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: 02-26-2014 TIME: 14:08_____
2. [ ] MANUALLY SUBMITTED COST REPORT
3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [F] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY IROQUOIS MEMORIAL HOSPITAL (14-0167) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2012 AND ENDING 09/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XVIII HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		12,074	-8,855	12,936		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		218				7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			20,497			10
10.01	HEALTH CLINIC - RHC II			24,043			10.01
10.02	HEALTH CLINIC - RHC III			41,395			10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		12,292	77,080	12,936		200

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

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

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	IROQUOIS MEMORIAL HOSPITAL	14-0167	99914	1	07/01/1996	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	IROQUOIS MEMORIAL HOSPITAL	14-U167	99914		12/31/2006	N	P	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	IROQUOIS RESIDENT HOME	14-6049	99914		08/18/2003	N	P	N	9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	IROQUOIS HOME HEALTH	14-7586	99914		09/30/1994	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE	IROQUOIS MEMORIAL HOSPICE	14-1616	99914		11/04/2004				14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	GILMAN CLINIC	14-3424	99914		09/04/1996	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	MILFORD CLINIC	14-3425	99914		10/09/1996	N	O	N	15.01
15.02	HOSPITAL-BASED HEALTH CLINIC - RHC III	KENTLAND CLINIC	15-3979	99915		10/29/1996	N	O	N	15.02
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 10/01/2012		TO: 09/30/2013						20
21	TYPE OF CONTROL			2						21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE 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.	496	69	3				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.			1				35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING: 10/01/2012		ENDING: 09/30/2013		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

		1	2
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	Y	Y	39

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

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL		1	2	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

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

		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(SEE INSTRUCTIONS)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY FTEs, AND PRIMARY CARE FTEs ADDED UNDER SECTION 5503). (SEE INSTRUCTIONS)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06

OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS)
ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
1	2	3	4	
				61.10

OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS)
ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.

61.20

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

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

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

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

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.

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

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

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

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

		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66 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

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

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

TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N		85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		86
		V	XIX	
TITLE V AND XIX INPATIENT SERVICES		1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS		1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108

		PHY-SICAL	OCCUP-ATIONAL	SPEECH	RESPI-RATORY	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	N	N	109

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 373,725 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.	Y	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

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

		1	2	
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

		1	2	
ALL PROVIDERS				
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	N		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	N	N		N	155
156	SUBPROVIDER - IPF	N	N			156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)	N	N			158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

MULTICAMPUS

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

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

NAME 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.		Y	167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.		0.75	169
170	IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS)		10/01/2012 09/30/2013	170

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

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

BED COMPLEMENT

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

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
	PS&R REPORT DATA	1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	01/09/2014	Y	01/09/2014	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

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

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

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

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

COST REPORT PREPARER CONTACT INFORMATION

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

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

	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)(SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30	49	17,885			1,762	337	2,632	1
2	HMO AND OTHER (SEE INSTRUCTIONS)						24	72		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									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.)		49	17,885			1,762	337	2,632	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						159	207	13
14	TOTAL (SEE INSTRUCTIONS)		49	17,885			1,762	496	2,839	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44	35	12,775			1,736		11,210	19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					2,617		3,619	22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116	1	365					9	24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88					1,045		3,281	26
26.01	RHC II	88.01					1,198		3,426	26.01
26.02	RHC III	88.02					3,215		9,097	26.02
27	TOTAL (SUM OF LINES 14-26)		85							27
28	OBSERVATION BED DAYS							96	957	28
29	AMBULANCE TRIPS						1,269			29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES --- TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)(SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30					577	145	944	1
2	HMO AND OTHER (SEE INSTRUCTIONS)						10			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)			274.61			577	145	944	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		27.95						19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101		6.40						22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116		13.08						24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88		3.61						26
26.01	RHC II	88.01		3.54						26.01
26.02	RHC III	88.02		11.56						26.02
27	TOTAL (SUM OF LINES 14-26)			340.75						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART II & III

PART II - WAGE DATA

		WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	15,972,041		15,972,041	708,757.00	22.54	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		514,029		514,029	4,122.00	124.70	5
6	NON-PHYSICIAN-PART B		736,274		736,274	34,898.00	21.10	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	965,645		965,645	54,429.00	17.74	9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		3,299,886		3,299,886	119,798.00	27.55	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		1,120,209		1,120,209	15,418.00	72.66	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)		1,934,983		1,934,983			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		718,001		718,001			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		46,182		46,182			23
24	WAGE-RELATED COSTS (RHC/FQHC)		136,065		136,065			24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		166,448		166,448	9,788.00	17.01	26
27	ADMINISTRATIVE & GENERAL		1,548,929		1,548,929	75,756.00	20.45	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		391,810		391,810	1,602.00	244.58	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		263,663		263,663	15,627.00	16.87	30
31	LAUNDRY & LINEN SERVICE		38,762		38,762	3,562.00	10.88	31
32	HOUSEKEEPING		298,990		298,990	29,079.00	10.28	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		352,676	-171,031	181,645	16,070.00	11.30	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)		11,855		11,855	198.00	59.87	35
36	CAFETERIA			171,031	171,031	15,133.00	11.30	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		573,503		573,503	16,646.00	34.45	38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		517,373		517,373	27,005.00	19.16	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	15,125,403	15,125,403	671,537.00	22.52	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	4,265,531	4,265,531	174,227.00	24.48	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	10,859,872	10,859,872	497,310.00	21.84	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	1,120,209	1,120,209	15,418.00	72.66	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	1,934,983	1,934,983		17.82%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	13,915,064	13,915,064	512,728.00	27.14	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	4,164,009	4,164,009	210,466.00	19.78	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	5,848	5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	1,046,670	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	114,552	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	734,265	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	19,059	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	14,589	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	1,934,983	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	1,120,209		1
2	HOSPITAL	1,120,209		2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II			14.01
14.02	HOSPITAL-BASED HEALTH CLINIC - RHC III			14.02
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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

HOME HEALTH AGENCY STATISTICAL DATA COUNTY:

	DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1	HOME HEALTH AIDE HOURS		2,704			2,704	1
2	UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION		201.00	5.00	44.00	250.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

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

		------- NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT) ------- STAFF 1	CONTRACT 2	TOTAL 3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	0.60		0.60	3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL	0.90		0.90	5
6	DIRECT NURSING SERVICE	2.15		2.15	6
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE	0.75		0.75	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE	0.15		0.15	10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE	0.05		0.05	12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE	0.05		0.05	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE	1.30		1.30	16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

		FULL EPISODES WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (COLS. 1-4) 5	
21	SKILLED NURSING VISITS	982	53	31	8	1,074	21
22	SKILLED NURSING VISIT CHARGES	147,997	8,069	4,720	1,218	162,004	22
23	PHYSICAL THERAPY VISITS	634	3	8	2	647	23
24	PHYSICAL THERAPY VISIT CHARGES	96,527	457	1,218	304	98,506	24
25	OCCUPATIONAL THERAPY VISITS	121	1	1		123	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	18,422	152	152		18,726	26
27	SPEECH PATHOLOGY VISITS	9				9	27
28	SPEECH PATHOLOGY VISIT CHARGES	1,370				1,370	28
29	MEDICAL SOCIAL SERVICE VISITS						29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES						30
31	HOME HEALTH AIDE VISITS	742	16	6		764	31
32	HOME HEALTH AIDE VISIT CHARGES	70,119	1,512	567		72,198	32
33	TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	2,488	73	46	10	2,617	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	334,435	10,190	6,657	1,522	352,804	35
36	TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	160		19	2	181	36
37	TOTAL NUMBER OF OUTLIER EPISODES		2			2	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	1,997	145			2,142	38

PROSPECTIVE PAYMENT FOR SNF WORKSHEET S-7
STATISTICAL DATA

		Y/N 1	DATE 2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y		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	128		128	15
16	RVB	128		128	16
17	RVA	284		284	17
18	RHC	249		249	18
19	RHB	143		143	19
20	RHA	532		532	20
21	RMC	12		12	21
22	RMB	55		55	22
23	RMA	72		72	23
24	RLB	2		2	24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2	11		11	29
30	HE1	7		7	30
31	HD2				31
32	HD1	14		14	32
33	HC2				33
34	HC1				34
35	HB2	14		14	35
36	HB1	19		19	36
37	LE2				37
38	LE1	4		4	38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1	12		12	44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	5		5	48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1	8		8	52
53	CA2				53
54	CA1	19		19	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	9		9	76
77	PA2				77
78	PA1	9		9	78
199	AAA				199
200	TOTAL	1,736		1,736	200

	SNF SERVICES	CBSA AT BEGINNING OF COST REPORTING PERIOD 1	CBSA ON/AFTER OCT 1 OF THE COST REPORTING PERIOD (IF APPLICABLE) 2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).	00014	00014	201

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

		EXPENSES 1	PERCENTAGE 2	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 3	
202	STAFFING	965,645	48.23%	Y	202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING	6,310	0.32%	Y	205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	2,002,335			207

RHC I WORKSHEET S-8

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

COMPONENT NO: 14-3424

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

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

SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 2	
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)			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 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			0830	1830	0700	1700	0700	1700	0830	1830	0830	1700			11

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

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

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

RHC II WORKSHEET S-8

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

COMPONENT NO: 14-3425

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

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

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

		1	2	
10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? 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 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			0830	1700	0700	1700	0830	1830	0830	1700	0700	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	TOTAL	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)	N					15

RHC III WORKSHEET S-8

HOSPITAL-BASED RURAL HEALTH CLINIC/ COMPONENT NO: 15-3979
FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 303 N SEVENTH	1
2	CITY: KENTLAND STATE: IN ZIP CODE: 47951 COUNTY: NEWTON	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 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
11	CLINIC			0700	1700	0830	1830	0700	1700	0830	1830	0700	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	TOTAL	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)	N					15

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

PART I - ENROLLMENT DAYS

		UNDUPLICATED DAYS						
		TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURSING FACILITY 3	TITLE XIX NURSING FACILITY 4	ALL OTHER 5	TOTAL (SUM OF COLS. 1, 2 & 5) 6	
1	CONTINUOUS HOME CARE	2	1				3	1
2	ROUTINE HOME CARE	4,659	178	2,682		70	4,907	2
3	INPATIENT RESPITE CARE	52	5				57	3
4	GENERAL INPATIENT CARE	8					8	4
5	TOTAL HOSPICE DAYS	4,721	184	2,682		70	4,975	5

PART II - CENSUS DATA

		TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURSING FACILITY 3	TITLE XIX NURSING FACILITY 4	ALL OTHER 5	TOTAL (SUM OF COLS. 1, 2 & 5) 6	
6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	176	5	102		6	187	6
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE	48						7
8	AVERAGE LENGTH OF STAY (LINE 5/LINE 6)	26.82	36.80	26.29		11.67	26.60	8
9	UNDUPLICATED CENSUS COUNT	176	5	102		6	187	9

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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA WORKSHEET S-10

	UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION		
1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)	0.408045	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	2,587,731	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	8,120,135	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	3,313,380	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.	725,649	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)	725,649	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	689,225	173,863	863,088	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	281,235	70,944	352,179	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	281,235	70,944	352,179	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)			1,919,999	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			232,320	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,687,679	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			688,649	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,040,828	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			1,766,477	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		1,770,661	1,770,661	-657,016	1
2	00200	CAP REL COSTS-MVBLE EQUIP				950,702	2
3	00300	OTHER CAP REL COSTS					3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	166,448	1,623,766	1,790,214	152,776	4
5.01	00540	ADMISSIONS	329,216	218,188	547,404		5.01
5.02	00550	PURCHASING, RECEIVING, AND STORES	116,333	112,807	229,140	-70,880	5.02
5.03	00560	DATA PROCESSING	217,155	435,472	652,627	18,600	5.03
5.04	00570	COMMUNICATIONS		129,540	129,540	27,700	5.04
5.05	00580	BUSINESS OFFICE	289,463	-25,416	264,047	-39	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	596,762	4,353,964	4,950,726	129,450	5.06
6	00600	MAINTENANCE & REPAIRS					6
7	00700	OPERATION OF PLANT	263,663	832,723	1,096,386	42,753	7
8	00800	LAUNDRY & LINEN SERVICE	38,762	6,881	45,643		8
9	00900	HOUSEKEEPING	298,990	67,939	366,929		9
10	01000	DIETARY	352,676	313,102	665,778	-322,871	10
11	01100	CAFETERIA				322,871	11
13	01300	NURSING ADMINISTRATION	573,503	66,122	639,625	-126	13
14	01400	CENTRAL SERVICES & SUPPLY		17,046	17,046		14
15	01500	PHARMACY					15
16	01600	MEDICAL RECORDS & LIBRARY	517,373	308,803	826,176	-15	16
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	2,036,324	811,817	2,848,141	-582,073	30
43	04300	NURSERY				323,820	43
44	04400	SKILLED NURSING FACILITY	965,645	239,403	1,205,048	-20,848	44
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	686,451	1,799,052	2,485,503	-1,111,177	50
52	05200	DELIVERY ROOM & LABOR ROOM				209,098	52
53	05300	ANESTHESIOLOGY		321,332	321,332	-11,918	53
54	05400	RADIOLOGY-DIAGNOSTIC	835,544	1,386,133	2,221,677	-531,738	54
60	06000	LABORATORY	632,494	813,104	1,445,598	-2,106	60
65	06500	RESPIRATORY THERAPY	344,983	150,875	495,858	-54,175	65
66	06600	PHYSICAL THERAPY	476,181	678,332	1,154,513	-12,116	66
69	06900	ELECTROCARDIOLOGY	54,206	81,082	135,288	-1,601	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				662,677	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				1,237,687	72
73	07300	DRUGS CHARGED TO PATIENTS	480,850	1,454,320	1,935,170	116,103	73
74	07400	RENAL DIALYSIS					74
		OUTPATIENT SERVICE COST CENTERS					
88	08800	RURAL HEALTH CLINIC	226,178	143,540	369,718	-9,810	88
88.01	08801	RHC II	211,618	170,659	382,277	-42,074	88.01
88.02	08802	RHC III	796,844	313,733	1,110,577	-68,032	88.02
90	09000	CLINIC	370,195	-77,764	292,431	-37,138	90
91	09100	EMERGENCY	794,298	858,467	1,652,765	-26,430	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92
		OTHER REIMBURSABLE COST CENTERS					
94	09400	HOME PROGRAM DIALYSIS					94
95	09500	AMBULANCE SERVICES	673,754	232,257	906,011	-41,959	95
101	10100	HOME HEALTH AGENCY	377,388	101,167	478,555	-5,903	101
		SPECIAL PURPOSE COST CENTERS					
113	11300	INTEREST EXPENSE		271,484	271,484	-271,484	113
116	11600	HOSPICE	686,092	444,866	1,130,958	-123,700	116
118		SUBTOTALS (SUM OF LINES 1-117)	14,409,389	20,425,457	34,834,846	189,008	118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,310	3,310	23,777	190
194	07950	IROQUOIS WOMEN'S HEALTH	1,410,188	830,670	2,240,858	-56,940	194
194.01	07951	OTHER NON-REIMBURSABLE COSTS	152,464	263,485	415,949	-155,845	194.01
194.03	07953	WELLNESS					194.03
194.04	07954	RENTED SPACE					194.04
200		TOTAL (SUM OF LINES 118-199)	15,972,041	21,522,922	37,494,963		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
		GENERAL SERVICE COST CENTERS				
1	00100	CAP REL COSTS-BLDG & FIXT	1,113,645	-47,281	1,066,364	1
2	00200	CAP REL COSTS-MVBLE EQUIP	950,702	-8,719	941,983	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	1,942,990	-4,760	1,938,230	4
5.01	00540	ADMISSIONS	547,404	-24,526	522,878	5.01
5.02	00550	PURCHASING, RECEIVING, AND STORES	158,260		158,260	5.02
5.03	00560	DATA PROCESSING	671,227		671,227	5.03
5.04	00570	COMMUNICATIONS	157,240		157,240	5.04
5.05	00580	BUSINESS OFFICE	264,008		264,008	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	5,080,176	-3,204,637	1,875,539	5.06
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	1,139,139	-12,785	1,126,354	7
8	00800	LAUNDRY & LINEN SERVICE	45,643	-6	45,637	8
9	00900	HOUSEKEEPING	366,929	-1,497	365,432	9
10	01000	DIETARY	342,907		342,907	10
11	01100	CAFETERIA	322,871	-145,112	177,759	11
13	01300	NURSING ADMINISTRATION	639,499	-828	638,671	13
14	01400	CENTRAL SERVICES & SUPPLY	17,046	-1,208	15,838	14
15	01500	PHARMACY				15
16	01600	MEDICAL RECORDS & LIBRARY	826,161	-552	825,609	16
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	2,266,068	-40,500	2,225,568	30
43	04300	NURSERY	323,820		323,820	43
44	04400	SKILLED NURSING FACILITY	1,184,200	-826	1,183,374	44
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	1,374,326	-363,688	1,010,638	50
52	05200	DELIVERY ROOM & LABOR ROOM	209,098		209,098	52
53	05300	ANESTHESIOLOGY	309,414	-309,253	161	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,689,939	-51,710	1,638,229	54
60	06000	LABORATORY	1,443,492	-2,400	1,441,092	60
65	06500	RESPIRATORY THERAPY	441,683	-21,230	420,453	65
66	06600	PHYSICAL THERAPY	1,142,397	-10,101	1,132,296	66
69	06900	ELECTROCARDIOLOGY	133,687	-20,386	113,301	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	662,677	-658	662,019	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS	1,237,687		1,237,687	72
73	07300	DRUGS CHARGED TO PATIENTS	2,051,273		2,051,273	73
74	07400	RENAL DIALYSIS				74
		OUTPATIENT SERVICE COST CENTERS				
88	08800	RURAL HEALTH CLINIC	359,908		359,908	88
88.01	08801	RHC II	340,203		340,203	88.01
88.02	08802	RHC III	1,042,545		1,042,545	88.02
90	09000	CLINIC	255,293	-67,025	188,268	90
91	09100	EMERGENCY	1,626,335	-726,142	900,193	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
		OTHER REIMBURSABLE COST CENTERS				
94	09400	HOME PROGRAM DIALYSIS				94
95	09500	AMBULANCE SERVICES	864,052	-63,679	800,373	95
101	10100	HOME HEALTH AGENCY	472,652		472,652	101
		SPECIAL PURPOSE COST CENTERS				
113	11300	INTEREST EXPENSE				113
116	11600	HOSPICE	1,007,258	-30,163	977,095	116
118		SUBTOTALS (SUM OF LINES 1-117)	35,023,854	-5,159,672	29,864,182	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,087		27,087	190
194	07950	IROQUOIS WOMEN'S HEALTH	2,183,918		2,183,918	194
194.01	07951	OTHER NON-REIMBURSABLE COSTS	260,104		260,104	194.01
194.03	07953	WELLNESS				194.03
194.04	07954	RENTED SPACE				194.04
200		TOTAL (SUM OF LINES 118-199)	37,494,963	-5,159,672	32,335,291	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	RECLASS MOVEABLE EQUIP DEPR	A	CAP REL COSTS-MVBLE EQUIP	2		897,166
500	TOTAL RECLASSIFICATIONS					897,166
	CODE LETTER - A					
1	RECLASS ADVERTISING	B	OTHER ADMINISTRATIVE AND GENE	5.06		175,036
500	TOTAL RECLASSIFICATIONS					175,036
	CODE LETTER - B					
1	RECLASS MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO P	71		662,677
500	TOTAL RECLASSIFICATIONS					662,677
	CODE LETTER - C					
1	RECLASS DRUGS CHARGED TO PATIENTS	D	DRUGS CHARGED TO PATIENTS	73		116,613
500	TOTAL RECLASSIFICATIONS					116,613
	CODE LETTER - D					
1	RECLASS TELEPHONE EXPENSE	E	COMMUNICATIONS	5.04		27,700
500	TOTAL RECLASSIFICATIONS					27,700
	CODE LETTER - E					
1	RECLASS INTEREST EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		229,221
2			CAP REL COSTS-MVBLE EQUIP	2		42,263
500	TOTAL RECLASSIFICATIONS					271,484
	CODE LETTER - F					
1	RECLASS CAFETERIA	G	CAFETERIA	11	171,031	151,840
500	TOTAL RECLASSIFICATIONS				171,031	151,840
	CODE LETTER - G					
1	RECLASS NURSERY COST	H	NURSERY	43	208,450	115,370
2			DELIVERY ROOM & LABOR ROOM	52	134,601	74,497
500	TOTAL RECLASSIFICATIONS				343,051	189,867
	CODE LETTER - H					

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5	
1	RECLASS OPERATION OF PLANT COST	I	OPERATION OF PLANT	7		42,753	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	TOTAL RECLASSIFICATIONS					42,753	500
	CODE LETTER - I						
1	RECLASS TRANSPORTATION	J	OTHER ADMINISTRATIVE AND GENE	5.06		22,341	1
2							2
500	TOTAL RECLASSIFICATIONS					22,341	500
	CODE LETTER - J						
1	RECLASS IT COST	K	DATA PROCESSING	5.03		19,148	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	TOTAL RECLASSIFICATIONS					19,148	500
	CODE LETTER - K						
1	RECLASS GIFT SHOP	L	GIFT, FLOWER, COFFEE SHOP & C	190		23,777	1
500	TOTAL RECLASSIFICATIONS					23,777	500
	CODE LETTER - L						
1	RECLASS SHELDON CLINIC	M	OTHER NON-REIMBURSABLE COSTS	194.01		13,327	1
2							2
500	TOTAL RECLASSIFICATIONS					13,327	500
	CODE LETTER - M						
1	RECLASS OTHER CAP RELATED COST	N	OTHER CAP REL COSTS	3		29,905	1
500	TOTAL RECLASSIFICATIONS					29,905	500
	CODE LETTER - N						
1	RECLASS EMPLOYEE BENEFITS	O	EMPLOYEE BENEFITS DEPARTMENT	4		152,776	1
2							2
3							3
4							4
5							5
500	TOTAL RECLASSIFICATIONS					152,776	500
	CODE LETTER - O						
1	RECLASS IMPL MED SUPPLIES	P	IMPL. DEV. CHARGED TO PATIENT	72		1,237,687	1
2							2
500	TOTAL RECLASSIFICATIONS					1,237,687	500
	CODE LETTER - P						
	GRAND TOTAL (INCREASES)				514,082	4,034,097	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	RECLASS MOVEABLE EQUIP DEPR	A	CAP REL COSTS-BLDG & FIXT	1		897,166	9 1
500	TOTAL RECLASSIFICATIONS					897,166	500
	CODE LETTER - A						
1	RECLASS ADVERTISING	B	RURAL HEALTH CLINIC	88		1,103	1
2			RHC II	88.01		3,286	2
3			RHC III	88.02		959	3
4			HOME HEALTH AGENCY	101		296	4
5			HOSPICE	116		2,836	5
6			IROQUOIS WOMEN'S HEALTH	194		1,654	6
7			OTHER NON-REIMBURSABLE COSTS	194.01		164,902	7
500	TOTAL RECLASSIFICATIONS					175,036	500
	CODE LETTER - B						
1	RECLASS MEDICAL SUPPLIES	C	PURCHASING, RECEIVING, AND ST	5.02		68,021	1
2			ADULTS & PEDIATRICS	30		48,490	2
3			SKILLED NURSING FACILITY	44		20,476	3
4			OPERATING ROOM	50		326,730	4
5			ANESTHESIOLOGY	53		11,918	5
6			RADIOLOGY-DIAGNOSTIC	54		69,768	6
7			RESPIRATORY THERAPY	65		54,173	7
8			PHYSICAL THERAPY	66		1,724	8
9			ELECTROCARDIOLOGY	69		1,601	9
10			CLINIC	90		228	10
11			EMERGENCY	91		26,430	11
12			AMBULANCE SERVICES	95		9,926	12
13			HOME HEALTH AGENCY	101		3,338	13
14			HOSPICE	116		13,895	14
15			IROQUOIS WOMEN'S HEALTH	194		5,959	15
500	TOTAL RECLASSIFICATIONS					662,677	500
	CODE LETTER - C						
1	RECLASS DRUGS CHARGED TO PATIENTS	D	ADULTS & PEDIATRICS	30		424	1
2			SKILLED NURSING FACILITY	44		372	2
3			OPERATING ROOM	50		1,544	3
4			RADIOLOGY-DIAGNOSTIC	54		6,148	4
5			LABORATORY	60		2,106	5
6			RESPIRATORY THERAPY	65		2	6
7			PHYSICAL THERAPY	66		356	7
8			CLINIC	90		18	8
9			AMBULANCE SERVICES	95		900	9
10			HOSPICE	116		104,743	10
500	TOTAL RECLASSIFICATIONS					116,613	500
	CODE LETTER - D						
1	RECLASS TELEPHONE EXPENSE	E	PURCHASING, RECEIVING, AND ST	5.02		214	1
2			DATA PROCESSING	5.03		548	2
3			OTHER ADMINISTRATIVE AND GENE	5.06		5,244	3
4			NURSING ADMINISTRATION	13		126	4
5			MEDICAL RECORDS & LIBRARY	16		15	5
6			RADIOLOGY-DIAGNOSTIC	54		465	6
7			CLINIC	90		12,869	7
8			AMBULANCE SERVICES	95		8,219	8
500	TOTAL RECLASSIFICATIONS					27,700	500
	CODE LETTER - E						
1	RECLASS INTEREST EXPENSE	F	INTEREST EXPENSE	113		271,484	11 1
2							11 2
500	TOTAL RECLASSIFICATIONS					271,484	500
	CODE LETTER - F						
1	RECLASS CAFETERIA	G	DIETARY	10	171,031	151,840	1
500	TOTAL RECLASSIFICATIONS				171,031	151,840	500
	CODE LETTER - G						
1	RECLASS NURSERY COST	H	ADULTS & PEDIATRICS	30	343,051	189,867	1
2							2
500	TOTAL RECLASSIFICATIONS				343,051	189,867	500
	CODE LETTER - H						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RECLASS OPERATION OF PLANT COST	I	OTHER ADMINISTRATIVE AND GENE	5.06		167		1
2			PHYSICAL THERAPY	66		10,036		2
3			RURAL HEALTH CLINIC	88		4,253		3
4			RHC II	88.01		6,069		4
5			RHC III	88.02		1,922		5
6			AMBULANCE SERVICES	95		4,679		6
7			HOME HEALTH AGENCY	101		2,229		7
8			HOSPICE	116		2,226		8
9			IROQUOIS WOMEN'S HEALTH	194		11,172		9
500	TOTAL RECLASSIFICATIONS					42,753		500
	CODE LETTER - I							
1	RECLASS TRANSPORTATION	J	AMBULANCE SERVICES	95		18,071		1
2			OTHER NON-REIMBURSABLE COSTS	194.01		4,270		2
500	TOTAL RECLASSIFICATIONS					22,341		500
	CODE LETTER - J							
1	RECLASS IT COST	K	IROQUOIS WOMEN'S HEALTH	194		11,209		1
2			PURCHASING, RECEIVING, AND ST	5.02		2,645		2
3			BUSINESS OFFICE	5.05		39		3
4			OTHER ADMINISTRATIVE AND GENE	5.06		3,210		4
5			ADULTS & PEDIATRICS	30		241		5
6			RADIOLOGY-DIAGNOSTIC	54		573		6
7			DRUGS CHARGED TO PATIENTS	73		510		7
8			CLINIC	90		517		8
9			AMBULANCE SERVICES	95		164		9
10			HOME HEALTH AGENCY	101		40		10
500	TOTAL RECLASSIFICATIONS					19,148		500
	CODE LETTER - K							
1	RECLASS GIFT SHOP	L	OTHER ADMINISTRATIVE AND GENE	5.06		23,777		1
500	TOTAL RECLASSIFICATIONS					23,777		500
	CODE LETTER - L							
1	RECLASS SHELDON CLINIC	M	CAP REL COSTS-BLDG & FIXT	1		7,703	9	1
2			OTHER ADMINISTRATIVE AND GENE	5.06		5,624		2
500	TOTAL RECLASSIFICATIONS					13,327		500
	CODE LETTER - M							
1	RECLASS OTHER CAP RELATED COST	N	OTHER ADMINISTRATIVE AND GENE	5.06		29,905	14	1
500	TOTAL RECLASSIFICATIONS					29,905		500
	CODE LETTER - N							
1	RECLASS EMPLOYEE BENEFITS	O	RURAL HEALTH CLINIC	88		4,454		1
2			RHC II	88.01		32,719		2
3			RHC III	88.02		65,151		3
4			CLINIC	90		23,506		4
5			IROQUOIS WOMEN'S HEALTH	194		26,946		5
500	TOTAL RECLASSIFICATIONS					152,776		500
	CODE LETTER - O							
1	RECLASS IMPL MED SUPPLIES	P	OPERATING ROOM	50		782,903		1
2			RADIOLOGY-DIAGNOSTIC	54		454,784		2
500	TOTAL RECLASSIFICATIONS					1,237,687		500
	CODE LETTER - P							
	GRAND TOTAL (DECREASES)				514,082	4,034,097		

RECONCILIATION OF CAPITAL COST CENTERS WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	249,035					249,035		1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	24,004,569	893,268		893,268	453,795	24,444,042		3
4	BUILDING IMPROVEMENTS	477,850	5,900		5,900		483,750		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	13,646,609	1,465,807		1,465,807	30,000	15,082,416		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	38,378,063	2,364,975		2,364,975	483,795	40,259,243		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	38,378,063	2,364,975		2,364,975	483,795	40,259,243		10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	1,770,661						1,770,661	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (SUM OF LINES 1-2)	1,770,661						1,770,661	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	ALLOCATION OF OTHER CAPITAL INSURANCE 5	TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT	24,927,792		24,927,792	0.623036			18,632	18,632	1
2	CAP REL COSTS-MVBLE EQUIP	15,082,416		15,082,416	0.376964			11,273	11,273	2
3	TOTAL (SUM OF LINES 1-2)	40,010,208		40,010,208	1.000000			29,905	29,905	3

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	865,792		181,940			18,632	1,066,364	1
2	CAP REL COSTS-MVBLE EQUIP	897,166		33,544			11,273	941,983	2
3	TOTAL	1,762,958		215,484			29,905	2,008,347	3

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-47,281	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-8,719	CAP REL COSTS-MVBLE EQUIP	2	11	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-502	OTHER ADMINISTRATIVE AND GENERA	5.06		4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-12,785	OPERATION OF PLANT	7		8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,500,579				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	-6	LAUNDRY & LINEN SERVICE	8		13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-145,112	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-658	MEDICAL SUPPLIES CHARGED TO PAT	71		16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-552	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	CNA CLASS REVENUE	B	-828	NURSING ADMINISTRATION	13		33
34	OTHER REVENUE SPORTS MEDICINE	B	-1,244	PHYSICAL THERAPY	66		34
35	OTHER REVENUE WELLNESS	B	-3,361	PHYSICAL THERAPY	66		35
36	AMBULANCE TOWNSHIP INCOME	B	-63,076	AMBULANCE SERVICES	95		36
37	BAD DEBTS	A	-1,969,230	OTHER ADMINISTRATIVE AND GENERA	5.06		37
38	RENTAL INCOME	B	-67,025	CLINIC	90		38
39	RENTAL INCOME	B	-5,400	PHYSICAL THERAPY	66		39
40	COLLECTION FEES REVENUE	B	-24,526	ADMISSIONS	5.01		40
41	OTHER REVENUE HSKP	B	-1,497	HOUSEKEEPING	9		41
42	OTHER REVENUE-CENTRAL SUPPLY	B	-1,208	CENTRAL SERVICES & SUPPLY	14		42
43	OTHER REVENUE REHAB	B	-96	PHYSICAL THERAPY	66		43
44							44
45	MISC INCOME A&G	B	-15,519	OTHER ADMINISTRATIVE AND GENERA	5.06		45
46	MISC INCOME AUXILLIARY	B	-23,616	OTHER ADMINISTRATIVE AND GENERA	5.06		46
47	MISC INCOME MED STAFF	B	-5,750	OTHER ADMINISTRATIVE AND GENERA	5.06		47
48	MISC INCOME EMPL COMMITTEE	B	-9,570	OTHER ADMINISTRATIVE AND GENERA	5.06		48
49							49
49.01	PHYSICIAN BENEFIT OFFSET	A	-2,380	EMPLOYEE BENEFITS DEPARTMENT	4		49.01
49.02	PHYSICIAN BENEFIT OFFSET	A	-2,380	EMPLOYEE BENEFITS DEPARTMENT	4		49.02
49.03	DONATION EXPENSE	A	-613	OTHER ADMINISTRATIVE AND GENERA	5.06		49.03
49.04	ALCOHOL EXPENSE	A	-2,627	OTHER ADMINISTRATIVE AND GENERA	5.06		49.04
49.08	ADVERTISING EXPENSE	A	-145,889	OTHER ADMINISTRATIVE AND GENERA	5.06		49.08
49.09	PHYSICIAN RECRUITMENT	A	-14,370	OTHER ADMINISTRATIVE AND GENERA	5.06		49.09
49.10	LOBBYING EXPENSE	A	-3,046	OTHER ADMINISTRATIVE AND GENERA	5.06		49.10
49.11	LOBBYING EXPENSE	A	-826	SKILLED NURSING FACILITY	44		49.11
49.12	PROVIDER TAX EXPENSE	A	-1,013,216	OTHER ADMINISTRATIVE AND GENERA	5.06		49.12
49.13	AMB CABLE COST	A	-603	AMBULANCE SERVICES	95		49.13
49.14	A&G CABLE TV COST	A	-689	OTHER ADMINISTRATIVE AND GENERA	5.06		49.14
49.15	HOSPICE PRO FEE	A	-30,163	HOSPICE	116		49.15

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO.	WKST A-7 REF
		1	2	3	4	5
49.16	ICU PRO FEE	A	-27,000	ADULTS & PEDIATRICS	30	49.16
49.17	SLEEP LAB PRO FEE	A	-7,730	RESPIRATORY THERAPY	65	49.17
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-5,159,672			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ-USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					5

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA-TION INCL FRINGES	PROFES-SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD-JUSTED RCE LIMIT	5 PERCENT OF UNAD-JUSTED RCE LIMIT	
	1	2		3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS	AGGREGATE	13,500	13,500						1
2	50	OPERATING ROOM	AGGREGATE	363,688	363,688						2
3	53	ANESTHESIOLOGY	AGGREGATE	309,253	309,253						3
4	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE	51,710	51,710						4
5	65	RESPIRATORY THERAPY	AGGREGATE	13,500	13,500						5
6	69	ELECTROCARDIOLOGY	AGGREGATE	20,386	20,386						6
7	60	LABORATORY	AGGREGATE	2,400	2,400						7
8	91	EMERGENCY	AGGREGATE	726,142	726,142						8
200		TOTAL		1,500,579	1,500,579						200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18	
1	30	ADULTS & PEDIATRICS	AGGREGATE							13,500	1
2	50	OPERATING ROOM	AGGREGATE							363,688	2
3	53	ANESTHESIOLOGY	AGGREGATE							309,253	3
4	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE							51,710	4
5	65	RESPIRATORY THERAPY	AGGREGATE							13,500	5
6	69	ELECTROCARDIOLOGY	AGGREGATE							20,386	6
7	60	LABORATORY	AGGREGATE							2,400	7
8	91	EMERGENCY	AGGREGATE							726,142	8
200		TOTAL								1,500,579	200

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	ADMITTING 5.01	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	1,066,364	1,066,364				1
2	CAP REL COSTS-MVBLE EQUIP	941,983		941,983			2
4	EMPLOYEE BENEFITS DEPARTMENT	1,938,230	4,267		1,942,497		4
5.01	ADMISSIONS	522,878	8,928		40,541	572,347	5.01
5.02	PURCHASING, RECEIVING, AND STORES	158,260	11,608		14,326		5.02
5.03	DATA PROCESSING	671,227	4,329	92,105	26,741		5.03
5.04	COMMUNICATIONS	157,240	2,834	2,574			5.04
5.05	BUSINESS OFFICE	264,008	9,927	774	35,645		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,875,539	35,691	2,937	73,487		5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	1,126,354	103,060	15,030	32,468		7
8	LAUNDRY & LINEN SERVICE	45,637	17,888		4,773		8
9	HOUSEKEEPING	365,432	5,181		36,819		9
10	DIETARY	342,907	24,269	4,057	22,368		10
11	CAFETERIA	177,759	8,053		21,061		11
13	NURSING ADMINISTRATION	638,671	13,776	152	70,623		13
14	CENTRAL SERVICES & SUPPLY	15,838	11,654	9,492			14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	825,609	13,280	2,076	63,711		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,225,568	157,871	70,233	208,523	37,071	30
43	NURSERY	323,820	4,344	5,037	25,669	2,188	43
44	SKILLED NURSING FACILITY	1,183,374	74,455	25,746	118,912	17,038	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,010,638	126,663	185,577	82,603	64,353	50
52	DELIVERY ROOM & LABOR ROOM	209,098	1,735		16,575	959	52
53	ANESTHESIOLOGY	161	852	16,865		2,794	53
54	RADIOLOGY-DIAGNOSTIC	1,638,229	42,544	338,116	100,963	128,310	54
60	LABORATORY	1,441,092	27,265	53,799	77,887	85,165	60
65	RESPIRATORY THERAPY	420,453	16,115	14,126	42,482	7,953	65
66	PHYSICAL THERAPY	1,132,296	95,735	14,617	58,638	28,812	66
69	ELECTROCARDIOLOGY	113,301	4,646	1,763	6,675	12,003	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	662,019				9,366	71
72	IMPL. DEV. CHARGED TO PATIENTS	1,237,687				21,652	72
73	DRUGS CHARGED TO PATIENTS	2,051,273	14,496	22,104	59,213	73,449	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	359,908	20,134	513	27,852		88
88.01	RHC II	340,203	6,969	305	26,059		88.01
88.02	RHC III	1,042,545	32,616	6,811	98,126		88.02
90	CLINIC	188,268	23,641	1,338	45,587	1,546	90
91	EMERGENCY	900,193	23,401	18,826	97,812	50,776	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	800,373	1,603	31,040	82,968	28,912	95
101	HOME HEALTH AGENCY	472,652	9,865	470	46,473		101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	977,095	9,927	684	84,487		116
118	SUBTOTALS (SUM OF LINES 1-117)	29,864,182	969,622	937,167	1,750,067	572,347	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,087	7,109				190
194	IROQUOIS WOMEN'S HEALTH	2,183,918	49,157	4,139	173,655		194
194.01	OTHER NON-REIMBURSABLE COSTS	260,104	40,476	677	18,775		194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	32,335,291	1,066,364	941,983	1,942,497	572,347	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	PURCHASING RECEIVING AND STORES 5.02	DATA PROCESSING 5.03	COMMUNICATIONS 5.04	BUSINESS OFFICE 5.05	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES	184,194					5.02
5.03	DATA PROCESSING	102	794,504				5.03
5.04	COMMUNICATIONS			162,648			5.04
5.05	BUSINESS OFFICE	233	23,165		333,752		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	506	17,114	8,865		2,014,139	5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	3,221	18,912	4,625		1,303,670	7
8	LAUNDRY & LINEN SERVICE	288	4,312	385		73,283	8
9	HOUSEKEEPING	2,096	35,193	771		445,492	9
10	DIETARY	1,575	19,448	1,927		416,551	10
11	CAFETERIA	1,483	18,314	771		227,441	11
13	NURSING ADMINISTRATION	161	20,145	4,240		747,768	13
14	CENTRAL SERVICES & SUPPLY	1,113		385		38,482	14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	428	32,682	12,333		950,119	16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	4,885	83,408	37,387	21,618	2,846,564	30
43	NURSERY		10,201	385	1,276	372,920	43
44	SKILLED NURSING FACILITY	2,899	70,367	4,240	9,936	1,506,967	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,436	31,041	13,104	37,527	1,552,942	50
52	DELIVERY ROOM & LABOR ROOM		6,586	771	560	236,284	52
53	ANESTHESIOLOGY	780			1,630	23,082	53
54	RADIOLOGY-DIAGNOSTIC	7,730	43,118	8,479	74,810	2,382,299	54
60	LABORATORY	20,193	37,716	6,167	49,664	1,798,948	60
65	RESPIRATORY THERAPY	3,918	18,925	2,698	4,638	531,308	65
66	PHYSICAL THERAPY	424	31,930	6,552	16,801	1,385,805	66
69	ELECTROCARDIOLOGY		3,489	1,542	7,000	150,419	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,837			5,462	702,684	71
72	IMPL. DEV. CHARGED TO PATIENTS	92,511			12,626	1,364,476	72
73	DRUGS CHARGED TO PATIENTS	405	19,331	3,083	42,832	2,286,186	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	312	9,078	2,313		420,110	88
88.01	RHC II	325	8,920	1,927		384,708	88.01
88.02	RHC III	838	29,094	2,698		1,212,728	88.02
90	CLINIC	623	18,659	5,781	902	286,345	90
91	EMERGENCY	2,685	38,375	6,167	29,610	1,167,845	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	856	54,151	771	16,860	1,017,534	95
101	HOME HEALTH AGENCY	400	16,114	3,083		549,057	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	3,657	32,926	5,396		1,114,172	116
118	SUBTOTALS (SUM OF LINES 1-117)	181,920	752,714	146,846	333,752	29,510,328	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40		771		35,007	190
194	IROQUOIS WOMEN'S HEALTH	1,185	31,553	15,031		2,458,638	194
194.01	OTHER NON-REIMBURSABLE COSTS	1,049	10,237			331,318	194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	184,194	794,504	162,648	333,752	32,335,291	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	OTHER ADMINISTRATIVE AND GENER 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	2,014,139					5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	86,599	1,390,269				7
8	LAUNDRY & LINEN SERVICE	4,868	28,078	106,229			8
9	HOUSEKEEPING	29,593	8,132	4,516	487,733		9
10	DIETARY	27,670	38,093	994	13,721	497,029	10
11	CAFETERIA	15,108	12,641		4,553		11
13	NURSING ADMINISTRATION	49,672	21,623		7,789		13
14	CENTRAL SERVICES & SUPPLY	2,556	18,293	25	6,589		14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	63,114	20,846		7,509		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	189,086	247,800	23,891	89,256	116,054	30
43	NURSERY	24,772	6,819	369	2,456		43
44	SKILLED NURSING FACILITY	100,103	116,869	45,241	42,096	337,699	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	103,157	198,816	11,439	71,614	975	50
52	DELIVERY ROOM & LABOR ROOM	15,696	2,723		981		52
53	ANESTHESIOLOGY	1,533	1,337		482		53
54	RADIOLOGY-DIAGNOSTIC	158,249	66,779	4,191	24,054		54
60	LABORATORY	119,499	42,797	134	15,416		60
65	RESPIRATORY THERAPY	35,293	25,294		9,111		65
66	PHYSICAL THERAPY	92,055	150,270	4,075	54,127		66
69	ELECTROCARDIOLOGY	9,992	7,293		2,627		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,677					71
72	IMPL. DEV. CHARGED TO PATIENTS	90,638					72
73	DRUGS CHARGED TO PATIENTS	151,864	22,754		8,196		73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	27,907	31,603		11,383		88
88.01	RHC II	25,555	10,939		3,940		88.01
88.02	RHC III	80,558	51,196		18,441		88.02
90	CLINIC	19,021	37,109	778	13,367	2,610	90
91	EMERGENCY	77,576	36,732	10,053	13,231	1,772	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	67,592	2,516	523	906		95
101	HOME HEALTH AGENCY	36,472	15,485		5,578		101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	74,011	15,582		5,613		116
118	SUBTOTALS (SUM OF LINES 1-117)	1,826,486	1,238,419	106,229	433,036	459,110	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,325	11,158		4,019		190
194	IROQUOIS WOMEN'S HEALTH	163,320	77,159		27,793		194
194.01	OTHER NON-REIMBURSABLE COSTS	22,008	63,533		22,885	37,919	194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	2,014,139	1,390,269	106,229	487,733	497,029	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		11	13	14	16	24	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	259,743					11
13	NURSING ADMINISTRATION	7,949	834,801				13
14	CENTRAL SERVICES & SUPPLY			65,945			14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	12,898			1,054,486		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	32,931	266,428	4,756	63,089	3,879,855	30
43	NURSERY	4,024	32,584		3,723	447,667	43
44	SKILLED NURSING FACILITY	27,773			28,996	2,205,744	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	12,252	99,151	45,947	109,519	2,205,812	50
52	DELIVERY ROOM & LABOR ROOM	2,603	21,037		1,633	280,957	52
53	ANESTHESIOLOGY				4,756	31,190	53
54	RADIOLOGY-DIAGNOSTIC	17,021		1,440	218,384	2,872,417	54
60	LABORATORY	14,885			144,937	2,136,616	60
65	RESPIRATORY THERAPY	7,472	60,452	70	13,535	682,535	65
66	PHYSICAL THERAPY	12,600			49,033	1,747,965	66
69	ELECTROCARDIOLOGY	1,381			20,427	192,139	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				15,939	765,300	71
72	IMPL. DEV. CHARGED TO PATIENTS				36,848	1,491,962	72
73	DRUGS CHARGED TO PATIENTS	7,631			125,000	2,601,631	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	3,587		462	4,973	500,025	88
88.01	RHC II	3,518		218	6,777	435,655	88.01
88.02	RHC III	11,487		1,956	14,840	1,391,206	88.02
90	CLINIC	7,363	59,601	521	2,631	429,346	90
91	EMERGENCY	15,143	122,577	1,276	86,413	1,532,618	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	21,374	172,971		49,204	1,332,620	95
101	HOME HEALTH AGENCY	6,359			7,257	620,208	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	12,997			22,283	1,244,658	116
118	SUBTOTALS (SUM OF LINES 1-117)	243,248	834,801	56,646	1,030,197	29,028,126	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					52,509	190
194	IROQUOIS WOMEN'S HEALTH	12,451		9,299	24,289	2,772,949	194
194.01	OTHER NON-REIMBURSABLE COSTS	4,044				481,707	194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	259,743	834,801	65,945	1,054,486	32,335,291	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT			1
2	CAP REL COSTS-MVBLE EQUIP			2
4	EMPLOYEE BENEFITS DEPARTMENT			4
5.01	ADMISSIONS			5.01
5.02	PURCHASING, RECEIVING, AND STORES			5.02
5.03	DATA PROCESSING			5.03
5.04	COMMUNICATIONS			5.04
5.05	BUSINESS OFFICE			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			5.06
6	MAINTENANCE & REPAIRS			6
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
13	NURSING ADMINISTRATION			13
14	CENTRAL SERVICES & SUPPLY			14
15	PHARMACY			15
16	MEDICAL RECORDS & LIBRARY			16
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS		3,879,855	30
43	NURSERY		447,667	43
44	SKILLED NURSING FACILITY		2,205,744	44
	ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM		2,205,812	50
52	DELIVERY ROOM & LABOR ROOM		280,957	52
53	ANESTHESIOLOGY		31,190	53
54	RADIOLOGY-DIAGNOSTIC		2,872,417	54
60	LABORATORY		2,136,616	60
65	RESPIRATORY THERAPY		682,535	65
66	PHYSICAL THERAPY		1,747,965	66
69	ELECTROCARDIOLOGY		192,139	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		765,300	71
72	IMPL. DEV. CHARGED TO PATIENTS		1,491,962	72
73	DRUGS CHARGED TO PATIENTS		2,601,631	73
74	RENAL DIALYSIS			74
	OUTPATIENT SERVICE COST CENTERS			
88	RURAL HEALTH CLINIC		500,025	88
88.01	RHC II		435,655	88.01
88.02	RHC III		1,391,206	88.02
90	CLINIC		429,346	90
91	EMERGENCY		1,532,618	91
92	OBSERVATION BEDS (NON-DISTINCT PART)			92
	OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS			94
95	AMBULANCE SERVICES		1,332,620	95
101	HOME HEALTH AGENCY		620,208	101
	SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE			113
116	HOSPICE		1,244,658	116
118	SUBTOTALS (SUM OF LINES 1-117)		29,028,126	118
	NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		52,509	190
194	IROQUOIS WOMEN'S HEALTH		2,772,949	194
194.01	OTHER NON-REIMBURSABLE COSTS		481,707	194.01
194.03	WELLNESS			194.03
194.04	RENTED SPACE			194.04
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	TOTAL (SUM OF LINES 118-201)		32,335,291	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 DEPARTMENT 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT		4,267		4,267	4,267	4
5.01	ADMISSIONS	4,753	8,928		13,681	89	5.01
5.02	PURCHASING, RECEIVING, AND STORES	726	11,608		12,334	32	5.02
5.03	DATA PROCESSING	3,006	4,329	92,105	99,440	59	5.03
5.04	COMMUNICATIONS		2,834	2,574	5,408		5.04
5.05	BUSINESS OFFICE	14,187	9,927	774	24,888	78	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,753	35,691	2,937	40,381	162	5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	78	103,060	15,030	118,168	71	7
8	LAUNDRY & LINEN SERVICE		17,888		17,888	11	8
9	HOUSEKEEPING		5,181		5,181	81	9
10	DIETARY	1,581	24,269	4,057	29,907	49	10
11	CAFETERIA	1,487	8,053		9,540	46	11
13	NURSING ADMINISTRATION	8,449	13,776	152	22,377	155	13
14	CENTRAL SERVICES & SUPPLY		11,654	9,492	21,146		14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	3,991	13,280	2,076	19,347	140	16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	27,611	157,871	70,233	255,715	455	30
43	NURSERY	936	4,344	5,037	10,317	56	43
44	SKILLED NURSING FACILITY	1,624	74,455	25,746	101,825	262	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	11,445	126,663	185,577	323,685	182	50
52	DELIVERY ROOM & LABOR ROOM	605	1,735		2,340	36	52
53	ANESTHESIOLOGY		852	16,865	17,717		53
54	RADIOLOGY-DIAGNOSTIC	171,985	42,544	338,116	552,645	222	54
60	LABORATORY	26,778	27,265	53,799	107,842	171	60
65	RESPIRATORY THERAPY	29,618	16,115	14,126	59,859	93	65
66	PHYSICAL THERAPY	5,124	95,735	14,617	115,476	129	66
69	ELECTROCARDIOLOGY	1,483	4,646	1,763	7,892	15	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS	5,751	14,496	22,104	42,351	130	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	1,121	20,134	513	21,768	61	88
88.01	RHC II	1,375	6,969	305	8,649	57	88.01
88.02	RHC III	4,851	32,616	6,811	44,278	216	88.02
90	CLINIC	1,386	23,641	1,338	26,365	100	90
91	EMERGENCY	4,965	23,401	18,826	47,192	215	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	27,264	1,603	31,040	59,907	183	95
101	HOME HEALTH AGENCY	5,729	9,865	470	16,064	102	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	80,719	9,927	684	91,330	186	116
118	SUBTOTALS (SUM OF LINES 1-117)	450,381	969,622	937,167	2,357,170	3,844	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		7,109		7,109		190
194	IROQUOIS WOMEN'S HEALTH	30,641	49,157	4,139	83,937	382	194
194.01	OTHER NON-REIMBURSABLE COSTS		40,476	677	41,153	41	194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	481,022	1,066,364	941,983	2,489,369	4,267	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	ADMITTING	PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	
		5.01	5.02	5.03	5.04	5.05	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMISSIONS	13,770					5.01
5.02	PURCHASING, RECEIVING, AND STORES		12,366				5.02
5.03	DATA PROCESSING		7	99,506			5.03
5.04	COMMUNICATIONS				5,408		5.04
5.05	BUSINESS OFFICE		16	2,901		27,883	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		34	2,143	295		5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		216	2,369	154		7
8	LAUNDRY & LINEN SERVICE		19	540	13		8
9	HOUSEKEEPING		141	4,408	26		9
10	DIETARY		106	2,436	64		10
11	CAFETERIA		100	2,294	26		11
13	NURSING ADMINISTRATION		11	2,523	141		13
14	CENTRAL SERVICES & SUPPLY		75		13		14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY		29	4,093	410		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	893	328	10,445	1,239	1,808	30
43	NURSERY	53		1,278	13	107	43
44	SKILLED NURSING FACILITY	410	195	8,813	141	831	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,550	96	3,888	436	3,139	50
52	DELIVERY ROOM & LABOR ROOM	23		825	26	47	52
53	ANESTHESIOLOGY	67	52			136	53
54	RADIOLOGY-DIAGNOSTIC	3,072	519	5,400	282	6,227	54
60	LABORATORY	2,052	1,356	4,724	205	4,154	60
65	RESPIRATORY THERAPY	192	263	2,370	90	388	65
66	PHYSICAL THERAPY	694	28	3,999	218	1,405	66
69	ELECTROCARDIOLOGY	289		437	51	585	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	226	1,735			457	71
72	IMPL. DEV. CHARGED TO PATIENTS	522	6,209			1,056	72
73	DRUGS CHARGED TO PATIENTS	1,770	27	2,421	103	3,582	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC		21	1,137	77		88
88.01	RHC II		22	1,117	64		88.01
88.02	RHC III		56	3,644	90		88.02
90	CLINIC	37	42	2,337	192	75	90
91	EMERGENCY	1,223	180	4,806	205	2,476	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	697	57	6,782	26	1,410	95
101	HOME HEALTH AGENCY		27	2,018	103		101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE		246	4,124	179		116
118	SUBTOTALS (SUM OF LINES 1-117)	13,770	12,213	94,272	4,882	27,883	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3		26		190
194	IROQUOIS WOMEN'S HEALTH		80	3,952	500		194
194.01	OTHER NON-REIMBURSABLE COSTS		70	1,282			194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	13,770	12,366	99,506	5,408	27,883	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	OTHER ADMINISTRATIVE AND GENER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.06	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	43,015					5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	1,850	122,828				7
8	LAUNDRY & LINEN SERVICE	104	2,481	21,056			8
9	HOUSEKEEPING	632	718	895	12,082		9
10	DIETARY	591	3,365	197	340	37,055	10
11	CAFETERIA	323	1,117		113		11
13	NURSING ADMINISTRATION	1,061	1,910		193		13
14	CENTRAL SERVICES & SUPPLY	55	1,616	5	163		14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	1,348	1,842		186		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	4,030	21,895	4,736	2,210	8,652	30
43	NURSERY	529	602	73	61		43
44	SKILLED NURSING FACILITY	2,138	10,325	8,966	1,043	25,176	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,204	17,565	2,267	1,774	73	50
52	DELIVERY ROOM & LABOR ROOM	335	241		24		52
53	ANESTHESIOLOGY	33	118		12		53
54	RADIOLOGY-DIAGNOSTIC	3,380	5,900	831	596		54
60	LABORATORY	2,553	3,781	27	382		60
65	RESPIRATORY THERAPY	754	2,235		226		65
66	PHYSICAL THERAPY	1,966	13,276	808	1,341		66
69	ELECTROCARDIOLOGY	213	644		65		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	997					71
72	IMPL. DEV. CHARGED TO PATIENTS	1,936					72
73	DRUGS CHARGED TO PATIENTS	3,244	2,010		203		73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	596	2,792		282		88
88.01	RHC II	546	966		98		88.01
88.02	RHC III	1,721	4,523		457		88.02
90	CLINIC	406	3,278	154	331	195	90
91	EMERGENCY	1,657	3,245	1,993	328	132	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	1,444	222	104	22		95
101	HOME HEALTH AGENCY	779	1,368		138		101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	1,581	1,377		139		116
118	SUBTOTALS (SUM OF LINES 1-117)	39,006	109,412	21,056	10,727	34,228	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50	986		100		190
194	IROQUOIS WOMEN'S HEALTH	3,489	6,817		688		194
194.01	OTHER NON-REIMBURSABLE COSTS	470	5,613		567	2,827	194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	43,015	122,828	21,056	12,082	37,055	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		11	13	14	16	24	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	13,559					11
13	NURSING ADMINISTRATION	415	28,786				13
14	CENTRAL SERVICES & SUPPLY			23,073			14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	673			28,068		16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,718	9,187	1,664	1,677	326,652	30
43	NURSERY	210	1,124		99	14,522	43
44	SKILLED NURSING FACILITY	1,450			771	162,346	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	640	3,419	16,078	2,912	379,908	50
52	DELIVERY ROOM & LABOR ROOM	136	725		43	4,801	52
53	ANESTHESIOLOGY				126	18,261	53
54	RADIOLOGY-DIAGNOSTIC	889		504	5,840	586,307	54
60	LABORATORY	777			3,853	131,877	60
65	RESPIRATORY THERAPY	390	2,085	24	360	69,329	65
66	PHYSICAL THERAPY	658			1,304	141,302	66
69	ELECTROCARDIOLOGY	72			543	10,806	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				424	3,839	71
72	IMPL. DEV. CHARGED TO PATIENTS				980	10,703	72
73	DRUGS CHARGED TO PATIENTS	398			3,323	59,562	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	187		162	132	27,215	88
88.01	RHC II	184		76	180	11,959	88.01
88.02	RHC III	600		684	395	56,664	88.02
90	CLINIC	384	2,055	182	70	36,203	90
91	EMERGENCY	791	4,227	446	2,297	71,413	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	1,116	5,964		1,308	79,242	95
101	HOME HEALTH AGENCY	332			193	21,124	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	678			592	100,432	116
118	SUBTOTALS (SUM OF LINES 1-117)	12,698	28,786	19,820	27,422	2,324,467	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					8,274	190
194	IROQUOIS WOMEN'S HEALTH	650		3,253	646	104,394	194
194.01	OTHER NON-REIMBURSABLE COSTS	211				52,234	194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	13,559	28,786	23,073	28,068	2,489,369	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT			1
2	CAP REL COSTS-MVBLE EQUIP			2
4	EMPLOYEE BENEFITS DEPARTMENT			4
5.01	ADMISSIONS			5.01
5.02	PURCHASING, RECEIVING, AND STORES			5.02
5.03	DATA PROCESSING			5.03
5.04	COMMUNICATIONS			5.04
5.05	BUSINESS OFFICE			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			5.06
6	MAINTENANCE & REPAIRS			6
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
13	NURSING ADMINISTRATION			13
14	CENTRAL SERVICES & SUPPLY			14
15	PHARMACY			15
16	MEDICAL RECORDS & LIBRARY			16
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS		326,652	30
43	NURSERY		14,522	43
44	SKILLED NURSING FACILITY		162,346	44
	ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM		379,908	50
52	DELIVERY ROOM & LABOR ROOM		4,801	52
53	ANESTHESIOLOGY		18,261	53
54	RADIOLOGY-DIAGNOSTIC		586,307	54
60	LABORATORY		131,877	60
65	RESPIRATORY THERAPY		69,329	65
66	PHYSICAL THERAPY		141,302	66
69	ELECTROCARDIOLOGY		10,806	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		3,839	71
72	IMPL. DEV. CHARGED TO PATIENTS		10,703	72
73	DRUGS CHARGED TO PATIENTS		59,562	73
74	RENAL DIALYSIS			74
	OUTPATIENT SERVICE COST CENTERS			
88	RURAL HEALTH CLINIC		27,215	88
88.01	RHC II		11,959	88.01
88.02	RHC III		56,664	88.02
90	CLINIC		36,203	90
91	EMERGENCY		71,413	91
92	OBSERVATION BEDS (NON-DISTINCT PART)			92
	OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS			94
95	AMBULANCE SERVICES		79,242	95
101	HOME HEALTH AGENCY		21,124	101
	SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE			113
116	HOSPICE		100,432	116
118	SUBTOTALS (SUM OF LINES 1-117)		2,324,467	118
	NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		8,274	190
194	IROQUOIS WOMEN'S HEALTH		104,394	194
194.01	OTHER NON-REIMBURSABLE COSTS		52,234	194.01
194.03	WELLNESS			194.03
194.04	RENTED SPACE			194.04
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	TOTAL (SUM OF LINES 118-201)		2,489,369	202

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL 4	ADMITTING GROSS CHARGES 5.01	PURCHASING RECEIVING AND STORES COST REQ'S 5.02	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	137,708					1
2	CAP REL COSTS-MVBLE EQUIP		865,192				2
4	EMPLOYEE BENEFITS DEPARTMENT	551		15,774,266			4
5.01	ADMISSIONS	1,153		329,216	67,263,368		5.01
5.02	PURCHASING, RECEIVING, AND STORES	1,499		116,333		2,814,182	5.02
5.03	DATA PROCESSING	559	84,597	217,155		1,561	5.03
5.04	COMMUNICATIONS	366	2,364				5.04
5.05	BUSINESS OFFICE	1,282	711	289,463		3,562	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	4,609	2,698	596,762		7,737	5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	13,309	13,805	263,663		49,210	7
8	LAUNDRY & LINEN SERVICE	2,310		38,762		4,404	8
9	HOUSEKEEPING	669		298,990		32,018	9
10	DIETARY	3,134	3,726	181,645		24,066	10
11	CAFETERIA	1,040		171,031		22,665	11
13	NURSING ADMINISTRATION	1,779	140	573,503		2,467	13
14	CENTRAL SERVICES & SUPPLY	1,505	8,718			17,008	14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	1,715	1,907	517,373		6,545	16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	20,387	64,508	1,693,273	4,356,682	74,633	30
43	NURSERY	561	4,626	208,450	257,098		43
44	SKILLED NURSING FACILITY	9,615	23,647	965,645	2,002,335	44,286	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	16,357	170,449	670,788	7,562,956	21,946	50
52	DELIVERY ROOM & LABOR ROOM	224		134,601	112,757		52
53	ANESTHESIOLOGY	110	15,490		328,406	11,918	53
54	RADIOLOGY-DIAGNOSTIC	5,494	310,552	819,881	15,078,921	118,108	54
60	LABORATORY	3,521	49,413	632,494	10,008,769	308,518	60
65	RESPIRATORY THERAPY	2,081	12,974	344,983	934,680	59,856	65
66	PHYSICAL THERAPY	12,363	13,425	476,181	3,386,010	6,479	66
69	ELECTROCARDIOLOGY	600	1,619	54,206	1,410,630		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				1,100,681	394,751	71
72	IMPL. DEV. CHARGED TO PATIENTS				2,544,589	1,413,368	72
73	DRUGS CHARGED TO PATIENTS	1,872	20,302	480,850	8,631,972	6,192	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	2,600	471	226,178		4,765	88
88.01	RHC II	900	280	211,618		4,965	88.01
88.02	RHC III	4,212	6,256	796,844		12,806	88.02
90	CLINIC	3,053	1,229	370,195	181,686	9,525	90
91	EMERGENCY	3,022	17,291	794,298	5,967,338	41,018	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	207	28,510	673,754	3,397,858	13,073	95
101	HOME HEALTH AGENCY	1,274	432	377,388		6,106	101
	SPECIAL PURPOSE COST CENTERS						
116	HOSPICE	1,282	628	686,092		55,880	116
118	SUBTOTALS (SUM OF LINES 1-117)	125,215	860,768	14,211,615	67,263,368	2,779,436	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918				607	190
194	IROQUOIS WOMEN'S HEALTH	6,348	3,802	1,410,187		18,111	194
194.01	OTHER NON-REIMBURSABLE COSTS	5,227	622	152,464		16,028	194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,066,364	941,983	1,942,497	572,347	184,194	202
203	UNIT COST MULT-WS B PT I	7.743660	1.088756	0.123143	0.008509	0.065452	203
204	COST TO BE ALLOC PER B PT II			4,267	13,770	12,366	204
205	UNIT COST MULT-WS B PT II			0.000271	0.000205	0.004394	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	DATA PROCESSING TIME SPENT 5.03	COMMUNICATIONS # OF PHONES 5.04	BUSINESS OFFICE GROSS CHARGES 5.05	RECON-CILIATION 5A.06	OTHER ADMINISTRATIVE AND GENER ACCUM COST 5.06	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING	656,499					5.03
5.04	COMMUNICATIONS		422				5.04
5.05	BUSINESS OFFICE	19,141		67,263,368			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	14,141	23		-2,014,139	30,321,152	5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	15,627	12			1,303,670	7
8	LAUNDRY & LINEN SERVICE	3,563	1			73,283	8
9	HOUSEKEEPING	29,080	2			445,492	9
10	DIETARY	16,070	5			416,551	10
11	CAFETERIA	15,133	2			227,441	11
13	NURSING ADMINISTRATION	16,646	11			747,768	13
14	CENTRAL SERVICES & SUPPLY		1			38,482	14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	27,005	32			950,119	16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	68,921	97	4,356,682		2,846,564	30
43	NURSERY	8,429	1	257,098		372,920	43
44	SKILLED NURSING FACILITY	58,144	11	2,002,335		1,506,967	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	25,649	34	7,562,956		1,552,942	50
52	DELIVERY ROOM & LABOR ROOM	5,442	2	112,757		236,284	52
53	ANESTHESIOLOGY			328,406		23,082	53
54	RADIOLOGY-DIAGNOSTIC	35,628	22	15,078,921		2,382,299	54
60	LABORATORY	31,165	16	10,008,769		1,798,948	60
65	RESPIRATORY THERAPY	15,638	7	934,680		531,308	65
66	PHYSICAL THERAPY	26,384	17	3,386,010		1,385,805	66
69	ELECTROCARDIOLOGY	2,883	4	1,410,630		150,419	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			1,100,681		702,684	71
72	IMPL. DEV. CHARGED TO PATIENTS			2,544,589		1,364,476	72
73	DRUGS CHARGED TO PATIENTS	15,973	8	8,631,972		2,286,186	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	7,501	6			420,110	88
88.01	RHC II	7,371	5			384,708	88.01
88.02	RHC III	24,040	7			1,212,728	88.02
90	CLINIC	15,418	15	181,686		286,345	90
91	EMERGENCY	31,709	16	5,967,338		1,167,845	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	44,745	2	3,397,858		1,017,534	95
101	HOME HEALTH AGENCY	13,315	8			549,057	101
	SPECIAL PURPOSE COST CENTERS						
116	HOSPICE	27,207	14			1,114,172	116
118	SUBTOTALS (SUM OF LINES 1-117)	621,968	381	67,263,368	-2,014,139	27,496,189	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		2			35,007	190
194	IROQUOIS WOMEN'S HEALTH	26,072	39			2,458,638	194
194.01	OTHER NON-REIMBURSABLE COSTS	8,459				331,318	194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	794,504	162,648	333,752		2,014,139	202
203	UNIT COST MULT-WS B PT I	1.210214	385.421801	0.004962		0.066427	203
204	COST TO BE ALLOC PER B PT II	99,506	5,408	27,883		43,015	204
205	UNIT COST MULT-WS B PT II	0.151571	12.815166	0.000415		0.001419	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS	SQUARE FEET	MEALS	FTE'S	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STORES						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	114,380					7
8	LAUNDRY & LINEN SERVICE	2,310	361,330				8
9	HOUSEKEEPING	669	15,360	111,401			9
10	DIETARY	3,134	3,380	3,134	47,410		10
11	CAFETERIA	1,040		1,040		26,140	11
13	NURSING ADMINISTRATION	1,779		1,779		800	13
14	CENTRAL SERVICES & SUPPLY	1,505	85	1,505			14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	1,715		1,715		1,298	16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	20,387	81,265	20,387	11,070	3,314	30
43	NURSERY	561	1,255	561		405	43
44	SKILLED NURSING FACILITY	9,615	153,885	9,615	32,212	2,795	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	16,357	38,910	16,357	93	1,233	50
52	DELIVERY ROOM & LABOR ROOM	224		224		262	52
53	ANESTHESIOLOGY	110		110			53
54	RADIOLOGY-DIAGNOSTIC	5,494	14,255	5,494		1,713	54
60	LABORATORY	3,521	455	3,521		1,498	60
65	RESPIRATORY THERAPY	2,081		2,081		752	65
66	PHYSICAL THERAPY	12,363	13,860	12,363		1,268	66
69	ELECTROCARDIOLOGY	600		600		139	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS	1,872		1,872		768	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	2,600		2,600		361	88
88.01	RHC II	900		900		354	88.01
88.02	RHC III	4,212		4,212		1,156	88.02
90	CLINIC	3,053	2,645	3,053	249	741	90
91	EMERGENCY	3,022	34,195	3,022	169	1,524	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	207	1,780	207		2,151	95
101	HOME HEALTH AGENCY	1,274		1,274		640	101
	SPECIAL PURPOSE COST CENTERS						
116	HOSPICE	1,282		1,282		1,308	116
118	SUBTOTALS (SUM OF LINES 1-117)	101,887	361,330	98,908	43,793	24,480	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918		918			190
194	IROQUOIS WOMEN'S HEALTH	6,348		6,348		1,253	194
194.01	OTHER NON-REIMBURSABLE COSTS	5,227		5,227	3,617	407	194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,390,269	106,229	487,733	497,029	259,743	202
203	UNIT COST MULT-WS B PT I	12.154826	0.293994	4.378174	10.483632	9.936611	203
204	COST TO BE ALLOC PER B PT II	122,828	21,056	12,082	37,055	13,559	204
205	UNIT COST MULT-WS B PT II	1.073859	0.058274	0.108455	0.781586	0.518707	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINIS-TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY CSS CSTED REQ' 14	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
	GENERAL SERVICE COST CENTERS				
1	CAP REL COSTS-BLDG & FIXT				1
2	CAP REL COSTS-MVBLE EQUIP				2
4	EMPLOYEE BENEFITS DEPARTMENT				4
5.01	ADMISSIONS				5.01
5.02	PURCHASING, RECEIVING, AND STORES				5.02
5.03	DATA PROCESSING				5.03
5.04	COMMUNICATIONS				5.04
5.05	BUSINESS OFFICE				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL				5.06
6	MAINTENANCE & REPAIRS				6
7	OPERATION OF PLANT				7
8	LAUNDRY & LINEN SERVICE				8
9	HOUSEKEEPING				9
10	DIETARY				10
11	CAFETERIA				11
13	NURSING ADMINISTRATION	215,951			13
14	CENTRAL SERVICES & SUPPLY		13,283		14
15	PHARMACY				15
16	MEDICAL RECORDS & LIBRARY			72,816,750	16
	INPATIENT ROUTINE SERV COST CENTERS				
30	ADULTS & PEDIATRICS	68,921	958	4,356,682	30
43	NURSERY	8,429		257,098	43
44	SKILLED NURSING FACILITY			2,002,335	44
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	25,649	9,255	7,562,956	50
52	DELIVERY ROOM & LABOR ROOM	5,442		112,757	52
53	ANESTHESIOLOGY			328,406	53
54	RADIOLOGY-DIAGNOSTIC		290	15,078,921	54
60	LABORATORY			10,008,769	60
65	RESPIRATORY THERAPY	15,638	14	934,680	65
66	PHYSICAL THERAPY			3,386,010	66
69	ELECTROCARDIOLOGY			1,410,630	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			1,100,681	71
72	IMPL. DEV. CHARGED TO PATIENTS			2,544,589	72
73	DRUGS CHARGED TO PATIENTS			8,631,972	73
74	RENAL DIALYSIS				74
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC		93	343,412	88
88.01	RHC II		44	467,961	88.01
88.02	RHC III		394	1,024,808	88.02
90	CLINIC	15,418	105	181,686	90
91	EMERGENCY	31,709	257	5,967,338	91
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
95	AMBULANCE SERVICES	44,745		3,397,858	95
101	HOME HEALTH AGENCY			501,124	101
	SPECIAL PURPOSE COST CENTERS				
116	HOSPICE			1,538,794	116
118	SUBTOTALS (SUM OF LINES 1-117)	215,951	11,410	71,139,467	118
	NONREIMBURSABLE COST CENTERS				
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
194	IROQUOIS WOMEN'S HEALTH		1,873	1,677,283	194
194.01	OTHER NON-REIMBURSABLE COSTS				194.01
194.03	WELLNESS				194.03
194.04	RENTED SPACE				194.04
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	COST TO BE ALLOC PER B PT I	834,801	65,945	1,054,486	202
203	UNIT COST MULT-WS B PT I	3.865696	4.964616	0.014481	203
204	COST TO BE ALLOC PER B PT II	28,786	23,073	28,068	204
205	UNIT COST MULT-WS B PT II	0.133299	1.737032	0.000385	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	3,879,855		3,879,855		3,879,855	30
43	NURSERY	447,667		447,667		447,667	43
44	SKILLED NURSING FACILITY	2,205,744		2,205,744		2,205,744	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,205,812		2,205,812		2,205,812	50
52	DELIVERY ROOM & LABOR ROOM	280,957		280,957		280,957	52
53	ANESTHESIOLOGY	31,190		31,190		31,190	53
54	RADIOLOGY-DIAGNOSTIC	2,872,417		2,872,417		2,872,417	54
60	LABORATORY	2,136,616		2,136,616		2,136,616	60
65	RESPIRATORY THERAPY	682,535		682,535		682,535	65
66	PHYSICAL THERAPY	1,747,965		1,747,965		1,747,965	66
69	ELECTROCARDIOLOGY	192,139		192,139		192,139	69
71	MEDICAL SUPPLIES CHARGED TO	765,300		765,300		765,300	71
72	IMPL. DEV. CHARGED TO PATIE	1,491,962		1,491,962		1,491,962	72
73	DRUGS CHARGED TO PATIENTS	2,601,631		2,601,631		2,601,631	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	500,025		500,025		500,025	88
88.01	RHC II	435,655		435,655		435,655	88.01
88.02	RHC III	1,391,206		1,391,206		1,391,206	88.02
90	CLINIC	429,346		429,346		429,346	90
91	EMERGENCY	1,532,618		1,532,618		1,532,618	91
92	OBSERVATION BEDS (NON-DISTI	1,034,555		1,034,555		1,034,555	92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	1,332,620		1,332,620		1,332,620	95
101	HOME HEALTH AGENCY	620,208		620,208		620,208	101
113	INTEREST EXPENSE						113
116	HOSPICE	1,244,658		1,244,658		1,244,658	116
200	SUBTOTAL (SEE INSTRUCTIONS)	30,062,681		30,062,681		30,062,681	200
201	LESS OBSERVATION BEDS	1,034,555		1,034,555		1,034,555	201
202	TOTAL (SEE INSTRUCTIONS)	29,028,126		29,028,126		29,028,126	202

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	CHARGES TOTAL (COLS. 6 + 7) 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,578,483		2,578,483				30
43	NURSERY	257,098		257,098				43
44	SKILLED NURSING FACILITY	2,002,335		2,002,335				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,691,776	5,871,180	7,562,956	0.291660	0.291660	0.291660	50
52	DELIVERY ROOM & LABOR ROOM	112,757		112,757	2.491703	2.491703	2.491703	52
53	ANESTHESIOLOGY	96,305	232,101	328,406	0.094974	0.094974	0.094974	53
54	RADIOLOGY-DIAGNOSTIC	1,830,801	13,248,120	15,078,921	0.190492	0.190492	0.190492	54
60	LABORATORY	1,500,606	8,508,163	10,008,769	0.213474	0.213474	0.213474	60
65	RESPIRATORY THERAPY	308,570	626,110	934,680	0.730234	0.730234	0.730234	65
66	PHYSICAL THERAPY	673,946	2,712,064	3,386,010	0.516231	0.516231	0.516231	66
69	ELECTROCARDIOLOGY	392,391	1,018,239	1,410,630	0.136208	0.136208	0.136208	69
71	MEDICAL SUPPLIES CHARGED TO	549,296	551,385	1,100,681	0.695297	0.695297	0.695297	71
72	IMPL. DEV. CHARGED TO PATIE	1,015,577	1,529,012	2,544,589	0.586327	0.586327	0.586327	72
73	DRUGS CHARGED TO PATIENTS	2,631,207	6,000,765	8,631,972	0.301395	0.301395	0.301395	73
74	RENAL DIALYSIS							74
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		343,412	343,412				88
88.01	RHC II		467,961	467,961				88.01
88.02	RHC III		1,024,808	1,024,808				88.02
90	CLINIC	691	180,995	181,686	2.363121	2.363121	2.363121	90
91	EMERGENCY	643,381	5,323,957	5,967,338	0.256834	0.256834	0.256834	91
92	OBSERVATION BEDS (NON-DISTI	349,764	1,428,435	1,778,199	0.581799	0.581799	0.581799	92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
95	AMBULANCE SERVICES	346	3,397,512	3,397,858	0.392194	0.392194	0.392194	95
101	HOME HEALTH AGENCY		501,124	501,124				101
113	INTEREST EXPENSE							113
116	HOSPICE		1,538,794	1,538,794				116
200	SUBTOTAL (SEE INSTRUCTIONS)	16,635,330	54,504,137	71,139,467				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	16,635,330	54,504,137	71,139,467				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	326,652		326,652	3,589	91.01	1,762	160,360	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	14,522		14,522	207	70.15			43
44	SKILLED NURSING FACILITY	162,346		162,346	11,210	14.48	1,736	25,137	44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	503,520		503,520	15,006		3,498	185,497	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	379,908	7,562,956	0.050233	846,413	42,518	50
52	DELIVERY ROOM & LABOR ROOM	4,801	112,757	0.042578			52
53	ANESTHESIOLOGY	18,261	328,406	0.055605	44,703	2,486	53
54	RADIOLOGY-DIAGNOSTIC	586,307	15,078,921	0.038883	1,237,134	48,103	54
60	LABORATORY	131,877	10,008,769	0.013176	1,077,450	14,196	60
65	RESPIRATORY THERAPY	69,329	934,680	0.074174	222,237	16,484	65
66	PHYSICAL THERAPY	141,302	3,386,010	0.041731	130,396	5,442	66
69	ELECTROCARDIOLOGY	10,806	1,410,630	0.007660	364,897	2,795	69
71	MEDICAL SUPPLIES CHARGED TO P	3,839	1,100,681	0.003488	375,469	1,310	71
72	IMPL. DEV. CHARGED TO PATIENT	10,703	2,544,589	0.004206	744,289	3,130	72
73	DRUGS CHARGED TO PATIENTS	59,562	8,631,972	0.006900	1,627,059	11,227	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	27,215	343,412	0.079249			88
88.01	RHC II	11,959	467,961	0.025556			88.01
88.02	RHC III	56,664	1,024,808	0.055292			88.02
90	CLINIC	36,203	181,686	0.199261	451	90	90
91	EMERGENCY	71,413	5,967,338	0.011967	507,075	6,068	91
92	OBSERVATION BEDS (NON-DISTINC	87,101	1,778,199	0.048983	234,574	11,490	92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	1,707,250	60,863,775		7,412,147	165,339	200

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

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

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

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

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	3,589		1,762		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	207				43
44	SKILLED NURSING FACILITY	11,210		1,736		44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	15,006		3,498		200

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

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

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO P							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINC							92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
95	AMBULANCE SERVICES							95
200	TOTAL (SUM OF LINES 50-199)							200

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

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

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	7,562,956			846,413		2,548,088		50
52	DELIVERY ROOM & LABOR ROOM	112,757							52
53	ANESTHESIOLOGY	328,406			44,703		75,139		53
54	RADIOLOGY-DIAGNOSTIC	15,078,921			1,237,134		6,048,539		54
60	LABORATORY	10,008,769			1,077,450		229,136		60
65	RESPIRATORY THERAPY	934,680			222,237		228,792		65
66	PHYSICAL THERAPY	3,386,010			130,396				66
69	ELECTROCARDIOLOGY	1,410,630			364,897		431,813		69
71	MEDICAL SUPPLIES CHARGED TO	1,100,681			375,469		337,822		71
72	IMPL. DEV. CHARGED TO PATIEN	2,544,589			744,289		1,012,715		72
73	DRUGS CHARGED TO PATIENTS	8,631,972			1,627,059		3,063,010		73
74	RENAL DIALYSIS								74
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC	343,412							88
88.01	RHC II	467,961							88.01
88.02	RHC III	1,024,808							88.02
90	CLINIC	181,686			451		6,171		90
91	EMERGENCY	5,967,338			507,075		1,584,641		91
92	OBSERVATION BEDS (NON-DISTIN	1,778,199			234,574		948,573		92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
95	AMBULANCE SERVICES								95
200	TOTAL (SUM OF LINES 50-199)	60,863,775			7,412,147		16,514,439		200

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

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

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.291660	2,548,088			743,175			50
52	DELIVERY ROOM & LABOR ROOM	2.491703							52
53	ANESTHESIOLOGY	0.094974	75,139			7,136			53
54	RADIOLOGY-DIAGNOSTIC	0.190492	6,048,539			1,152,198			54
60	LABORATORY	0.213474	229,136			48,915			60
65	RESPIRATORY THERAPY	0.730234	228,792			167,072			65
66	PHYSICAL THERAPY	0.516231							66
69	ELECTROCARDIOLOGY	0.136208	431,813			58,816			69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.695297	337,822			234,887			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.586327	1,012,715			593,782			72
73	DRUGS CHARGED TO PATIENTS	0.301395	3,063,010	4,128		923,176	1,244		73
74	RENAL DIALYSIS								74
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	2.363121	6,171			14,583			90
91	EMERGENCY	0.256834	1,584,641			406,990			91
92	OBSERVATION BEDS (NON-DISTINCT	0.581799	948,573			551,879			92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
95	AMBULANCE SERVICES	0.392194							95
200	SUBTOTAL (SEE INSTRUCTIONS)		16,514,439	4,128		4,902,609	1,244		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)		16,514,439	4,128		4,902,609	1,244		202

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

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B-SNF (14-U167)
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.291660							50
52	DELIVERY ROOM & LABOR ROOM	2.491703							52
53	ANESTHESIOLOGY	0.094974							53
54	RADIOLOGY-DIAGNOSTIC	0.190492							54
60	LABORATORY	0.213474							60
65	RESPIRATORY THERAPY	0.730234							65
66	PHYSICAL THERAPY	0.516231							66
69	ELECTROCARDIOLOGY	0.136208							69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.695297							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.586327							72
73	DRUGS CHARGED TO PATIENTS	0.301395							73
74	RENAL DIALYSIS								74
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	2.363121							90
91	EMERGENCY	0.256834							91
92	OBSERVATION BEDS (NON-DISTINCT	0.581799							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
95	AMBULANCE SERVICES	0.392194							95
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

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

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

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO P							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINC							92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
95	AMBULANCE SERVICES							95
200	TOTAL (SUM OF LINES 50-199)							200

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

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

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	7,562,956							50
52	DELIVERY ROOM & LABOR ROOM	112,757							52
53	ANESTHESIOLOGY	328,406							53
54	RADIOLOGY-DIAGNOSTIC	15,078,921			14,982				54
60	LABORATORY	10,008,769			38,768				60
65	RESPIRATORY THERAPY	934,680			56				65
66	PHYSICAL THERAPY	3,386,010			506,502				66
69	ELECTROCARDIOLOGY	1,410,630			427				69
71	MEDICAL SUPPLIES CHARGED TO	1,100,681			5,930				71
72	IMPL. DEV. CHARGED TO PATIEN	2,544,589							72
73	DRUGS CHARGED TO PATIENTS	8,631,972			66,982				73
74	RENAL DIALYSIS								74
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC	343,412							88
88.01	RHC II	467,961							88.01
88.02	RHC III	1,024,808							88.02
90	CLINIC	181,686							90
91	EMERGENCY	5,967,338							91
92	OBSERVATION BEDS (NON-DISTIN	1,778,199			2,819				92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
95	AMBULANCE SERVICES								95
200	TOTAL (SUM OF LINES 50-199)	60,863,775			636,466				200

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

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

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.291660							50
52	DELIVERY ROOM & LABOR ROOM	2.491703							52
53	ANESTHESIOLOGY	0.094974							53
54	RADIOLOGY-DIAGNOSTIC	0.190492							54
60	LABORATORY	0.213474							60
65	RESPIRATORY THERAPY	0.730234							65
66	PHYSICAL THERAPY	0.516231							66
69	ELECTROCARDIOLOGY	0.136208							69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.695297							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.586327							72
73	DRUGS CHARGED TO PATIENTS	0.301395							73
74	RENAL DIALYSIS								74
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	2.363121							90
91	EMERGENCY	0.256834							91
92	OBSERVATION BEDS (NON-DISTINCT	0.581799							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
95	AMBULANCE SERVICES	0.392194							95
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	326,652		326,652	3,589	91.01	337	30,670	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	14,522		14,522	207	70.15	159	11,154	43
44	SKILLED NURSING FACILITY	162,346		162,346	11,210	14.48			44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	503,520		503,520	15,006		496	41,824	200

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

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	379,908	7,562,956	0.050233			50
52	DELIVERY ROOM & LABOR ROOM	4,801	112,757	0.042578			52
53	ANESTHESIOLOGY	18,261	328,406	0.055605			53
54	RADIOLOGY-DIAGNOSTIC	586,307	15,078,921	0.038883			54
60	LABORATORY	131,877	10,008,769	0.013176			60
65	RESPIRATORY THERAPY	69,329	934,680	0.074174			65
66	PHYSICAL THERAPY	141,302	3,386,010	0.041731			66
69	ELECTROCARDIOLOGY	10,806	1,410,630	0.007660			69
71	MEDICAL SUPPLIES CHARGED TO P	3,839	1,100,681	0.003488			71
72	IMPL. DEV. CHARGED TO PATIENT	10,703	2,544,589	0.004206			72
73	DRUGS CHARGED TO PATIENTS	59,562	8,631,972	0.006900			73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	27,215	343,412	0.079249			88
88.01	RHC II	11,959	467,961	0.025556			88.01
88.02	RHC III	56,664	1,024,808	0.055292			88.02
90	CLINIC	36,203	181,686	0.199261			90
91	EMERGENCY	71,413	5,967,338	0.011967			91
92	OBSERVATION BEDS (NON-DISTINC	87,101	1,778,199	0.048983			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	1,707,250	60,863,775				200

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

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

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

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

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	3,589		337		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	207		159		43
44	SKILLED NURSING FACILITY	11,210				44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	15,006		496		200

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

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

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO P							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINC							92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
95	AMBULANCE SERVICES							95
200	TOTAL (SUM OF LINES 50-199)							200

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

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

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	7,562,956							50
52	DELIVERY ROOM & LABOR ROOM	112,757							52
53	ANESTHESIOLOGY	328,406							53
54	RADIOLOGY-DIAGNOSTIC	15,078,921							54
60	LABORATORY	10,008,769							60
65	RESPIRATORY THERAPY	934,680							65
66	PHYSICAL THERAPY	3,386,010							66
69	ELECTROCARDIOLOGY	1,410,630							69
71	MEDICAL SUPPLIES CHARGED TO	1,100,681							71
72	IMPL. DEV. CHARGED TO PATIEN	2,544,589							72
73	DRUGS CHARGED TO PATIENTS	8,631,972							73
74	RENAL DIALYSIS								74
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC	343,412							88
88.01	RHC II	467,961							88.01
88.02	RHC III	1,024,808							88.02
90	CLINIC	181,686							90
91	EMERGENCY	5,967,338							91
92	OBSERVATION BEDS (NON-DISTIN	1,778,199							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
95	AMBULANCE SERVICES	3,397,858							95
200	TOTAL (SUM OF LINES 50-199)	60,863,775							200

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

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

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.291660							50
52	DELIVERY ROOM & LABOR ROOM	2.491703							52
53	ANESTHESIOLOGY	0.094974							53
54	RADIOLOGY-DIAGNOSTIC	0.190492							54
60	LABORATORY	0.213474							60
65	RESPIRATORY THERAPY	0.730234							65
66	PHYSICAL THERAPY	0.516231							66
69	ELECTROCARDIOLOGY	0.136208							69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.695297							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.586327							72
73	DRUGS CHARGED TO PATIENTS	0.301395							73
74	RENAL DIALYSIS								74
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	2.363121							90
91	EMERGENCY	0.256834							91
92	OBSERVATION BEDS (NON-DISTINCT	0.581799							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
95	AMBULANCE SERVICES	0.392194							95
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,589	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,589	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,632	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,762	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	192.90	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	197.90	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,879,855	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,879,855	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,879,855	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,081.04	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,904,792	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)	1,904,792	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)					2,451,705	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					4,356,497	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					160,360	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					165,339	51
52	TOTAL PROGRAM EXCLUDABLE COST					325,699	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					4,030,798	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)	957	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	1,081.04	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	1,034,555	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	326,652	3,879,855	0.084192	1,034,555	87,101	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	11,210	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	11,210	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	11,210	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,736	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,205,744	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,205,744	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,205,744	37

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

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

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	2,205,744	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	196.77	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	341,593	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	341,593	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	341,593	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	298,652	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	640,245	86

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,589	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,589	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,632	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	337	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	207	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	159	16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	192.90	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	197.90	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,879,855	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,879,855	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,879,855	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,081.04	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	364,310	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)	364,310	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)	447,667	207	2,162.64	159	343,860	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					708,170	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					41,824	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					41,824	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					666,346	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)	957	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)		88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)		89

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

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

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

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		1,631,441		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.291660	846,413	246,865	50
52	DELIVERY ROOM & LABOR ROOM	2.491703			52
53	ANESTHESIOLOGY	0.094974	44,703	4,246	53
54	RADIOLOGY-DIAGNOSTIC	0.190492	1,237,134	235,664	54
60	LABORATORY	0.213474	1,077,450	230,008	60
65	RESPIRATORY THERAPY	0.730234	222,237	162,285	65
66	PHYSICAL THERAPY	0.516231	130,396	67,314	66
69	ELECTROCARDIOLOGY	0.136208	364,897	49,702	69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.695297	375,469	261,062	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.586327	744,289	436,397	72
73	DRUGS CHARGED TO PATIENTS	0.301395	1,627,059	490,387	73
74	RENAL DIALYSIS				74
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	2.363121	451	1,066	90
91	EMERGENCY	0.256834	507,075	130,234	91
92	OBSERVATION BEDS (NON-DISTINCT	0.581799	234,574	136,475	92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		7,412,147	2,451,705	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		7,412,147		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B SNF (14-U167)	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.291660			50
52	DELIVERY ROOM & LABOR ROOM	2.491703			52
53	ANESTHESIOLOGY	0.094974			53
54	RADIOLOGY-DIAGNOSTIC	0.190492			54
60	LABORATORY	0.213474			60
65	RESPIRATORY THERAPY	0.730234			65
66	PHYSICAL THERAPY	0.516231			66
69	ELECTROCARDIOLOGY	0.136208			69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.695297			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.586327			72
73	DRUGS CHARGED TO PATIENTS	0.301395			73
74	RENAL DIALYSIS				74
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	2.363121			90
91	EMERGENCY	0.256834			91
92	OBSERVATION BEDS (NON-DISTINCT	0.581799			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

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

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.291660			50
52	DELIVERY ROOM & LABOR ROOM	2.491703			52
53	ANESTHESIOLOGY	0.094974			53
54	RADIOLOGY-DIAGNOSTIC	0.190492	14,982	2,854	54
60	LABORATORY	0.213474	38,768	8,276	60
65	RESPIRATORY THERAPY	0.730234	56	41	65
66	PHYSICAL THERAPY	0.516231	506,502	261,472	66
69	ELECTROCARDIOLOGY	0.136208	427	58	69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.695297	5,930	4,123	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.586327			72
73	DRUGS CHARGED TO PATIENTS	0.301395	66,982	20,188	73
74	RENAL DIALYSIS				74
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	2.363121			90
91	EMERGENCY	0.256834			91
92	OBSERVATION BEDS (NON-DISTINCT	0.581799	2,819	1,640	92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		636,466	298,652	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		636,466		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

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

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.291660			50
52	DELIVERY ROOM & LABOR ROOM	2.491703			52
53	ANESTHESIOLOGY	0.094974			53
54	RADIOLOGY-DIAGNOSTIC	0.190492			54
60	LABORATORY	0.213474			60
65	RESPIRATORY THERAPY	0.730234			65
66	PHYSICAL THERAPY	0.516231			66
69	ELECTROCARDIOLOGY	0.136208			69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.695297			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.586327			72
73	DRUGS CHARGED TO PATIENTS	0.301395			73
74	RENAL DIALYSIS				74
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	2.363121			90
91	EMERGENCY	0.256834			91
92	OBSERVATION BEDS (NON-DISTINCT	0.581799			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	3,756,237	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	16,568	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	46.38	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0293	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.2001	31
32	SUM OF LINES 30 AND 31	0.2294	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0814	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	305,758	34
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	4,078,563	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	4,461,326	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	4,461,326	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	298,301	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	4,759,627	59
60	PRIMARY PAYER PAYMENTS	2,061	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	4,757,566	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	505,564	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	7,253	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	104,644	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	68,019	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	103,429	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	4,312,768	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.93	HVBP PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	-9,036	70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (SEE INSTRUCTIONS)	-11,291	70.94
70.97	LOW VOLUME ADJUSTMENT FOR FISCAL YEAR (2013)	532,060	70.97
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	4,824,501	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	48,245	71.01
72	INTERIM PAYMENTS	4,764,182	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	12,074	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	68,041	75

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	1,244	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	4,902,609	2
3	PPS PAYMENTS	4,777,851	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	5,787	4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)	0.805	5
6	LINE 2 TIMES LINE 5	3,946,600	6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	1,244	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	4,128	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)	4,128	14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	4,128	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)	2,884	19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	1,244	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)	4,783,638	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,063,001	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	3,721,881	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	3,721,881	30
31	PRIMARY PAYER PAYMENTS	52	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	3,721,829	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)	203,371	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	132,191	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	181,997	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	3,854,020	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	3,854,020	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	38,540	40.01
41	INTERIM PAYMENTS	3,824,335	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	-8,855	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)		40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		40.01
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

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

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

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				4,848,800		3,810,829	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	03/27/2013	59,570	03/20/2013	13,506	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	03/20/2013	144,188			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		-84,618		13,506	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)				4,764,182		3,824,335	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE		NONE	5.01
		TO	.02					5.02
		PROVIDER	.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER	.50		NONE		NONE	5.50
		TO	.51					5.51
		PROGRAM	.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01		60,319		29,685	6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				4,824,501		3,854,020	7

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

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

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] SNF (14-6049) [ ] 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				476,934			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					
	PROGRAM TO PROVIDER	.02					3.02
		.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)				476,934			4
TO BE COMPLETED BY CONTRACTOR							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01		NONE		NONE	5.01
		.02					5.02
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER TO PROGRAM	.50		NONE		NONE	5.50
		.51					5.51
		.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01		5,038			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				481,972			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 (14-0167) [ ] 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	944	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,762	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	24	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	2,632	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	71,139,467	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	863,088	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)	1,030,350	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	20,607	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)	1,009,743	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	996,807	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	12,936	32

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VI

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

	PROSPECTIVE PAYMENT AMOUNT		
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	608,027	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (SUM OF LINES 1-3)	608,027	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	MEDICAL AND OTHER SERVICES		5
6	DEDUCTIBLES		6
7	COINSURANCE	126,055	7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		9
10	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	481,972	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	481,972	15
15.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	4,820	15.01
16	INTERIM PAYMENTS	476,934	16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS 15.01, 16 AND 17)	218	18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

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

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

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

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	394,043				1
2	TEMPORARY INVESTMENTS	589,447				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	5,474,214				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,200,000				6
7	INVENTORY	1,058,900				7
8	PREPAID EXPENSES	1,749,479				8
9	OTHER CURRENT ASSETS	1,409,747				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	9,475,830				11
	FIXED ASSETS					
12	LAND	249,035				12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	24,444,042				15
16	ACCUMULATED DEPRECIATION	-14,246,143				16
17	LEASEHOLD IMPROVEMENTS	483,750				17
18	ACCUMULATED AMORTIZATION	-437,077				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	15,082,416				23
24	ACCUMULATED DEPRECIATION	-11,268,335				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)	14,307,688				30
	OTHER ASSETS					
31	INVESTMENTS	905,154				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	7,696,839				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	8,601,993				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	32,385,511				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,806,224				37
38	SALARIES, WAGES & FEES PAYABLE	2,181,336				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)	872,305				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	412,000				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	5,271,865				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	5,821,858				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	5,821,858				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	11,093,723				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	21,291,788				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)	21,291,788				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	32,385,511				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	22,467,767								1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	-1,178,507								2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	21,289,260								3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5	INCREASE IN PERPETUAL TRUST	2,528								5
6										6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)	2,528								10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	21,291,788								11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13										13
14										14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	21,291,788								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	2,578,483		2,578,483	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	2,002,335		2,002,335	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	4,580,818		4,580,818	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)	4,580,818		4,580,818	17
18	ANCILLARY SERVICES	10,403,232	40,697,139	51,100,371	18
19	OUTPATIENT SERVICES	993,836	6,933,657	7,927,493	19
20	RHC		343,142	343,142	20
20.01	RHC II		467,961	467,961	20.01
20.02	RHC III		1,024,808	1,024,808	20.02
21	FQHC				21
22	HOME HEALTH AGENCY		501,124	501,124	22
23	AMBULANCE	346	3,397,512	3,397,858	23
25	ASC				25
26	HOSPICE		1,538,794	1,538,794	26
27	IROQUOIS WOMENS HEALTH		1,677,283	1,677,283	27
27.01	NURSERY	257,098		257,098	27.01
27.03	PROFESSIONAL FEES	136,624	151,131	287,755	27.03
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	16,371,954	56,732,551	73,104,505	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		37,494,963	29
30	ADD (SPECIFY)			30
31				31
32		670,879		32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)		670,879	36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		38,165,842	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	73,104,505	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	39,522,860	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	33,581,645	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	38,165,842	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-4,584,197	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	785,396	6
7	INCOME FROM INVESTMENTS	56,000	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	502	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	6	13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	145,112	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	658	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	552	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 (EHR MEDICARE AND MEDICAID)	1,169,444	24
24.01	OTHER (TRUST DONATION)	230,000	24.01
24.02	OTHER (UNREALIZED GAINS)	247,960	24.02
24.03	OTHER (OTHER)	770,060	24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	3,405,690	25
26	TOTAL (LINE 5 PLUS LINE 25)	-1,178,507	26
27	OTHER EXPENSES (LOSS ON SALE OF ASSET)		27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-1,178,507	29

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

		SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR-TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (SEE INSTRUCTIONS)							4
5	ADMINISTRATIVE AND GENERAL	29,236	2,210			57,312	88,758	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE	228,643	17,285				245,928	6
7	PHYSICAL THERAPY	73,436	5,552		10,009		88,997	7
8	OCCUPATIONAL THERAPY	15,865	1,199		1,894		18,958	8
9	SPEECH PATHOLOGY	907	69		84		1,060	9
10	MEDICAL SOCIAL SERVICES	453	34				487	10
11	HOME HEALTH AIDE	28,848	2,181				31,029	11
12	SUPPLIES (SEE INSTRUCTIONS)					3,338	3,338	12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
24	TOTAL (SUM OF LINES 1-23)	377,388	28,530		11,987	60,650	478,555	24

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

		RECLASS-IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (SEE INSTRUCTIONS)					4
5	ADMINISTRATIVE AND GENERAL	-2,565	86,193		86,193	5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		245,928		245,928	6
7	PHYSICAL THERAPY		88,997		88,997	7
8	OCCUPATIONAL THERAPY		18,958		18,958	8
9	SPEECH PATHOLOGY		1,060		1,060	9
10	MEDICAL SOCIAL SERVICES		487		487	10
11	HOME HEALTH AIDE		31,029		31,029	11
12	SUPPLIES (SEE INSTRUCTIONS)	-3,338				12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
24	TOTAL (SUM OF LINES 1-23)	-5,903	472,652		472,652	24

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

		NET EXPENSES FOR COST ALLOCATION 0	CAP REL COSTS BLDG & FIXTURES 1	CAP REL COSTS MVBL EQUIPMENT 2	PLANT OPERATN & MAINT 3	TRANSPORT-ATION 4	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	GENERAL SERVICE COST CENTER									
1	CAPITAL RELATED-BLDGS & FIXT									1
2	CAPITAL RELATED-MOVABLE EQUIP									2
3	PLANT OPERATION & MAINTENANCE									3
4	TRANSPORTATION (SEE INSTR.)									4
5	ADMINISTRATIVE AND GENERAL	86,193					86,193	86,193		5
	HHA REIMBURSABLE SERVICES									
6	SKILLED NURSING CARE	245,928					245,928	54,229	300,157	6
7	PHYSICAL THERAPY	88,997					88,997	19,624	108,621	7
8	OCCUPATIONAL THERAPY	18,958					18,958	4,180	23,138	8
9	SPEECH PATHOLOGY	1,060					1,060	234	1,294	9
10	MEDICAL SOCIAL SERVICES	487					487	107	594	10
11	HOME HEALTH AIDE	31,029					31,029	6,842	37,871	11
12	SUPPLIES (SEE INSTRUCTIONS)							977	977	12
13	DRUGS									13
14	DME									14
	HHA NONREIMBURSABLE SERVICES									
15	HOME DIALYSIS AIDE SERVICES									15
16	RESPIRATORY THERAPY									16
17	PRIVATE DUTY NURSING									17
18	CLINIC									18
19	HEALTH PROMOTION ACTIVITIES									19
20	DAY CARE PROGRAM									20
21	HOME DELIVERED MEALS PROGRAM									21
22	HOMEMAKER SERVICE									22
23	ALL OTHERS									23
24	TOTAL (SUM OF LINES 1-23)	472,652					472,652		472,652	24

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

		CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT-ATION (MILEAGE) 4	RECONCIL-IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXT							1
2	CAPITAL RELATED-MOVABLE EQUIP							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (SEE INSTR.)							4
5	ADMINISTRATIVE AND GENERAL					-86,193	390,890	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						245,928	6
7	PHYSICAL THERAPY						88,997	7
8	OCCUPATIONAL THERAPY						18,958	8
9	SPEECH PATHOLOGY						1,060	9
10	MEDICAL SOCIAL SERVICES						487	10
11	HOME HEALTH AIDE						31,029	11
12	SUPPLIES (SEE INSTRUCTIONS)					4,429	4,429	12
13	DRUGS					2	2	13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (SUM OF LINES 1-23)					-81,762	390,890	24
25	COST TO BE ALLOC (PER W/S H)						86,193	25
26	UNIT COST MULTIPLIER						0.220504	26

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

	HHA COST CENTER	HHA TRIAL BALANCE 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS DEPARTMENT 4	ADMITTING 5.01	PURCHASING RECEIVING AND STORES 5.02	DATA PROCESSING 5.03	
1	ADMINISTRATIVE AND GENERAL		9,865	470		3,442		400	16,114	1
2	SKILLED NURSING CARE	300,157				28,155				2
3	PHYSICAL THERAPY	108,621				9,043				3
4	OCCUPATIONAL THERAPY	23,138				1,954				4
5	SPEECH PATHOLOGY	1,294				112				5
6	MEDICAL SOCIAL SERVICES	594				56				6
7	HOME HEALTH AIDE	37,871				3,711				7
8	SUPPLIES	977								8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	472,652	9,865	470		46,473		400	16,114	20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

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

	HHA COST CENTER	COMMUNICATIONS	BUSINESS OFFICE	SUBTOTAL (COLS.0-4)	OTHER ADMINISTRATIVE AND GENER	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.04	5.05	4A	5.06	6	7	8	9	
1	ADMINISTRATIVE AND GENERAL	3,083		33,374	2,217		15,485		5,578	1
2	SKILLED NURSING CARE			328,312	21,809					2
3	PHYSICAL THERAPY			117,664	7,816					3
4	OCCUPATIONAL THERAPY			25,092	1,667					4
5	SPEECH PATHOLOGY			1,406	93					5
6	MEDICAL SOCIAL SERVICES			650	43					6
7	HOME HEALTH AIDE			41,582	2,762					7
8	SUPPLIES			977	65					8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	3,083		549,057	36,472		15,485		5,578	20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

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

	HHA COST CENTER	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL (SUM OF COL.4A-23)	I&R COST & POST STEP-DOWN ADJS	
		10	11	13	14	15	16	24	25	
1	ADMINISTRATIVE AND GENERAL		6,359				7,257	70,270		1
2	SKILLED NURSING CARE							350,121		2
3	PHYSICAL THERAPY							125,480		3
4	OCCUPATIONAL THERAPY							26,759		4
5	SPEECH PATHOLOGY							1,499		5
6	MEDICAL SOCIAL SERVICES							693		6
7	HOME HEALTH AIDE							44,344		7
8	SUPPLIES							1,042		8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)		6,359				7,257	620,208		20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

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

	HHA COST CENTER	SUBTOTAL (SUM OF COL.4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1	ADMINISTRATIVE AND GENERAL	70,270			1
2	SKILLED NURSING CARE	350,121	44,737	394,858	2
3	PHYSICAL THERAPY	125,480	16,034	141,514	3
4	OCCUPATIONAL THERAPY	26,759	3,419	30,178	4
5	SPEECH PATHOLOGY	1,499	192	1,691	5
6	MEDICAL SOCIAL SERVICES	693	89	782	6
7	HOME HEALTH AIDE	44,344	5,666	50,010	7
8	SUPPLIES	1,042	133	1,175	8
9	DRUGS				9
10	DME				10
11	HOME DIALYSIS AIDE SERVICES				11
12	RESPIRATORY THERAPY				12
13	PRIVATE DUTY NURSING				13
14	CLINIC				14
15	HEALTH PROMOTION ACTIVITIES				15
16	DAY CARE PROGRAM				16
17	HOME DELIVERED MEALS PROGRAM				17
18	HOMEMAKER SERVICE				18
19	ALL OTHERS				19
20	TOTAL (SUM OF LINES 1-19)	620,208	70,270	620,208	20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.		0.127778		21

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

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	ADMITTING GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	DATA PROCESSING TIME SPENT	COMMUNICATIONS # OF PHONES	
		1	2	3	4	5.01	5.02	5.03	5.04	
1	ADMINISTRATIVE AND GENERAL	1,274	432		27,947		6,106	13,315	8	1
2	SKILLED NURSING CARE				228,642					2
3	PHYSICAL THERAPY				73,436					3
4	OCCUPATIONAL THERAPY				15,865					4
5	SPEECH PATHOLOGY				907					5
6	MEDICAL SOCIAL SERVICES				453					6
7	HOME HEALTH AIDE				30,138					7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTAL (SUM OF LINES 1-19)	1,274	432		377,388		6,106	13,315	8	20
21	TOTAL COST TO BE ALLOCATED	9,865	470		46,473		400	16,114	3,083	21
22	UNIT COST MULTIPLIER	7.743328						1.210214		22
22	UNIT COST MULTIPLIER		1.087963		0.123144		0.065509		385.375000	22

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

	HHA COST CENTER	BUSINESS OFFICE GROSS CHARGES 5.05	RECON-CILIATION 4A.06	OTHER ADMINISTRATIVE AND GENER ACCUM COST 5.06	MAIN-TENANCE & REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS 8	HOUSE-KEEPING SQUARE FEET 9	DIETARY MEALS 10	
1	ADMINISTRATIVE AND GENERAL			33,374		1,274		1,274		1
2	SKILLED NURSING CARE			328,312						2
3	PHYSICAL THERAPY			117,664						3
4	OCCUPATIONAL THERAPY			25,092						4
5	SPEECH PATHOLOGY			1,406						5
6	MEDICAL SOCIAL SERVICES			650						6
7	HOME HEALTH AIDE			41,582						7
8	SUPPLIES			977						8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTAL (SUM OF LINES 1-19)			549,057		1,274		1,274		20
21	TOTAL COST TO BE ALLOCATED			36,472		15,485		5,578		21
22	UNIT COST MULTIPLIER			0.066427		12.154631		4.378336		22
22	UNIT COST MULTIPLIER									22

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

	HHA COST CENTER	CAFETERIA FTE'S 11	NURSING ADMINIS-TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY CSS CSTED REQ' 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
1	ADMINISTRATIVE AND GENERAL	640				501,124	1
2	SKILLED NURSING CARE						2
3	PHYSICAL THERAPY						3
4	OCCUPATIONAL THERAPY						4
5	SPEECH PATHOLOGY						5
6	MEDICAL SOCIAL SERVICES						6
7	HOME HEALTH AIDE						7
8	SUPPLIES						8
9	DRUGS						9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING						13
14	CLINIC						14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
19.50	TELEMEDICINE						19.50
20	TOTAL (SUM OF LINES 1-19)	640				501,124	20
21	TOTAL COST TO BE ALLOCATED	6,359				7,257	21
22	UNIT COST MULTIPLIER	9.935938				0.014481	22
22	UNIT COST MULTIPLIER						22

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

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

	COST PER VISIT COMPUTATION PATIENT SERVICES	FROM WKST H-2, PART I, COL 28, LINE	FACILITY COSTS (FROM WKST H-2, PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS COLS. 1+2)	TOTAL VISITS	AVERAGE COST PER VISIT (COL.3 ÷ COL.4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	394,858		394,858	1,578	250.23	1
2	PHYSICAL THERAPY	3	141,514		141,514	967	146.34	2
3	OCCUPATIONAL THERAPY	4	30,178		30,178	204	147.93	3
4	SPEECH PATHOLOGY	5	1,691		1,691	9	187.89	4
5	MEDICAL SOCIAL SERVICES	6	782		782	3	260.67	5
6	HOME HEALTH AIDE	7	50,010		50,010	858	58.29	6
7	TOTAL (SUM OF LINES 1-6)		619,033		619,033	3,619		7

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

	SUPPLIES AND DRUGS COST COMPUTATIONS OTHER PATIENT SERVICES	FROM WKST H-2, PART I, COL 28, LINE	FACILITY COSTS (FROM WKST H-2, PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS COLS. 1+2)	TOTAL CHARGES (FROM HHA RECORD)	RATIO (COL.3 ÷ COL.4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	1,175	2,061	3,236	2,964	1.091768	15
16	COST OF DRUGS	9						16

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

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION / PATIENT SERVICES	PROGRAM VISITS PART A (6)	PROGRAM VISITS PART B NOT SUBJ TO DEDUCTIBLES & COINSUR (7)	PROGRAM VISITS PART B SUBJECT TO DEDUCTIBLES & COINSUR (8)	COST OF SERVICES PART A (9)	COST OF SERVICES PART B NOT SUBJ TO DEDUCTIBLES & COINSUR (10)	COST OF SERVICES PART B SUBJECT TO DEDUCTIBLES & COINSUR (11)	TOTAL PROGRAM COST (SUM OF COLS.9-10) (12)	
1 SKILLED NURSING CARE	445	629		111,352	157,395		268,747	1
2 PHYSICAL THERAPY	422	225		61,755	32,927		94,682	2
3 OCCUPATIONAL THERAPY	82	41		12,130	6,065		18,195	3
4 SPEECH PATHOLOGY	9			1,691			1,691	4
5 MEDICAL SOCIAL SERVICES								5
6 HOME HEALTH AIDE	258	506		15,039	29,495		44,534	6
7 TOTAL (SUM OF LINES 1-6)	1,216	1,401		201,967	225,882		427,849	7

PATIENT SERVICES	CBSA NO. (1)	PROGRAM VISITS PART A (2)	PROGRAM VISITS PART B NOT SUBJ TO DEDUCTIBLES & COINSUR (3)	PROGRAM VISITS PART B SUBJECT TO DEDUCTIBLES & COINSUR (4)	
8 SKILLED NURSING CARE	99914	423	619		8
8.01 SKILLED NURSING CARE	16580	7	5		8.01
8.02 SKILLED NURSING CARE	19180	15	5		8.02
9 PHYSICAL THERAPY	99914	411	217		9
9.01 PHYSICAL THERAPY	16580	1	8		9.01
9.02 PHYSICAL THERAPY	19180	10			9.02
10 OCCUPATIONAL THERAPY	99914	81	41		10
10.01 OCCUPATIONAL THERAPY	16580				10.01
10.02 OCCUPATIONAL THERAPY	19180	1			10.02
11 SPEECH PATHOLOGY	99914	9			11
11.01 SPEECH PATHOLOGY	16580				11.01
11.02 SPEECH PATHOLOGY	19180				11.02
12 MEDICAL SOCIAL SERVICES	99914				12
12.01 MEDICAL SOCIAL SERVICES	16580				12.01
12.02 MEDICAL SOCIAL SERVICES	19180				12.02
13 HOME HEALTH AIDE	99914	234	506		13
13.01 HOME HEALTH AIDE	16580	16			13.01
13.02 HOME HEALTH AIDE	19180	8			13.02
14 TOTAL (SUM OF LINES 8-13)		1,216	1,401		14

SUPPLIES AND DRUGS COST COMPUTATIONS / OTHER PATIENT SERVICES	PROGRAM COVERED CHARGES PART A (6)	PROGRAM COVERED CHARGES PART B NOT SUBJ TO DEDUCTIBLES & COINSUR (7)	PROGRAM COVERED CHARGES PART B SUBJECT TO DEDUCTIBLES & COINSUR (8)	COST OF SERVICES PART A (9)	COST OF SERVICES PART B NOT SUBJ TO DEDUCTIBLES & COINSUR (10)	COST OF SERVICES PART B SUBJECT TO DEDUCTIBLES & COINSUR (11)	
15 COST OF MEDICAL SUPPLIES							15
16 COST OF DRUGS							16

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

	FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO (1)	TOTAL HHA CHARGES (FROM PROVIDER RECORDS) (2)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2) (3)	TRANSFER TO PART I AS INDICATED (4)	
1 PHYSICAL THERAPY	66	0.516231			COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY	67				COL 2, LINE 3	2
3 SPEECH PATHOLOGY	68				COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHARGED TO PA	71	0.695297	2,964	2,061	COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	73	0.301395			COL 2, LINE 16	5

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

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

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10	TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	192,575	177,525	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS		4,391	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	4,221	1,648	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	266	218	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS		439	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22	SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	197,062	184,221	22
23	EXCESS REASONABLE COST (FROM LINE 8)			23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	197,062	184,221	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26	NET COST (LINE 24 MINUS LINE 25)	197,062	184,221	26
27	REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	197,062	184,221	29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31	SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	197,062	184,221	31
31.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	1,845	1,829	31.01
32	INTERIM PAYMENTS (SEE INSTRUCTIONS)	195,217	182,392	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)			34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2			35

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

HHA NO.: 14-7586 WORKSHEET H-5

	DESCRIPTION			PART A MO/DAY/YR 1	PART A AMOUNT 2	PART B MO/DAY/YR 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				195,217		182,392	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 H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)				195,217		182,392	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		NONE		NONE	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
			.50		NONE		NONE	5.50
			.51					5.51
		PROVIDER TO PROGRAM	.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO PROVIDER	.01		1,845		1,829	6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				197,062		184,221	7

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

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

		SALARIES (FROM WKST K-1) 1	EMPLOYEE BENEFITS (FROM WKST K-2) 2	TRANS-PORTATION (SEE INSTR.) 3	CONTRACTED SERVICES (FROM WKST K-3) 4	OTHER 5	TOTAL (COLS. 1-5) 6	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED COSTS-BLDG AND FIXT.							1
2	CAPITAL RELATED COSTS-MOVABLE EQUIP.							2
3	PLANT OPERATION AND MAINTENANCE					2,225	2,225	3
4	TRANSPORTATION - STAFF							4
5	VOLUNTEER SERVICE COORDINATION							5
6	ADMINISTRATIVE AND GENERAL	79,446	5,280		31,490	197,592	313,808	6
	INPATIENT CARE SERVICE							
7	INPATIENT - GENERAL CARE							7
8	INPATIENT - RESPITE CARE							8
	VISITING SERVICES							
9	PHYSICIAN SERVICES							9
10	NURSING CARE	527,656	35,304		28,470	139,179	730,609	10
11	NURSING CARE-CONTINUOUS HOME CARE							11
12	PHYSICAL THERAPY							12
13	OCCUPATIONAL THERAPY							13
14	SPEECH/LANGUAGE PATHOLOGY							14
15	MEDICAL SOCIAL SERVICES							15
16	SPIRITUAL COUNSELING							16
17	DIETARY COUNSELING							17
18	COUNSELING - OTHER							18
19	HOME HEALTH AIDE AND HOMEMAKER							19
20	HH AIDE & HOMEMAKER-CONT. HOME CARE							20
21	OTHER	78,990	5,325				84,315	21
	OTHER HOSPICE SERVICE COSTS							
22	DRUGS, BIOLOGICAL & INFUSION THERAPY							22
23	ANALGESICS							23
24	SEDATIVES/HYPNOTICS							24
25	OTHER - SPECIFY							25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN							26
27	PATIENT TRANSPORTATION							27
28	IMAGING SERVICES							28
29	LABS AND DIAGNOSTICS							29
30	MEDICAL SUPPLIES							30
31	OUTPATIENT SERVICES (INCLUDING E/R DEPT.)							31
32	RADIATION THERAPY							32
33	CHEMOTHERAPY							33
34	OTHER							34
	HOSPICE NONREIMBURSABLE SERVICE							
35	BEREAVEMENT PROGRAM COSTS							35
36	VOLUNTEER PROGRAM COSTS							36
37	FUNDRAISING							37
38	OTHER PROGRAM COSTS							38
39	TOTAL (SUM OF LINES 1-38)	686,092	45,909		59,960	338,996	1,130,957	39

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

		RECLASSIFI-CATION 7	SUBTOTAL (COL.6 ± COL.7) 8	ADJUST-MENTS 9	TOTAL (COL.8 ± COL.9) 10	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED COSTS-BLDG AND FIXT.					1
2	CAPITAL RELATED COSTS-MOVABLE EQUIP.					2
3	PLANT OPERATION AND MAINTENANCE	-2,225				3
4	TRANSPORTATION - STAFF					4
5	VOLUNTEER SERVICE COORDINATION					5
6	ADMINISTRATIVE AND GENERAL	-2,836	310,972	-30,163	280,809	6
	INPATIENT CARE SERVICE					
7	INPATIENT - GENERAL CARE					7
8	INPATIENT - RESPITE CARE					8
	VISITING SERVICES					
9	PHYSICIAN SERVICES					9
10	NURSING CARE	-118,638	611,971		611,971	10
11	NURSING CARE-CONTINUOUS HOME CARE					11
12	PHYSICAL THERAPY					12
13	OCCUPATIONAL THERAPY					13
14	SPEECH/LANGUAGE PATHOLOGY					14
15	MEDICAL SOCIAL SERVICES					15
16	SPIRITUAL COUNSELING					16
17	DIETARY COUNSELING					17
18	COUNSELING - OTHER					18
19	HOME HEALTH AIDE AND HOMEMAKER					19
20	HH AIDE & HOMEMAKER-CONT. HOME CARE					20
21	OTHER		84,315		84,315	21
	OTHER HOSPICE SERVICE COSTS					
22	DRUGS, BIOLOGICAL & INFUSION THERAPY					22
23	ANALGESICS					23
24	SEDATIVES/HYPNOTICS					24
25	OTHER - SPECIFY					25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN					26
27	PATIENT TRANSPORTATION					27
28	IMAGING SERVICES					28
29	LABS AND DIAGNOSTICS					29
30	MEDICAL SUPPLIES					30
31	OUTPATIENT SERVICES (INCLUDING E/R DEPT.)					31
32	RADIATION THERAPY					32
33	CHEMOTHERAPY					33
34	OTHER					34
	HOSPICE NONREIMBURSABLE SERVICE					
35	BEREAVEMENT PROGRAM COSTS					35
36	VOLUNTEER PROGRAM COSTS					36
37	FUNDRAISING					37
38	OTHER PROGRAM COSTS					38
39	TOTAL (SUM OF LINES 1-38)	-247,398	1,007,258	-60,326	977,095	39

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

		ADMINI-STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER-VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9	
	GENERAL SERVICE COST CENTER										
1	CAP REL COSTS-BLDG AND FIXT.										1
2	CAP REL COSTS-MOVABLE EQUIP.										2
3	PLANT OPERATION & MAINT.										3
4	TRANSPORTATION - STAFF										4
5	VOLUNTEER SERVICE COORD.										5
6	ADMINISTRATIVE AND GENERAL	79,446								79,446	6
	INPATIENT CARE SERVICE										
7	INPATIENT - GENERAL CARE										7
8	INPATIENT - RESPITE CARE										8
	VISITING SERVICES										
9	PHYSICIAN SERVICES										9
10	NURSING CARE	527,656								527,656	10
11	NURSING CARE-CONT.HOME CARE										11
12	PHYSICAL THERAPY										12
13	OCCUPATIONAL THERAPY										13
14	SPEECH/LANGUAGE PATHOLOGY										14
15	MEDICAL SOCIAL SERVICES										15
16	SPIRITUAL COUNSELING										16
17	DIETARY COUNSELING										17
18	COUNSELING - OTHER										18
19	HH AIDE AND HOMEMAKER										19
20	HH AIDE & HMKR-CONT.HME CARE										20
21	OTHER	78,990								78,990	21
	OTHER HOSPICE SERVICE COSTS										
22	DRUGS, BIOL. & INFUS. THER.										22
23	ANALGESICS										23
24	SEDATIVES / HYPNOTICS										24
25	OTHER - SPECIFY										25
26	DURABLE MED. EQUIP./OXYGEN										26
27	PATIENT TRANSPORTATION										27
28	IMAGING SERVICES										28
29	LABS AND DIAGNOSTICS										29
30	MEDICAL SUPPLIES										30
31	OUTPAT.SERV.(INCL.E/R DEPT.)										31
32	RADIATION THERAPY										32
33	CHEMOTHERAPY										33
34	OTHER										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	BEREAVEMENT PROGRAM COSTS										35
36	VOLUNTEER PROGRAM COSTS										36
37	FUNDRAISING										37
38	OTHER PROGRAM COSTS										38
39	TOTAL (SUM OF LINES 1-38)	686,092								686,092	39

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

		ADMINI-STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER-VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9	
	GENERAL SERVICE COST CENTER										
1	CAP REL COSTS-BLDG AND FIXT.										1
2	CAP REL COSTS-MOVABLE EQUIP.										2
3	PLANT OPERATION & MAINT.										3
4	TRANSPORTATION - STAFF										4
5	VOLUNTEER SERVICE COORD.										5
6	ADMINISTRATIVE AND GENERAL	5,280								5,280	6
	INPATIENT CARE SERVICE										
7	INPATIENT - GENERAL CARE										7
8	INPATIENT - RESPITE CARE										8
	VISITING SERVICES										
9	PHYSICIAN SERVICES										9
10	NURSING CARE	35,304								35,304	10
11	NURSING CARE-CONT.HOME CARE										11
12	PHYSICAL THERAPY										12
13	OCCUPATIONAL THERAPY										13
14	SPEECH/LANGUAGE PATHOLOGY										14
15	MEDICAL SOCIAL SERVICES										15
16	SPIRITUAL COUNSELING										16
17	DIETARY COUNSELING										17
18	COUNSELING - OTHER										18
19	HH AIDE AND HOMEMAKER										19
20	HH AIDE & HMKR-CONT.HME CARE										20
21	OTHER	5,325								5,325	21
	OTHER HOSPICE SERVICE COSTS										
22	DRUGS, BIOL. & INFUS. THER.										22
23	ANALGESICS										23
24	SEDATIVES / HYPNOTICS										24
25	OTHER - SPECIFY										25
26	DURABLE MED. EQUIP./OXYGEN										26
27	PATIENT TRANSPORTATION										27
28	IMAGING SERVICES										28
29	LABS AND DIAGNOSTICS										29
30	MEDICAL SUPPLIES										30
31	OUTPAT.SERV.(INCL.E/R DEPT.)										31
32	RADIATION THERAPY										32
33	CHEMOTHERAPY										33
34	OTHER										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	BEREAVEMENT PROGRAM COSTS										35
36	VOLUNTEER PROGRAM COSTS										36
37	FUNDRAISING										37
38	OTHER PROGRAM COSTS										38
39	TOTAL (SUM OF LINES 1-38)	45,909								45,909	39

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

		ADMINI-STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER-VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9	
	GENERAL SERVICE COST CENTER										
1	CAP REL COSTS-BLDG AND FIXT.										1
2	CAP REL COSTS-MOVABLE EQUIP.										2
3	PLANT OPERATION & MAINT.										3
4	TRANSPORTATION - STAFF										4
5	VOLUNTEER SERVICE COORD.										5
6	ADMINISTRATIVE AND GENERAL								31,490	31,490	6
	INPATIENT CARE SERVICE										
7	INPATIENT - GENERAL CARE										7
8	INPATIENT - RESPITE CARE										8
	VISITING SERVICES										
9	PHYSICIAN SERVICES										9
10	NURSING CARE					28,470				28,470	10
11	NURSING CARE-CONT.HOME CARE										11
12	PHYSICAL THERAPY										12
13	OCCUPATIONAL THERAPY										13
14	SPEECH/LANGUAGE PATHOLOGY										14
15	MEDICAL SOCIAL SERVICES										15
16	SPIRITUAL COUNSELING										16
17	DIETARY COUNSELING										17
18	COUNSELING - OTHER										18
19	HH AIDE AND HOMEMAKER										19
20	HH AIDE & HMKR-CONT.HME CARE										20
21	OTHER										21
	OTHER HOSPICE SERVICE COSTS										
22	DRUGS, BIOL. & INFUS. THER.										22
23	ANALGESICS										23
24	SEDATIVES / HYPNOTICS										24
25	OTHER - SPECIFY										25
26	DURABLE MED. EQUIP./OXYGEN										26
27	PATIENT TRANSPORTATION										27
28	IMAGING SERVICES										28
29	LABS AND DIAGNOSTICS										29
30	MEDICAL SUPPLIES										30
31	OUTPAT.SERV.(INCL.E/R DEPT.)										31
32	RADIATION THERAPY										32
33	CHEMOTHERAPY										33
34	OTHER										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	BEREAVEMENT PROGRAM COSTS										35
36	VOLUNTEER PROGRAM COSTS										36
37	FUNDRAISING										37
38	OTHER PROGRAM COSTS										38
39	TOTAL (SUM OF LINES 1-38)					28,470			31,490	59,960	39

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

		NET EXPENSES FOR COST ALLOCATION 0	CAP REL COSTS BLDG & FIXTURES 1	CAP REL COSTS MVBL EQUIPMENT 2	PLANT OPERATN & MAINT 3	TRANSPO-RTATION 4	VOLUNTEER SERV. CO-ORDINATOR 5	SUBTOTAL (COLS.0-5) 5A	ADMIN & GENERAL 6	TOTAL (COL.5 ± COL.6) 7	
	GENERAL SERVICE COST CENTER										
1	CAP REL COSTS-BLDG AND FIXT.										1
2	CAP REL COSTS-MOVABLE EQUIP.										2
3	PLANT OPERATION & MAINT.										3
4	TRANSPORTATION - STAFF										4
5	VOLUNTEER SERVICE COORD.										5
6	ADMINISTRATIVE AND GENERAL	280,809						280,809	280,809		6
	INPATIENT CARE SERVICE										
7	INPATIENT - GENERAL CARE										7
8	INPATIENT - RESPITE CARE										8
	VISITING SERVICES										
9	PHYSICIAN SERVICES										9
10	NURSING CARE	611,971						611,971	246,805	858,776	10
11	NURSING CARE-CONTINUOUS HOME										11
12	PHYSICAL THERAPY										12
13	OCCUPATIONAL THERAPY										13
14	SPEECH/LANGUAGE PATHOLOGY										14
15	MEDICAL SOCIAL SERVICES										15
16	SPIRITUAL COUNSELING										16
17	DIETARY COUNSELING										17
18	COUNSELING - OTHER										18
19	HH AIDE AND HOMEMAKER										19
20	HH AIDE & HMKR-CONT. HOME CA										20
21	OTHER	84,315						84,315	34,004	118,319	21
	OTHER HOSPICE SERVICE COSTS										
22	DRUGS, BIOL. & INFUS. THER.										22
23	ANALGESICS										23
24	SEDATIVES / HYPNOTICS										24
25	OTHER - SPECIFY										25
26	DURABLE MED. EQUIP./OXYGEN										26
27	PATIENT TRANSPORTATION										27
28	IMAGING SERVICES										28
29	LABS AND DIAGNOSTICS										29
30	MEDICAL SUPPLIES										30
31	OUTPAT.SERV.(INCL.E/R DEPT.)										31
32	RADIATION THERAPY										32
33	CHEMOTHERAPY										33
34	OTHER										34
	HOSPICE NONREIMBURSABLE SERV.										
35	BEREAVEMENT PROGRAM COSTS										35
36	VOLUNTEER PROGRAM COSTS										36
37	FUNDRAISING										37
38	OTHER PROGRAM COSTS										38
39	TOTAL (SUM OF LINES 1-38)	977,095						977,095		977,095	39

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

		CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPO-RTATION (MILEAGE) 4	VOLUNTEER SERV. CO-ORDINATOR (HOURS) 5	RECONCIL-IATION 6A	ADMIN & GENERAL (ACCUM COST) 6	
	GENERAL SERVICE COST CENTER								
1	CAP REL COSTS-BLDG AND FIXT.								1
2	CAP REL COSTS-MOVABLE EQUIP.								2
3	PLANT OPERATION & MAINT.								3
4	TRANSPORTATION - STAFF								4
5	VOLUNTEER SERVICE COORD.								5
6	ADMINISTRATIVE AND GENERAL						-280,809	696,286	6
	INPATIENT CARE SERVICE								
7	INPATIENT - GENERAL CARE								7
8	INPATIENT - RESPITE CARE								8
	VISITING SERVICES								
9	PHYSICIAN SERVICES								9
10	NURSING CARE							611,971	10
11	NURSING CARE-CONTINUOUS HOME								11
12	PHYSICAL THERAPY								12
13	OCCUPATIONAL THERAPY								13
14	SPEECH/LANGUAGE PATHOLOGY								14
15	MEDICAL SOCIAL SERVICES								15
16	SPIRITUAL COUNSELING								16
17	DIETARY COUNSELING								17
18	COUNSELING - OTHER								18
19	HH AIDE AND HOMEMAKER								19
20	HH AIDE & HMKR-CONT. HOME CA								20
21	OTHER							84,315	21
	OTHER HOSPICE SERVICE COSTS								
22	DRUGS, BIOL. & INFUS. THER.								22
23	ANALGESICS								23
24	SEDATIVES / HYPNOTICS								24
25	OTHER - SPECIFY								25
26	DURABLE MED. EQUIP./OXYGEN								26
27	PATIENT TRANSPORTATION								27
28	IMAGING SERVICES								28
29	LABS AND DIAGNOSTICS								29
30	MEDICAL SUPPLIES								30
31	OUTPAT.SERV.(INCL.E/R DEPT.)								31
32	RADIATION THERAPY								32
33	CHEMOTHERAPY								33
34	OTHER								34
	HOSPICE NONREIMBURSABLE SERVICE								
35	BEREAVEMENT PROGRAM COSTS								35
36	VOLUNTEER PROGRAM COSTS								36
37	FUNDRAISING								37
38	OTHER PROGRAM COSTS								38
39	COST TO BE ALLOCATED							280,809	39
40	UNIT COST MULTIPLIER							0.403295	40

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

	HOSPICE COST CENTER	HOSPICE TRIAL BALANCE 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS DEPARTMENT 4	ADMITTING 5.01	PURCHASING RECEIVING AND STORES 5.02	DATA PROCESSING 5.03	
1	ADMINISTRATIVE AND GENERAL		9,927	684		9,783		3,657	32,926	1
2	INPATIENT - GENERAL CARE									2
3	INPATIENT - RESPITE CARE									3
4	PHYSICIAN SERVICES									4
5	NURSING CARE	858,776				64,977				5
6	NURSING CARE-CONTINUOUS HOM									6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH/LANGUAGE PATHOLOGY									9
10	MEDICAL SOCIAL SERV. - DIRE									10
11	SPIRITUAL COUNSELING									11
12	DIETARY COUNSELING									12
13	COUNSELING - OTHER									13
14	HOME HLTH AIDE & HOMEMAKERS									14
15	HH AIDE & HMKR-CONT. HOME C									15
16	OTHER	118,319				9,727				16
17	DRUGS,BIOLOGICALS & INFUSIO									17
18	ANALGESICS									18
19	SEDATIVES / HYPNOTICS									19
20	OTHER - SPECIFY									20
21	DURABLE MED. EQUIP./OXYGEN									21
22	PATIENT TRANSPORTATION									22
23	IMAGING SERVICES									23
24	LABS AND DIAGNOSTICS									24
25	MEDICAL SUPPLIES									25
26	OUTPAT. SERV.(INCL.E/R DEPT									26
27	RADIATION THERAPY									27
28	CHEMOTHERAPY									28
29	OTHER									29
30	BEREAVEMENT PROGRAM COSTS									30
31	VOLUNTEER PROGRAM COSTS									31
32	FUNDRAISING									32
33	OTHER PROGRAM COSTS									33
34	TOTALS (SUM OF LINES 1-33)	977,095	9,927	684		84,487		3,657	32,926	34
35	UNIT COST MULTIPLIER									35

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

	HOSPICE COST CENTER	COMMUNICATIONS	BUSINESS OFFICE	SUBTOTAL	OTHER ADMINISTRATIVE AND GENER	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.04	5.05	4A	5.06	6	7	8	9	
1	ADMINISTRATIVE AND GENERAL	5,396		62,373	4,143		15,582		5,613	1
2	INPATIENT - GENERAL CARE									2
3	INPATIENT - RESPITE CARE									3
4	PHYSICIAN SERVICES									4
5	NURSING CARE			923,753	61,362					5
6	NURSING CARE-CONTINUOUS HOM									6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH/LANGUAGE PATHOLOGY									9
10	MEDICAL SOCIAL SERV. - DIRE									10
11	SPIRITUAL COUNSELING									11
12	DIETARY COUNSELING									12
13	COUNSELING - OTHER									13
14	HOME HLTH AIDE & HOMEMAKERS									14
15	HH AIDE & HMKR-CONT. HOME C									15
16	OTHER			128,046	8,506					16
17	DRUGS,BIOLOGICALS & INFUSIO									17
18	ANALGESICS									18
19	SEDATIVES / HYPNOTICS									19
20	OTHER - SPECIFY									20
21	DURABLE MED. EQUIP./OXYGEN									21
22	PATIENT TRANSPORTATION									22
23	IMAGING SERVICES									23
24	LABS AND DIAGNOSTICS									24
25	MEDICAL SUPPLIES									25
26	OUTPAT. SERV.(INCL.E/R DEPT									26
27	RADIATION THERAPY									27
28	CHEMOTHERAPY									28
29	OTHER									29
30	BEREAVEMENT PROGRAM COSTS									30
31	VOLUNTEER PROGRAM COSTS									31
32	FUNDRAISING									32
33	OTHER PROGRAM COSTS									33
34	TOTALS (SUM OF LINES 1-33)	5,396		1,114,172	74,011		15,582		5,613	34
35	UNIT COST MULTIPLIER									35

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

	HOSPICE COST CENTER	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL (COLS. 4A-23)	I&R COST & POST STEP-DOWN ADJS	
		10	11	13	14	15	16	24	25	
1	ADMINISTRATIVE AND GENERAL		12,997				22,283	122,991		1
2	INPATIENT - GENERAL CARE									2
3	INPATIENT - RESPITE CARE									3
4	PHYSICIAN SERVICES									4
5	NURSING CARE							985,115		5
6	NURSING CARE-CONTINUOUS HOM									6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH/LANGUAGE PATHOLOGY									9
10	MEDICAL SOCIAL SERV. - DIRE									10
11	SPIRITUAL COUNSELING									11
12	DIETARY COUNSELING									12
13	COUNSELING - OTHER									13
14	HOME HLTH AIDE & HOMEMAKERS									14
15	HH AIDE & HMKR-CONT. HOME C									15
16	OTHER							136,552		16
17	DRUGS,BIOLOGICALS & INFUSIO									17
18	ANALGESICS									18
19	SEDATIVES / HYPNOTICS									19
20	OTHER - SPECIFY									20
21	DURABLE MED. EQUIP./OXYGEN									21
22	PATIENT TRANSPORTATION									22
23	IMAGING SERVICES									23
24	LABS AND DIAGNOSTICS									24
25	MEDICAL SUPPLIES									25
26	OUTPAT. SERV.(INCL.E/R DEPT									26
27	RADIATION THERAPY									27
28	CHEMOTHERAPY									28
29	OTHER									29
30	BEREAVEMENT PROGRAM COSTS									30
31	VOLUNTEER PROGRAM COSTS									31
32	FUNDRAISING									32
33	OTHER PROGRAM COSTS									33
34	TOTALS (SUM OF LINES 1-33)		12,997				22,283	1,244,658		34
35	UNIT COST MULTIPLIER									35

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

	HOSPICE COST CENTER	SUBTOTAL (COLS. 24 ± 25) 26	ALLOC HOSP A&G (SEE PART II) 27	TOTAL HOSP COSTS (COL 26 ± 27) 28	
1	ADMINISTRATIVE AND GENERAL	122,991			1
2	INPATIENT - GENERAL CARE				2
3	INPATIENT - RESPITE CARE				3
4	PHYSICIAN SERVICES				4
5	NURSING CARE	985,115	108,018	1,093,133	5
6	NURSING CARE-CONTINUOUS HOM				6
7	PHYSICAL THERAPY				7
8	OCCUPATIONAL THERAPY				8
9	SPEECH/LANGUAGE PATHOLOGY				9
10	MEDICAL SOCIAL SERV. - DIRE				10
11	SPIRITUAL COUNSELING				11
12	DIETARY COUNSELING				12
13	COUNSELING - OTHER				13
14	HOME HLTH AIDE & HOMEMAKERS				14
15	HH AIDE & HMKR-CONT. HOME C				15
16	OTHER	136,552	14,973	151,525	16
17	DRUGS,BIOLOGICALS & INFUSIO				17
18	ANALGESICS				18
19	SEDATIVES / HYPNOTICS				19
20	OTHER - SPECIFY				20
21	DURABLE MED. EQUIP./OXYGEN				21
22	PATIENT TRANSPORTATION				22
23	IMAGING SERVICES				23
24	LABS AND DIAGNOSTICS				24
25	MEDICAL SUPPLIES				25
26	OUTPAT. SERV.(INCL.E/R DEPT				26
27	RADIATION THERAPY				27
28	CHEMOTHERAPY				28
29	OTHER				29
30	BEREAVEMENT PROGRAM COSTS				30
31	VOLUNTEER PROGRAM COSTS				31
32	FUNDRAISING				32
33	OTHER PROGRAM COSTS				33
34	TOTALS (SUM OF LINES 1-33)	1,244,658		1,244,658	34
35	UNIT COST MULTIPLIER		0.109650		35

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

	HOSPICE COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW 2	OTHER CAP REL COSTS NOT USED 3	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL 4	ADMITTING GROSS CHARGES 5.01	PURCHASING RECEIVING AND STORES COST REQ'S 5.02	DATA PROCESSING TIME SPENT 5.03	COMMUNICATIONS # OF PHONES 5.04	
1	ADMINISTRATIVE AND GENERAL	1,282	628		79,446		55,880	27,207	14	1
2	INPATIENT - GENERAL CARE									2
3	INPATIENT - RESPITE CARE									3
4	PHYSICIAN SERVICES									4
5	NURSING CARE				527,656					5
6	NURSING CARE-CONTINUOUS HOM									6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH/LANGUAGE PATHOLOGY									9
10	MEDICAL SOCIAL SERV. - DIRE									10
11	SPIRITUAL COUNSELING									11
12	DIETARY COUNSELING									12
13	COUNSELING - OTHER									13
14	HOME HLTH AIDE & HOMEMAKERS									14
15	HH AIDE & HMKR-CONT. HOME C									15
16	OTHER				78,990					16
17	DRUGS,BIOLOGICALS & INFUSIO									17
18	ANALGESICS									18
19	SEDATIVES / HYPNOTICS									19
20	OTHER - SPECIFY									20
21	DURABLE MED. EQUIP./OXYGEN									21
22	PATIENT TRANSPORTATION									22
23	IMAGING SERVICES									23
24	LABS AND DIAGNOSTICS									24
25	MEDICAL SUPPLIES									25
26	OUTPAT. SERV.(INCL.E/R DEPT									26
27	RADIATION THERAPY									27
28	CHEMOTHERAPY									28
29	OTHER									29
30	BEREAVEMENT PROGRAM COSTS									30
31	VOLUNTEER PROGRAM COSTS									31
32	FUNDRAISING									32
33	OTHER PROGRAM COSTS									33
34	TOTALS (SUM OF LINES 1-33)	1,282	628		686,092		55,880	27,207	14	34
35	TOTAL COST TO BE ALLOCATED	9,927	684		84,487		3,657	32,926	5,396	35
36	UNIT COST MULTIPLIER	7.743370	1.089172		0.123142		0.065444	1.210203	385.428571	36

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

	HOSPICE COST CENTER	BUSINESS OFFICE GROSS CHARGES 5.05	RECON-CILIATION 4A.06	OTHER ADMINISTRATIVE AND GENER ACCUM COST 5.06	MAIN-TENANCE & REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS 8	HOUSE-KEEPING SQUARE FEET 9	DIETARY MEALS 10	
1	ADMINISTRATIVE AND GENERAL			62,373		1,282		1,282		1
2	INPATIENT - GENERAL CARE									2
3	INPATIENT - RESPITE CARE									3
4	PHYSICIAN SERVICES									4
5	NURSING CARE			923,753						5
6	NURSING CARE-CONTINUOUS HOM									6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH/LANGUAGE PATHOLOGY									9
10	MEDICAL SOCIAL SERV. - DIRE									10
11	SPIRITUAL COUNSELING									11
12	DIETARY COUNSELING									12
13	COUNSELING - OTHER									13
14	HOME HLTH AIDE & HOMEMAKERS									14
15	HH AIDE & HMKR-CONT. HOME C									15
16	OTHER			128,046						16
17	DRUGS,BIOLOGICALS & INFUSIO									17
18	ANALGESICS									18
19	SEDATIVES / HYPNOTICS									19
20	OTHER - SPECIFY									20
21	DURABLE MED. EQUIP./OXYGEN									21
22	PATIENT TRANSPORTATION									22
23	IMAGING SERVICES									23
24	LABS AND DIAGNOSTICS									24
25	MEDICAL SUPPLIES									25
26	OUTPAT. SERV.(INCL.E/R DEPT									26
27	RADIATION THERAPY									27
28	CHEMOTHERAPY									28
29	OTHER									29
30	BEREAVEMENT PROGRAM COSTS									30
31	VOLUNTEER PROGRAM COSTS									31
32	FUNDRAISING									32
33	OTHER PROGRAM COSTS									33
34	TOTALS (SUM OF LINES 1-33)			1,114,172		1,282		1,282		34
35	TOTAL COST TO BE ALLOCATED			74,011		15,582		5,613		35
36	UNIT COST MULTIPLIER			0.066427		12.154446		4.378315		36

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

	HOSPICE COST CENTER	CAFETERIA FTE'S 11	NURSING ADMINIS-TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY CSS CSTED REQ' 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
1	ADMINISTRATIVE AND GENERAL	1,308			1,538,794		1
2	INPATIENT - GENERAL CARE						2
3	INPATIENT - RESPITE CARE						3
4	PHYSICIAN SERVICES						4
5	NURSING CARE						5
6	NURSING CARE-CONTINUOUS HOM						6
7	PHYSICAL THERAPY						7
8	OCCUPATIONAL THERAPY						8
9	SPEECH/LANGUAGE PATHOLOGY						9
10	MEDICAL SOCIAL SERV. - DIRE						10
11	SPIRITUAL COUNSELING						11
12	DIETARY COUNSELING						12
13	COUNSELING - OTHER						13
14	HOME HLTH AIDE & HOMEMAKERS						14
15	HH AIDE & HMKR-CONT. HOME C						15
16	OTHER						16
17	DRUGS,BIOLOGICALS & INFUSIO						17
18	ANALGESICS						18
19	SEDATIVES / HYPNOTICS						19
20	OTHER - SPECIFY						20
21	DURABLE MED. EQUIP./OXYGEN						21
22	PATIENT TRANSPORTATION						22
23	IMAGING SERVICES						23
24	LABS AND DIAGNOSTICS						24
25	MEDICAL SUPPLIES						25
26	OUTPAT. SERV.(INCL.E/R DEPT						26
27	RADIATION THERAPY						27
28	CHEMOTHERAPY						28
29	OTHER						29
30	BEREAVEMENT PROGRAM COSTS						30
31	VOLUNTEER PROGRAM COSTS						31
32	FUNDRAISING						32
33	OTHER PROGRAM COSTS						33
34	TOTALS (SUM OF LINES 1-33)	1,308			1,538,794		34
35	TOTAL COST TO BE ALLOCATED	12,997			22,283		35
36	UNIT COST MULTIPLIER	9.936544			0.014481		36

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

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

		WKST C, PART I, COL. 9, LINE 0	COST TO CHARGE RATIO 1	TOTAL HOSPICE CHARGES (PROVIDER RECORDS) 2	HOSPICE SHARED ANCILLARY COSTS (COL.1 x 2) 3	
	ANCILLARY SERVICE COST CENTERS					
1	PHYSICAL THERAPY	66	0.516231			1
2	OCCUPATIONAL THERAPY	67				2
3	SPEECH/LANGUAGE PATHOLOGY	68				3
4	DRUGS, BIOLOGICALS AND INFUSION	73	0.301395			4
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96				5
6	LABS AND DIAGNOSTICS	60	0.213474			6
7	MEDICAL SUPPLIES	71	0.695297			7
8	OUTPATIENT SERVICES (INCL. E/R DEPT)	93				8
9	RADIATION THERAPY	55				9
10	OTHER ANCILLARY (SPECIFY)	76				10
11	TOTALS (SUM OF LINES 1-10)					11

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

	COMPUTATION OF PER DIEM COST	TITLE XVIII 1	TITLE XIX 2	OTHER 3	TOTAL 4	
1	TOTAL COST (SEE INSTRUCTIONS)				1,244,658	1
2	TOTAL UNDUPLICATED DAYS (WKST S-9, COL. 6, LINE 5)				4,975	2
3	AVERAGE COST PER DIEM (LINE 1 DIVIDED BY LINE 2)				250.18	3
4	UNDUPLICATED MEDICARE DAYS (WKST S-9, COL. 1, LINE 5)	4,721				4
5	AGGREGATE MEDICARE COST (LINE 3 TIMES LINE 4)	1,181,100				5
6	UNDUPLICATED MEDICAID DAYS (WKST S-9, COL. 2, LINE 5)		184			6
7	AGGREGATE MEDICAID COST (LINE 3 TIMES LINE 6)		46,033			7
8	UNDUPLICATED SNF DAYS (WKST S-9, COL. 3, LINE 5)	2,682				8
9	AGGREGATE SNF COST (LINE 3 TIMES LINE 8)	670,983				9
10	UNDUPLICATED NF DAYS (WKST S-9, COL. 4, LINE 5)					10
11	AGGREGATE NF COST (LINE 3 TIMES LINE 10)					11
12	OTHER UNDUPLICATED DAYS (WKST S-9, COL. 5, LINE 5)			70		12
13	AGGREGATE COST FOR OTHER DAYS (LINE 3 TIMES LINE 12)			17,513		13

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	296,851	1
2	CAPITAL DRG OUTLIER PAYMENTS	1,450	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	7.21	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	298,301	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES WORKSHEET L-1
PART I

	COST CENTER DESCRIPTION	EXTRAORDI-NARY 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 DEPARTMENT						4
5.01	ADMISSIONS						5.01
5.02	PURCHASING, RECEIVING, AND STO						5.02
5.03	DATA PROCESSING						5.03
5.04	COMMUNICATIONS						5.04
5.05	BUSINESS OFFICE						5.05
5.06	OTHER ADMINISTRATIVE AND GENER						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY						60
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PA						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
88	RURAL HEALTH CLINIC						88
88.01	RHC II						88.01
88.02	RHC III						88.02
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES						95
101	HOME HEALTH AGENCY						101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE						116
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CA						190
194	IROQUOIS WOMEN'S HEALTH						194
194.01	OTHER NON-REIMBURSABLE COSTS						194.01
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINE 118 AND						202
	LINES 190-201)						
203	TOTAL STATISTICAL BASIS						203
204	UNIT COST MULTIPLIER						204
204	UNIT COST MULTIPLIER						204

RHC I WORKSHEET M-1

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

COMPONENT NO: 14-3424

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	119,705		119,705		119,705		119,705	1
2	PHYSICIAN ASSISTANT	17,508		17,508		17,508		17,508	2
3	NURSE PRACTITIONER	11,801	47,479	59,280		59,280		59,280	3
4	VISITING NURSE								4
5	OTHER NURSE	49,336		49,336		49,336		49,336	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)	198,350	47,479	245,829		245,829		245,829	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (SUM OF LINES 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		2,556	2,556		2,556		2,556	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		6,013	6,013		6,013		6,013	18
19	OTHER HEALTH CARE COSTS		5,183	5,183		5,183		5,183	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		13,752	13,752		13,752		13,752	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	198,350	61,231	259,581		259,581		259,581	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		1,633	1,633		1,633		1,633	29
30	ADMINISTRATIVE COSTS	27,828	70,866	98,694		98,694		98,694	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	27,828	72,499	100,327		100,327		100,327	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	226,178	133,730	359,908		359,908		359,908	32

RHC I WORKSHEET M-2

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

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.40	1,781	4,200	1,680		1
2	PHYSICIAN ASSISTANTS	0.12	530	2,100	252		2
3	NURSE PRACTITIONERS	0.37	970	2,100	777		3
4	SUBTOTAL (SUM OF LINES 1-3)	0.89	3,281		2,709	3,281	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.89	3,281			3,281	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)	259,581	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)	259,581	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)	100,327	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	140,117	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	240,444	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	240,444	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	240,444	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	500,025	20

RHC I WORKSHEET M-3

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

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	500,025	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	3,462	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	496,563	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	3,281	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	3,281	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	151.35	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. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	151.35	151.35	151.35	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	262	783		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	39,654	118,507		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)		158,161		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		73,302		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		130		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		280		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		113,053		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		113,333		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		16,565		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		16,234		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		113,333		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		3,103		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		116,436		22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		7,729		23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		6,802		23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		7,729		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		123,238		26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		1,232		26.01
27	INTERIM PAYMENTS		101,509		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		20,497		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2				30

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

RHC I WORKSHEET M-4

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

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	245,829	245,829	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000571	0.002792	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	140	686	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	485	486	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	625	1,172	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	259,581	259,581	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	240,444	240,444	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.002408	0.004515	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	579	1,086	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,204	2,258	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	9	44	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	133.78	51.32	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	9	37	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	1,204	1,899	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)		3,462	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		3,103	16

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

RHC I COMPONENT NO: 14-3424

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				96,408	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	03/20/2013	3,512	3.01
			.02	09/17/2013	1,589	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		5,101	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				101,509	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 TO PROVIDER	.01		NONE	5.01
			.02			5.02
			.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER TO PROGRAM	.50		NONE	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		21,729	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				123,238	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: 14-3425

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	79,127		79,127		79,127		79,127	1
2	PHYSICIAN ASSISTANT	45,858		45,858		45,858		45,858	2
3	NURSE PRACTITIONER		34,470	34,470		34,470		34,470	3
4	VISITING NURSE								4
5	OTHER NURSE	63,238		63,238		63,238		63,238	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)	188,223	34,470	222,693		222,693		222,693	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (SUM OF LINES 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		2,880	2,880		2,880		2,880	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		4,009	4,009		4,009		4,009	18
19	OTHER HEALTH CARE COSTS		7,471	7,471		7,471		7,471	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		14,360	14,360		14,360		14,360	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	188,223	48,830	237,053		237,053		237,053	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS	23,395	79,755	103,150		103,150		103,150	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	23,395	79,755	103,150		103,150		103,150	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	211,618	128,585	340,203		340,203		340,203	32

RHC II WORKSHEET M-2

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

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.45	1,843	4,200	1,890		1
2	PHYSICIAN ASSISTANTS	0.34	1,031	2,100	714		2
3	NURSE PRACTITIONERS	0.15	552	2,100	315		3
4	SUBTOTAL (SUM OF LINES 1-3)	0.94	3,426		2,919	3,426	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.94	3,426			3,426	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)	237,053	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)	237,053	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)	103,150	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	95,452	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	198,602	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	198,602	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	198,602	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	435,655	20

RHC II WORKSHEET M-3

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

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	435,655	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	4,317	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	431,338	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	3,426	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	3,426	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	125.90	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. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	125.90	125.90	125.90	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	300	898		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	37,770	113,058		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)		150,828		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		86,462		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		300		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		523		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		108,185		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		108,708		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		15,074		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		19,982		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		108,708		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		3,476		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		112,184		22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		12,779		23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		11,246		23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		12,779		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		123,430		26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		1,234		26.01
27	INTERIM PAYMENTS		98,153		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		24,043		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2				30

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

RHC II WORKSHEET M-4

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

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	222,693	222,693	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000468	0.004815	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	104	1,072	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	377	796	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	481	1,868	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	237,053	237,053	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	198,602	198,602	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.002029	0.007880	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	403	1,565	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	884	3,433	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	7	72	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	126.29	47.68	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	6	57	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	758	2,718	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)		4,317	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		3,476	16

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

RHC II COMPONENT NO: 14-3425

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				104,362	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE	3.01
			.02			3.02
		PROGRAM	.03			3.03
		TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50			3.50
			.51	03/20/2013	5,124	3.51
		PROVIDER	.52	09/17/2013	1,085	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		-6,209	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				98,153	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE	5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER	.50		NONE	5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99			5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO PROVIDER	.01		25,277	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				123,430	7

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

RHC III WORKSHEET M-1

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

COMPONENT NO: 15-3979

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	299,534		299,534		299,534		299,534	1
2	PHYSICIAN ASSISTANT	92,122		92,122		92,122		92,122	2
3	NURSE PRACTITIONER	178,159		178,159		178,159		178,159	3
4	VISITING NURSE								4
5	OTHER NURSE	143,193		143,193		143,193		143,193	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)	713,008		713,008		713,008		713,008	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (SUM OF LINES 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		7,974	7,974		7,974		7,974	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		10,693	10,693		10,693		10,693	18
19	OTHER HEALTH CARE COSTS		13,002	13,002		13,002		13,002	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		31,669	31,669		31,669		31,669	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	713,008	31,669	744,677		744,677		744,677	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		12,152	12,152	-1,922	10,230		10,230	29
30	ADMINISTRATIVE COSTS	83,836	269,912	353,748	-66,110	287,638		287,638	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	83,836	282,064	365,900	-68,032	297,868		297,868	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	796,844	313,733	1,110,577	-68,032	1,042,545		1,042,545	32

RHC III WORKSHEET M-2

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

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.43	2,871	4,200	1,806		1
2	PHYSICIAN ASSISTANTS	0.95	2,795	2,100	1,995		2
3	NURSE PRACTITIONERS	1.17	3,431	2,100	2,457		3
4	SUBTOTAL (SUM OF LINES 1-3)	2.55	9,097		6,258	9,097	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2.55	9,097			9,097	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)	744,677	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)	744,677	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)	297,868	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	348,661	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	646,529	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	646,529	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	646,529	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,391,206	20

RHC III WORKSHEET M-3

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

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	1,391,206	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	7,562	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,383,644	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	9,097	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	9,097	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	152.10	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. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	152.10	152.10	152.10	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	804	2,411		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	122,288	366,713		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)		489,001		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		244,934		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%)		356,197		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		356,197		16.05
17	PRIMARY PAYOR PAYMENTS		210		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		43,755		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		56,565		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		355,987		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		5,186		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		361,173		22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		15,980		23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		14,062		23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		15,980		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		375,235		26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		3,752		26.01
27	INTERIM PAYMENTS		330,088		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		41,395		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2				30

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

RHC III WORKSHEET M-4

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

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	713,008	713,008	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000159	0.002577	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	113	1,837	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	485	1,613	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	598	3,450	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	744,677	744,677	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	646,529	646,529	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.000803	0.004633	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	519	2,995	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,117	6,445	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	9	146	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	124.11	44.14	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	8	95	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	993	4,193	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		7,562	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		5,186	16

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

RHC III COMPONENT NO: 15-3979

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				322,083	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	03/20/2013	2,639	3.01
			.02	09/17/2013	5,366	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		8,005	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				330,088	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE	5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER	.50		NONE	5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99			5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO PROVIDER	.01		45,147	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				375,235	7

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

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3 Part IV, Line 4) EXHIBIT 3

	STEP 1: Determine the 3-Year Averaging Period	
1	Wage index fiscal year ending date	1
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	5
	STEP 2 (OPTIONAL): Adjust Averaging Period for a New Plan (SEE INSTRUCTIONS)	
6	Effective date of pension plan	6
7	First day of the provider cost reporting period containing the pension plan effective date	7
8	Starting date of the adjusted averaging period (date on Line 7, adjusted to first of month)	8
	If this date occurs after the period shown on line 2, stop here and see instructions.	
	STEP 3: Average Pension Contributions During the Averaging Period	
9	Beginning date of averaging period from Line 4 or Line 8, as applicable	9
10	Ending date of averaging period from Line 5	10
11	Enter provider contributions made during averaging period on Lines 9 & 10	11
11.01		11.01
12	Total calendar months included in averaging period (36 unless Step 2 completed)	12
13	Total contributions made during averaging period	13
14	Average monthly contribution (Line 13 divided by Line 12)	14
15	Number of months in provider cost reporting period on Line 2	15
16	Average pension contributions (Line 14 times Line 15)	16
	STEP 4: Total Pension Cost for Wage Index	
17	Annual prefunding installment (SEE INSTRUCTIONS)	17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	19

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97) EXHIBIT 4

		Amounts From E Part A (1)	Prior to 10/1/2010 or after 9/30/2013 Pre/Post Entitlement (2)	NOT APPLICABLE (3)	(3.01)	10/01/2012 through 09/30/2013 (4)	(4.01)	(Columns 2 through 4) TOTAL (5)	
1	DRG Amounts Other than Outlier Payments	3,756,237				3,756,237		3,756,237	1
2	Outlier payments for discharges	16,568				16,568		16,568	2
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments								4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT								
5	Amount from Worksheet E Part A, Line 21								5
6	IME payment adjustment								6
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422								
7	Amount from Worksheet E Part A, Line 27								7
8	IME add-on adjustment								8
9	Total IME payment								9
	DISPROPORTIONATE SHARE ADJUSTMENT								
10	Allowable disproportionate share percentage	0.0814	0.0814	0.0814	0.0814	0.0814	0.0814		10
11	Disproportionate share adjustment	305,758				305,758		305,758	11
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES								
12	Total ESRD additional payment								12
13	Subtotal	4,078,563				4,078,563		4,078,563	13
14	Hospital specific payments	4,461,326				4,461,326		4,461,326	14
15	Total payment for inpatient operating costs - E Part A Line 49	4,461,326				4,461,326		4,461,326	15
16	Payment for inpatient program capital	298,301				298,301		298,301	16
17	Special add-on payments for new technologies								17
18	Capital outlier reconciliation adjustment amount								18
19	SUBTOTAL					4,759,627		4,759,627	19
	CAPITAL PAYMENTS								
20	Capital DRG other than outlier	296,851				296,851		296,851	20
21	Capital DRG outlier payments	1,450				1,450		1,450	21
22	Indirect medical education percentage								22
23	Indirect medical education adjustment								23
24	Allowable disproportionate share percentage								24
25	Disproportionate share adjustment								25
26	Total prospective capital payments	298,301				298,301		298,301	26
	LOW VOLUME ADJUSTMENT								
27	Low volume adjustment factor					0.111786			27
28	Low Volume Adjustment								28
29	Low Volume Adjustment					532,060		532,060	29