0.155927			56.10
60	LABORATORY	372,258	6,465,135	6,837,393	0.311470			60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
66	PHYSICAL THERAPY	136,987	1,649,074	1,786,061	0.865389			66
67	OCCUPATIONAL THERAPY	120,949	104,491	225,440	1.162793			67
68	SPEECH PATHOLOGY	7,772	106,143	113,915	0.442900			68
69	ELECTROCARDIOLOGY	26,622	369,970	396,592	0.148372			69
71	MEDICAL SUPPLIES CHRGED TO	288,899	912,613	1,201,512	0.181695			71
73	DRUGS CHARGED TO PATIENTS	618,707	1,352,776	1,971,483	0.399856			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)		973,939	973,939				88
88.01	RHC II		2,709,419	2,709,419				88.01
91	EMERGENCY		3,170,402	3,170,402	1.006235			91
92	OBSERVATION BEDS		522,461	522,461	0.786690			92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		1,011,136	1,011,136	0.844636			95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THE							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	3,153,046	26,589,557	29,742,603				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		26,589,557	29,742,603				202

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1301)	[ ]	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	1.263103		522,493			659,962		50
53	ANESTHESIOLOGY	0.993735		34,054			33,841		53
54	RADIOLOGY-DIAGNOSTIC	0.505639		1,403,641			709,736		54
56.10	ULTRASOUND	0.155927		46,063			7,182		56.10
60	LABORATORY	0.311470		2,082,953			648,777		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	PHYSICAL THERAPY	0.865389		426,208			368,836		66
67	OCCUPATIONAL THERAPY	1.162793		20,184			23,470		67
68	SPEECH PATHOLOGY	0.442900		2,550			1,129		68
69	ELECTROCARDIOLOGY	0.148372		196,599			29,170		69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.181695		268,437			48,774		71
73	DRUGS CHARGED TO PATIENTS	0.399856		411,530			164,553		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)								88
88.01	RHC II								88.01
91	EMERGENCY	1.006235		848,463			853,753		91
92	OBSERVATION BEDS	0.786690		180,705			142,159		92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.844636							95
200	SUBTOTAL (SEE INSTRUCTIONS)			6,443,880			3,691,342		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			6,443,880			3,691,342		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-Z301)
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	1.263103							50
53	ANESTHESIOLOGY	0.993735							53
54	RADIOLOGY-DIAGNOSTIC	0.505639							54
56.10	ULTRASOUND	0.155927							56.10
60	LABORATORY	0.311470							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	PHYSICAL THERAPY	0.865389							66
67	OCCUPATIONAL THERAPY	1.162793							67
68	SPEECH PATHOLOGY	0.442900							68
69	ELECTROCARDIOLOGY	0.148372							69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.181695							71
73	DRUGS CHARGED TO PATIENTS	0.399856							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)								88
88.01	RHC II								88.01
91	EMERGENCY	1.006235							91
92	OBSERVATION BEDS	0.786690							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.844636							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 (14-1301)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[XX]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	1,377	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	804	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	678	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	238	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)	239	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	48	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)	48	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	380	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)	177	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)	177	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	125.00	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	125.00	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,190,655	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)	6,000	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	6,000	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,567,988	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,622,667	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,463,289	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,463,289	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.792310	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)	2,158.24	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)	2,622,667	37

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1 PART II

CHECK APPLICABLE BOXES	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1301)	[ ]	SUB (OTHER)	[ ] PPS
	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
	[ ]	TITLE XIX-INPT	[ ]	IRF			[XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	3,262.03	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,239,571	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)	1,239,571	41

		TOTAL INPATIENT COST (1)	TOTAL INPATIENT DAYS (2)	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) (3)	PROGRAM DAYS (4)	PROGRAM COST (COL. 3 x COL. 4) (5)	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					243,900	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,483,471	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					577,379	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					577,379	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					1,154,758	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)	126	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	3,262.02	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	411,015	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	744,798	2,622,667	0.283985	411,015	116,722	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 (14-1301)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		528,734		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	1.263103	1,718	2,170	50
53	ANESTHESIOLOGY	0.993735			53
54	RADIOLOGY-DIAGNOSTIC	0.505639	37,238	18,829	54
56.10	ULTRASOUND	0.155927			56.10
60	LABORATORY	0.311470	177,751	55,364	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	PHYSICAL THERAPY	0.865389	29,431	25,469	66
67	OCCUPATIONAL THERAPY	1.162793	15,889	18,476	67
68	SPEECH PATHOLOGY	0.442900	2,852	1,263	68
69	ELECTROCARDIOLOGY	0.148372	20,902	3,101	69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.181695	124,360	22,596	71
73	DRUGS CHARGED TO PATIENTS	0.399856	241,667	96,632	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC (RHC)				88
88.01	RHC II				88.01
91	EMERGENCY	1.006235			91
92	OBSERVATION BEDS	0.786690			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		651,808	243,900	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		651,808		202

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B SNF (14-Z301)	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	1.263103			50
53	ANESTHESIOLOGY	0.993735			53
54	RADIOLOGY-DIAGNOSTIC	0.505639	9,118	4,610	54
56.10	ULTRASOUND	0.155927			56.10
60	LABORATORY	0.311470	51,408	16,012	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	PHYSICAL THERAPY	0.865389	53,999	46,730	66
67	OCCUPATIONAL THERAPY	1.162793	53,910	62,686	67
68	SPEECH PATHOLOGY	0.442900	4,153	1,839	68
69	ELECTROCARDIOLOGY	0.148372	1,167	173	69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.181695	54,700	9,939	71
73	DRUGS CHARGED TO PATIENTS	0.399856	137,493	54,977	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC (RHC)				88
88.01	RHC II				88.01
91	EMERGENCY	1.006235			91
92	OBSERVATION BEDS	0.786690			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		365,948	196,966	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		365,948		202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-1301) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,691,342	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)	3,691,342	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	3,728,255	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)	20,358	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	860,755	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	2,847,142	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	2,847,142	30
31	PRIMARY PAYER PAYMENTS	1,816	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,845,326	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)	145,490	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	145,490	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	107,892	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	2,990,816	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	2,990,816	40
41	INTERIM PAYMENTS	2,479,643	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	511,173	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	19,113	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 (14-1301) [ ] 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				1,222,658		2,479,643	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)				1,222,658		2,479,643	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					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					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.)							7

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

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

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF [XX] SUB (OTHER) [ ] SNF [XX] SWING BED SNF (14-Z301)

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				1,152,930			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					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)				1,152,930			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					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					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.)							7

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

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

CHECK APPLICABLE BOX [XX] HOSPITAL (14-1301) [ ] CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	187	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	380	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	678	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	29,742,603	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	630,779	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	[ ]	TITLE V	[XX]	SWING BED - SNF (14-Z301)
APPLICABLE	[XX]	TITLE XVIII	[ ]	SWING BED - NF
BOXES	[ ]	TITLE XIX		

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	1,166,306		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)	198,936		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			4
5	PROGRAM DAYS	354		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	1,365,242		8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	1,365,242		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)	1,078		11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	1,364,164		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)			13
14	80% OF PART B COSTS (LINE 12 x 80%)			14
15	SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	1,364,164		15
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			16
17	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			17
18	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			18
19	TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	1,364,164		19
20	INTERIM PAYMENTS	1,152,930		20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	211,234		22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	7,019		23

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART V

CHECK [XX] HOSPITAL (14-1301)
APPLICABLE BOX: [ ] SUB (OTHER)

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

1	INPATIENT SERVICES	1,483,471	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,483,471	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	1,498,306	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6 AND 17)	1,498,306	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	81,044	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,417,262	22
23	COINSURANCE	1,156	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,416,106	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	36,687	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	36,687	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	9,016	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,452,793	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,452,793	30
31	INTERIM PAYMENTS	1,222,658	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	230,135	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	7,699	34

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1,015,770				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	5,983,078				4
5	OTHER RECEIVABLES	759,101				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,667,000				6
7	INVENTORY	274,824				7
8	PREPAID EXPENSES	491,675				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	6,857,448				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS	4,554,562				13
14	ACCUMULATED DEPRECIATION	-194,697				14
15	BUILDINGS	18,678,888				15
16	ACCUMULATED DEPRECIATION	-676,052				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	9,940,090				19
20	ACCUMULATED DEPRECIATION	-481,876				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	5,207,524				23
24	ACCUMULATED DEPRECIATION	-2,128,533				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)	34,899,906				30
	OTHER ASSETS					
31	INVESTMENTS	5,734,469				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	10,068,764				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	15,803,233				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	57,560,587				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,714,142				37
38	SALARIES, WAGES & FEES PAYABLE	1,619,106				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)	656,300				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	1,622,912				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	5,612,460				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE	29,617,195				46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	437,443				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	30,054,638				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	35,667,098				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	21,893,489				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)	21,893,489				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	57,560,587				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		25,068,784							1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		-3,267,667							2
3	TOTAL (SUM OF LINE 1 AND LINE 2)		21,801,117							3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5	CONTRIBUTIONS	403,706								5
6										6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)		403,706							10
11	SUBTOTAL (LINE 3 PLUS LINE 10)		22,204,823							11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13	ASSETS RELEASED FROM RESTRIC	300,260								13
14	CHANGE IN BENEFICIAL TRUST	11,074								14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)		311,334							18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		21,893,489							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	1,467,004		1,467,004	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	1,467,004		1,467,004	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	1,467,004		1,467,004	17
18	ANCILLARY SERVICES	1,698,352	24,112,323	25,810,675	18
19	OUTPATIENT SERVICES				19
20	RHC		973,939	973,939	20
20.01	RHC II		2,709,419	2,709,419	20.01
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE		1,041,961	1,041,961	23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	3,165,356	28,837,642	32,002,998	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		25,658,755	29
30	ADD (SPECIFY)			30
31	AUXILIARY	34,978		31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)		34,978	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)		25,693,733	43

STATEMENT OF REVENUES AND EXPENSES — WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	32,002,998	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	10,872,957	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	21,130,041	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	25,693,733	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-4,563,692	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		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 (GRANT REVENUE)	270,290	24
24.01	OTHER (LOSS ON THE SALE OF PROPERTY)	-171,070	24.01
24.02	OTHER (OTHER INCOME)	400,280	24.02
24.03	OTHER (RESTRICTED ASSETS RELEASED)	300,260	24.03
24.04	OTHER (INVESTEMENT RETURN)	496,269	24.04
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,296,029	25
26	TOTAL (LINE 5 PLUS LINE 25)	-3,267,663	26
27	OTHER EXPENSES (AUXILIARY EXPENSES)		27
27.01	OTHER EXPENSES (ROUNDING)	4	27.01
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	4	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-3,267,667	29

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	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES AP						21
22	I&R SRVCES-OTHER PRGM COSTS AP						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
56.10	ULTRASOUND						56.10
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHRGED TO PAT						71
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	RURAL HEALTH CLINIC (RHC)						88
88.01	RHC II						88.01
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAP						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CA						190
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: 14-3438

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	44,307		44,307		44,307		44,307	1
2	PHYSICIAN ASSISTANT	122,406		122,406		122,406		122,406	2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE	84,736		84,736		84,736		84,736	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)	251,449		251,449		251,449		251,449	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		75,638	75,638		75,638		75,638	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		75,638	75,638		75,638		75,638	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	251,449	75,638	327,087		327,087		327,087	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		17,413	17,413		17,413		17,413	29
30	ADMINISTRATIVE COSTS	55,494	86,436	141,930		141,930		141,930	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	55,494	103,849	159,343		159,343		159,343	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	306,943	179,487	486,430		486,430		486,430	32

RHC I WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3438

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	0.28	903	4,200	1,176		1
2	PHYSICIAN ASSISTANTS	1.04	4,244	2,100	2,184		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	1.32	5,147		3,360	5,147	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.32	5,147			5,147	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)	327,087	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)	327,087	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)	159,343	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	219,680	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	379,023	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	379,023	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	379,023	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	706,110	20

RHC I WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3438

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)	706,110	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	14,693	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	691,417	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	5,147	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,147	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	134.33	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)	134.33	134.33	134.33	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	628	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	84,359	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)	84,359	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)	59,659	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	61,661	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	61,661	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR	7,283	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	22,275	19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)	61,661	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	2,061	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	63,722	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	63,722	26
27	INTERIM PAYMENTS	64,118	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	-396	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2	358	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: 14-3438

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)	251,449	251,449	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.001000	0.009300	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	251	2,338	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	1,117	3,100	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,368	5,438	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	327,087	327,087	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	379,023	379,023	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.004182	0.016626	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	1,585	6,302	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	2,953	11,740	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	28	262	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	105.46	44.81	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		46	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		2,061	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		14,693	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)		2,061	16

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

RHC I
COMPONENT NO: 14-3438

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				64,118	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 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	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 M-3, LINE 27)				64,118	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.		.01			5.01
		PROGRAM TO PROVIDER	.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			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 (SEE INSTR.	PROGRAM TO PROVIDER	.01			6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

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

RHC II WORKSHEET M-1

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

COMPONENT NO: 14-3495

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	666,588		666,588		666,588		666,588	1
2	PHYSICIAN ASSISTANT	81,148		81,148		81,148		81,148	2
3	NURSE PRACTITIONER	106,323		106,323		106,323		106,323	3
4	VISITING NURSE								4
5	OTHER NURSE	306,183		306,183		306,183		306,183	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)	1,160,242		1,160,242		1,160,242		1,160,242	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		424,326	424,326		424,326		424,326	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		424,326	424,326		424,326		424,326	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,160,242	424,326	1,584,568		1,584,568		1,584,568	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		11,073	11,073		11,073	7,094	18,167	29
30	ADMINISTRATIVE COSTS	378,680	511,659	890,339		890,339		890,339	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	378,680	522,732	901,412		901,412	7,094	908,506	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,538,922	947,058	2,485,980		2,485,980	7,094	2,493,074	32

RHC II WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3495

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	2.79	9,568	4,200	11,718		1
2	PHYSICIAN ASSISTANTS	0.67	1,208	2,100	1,407		2
3	NURSE PRACTITIONERS	1.00	2,575	2,100	2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	4.46	13,351		15,225	15,225	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	4.46	13,351			15,225	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)	1,584,568	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	1,584,568	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)	908,506	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	1,672,240	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	2,580,746	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	2,580,746	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	2,580,746	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	4,165,314	20

RHC II WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3495

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)	4,165,314	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	43,974	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	4,121,340	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	15,225	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	15,225	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	270.70	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)	270.70	270.70	270.70	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	3,016	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	816,431	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)	816,431	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)	252,832	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)	3,016	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	9,739	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	608,950	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	618,689	16.05
17	PRIMARY PAYOR PAYMENTS	334	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR	45,505	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	92,588	19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)	618,355	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	12,574	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	630,929	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	630,929	26
27	INTERIM PAYMENTS	503,185	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	127,744	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2	3,404	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: 14-3495

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)	1,160,242	1,160,242	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000500	0.004100	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	580	4,757	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	1,636	9,756	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	2,216	14,513	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,584,568	1,584,568	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	2,580,746	2,580,746	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001398	0.009159	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	3,608	23,637	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	5,824	38,150	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	41	358	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	142.05	106.56	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		118	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		12,574	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)		43,974	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)		12,574	16

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

RHC II
COMPONENT NO: 14-3495

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				503,185	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		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 M-3, LINE 27)				503,185	4
		TO BE COMPLETED BY INTERMEDIARY				
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01			5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER	.50			5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99			5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO PROVIDER	.01			6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

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