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

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY KIRBY HOSPITAL (14-1301) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(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		-682,121	-333,587	1,074,022		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-878,108				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-22,059			10
10.01	HEALTH CLINIC - RHC II			-81,892			10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-1,560,229	-437,538	1,074,022		200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1000 MEDICAL CENTER DR P.O.BOX: 1
2 CITY: MONTICELLO STATE: IL ZIP CODE: 61856 COUNTY: PIATT 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	KIRBY HOSPITAL	14-1301	16580	1	08/08/1999	N	O	N	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	KIRBY HOSPITAL-SWING BED	14-Z301	16580		08/08/1999	N	O	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	ATWOOD RURAL HEALTH CLINIC	14-3438	16580		11/17/1997	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	KIRBY MEDICAL GROUP RURAL HEAL	14-3495	16580		11/20/2008	N	O	N	15.01
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2012		TO: 06/30/2013						20
21	TYPE OF CONTROL	12								21

INPATIENT PPS INFORMATION

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

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

		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)	N	N	39

		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

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

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

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

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

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

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

		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
	SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.				
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				64

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

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

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

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

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

INPATIENT PSYCHIATRIC FACILITY PPS

70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.		71

INPATIENT REHABILITATION FACILITY PPS

75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.		76

LONG TERM CARE HOSPITAL PPS

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

TEFRA PROVIDERS

85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N	86

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

		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

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

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

	MISCELLANEOUS COST REPORTING INFORMATION		
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	2	118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 116,190 PAID LOSSES: SELF INSURANCE:		118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	121

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

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

ALL PROVIDERS

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

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

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:		141
142	STREET:	P.O. BOX:			142
143	CITY:	STATE:	ZIP CODE:		143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?			Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.			N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	149

	DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE V 3	TITLE XIX 4	
155	HOSPITAL	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.	2,829,185		168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.			169
170	IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS)	07/01/2012	06/30/2013	170

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

		Y/N
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	N 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.	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	14

BED COMPLEMENT

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

		PART A Y/N 1	PART A DATE 2	PART B Y/N 3	PART B DATE 4	
	PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	09/11/2013	Y	09/11/2013	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.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
	INTEREST EXPENSE		
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	N	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31
	PURCHASED SERVICES		
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
	PROVIDER-BASED PHYSICIANS		
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	35

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: THOMAS	LAST NAME: CURTIS	TITLE: CPA		41
42	EMPLOYER: THE CURTIS GROUP, INC.				42
43	PHONE NUMBER: 217-483-9092	E-MAIL ADDRESS: TCURTISCPA@GMAIL.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	16	5,840	46,513.00		490	31	794	1
2	HMO AND OTHER (SEE INSTRUCTIONS)						194			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						657		1,046	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								133	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		16	5,840	46,513.00		1,147	31	1,973	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)		16	5,840	46,513.00		1,147	31	1,973	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88							4,583	26
26.01	RHC II	88.01							15,426	26.01
27	TOTAL (SUM OF LINES 14-26)		16							27
28	OBSERVATION BED DAYS								108	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- 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					156	14	430	1
2	HMO AND OTHER (SEE INSTRUCTIONS)						54			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)			149.63			156	14	430	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88		5.64						26
26.01	RHC II	88.01		20.34						26.01
27	TOTAL (SUM OF LINES 14-26)			175.61						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART II & III

PART II - WAGE DATA

		WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200						1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)							10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)							17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT							26
27	ADMINISTRATIVE & GENERAL							27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT							30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING							32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY							34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION							38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY							41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

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

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

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

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

PROSPECTIVE PAYMENT FOR SNF | WORKSHEET S-7
STATISTICAL DATA

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

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

PROSPECTIVE PAYMENT FOR SNF | WORKSHEET S-7
STATISTICAL DATA

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4	
69	PE2			69	69
70	PE1			70	70
71	PD2			71	71
72	PD1			72	72
73	PC2			73	73
74	PC1			74	74
75	PB2			75	75
76	PB1			76	76
77	PA2			77	77
78	PA1			78	78
199	AAA			199	199
200	TOTAL			200	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).			201

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

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

RHC I WORKSHEET S-8

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

COMPONENT NO: 14-3438

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 108 S MAIN ST	1
2	CITY: ATWOOD STATE: IL ZIP CODE: 61913 COUNTY: DOUGLAS	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

		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	0830	1600	0830	1600	0830	1600	0830	1600			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: 14-3495

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1000 MEDICAL CT
2 CITY: MONTICELLO STATE: IL ZIP CODE: 61856 COUNTY: PIATT
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

		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	1800	0700	1600	0700	1600	0700	1600	0700	1600			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

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)	0.662839	1

MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)

2	NET REVENUE FROM MEDICAID	1,448,151	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	3,282,679	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	2,175,888	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.	727,737	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)	727,737	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	2,188,255		2,188,255	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	1,450,461		1,450,461	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	1,450,461		1,450,461	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				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)			210,043	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			133,253	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			76,790	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			50,899	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,501,360	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			2,229,097	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		1,878,541	1,878,541	1,859,566	1
2	00200	CAP REL COSTS-MVBLE EQUIP		1,453,402	1,453,402	84,307	2
3	00300	OTHER CAP REL COSTS					3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		106,625	106,625		4
5	00500	ADMINISTRATIVE & GENERAL	2,112,816	4,797,800	6,910,616	-1,972,304	5
6	00600	MAINTENANCE & REPAIRS	167,671	197,958	365,629		6
7	00700	OPERATION OF PLANT		411,481	411,481	-63,428	7
8	00800	LAUNDRY & LINEN SERVICE		91,871	91,871		8
9	00900	HOUSEKEEPING	253,956	118,291	372,247		9
10	01000	DIETARY	219,984	209,875	429,859	-325,011	10
11	01100	CAFETERIA				325,011	11
13	01300	NURSING ADMINISTRATION					13
14	01400	CENTRAL SERVICES & SUPPLY	77,362	121,211	198,573	-109,151	14
15	01500	PHARMACY	51,492	366,786	418,278	-190,037	15
16	01600	MEDICAL RECORDS & LIBRARY	428,298	235,719	664,017		16
17	01700	SOCIAL SERVICE					17
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	1,044,481	583,174	1,627,655	103,183	30
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	278,676	643,568	922,244		50
53	05300	ANESTHESIOLOGY	92,825	20,284	113,109		53
54	05400	RADIOLOGY-DIAGNOSTIC	472,117	751,940	1,224,057		54
56.10	03630	ULTRASOUND		9,458	9,458		56.10
60	06000	LABORATORY	474,847	1,067,068	1,541,915	-8,946	60
66	06600	PHYSICAL THERAPY	443,355	212,495	655,850		66
67	06700	OCCUPATIONAL THERAPY	160,405	49,260	209,665		67
68	06800	SPEECH PATHOLOGY		35,436	35,436		68
69	06900	ELECTROCARDIOLOGY	19,180	3,668	22,848	42,269	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				109,151	71
73	07300	DRUGS CHARGED TO PATIENTS				190,037	73
74	07400	RENAL DIALYSIS					74
		OUTPATIENT SERVICE COST CENTERS					
88	08800	RURAL HEALTH CLINIC	289,614	172,162	461,776		88
88.01	08801	RHC II	1,428,415	751,693	2,180,108		88.01
91	09100	EMERGENCY	750,663	2,064,505	2,815,168	154,694	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92
		OTHER REIMBURSABLE COST CENTERS					
94	09400	HOME PROGRAM DIALYSIS					94
95	09500	AMBULANCE SERVICES	240,005	191,169	431,174	-188,017	95
		SPECIAL PURPOSE COST CENTERS					
118		SUBTOTALS (SUM OF LINES 1-117)	9,006,162	16,545,440	25,551,602	11,324	118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
190.01	19001	FOUNDATION	42,721	63,001	105,722	-11,324	190.01
192	19200	PHYSICIANS' PRIVATE OFFICES					192
200		TOTAL (SUM OF LINES 118-199)	9,048,883	16,608,441	25,657,324		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	3,738,107	15,878	3,753,985	1
2	00200	CAP REL COSTS-MVBLE EQUIP	1,537,709	-753,160	784,549	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	106,625		106,625	4
5	00500	ADMINISTRATIVE & GENERAL	4,938,312	-359,787	4,578,525	5
6	00600	MAINTENANCE & REPAIRS	365,629		365,629	6
7	00700	OPERATION OF PLANT	348,053	12,287	360,340	7
8	00800	LAUNDRY & LINEN SERVICE	91,871		91,871	8
9	00900	HOUSEKEEPING	372,247		372,247	9
10	01000	DIETARY	104,848		104,848	10
11	01100	CAFETERIA	325,011	-93,002	232,009	11
13	01300	NURSING ADMINISTRATION				13
14	01400	CENTRAL SERVICES & SUPPLY	89,422		89,422	14
15	01500	PHARMACY	228,241		228,241	15
16	01600	MEDICAL RECORDS & LIBRARY	664,017	-54	663,963	16
17	01700	SOCIAL SERVICE				17
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	1,730,838	-182,500	1,548,338	30
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	922,244	-135,730	786,514	50
53	05300	ANESTHESIOLOGY	113,109		113,109	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,224,057	-248,555	975,502	54
56.10	03630	ULTRASOUND	9,458		9,458	56.10
60	06000	LABORATORY	1,532,969		1,532,969	60
66	06600	PHYSICAL THERAPY	655,850	-48,405	607,445	66
67	06700	OCCUPATIONAL THERAPY	209,665		209,665	67
68	06800	SPEECH PATHOLOGY	35,436		35,436	68
69	06900	ELECTROCARDIOLOGY	65,117	-19,180	45,937	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	109,151		109,151	71
73	07300	DRUGS CHARGED TO PATIENTS	190,037		190,037	73
74	07400	RENAL DIALYSIS				74
		OUTPATIENT SERVICE COST CENTERS				
88	08800	RURAL HEALTH CLINIC	461,776		461,776	88
88.01	08801	RHC II	2,180,108		2,180,108	88.01
91	09100	EMERGENCY	2,969,862	-437,800	2,532,062	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
		OTHER REIMBURSABLE COST CENTERS				
94	09400	HOME PROGRAM DIALYSIS				94
95	09500	AMBULANCE SERVICES	243,157	100	243,257	95
		SPECIAL PURPOSE COST CENTERS				
118		SUBTOTALS (SUM OF LINES 1-117)	25,562,926	-2,249,908	23,313,018	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
190.01	19001	FOUNDATION	94,398		94,398	190.01
192	19200	PHYSICIANS' PRIVATE OFFICES		12,287	12,287	192
200		TOTAL (SUM OF LINES 118-199)	25,657,324	-2,237,621	23,419,703	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE: COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS MEDICAL SUPPLY EXPENSES	A	MEDICAL SUPPLIES CHARGED TO P	71		109,151	1
2	RECLASS DRUG COSTS	A	DRUGS CHARGED TO PATIENTS	73		190,037	2
3	RECLASS PROPERTY INS	A	CAP REL COSTS-BLDG & FIXT	1		36,760	3
4	RECLASS PROPERTY INS	A	CAP REL COSTS-MVBLE EQUIP	2		26,668	4
5	RECLASS INTEREST EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1		1,822,806	5
6	RECLASS INTEREST EXPENSE	A	CAP REL COSTS-MVBLE EQUIP	2		57,639	6
7	RECLASS FOUNDATION EXPENSES	A	ADMINISTRATIVE & GENERAL	5	9,700	1,624	7
8	RECLASS DIETARY COSTS	A	CAFETERIA	11	166,327	158,684	8
9	RECLASS A RUSSELL SALARY	A	ADULTS & PEDIATRICS	30	90,292	12,891	9
10	EKG EXPENSES	A	ELECTROCARDIOLOGY	69	33,724	8,545	10
11	EKG EXPENSES	A					11
500	TOTAL RECLASSIFICATIONS				300,043	2,424,805	500
	CODE LETTER - A						
1	RECLASS AMBULANC TO ER	B	EMERGENCY	91	188,017		1
500	TOTAL RECLASSIFICATIONS				188,017		500
	CODE LETTER - B						
	GRAND TOTAL (INCREASES)				488,060	2,424,805	

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 MEDICAL SUPPLY EXPENSES	A	CENTRAL SERVICES & SUPPLY	14		109,151		1
2	RECLASS DRUG COSTS	A	PHARMACY	15		190,037		2
3	RECLASS PROPERTY INS	A	OPERATION OF PLANT	7		36,760	12	3
4	RECLASS PROPERTY INS	A	OPERATION OF PLANT	7		26,668	12	4
5	RECLASS INTEREST EXPENSE	A	ADMINISTRATIVE & GENERAL	5		1,822,806	11	5
6	RECLASS INTEREST EXPENSE	A	ADMINISTRATIVE & GENERAL	5		57,639	11	6
7	RECLASS FOUNDATION EXPENSES	A	FOUNDATION	190.01	9,700	1,624		7
8	RECLASS DIETARY COSTS	A	DIETARY	10	166,327	158,684		8
9	RECLASS A RUSSELL SALARY	A	ADMINISTRATIVE & GENERAL	5	90,292	12,891		9
10	EKG EXPENSES	A	LABORATORY	60	6,981	1,965		10
11	EKG EXPENSES	A	EMERGENCY	91	26,743	6,580		11
500	TOTAL RECLASSIFICATIONS				300,043	2,424,805		500
	CODE LETTER - A							
1	RECLASS AMBULANC TO ER	B	AMBULANCE SERVICES	95	188,017			1
500	TOTAL RECLASSIFICATIONS				188,017			500
	CODE LETTER - B							
	GRAND TOTAL (DECREASES)				488,060	2,424,805		

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								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES								3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT								6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)								8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)								10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	1,878,541						1,878,541	1
2	CAP REL COSTS-MVBLE EQUIP	1,453,402						1,453,402	2
3	TOTAL (SUM OF LINES 1-2)	3,331,943						3,331,943	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS 1	COMPUTATION OF RATIOS CAPITALIZED LEASES 2	COMPUTATION OF RATIOS GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	COMPUTATION OF RATIOS RATIO (SEE INSTR.) 4	ALLOCATION OF OTHER CAPITAL INSURANCE 5	ALLOCATION OF OTHER CAPITAL TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT									1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (SUM OF LINES 1-2)									3

	DESCRIPTION	SUMMARY OF CAPITAL DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	1,878,541		1,792,609	36,760		46,075	3,753,985	1
2	CAP REL COSTS-MVBLE EQUIP	1,453,402		77,374	26,668		-772,895	784,549	2
3	TOTAL	3,331,943		1,869,983	63,428		-726,820	4,538,534	3

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-30,197	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	19,735	CAP REL COSTS-MVBLE EQUIP	2	11	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,023,765				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-93,002	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-54	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES	A	46,075	CAP REL COSTS-BLDG & FIXT	1	14	26
27	DEPRECIATION--MOVABLE EQUIPMENT	A	5,901	CAP REL COSTS-MVBLE EQUIP	2	14	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	MISC INCOME	B	-4,734	ADMINISTRATIVE & GENERAL	5		33
34	MISC INCOME-AMBULANCE	B	100	AMBULANCE SERVICES	95		34
35	CANCER CLINIC INCOME	B	-15,123	ADMINISTRATIVE & GENERAL	5		35
36	PHASE III CARDIAC REHAB INCOME	B	-48,405	PHYSICAL THERAPY	66		36
37	PUBLIC RELATIONS COSTS - UNALLOWAB	A	-191,694	ADMINISTRATIVE & GENERAL	5		37
38	LOBBYING PORTION OF IHA-AHA DUES	A	-5,940	ADMINISTRATIVE & GENERAL	5		38
39	PROPERTY TAXES	A	-17,112	ADMINISTRATIVE & GENERAL	5		39
40	MEDICAID ASSESSMENT TAX	A	-117,492	ADMINISTRATIVE & GENERAL	5		40
41	KEY EMPLOYEE - LIFE INSURANCE	A	-14,448	ADMINISTRATIVE & GENERAL	5		41
42	TRUST DEPR HOSP ADMIN	A	6,756	ADMINISTRATIVE & GENERAL	5		42
43	TRUST DEPR OP OF PLANT	A	12,287	OPERATION OF PLANT	7		43
44	TRUST DEPR PRVT PHYS OFFICES	A	12,287	PHYSICIANS' PRIVATE OFFICES	192		44
45	HIT 2013 DEPRECIATION EXPENSE	A	-778,796	CAP REL COSTS-MVBLE EQUIP	2	14	45
46							46
47							47
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-2,237,621				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. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERATION INCL FRINGES 3	PROFESSIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9	
1	50	OPERATING ROOM	SLEEP LAB PHYS	135,730	135,730						1
2	54	RADIOLOGY-DIAGNOSTIC	RADIOLOGISTS	248,555	248,555						2
3	69	ELECTROCARDIOLOGY	AGGREGATE	19,180	19,180						3
4	91	EMERGENCY	ER PHYS	1,793,163	437,800	1,355,363					4
5	88	RURAL HEALTH CLINIC	RHC I PHYS	290,190		290,190					5
6	88.01	RHC II	RHC II PHYS	1,364,869		1,364,869					6
7	30	ADULTS & PEDIATRICS	HOSPITALISTS	182,500	182,500						7
200		TOTAL		4,034,187	1,023,765	3,010,422					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	50	OPERATING ROOM	SLEEP LAB PHYS							135,730	1
2	54	RADIOLOGY-DIAGNOSTIC	RADIOLOGISTS							248,555	2
3	69	ELECTROCARDIOLOGY	AGGREGATE							19,180	3
4	91	EMERGENCY	ER PHYS							437,800	4
5	88	RURAL HEALTH CLINIC	RHC I PHYS								5
6	88.01	RHC II	RHC II PHYS								6
7	30	ADULTS & PEDIATRICS	HOSPITALISTS							182,500	7
200		TOTAL								1,023,765	200

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

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	53	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		326.50				9
10	AHSEA		66.10				10
11	STANDARD TRAVEL ALLOWANCE	33.05	33.05				11
12	NO OF TRAVEL HRS (PROV SITE)		92				12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)		364				13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	21,582	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	21,582	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	21,582	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	66.10	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	51,558	22
23	TOTAL SALARY EQUIVALENCY	51,558	23

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

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	1,752	24
25	ASSISTANTS		25
26	SUBTOTAL	1,752	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	1,752	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS	6,081	29
30	ASSISTANTS		30
31	SUBTOTAL	6,081	31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	1,752	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	51,558	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	1,752	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	53,310	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES		64
65	EXCESS OVER LIMITATION		65

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

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	129	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		437.50				9
10	AHSEA		66.10				10
11	STANDARD TRAVEL ALLOWANCE	33.05	33.05				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	28,919	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	28,919	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	28,919	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	66.10	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	51,558	22
23	TOTAL SALARY EQUIVALENCY	51,558	23

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

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	4,263	24
25	ASSISTANTS		25
26	SUBTOTAL	4,263	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	4,263	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	4,263	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	51,558	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	4,263	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	55,821	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES		64
65	EXCESS OVER LIMITATION		65

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	3,753,985	3,753,985				1
2	CAP REL COSTS-MVBLE EQUIP	784,549		784,549			2
4	EMPLOYEE BENEFITS DEPARTMENT	106,625			106,625		4
5	ADMINISTRATIVE & GENERAL	4,578,525	263,275	93,679	23,946	4,959,425	5
6	MAINTENANCE & REPAIRS	365,629	14,172	789	1,976	382,566	6
7	OPERATION OF PLANT	360,340	754,187	61,922		1,176,449	7
8	LAUNDRY & LINEN SERVICE	91,871	16,586			108,457	8
9	HOUSEKEEPING	372,247	62,407	743	2,992	438,389	9
10	DIETARY	104,848	130,063	41,240	632	276,783	10
11	CAFETERIA	232,009	61,725		1,960	295,694	11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY	89,422	66,344		912	156,678	14
15	PHARMACY	228,241	56,004		607	284,852	15
16	MEDICAL RECORDS & LIBRARY	663,963	82,615	8,276	5,047	759,901	16
17	SOCIAL SERVICE						17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,548,338	514,059	74,201	13,371	2,149,969	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	786,514	423,256	63,701	3,284	1,276,755	50
53	ANESTHESIOLOGY	113,109			1,094	114,203	53
54	RADIOLOGY-DIAGNOSTIC	975,502	188,691	320,451	5,563	1,490,207	54
56.10	ULTRASOUND	9,458	6,613	39,841		55,912	56.10
60	LABORATORY	1,532,969	72,695	23,343	5,513	1,634,520	60
66	PHYSICAL THERAPY	607,445	226,482	3,200	5,224	842,351	66
67	OCCUPATIONAL THERAPY	209,665			1,890	211,555	67
68	SPEECH PATHOLOGY	35,436				35,436	68
69	ELECTROCARDIOLOGY	45,937			623	46,560	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	109,151				109,151	71
73	DRUGS CHARGED TO PATIENTS	190,037				190,037	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	461,776	32,490	2,332	3,413	500,011	88
88.01	RHC II	2,180,108	389,927	19,262	16,831	2,606,128	88.01
91	EMERGENCY	2,532,062	330,407	16,177	10,745	2,889,391	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	243,257	45,454	15,392	613	304,716	95
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	23,313,018	3,737,452	784,549	106,236	23,296,096	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		16,533			16,533	190
190.01	FOUNDATION	94,398			389	94,787	190.01
192	PHYSICIANS' PRIVATE OFFICES	12,287				12,287	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	23,419,703	3,753,985	784,549	106,625	23,419,703	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL 5	MAIN-TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL	4,959,425					5
6	MAINTENANCE & REPAIRS	102,778	485,344				6
7	OPERATION OF PLANT	316,058	105,287	1,597,794			7
8	LAUNDRY & LINEN SERVICE	29,137	2,316	9,852	149,762		8
9	HOUSEKEEPING	117,775	8,713	37,071	15,680	617,628	9
10	DIETARY	74,359	18,158	77,260		30,390	10
11	CAFETERIA	79,439	8,617	36,666		14,422	11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY	42,092	9,262	39,409		15,501	14
15	PHARMACY	76,527	7,819	33,267		13,085	15
16	MEDICAL RECORDS & LIBRARY	204,150	11,534	49,075		19,303	16
17	SOCIAL SERVICE						17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	577,598	71,767	305,361	76,798	120,114	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	343,005	59,090	251,422	27,861	98,895	50
53	ANESTHESIOLOGY	30,681					53
54	RADIOLOGY-DIAGNOSTIC	400,350	26,343	112,086		44,088	54
56.10	ULTRASOUND	15,021	923	3,928		1,545	56.10
60	LABORATORY	439,120	10,149	43,182		16,985	60
66	PHYSICAL THERAPY	226,301	31,619	134,534		52,918	66
67	OCCUPATIONAL THERAPY	56,835					67
68	SPEECH PATHOLOGY	9,520					68
69	ELECTROCARDIOLOGY	12,509					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,324					71
73	DRUGS CHARGED TO PATIENTS	51,054					73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	134,330	4,536			7,591	88
88.01	RHC II	700,147	54,437	231,624		91,108	88.01
91	EMERGENCY	776,244	46,120	196,236	27,035	77,200	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	81,863	6,346	27,000	2,388	10,620	95
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	4,926,217	483,036	1,587,973	149,762	613,765	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,442	2,308	9,821		3,863	190
190.01	FOUNDATION	25,465					190.01
192	PHYSICIANS' PRIVATE OFFICES	3,301					192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	4,959,425	485,344	1,597,794	149,762	617,628	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	14	15	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	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY	476,950					10
11	CAFETERIA		434,838				11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY		11,125	274,067			14
15	PHARMACY		5,321	37,711	458,582		15
16	MEDICAL RECORDS & LIBRARY		57,559	883		1,102,405	16
17	SOCIAL SERVICE						17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	476,950	112,023	7,062		203,850	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		20,460	57,873		111,572	50
53	ANESTHESIOLOGY		1,451	1,601			53
54	RADIOLOGY-DIAGNOSTIC		41,452	4,787		164,217	54
56.10	ULTRASOUND					24,079	56.10
60	LABORATORY		50,691	83,840		258,140	60
66	PHYSICAL THERAPY		33,423	2,694		36,493	66
67	OCCUPATIONAL THERAPY		9,867			5,683	67
68	SPEECH PATHOLOGY					3,739	68
69	ELECTROCARDIOLOGY			25			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			21,670			71
73	DRUGS CHARGED TO PATIENTS				458,582		73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC			8,144			88
88.01	RHC II			37,163			88.01
91	EMERGENCY		52,867	8,520		294,632	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES		38,599	1,829			95
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	476,950	434,838	273,802	458,582	1,102,405	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.01	FOUNDATION			265			190.01
192	PHYSICIANS' PRIVATE OFFICES						192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	476,950	434,838	274,067	458,582	1,102,405	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS				
1	CAP REL COSTS-BLDG & FIXT				1
2	CAP REL COSTS-MVBLE EQUIP				2
4	EMPLOYEE BENEFITS DEPARTMENT				4
5	ADMINISTRATIVE & GENERAL				5
6	MAINTENANCE & REPAIRS				6
7	OPERATION OF PLANT				7
8	LAUNDRY & LINEN SERVICE				8
9	HOUSEKEEPING				9
10	DIETARY				10
11	CAFETERIA				11
13	NURSING ADMINISTRATION				13
14	CENTRAL SERVICES & SUPPLY				14
15	PHARMACY				15
16	MEDICAL RECORDS & LIBRARY				16
17	SOCIAL SERVICE				17
	INPATIENT ROUTINE SERV COST CENTERS				
30	ADULTS & PEDIATRICS	4,101,492		4,101,492	30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	2,246,933		2,246,933	50
53	ANESTHESIOLOGY	147,936		147,936	53
54	RADIOLOGY-DIAGNOSTIC	2,283,530		2,283,530	54
56.10	ULTRASOUND	101,408		101,408	56.10
60	LABORATORY	2,536,627		2,536,627	60
66	PHYSICAL THERAPY	1,360,333		1,360,333	66
67	OCCUPATIONAL THERAPY	283,940		283,940	67
68	SPEECH PATHOLOGY	48,695		48,695	68
69	ELECTROCARDIOLOGY	59,094		59,094	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	160,145		160,145	71
73	DRUGS CHARGED TO PATIENTS	699,673		699,673	73
74	RENAL DIALYSIS				74
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC	654,612		654,612	88
88.01	RHC II	3,720,607		3,720,607	88.01
91	EMERGENCY	4,368,245		4,368,245	91
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
95	AMBULANCE SERVICES	473,361		473,361	95
	SPECIAL PURPOSE COST CENTERS				
118	SUBTOTALS (SUM OF LINES 1-117)	23,246,631		23,246,631	118
	NONREIMBURSABLE COST CENTERS				
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,967		36,967	190
190.01	FOUNDATION	120,517		120,517	190.01
192	PHYSICIANS' PRIVATE OFFICES	15,588		15,588	192
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	TOTAL (SUM OF LINES 118-201)	23,419,703		23,419,703	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	ADMINIS-TRATIVE & GENERAL 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL		263,275	93,679	356,954	356,954	5
6	MAINTENANCE & REPAIRS		14,172	789	14,961	7,397	6
7	OPERATION OF PLANT		754,187	61,922	816,109	22,748	7
8	LAUNDRY & LINEN SERVICE		16,586		16,586	2,097	8
9	HOUSEKEEPING		62,407	743	63,150	8,477	9
10	DIETARY		130,063	41,240	171,303	5,352	10
11	CAFETERIA		61,725		61,725	5,718	11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY		66,344		66,344	3,030	14
15	PHARMACY		56,004		56,004	5,508	15
16	MEDICAL RECORDS & LIBRARY		82,615	8,276	90,891	14,693	16
17	SOCIAL SERVICE						17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		514,059	74,201	588,260	41,572	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		423,256	63,701	486,957	24,687	50
53	ANESTHESIOLOGY					2,208	53
54	RADIOLOGY-DIAGNOSTIC		188,691	320,451	509,142	28,815	54
56.10	ULTRASOUND		6,613	39,841	46,454	1,081	56.10
60	LABORATORY		72,695	23,343	96,038	31,605	60
66	PHYSICAL THERAPY		226,482	3,200	229,682	16,288	66
67	OCCUPATIONAL THERAPY					4,091	67
68	SPEECH PATHOLOGY					685	68
69	ELECTROCARDIOLOGY					900	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					2,111	71
73	DRUGS CHARGED TO PATIENTS					3,675	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC		32,490	2,332	34,822	9,668	88
88.01	RHC II		389,927	19,262	409,189	50,392	88.01
91	EMERGENCY		330,407	16,177	346,584	55,873	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES		45,454	15,392	60,846	5,892	95
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)		3,737,452	784,549	4,522,001	354,563	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		16,533		16,533	320	190
190.01	FOUNDATION					1,833	190.01
192	PHYSICIANS' PRIVATE OFFICES					238	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		3,753,985	784,549	4,538,534	356,954	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS	22,358					6
7	OPERATION OF PLANT	4,849	843,706				7
8	LAUNDRY & LINEN SERVICE	107	5,202	23,992			8
9	HOUSEKEEPING	401	19,575	2,512	94,115		9
10	DIETARY	836	40,797		4,631	222,919	10
11	CAFETERIA	397	19,361		2,198		11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY	427	20,810		2,362		14
15	PHARMACY	360	17,567		1,994		15
16	MEDICAL RECORDS & LIBRARY	531	25,914		2,941		16
17	SOCIAL SERVICE						17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	3,306	161,245	12,303	18,303	222,919	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,722	132,762	4,463	15,070		50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	1,214	59,186		6,718		54
56.10	ULTRASOUND	43	2,074		235		56.10
60	LABORATORY	468	22,802		2,588		60
66	PHYSICAL THERAPY	1,457	71,040		8,064		66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	209			1,157		88
88.01	RHC II	2,508	122,307		13,883		88.01
91	EMERGENCY	2,125	103,621	4,331	11,764		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	292	14,257	383	1,618		95
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	22,252	838,520	23,992	93,526	222,919	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	106	5,186		589		190
190.01	FOUNDATION						190.01
192	PHYSICIANS' PRIVATE OFFICES						192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	22,358	843,706	23,992	94,115	222,919	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		11	14	15	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	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	89,399					11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY	2,287	95,260				14
15	PHARMACY	1,094	13,107	95,634			15
16	MEDICAL RECORDS & LIBRARY	11,834	307		147,111		16
17	SOCIAL SERVICE						17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	23,031	2,455		27,203	1,100,597	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	4,206	20,115		14,889	705,871	50
53	ANESTHESIOLOGY	298	556			3,062	53
54	RADIOLOGY-DIAGNOSTIC	8,522	1,664		21,914	637,175	54
56.10	ULTRASOUND				3,213	53,100	56.10
60	LABORATORY	10,422	29,142		34,448	227,513	60
66	PHYSICAL THERAPY	6,871	936		4,870	339,208	66
67	OCCUPATIONAL THERAPY	2,029			758	6,878	67
68	SPEECH PATHOLOGY				499	1,184	68
69	ELECTROCARDIOLOGY		9			909	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		7,532			9,643	71
73	DRUGS CHARGED TO PATIENTS			95,634		99,309	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC		2,831			48,687	88
88.01	RHC II		12,917			611,196	88.01
91	EMERGENCY	10,869	2,961		39,317	577,445	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	7,936	636			91,860	95
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	89,399	95,168	95,634	147,111	4,513,637	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					22,734	190
190.01	FOUNDATION		92			1,925	190.01
192	PHYSICIANS' PRIVATE OFFICES					238	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	89,399	95,260	95,634	147,111	4,538,534	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	ADMINISTRATIVE & GENERAL			5
6	MAINTENANCE & REPAIRS			6
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
13	NURSING ADMINISTRATION			13
14	CENTRAL SERVICES & SUPPLY			14
15	PHARMACY			15
16	MEDICAL RECORDS & LIBRARY			16
17	SOCIAL SERVICE			17
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS		1,100,597	30
	ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM		705,871	50
53	ANESTHESIOLOGY		3,062	53
54	RADIOLOGY-DIAGNOSTIC		637,175	54
56.10	ULTRASOUND		53,100	56.10
60	LABORATORY		227,513	60
66	PHYSICAL THERAPY		339,208	66
67	OCCUPATIONAL THERAPY		6,878	67
68	SPEECH PATHOLOGY		1,184	68
69	ELECTROCARDIOLOGY		909	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		9,643	71
73	DRUGS CHARGED TO PATIENTS		99,309	73
74	RENAL DIALYSIS			74
	OUTPATIENT SERVICE COST CENTERS			
88	RURAL HEALTH CLINIC		48,687	88
88.01	RHC II		611,196	88.01
91	EMERGENCY		577,445	91
92	OBSERVATION BEDS (NON-DISTINCT PART)			92
	OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS			94
95	AMBULANCE SERVICES		91,860	95
	SPECIAL PURPOSE COST CENTERS			
118	SUBTOTALS (SUM OF LINES 1-117)		4,513,637	118
	NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		22,734	190
190.01	FOUNDATION		1,925	190.01
192	PHYSICIANS' PRIVATE OFFICES		238	192
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	TOTAL (SUM OF LINES 118-201)		4,538,534	202

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	71,522					1
2	CAP REL COSTS-MVBLE EQUIP		672,474				2
4	EMPLOYEE BENEFITS DEPARTMENT			9,048,883			4
5	ADMINISTRATIVE & GENERAL	5,016	80,297	2,032,224	-4,959,425	18,460,278	5
6	MAINTENANCE & REPAIRS	270	676	167,671		382,566	6
7	OPERATION OF PLANT	14,369	53,076			1,176,449	7
8	LAUNDRY & LINEN SERVICE	316				108,457	8
9	HOUSEKEEPING	1,189	637	253,956		438,389	9
10	DIETARY	2,478	35,349	53,657		276,783	10
11	CAFETERIA	1,176		166,327		295,694	11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY	1,264		77,362		156,678	14
15	PHARMACY	1,067		51,492		284,852	15
16	MEDICAL RECORDS & LIBRARY	1,574	7,094	428,298		759,901	16
17	SOCIAL SERVICE						17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	9,794	63,601	1,134,773		2,149,969	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	8,064	54,601	278,676		1,276,755	50
53	ANESTHESIOLOGY			92,825		114,203	53
54	RADIOLOGY-DIAGNOSTIC	3,595	274,674	472,117		1,490,207	54
56.10	ULTRASOUND	126	34,150			55,912	56.10
60	LABORATORY	1,385	20,008	467,866		1,634,520	60
66	PHYSICAL THERAPY	4,315	2,743	443,355		842,351	66
67	OCCUPATIONAL THERAPY			160,405		211,555	67
68	SPEECH PATHOLOGY					35,436	68
69	ELECTROCARDIOLOGY			52,904		46,560	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					109,151	71
73	DRUGS CHARGED TO PATIENTS					190,037	73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	619	1,999	289,614		500,011	88
88.01	RHC II	7,429	16,510	1,428,415		2,606,128	88.01
91	EMERGENCY	6,295	13,866	911,937		2,889,391	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	866	13,193	51,988		304,716	95
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	71,207	672,474	9,015,862	-4,959,425	18,336,671	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315				16,533	190
190.01	FOUNDATION			33,021		94,787	190.01
192	PHYSICIANS' PRIVATE OFFICES					12,287	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	3,753,985	784,549	106,625		4,959,425	202
203	UNIT COST MULT-WS B PT I	52.487137	1.166661	0.011783		0.268654	203
204	COST TO BE ALLOC PER B PT II					356,954	204
205	UNIT COST MULT-WS B PT II					0.019336	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS	66,235					6
7	OPERATION OF PLANT	14,369	51,247				7
8	LAUNDRY & LINEN SERVICE	316	316	87,747			8
9	HOUSEKEEPING	1,189	1,189	9,187	50,362		9
10	DIETARY	2,478	2,478		2,478	6,673	10
11	CAFETERIA	1,176	1,176		1,176		11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY	1,264	1,264		1,264		14
15	PHARMACY	1,067	1,067		1,067		15
16	MEDICAL RECORDS & LIBRARY	1,574	1,574		1,574		16
17	SOCIAL SERVICE						17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	9,794	9,794	44,997	9,794	6,673	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	8,064	8,064	16,324	8,064		50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	3,595	3,595		3,595		54
56.10	ULTRASOUND	126	126		126		56.10
60	LABORATORY	1,385	1,385		1,385		60
66	PHYSICAL THERAPY	4,315	4,315		4,315		66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	619			619		88
88.01	RHC II	7,429	7,429		7,429		88.01
91	EMERGENCY	6,294	6,294	15,840	6,295		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	866	866	1,399	866		95
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	65,920	50,932	87,747	50,047	6,673	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	315		315		190
190.01	FOUNDATION						190.01
192	PHYSICIANS' PRIVATE OFFICES						192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	485,344	1,597,794	149,762	617,628	476,950	202
203	UNIT COST MULT-WS B PT I	7.327606	31.178293	1.706748	12.263770	71.474599	203
204	COST TO BE ALLOC PER B PT II	22,358	843,706	23,992	94,115	222,919	204
205	UNIT COST MULT-WS B PT II	0.337556	16.463520	0.273422	1.868770	33.406114	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	CAFETERIA FTE'S 11	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS DEPARTMENT					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA	8,990				11
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY	230	1,387,063			14
15	PHARMACY	110	190,857	100		15
16	MEDICAL RECORDS & LIBRARY	1,190	4,467		7,371	16
17	SOCIAL SERVICE					17
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	2,316	35,742		1,363	30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	423	292,897		746	50
53	ANESTHESIOLOGY	30	8,102			53
54	RADIOLOGY-DIAGNOSTIC	857	24,229		1,098	54
56.10	ULTRASOUND				161	56.10
60	LABORATORY	1,048	424,321		1,726	60
66	PHYSICAL THERAPY	691	13,635		244	66
67	OCCUPATIONAL THERAPY	204			38	67
68	SPEECH PATHOLOGY				25	68
69	ELECTROCARDIOLOGY		125			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		109,672			71
73	DRUGS CHARGED TO PATIENTS			100		73
74	RENAL DIALYSIS					74
	OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC		41,219			88
88.01	RHC II		188,083			88.01
91	EMERGENCY	1,093	43,118		1,970	91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
94	HOME PROGRAM DIALYSIS					94
95	AMBULANCE SERVICES	798	9,255			95
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	8,990	1,385,722	100	7,371	118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
190.01	FOUNDATION		1,341			190.01
192	PHYSICIANS' PRIVATE OFFICES					192
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	COST TO BE ALLOC PER B PT I	434,838	274,067	458,582	1,102,405	202
203	UNIT COST MULT-WS B PT I	48.369077	0.197588	4,585.820000	149.559761	203
204	COST TO BE ALLOC PER B PT II	89,399	95,260	95,634	147,111	204
205	UNIT COST MULT-WS B PT II	9.944271	0.068677	956.340000	19.958079	205

COMPUTATION OF RATIO OF COST TO CHARGES — WORKSHEET C PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	4,101,492		4,101,492			30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,246,933		2,246,933			50
53	ANESTHESIOLOGY	147,936		147,936			53
54	RADIOLOGY-DIAGNOSTIC	2,283,530		2,283,530			54
56.10	ULTRASOUND	101,408		101,408			56.10
60	LABORATORY	2,536,627		2,536,627			60
66	PHYSICAL THERAPY	1,360,333		1,360,333			66
67	OCCUPATIONAL THERAPY	283,940		283,940			67
68	SPEECH PATHOLOGY	48,695		48,695			68
69	ELECTROCARDIOLOGY	59,094		59,094			69
71	MEDICAL SUPPLIES CHARGED TO	160,145		160,145			71
73	DRUGS CHARGED TO PATIENTS	699,673		699,673			73
74	RENAL DIALYSIS						74
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	654,612		654,612			88
88.01	RHC II	3,720,607		3,720,607			88.01
91	EMERGENCY	4,368,245		4,368,245			91
92	OBSERVATION BEDS (NON-DISTI	226,472		226,472			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES	473,361		473,361			95
200	SUBTOTAL (SEE INSTRUCTIONS)	23,473,103		23,473,103			200
201	LESS OBSERVATION BEDS	226,472		226,472			201
202	TOTAL (SEE INSTRUCTIONS)	23,246,631		23,246,631			202

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

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	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	2,280,971		2,280,971				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	63,028	2,382,235	2,445,263	0.918892			50
53	ANESTHESIOLOGY	8,073	229,631	237,704	0.622354			53
54	RADIOLOGY-DIAGNOSTIC	101,925	5,315,220	5,417,145	0.421538			54
56.10	ULTRASOUND	26,375	526,356	552,731	0.183467			56.10
60	LABORATORY	519,291	8,598,940	9,118,231	0.278193			60
66	PHYSICAL THERAPY	200,939	2,093,052	2,293,991	0.592998			66
67	OCCUPATIONAL THERAPY	144,312	119,151	263,463	1.077722			67
68	SPEECH PATHOLOGY	22,608	106,770	129,378	0.376378			68
69	ELECTROCARDIOLOGY	23,025	476,550	499,575	0.118289			69
71	MEDICAL SUPPLIES CHARGED TO	422,288	634,925	1,057,213	0.151478			71
73	DRUGS CHARGED TO PATIENTS	1,145,753	1,485,144	2,630,897	0.265945			73
74	RENAL DIALYSIS							74
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		816,749	816,749				88
88.01	RHC II		2,411,952	2,411,952				88.01
91	EMERGENCY		3,333,288	3,333,288	1.310491			91
92	OBSERVATION BEDS (NON-DISTI		362,871	362,871	0.624112			92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
95	AMBULANCE SERVICES		1,219,870	1,219,870	0.388042			95
200	SUBTOTAL (SEE INSTRUCTIONS)	4,958,588	30,112,704	35,071,292				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		30,112,704	35,071,292				202

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1301)	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.918892		659,221			605,753		50
53	ANESTHESIOLOGY	0.622354		73,269			45,599		53
54	RADIOLOGY-DIAGNOSTIC	0.421538		1,523,661			642,281		54
56.10	ULTRASOUND	0.183467		95,551			17,530		56.10
60	LABORATORY	0.278193		2,797,901			778,356		60
66	PHYSICAL THERAPY	0.592998		679,246			402,792		66
67	OCCUPATIONAL THERAPY	1.077722		22,755			24,524		67
68	SPEECH PATHOLOGY	0.376378		4,451			1,675		68
69	ELECTROCARDIOLOGY	0.118289		199,487			23,597		69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.151478		193,996			29,386		71
73	DRUGS CHARGED TO PATIENTS	0.265945		642,025			170,743		73
74	RENAL DIALYSIS								74
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
91	EMERGENCY	1.310491		1,036,655			1,358,527		91
92	OBSERVATION BEDS (NON-DISTINCT	0.624112		120,425			75,159		92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
95	AMBULANCE SERVICES	0.388042							95
200	SUBTOTAL (SEE INSTRUCTIONS)			8,048,643			4,175,922		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			8,048,643			4,175,922		202

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

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

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.918892							50
53	ANESTHESIOLOGY	0.622354							53
54	RADIOLOGY-DIAGNOSTIC	0.421538							54
56.10	ULTRASOUND	0.183467							56.10
60	LABORATORY	0.278193							60
66	PHYSICAL THERAPY	0.592998							66
67	OCCUPATIONAL THERAPY	1.077722							67
68	SPEECH PATHOLOGY	0.376378							68
69	ELECTROCARDIOLOGY	0.118289							69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.151478							71
73	DRUGS CHARGED TO PATIENTS	0.265945							73
74	RENAL DIALYSIS								74
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
91	EMERGENCY	1.310491							91
92	OBSERVATION BEDS (NON-DISTINCT	0.624112							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
95	AMBULANCE SERVICES	0.388042							95
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1

COMPUTATION OF INPATIENT OPERATING COST — PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	2,081	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	902	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	794	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	523	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)	523	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	66	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)	67	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	490	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)	657	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	125.00	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	125.00	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,101,492	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)	8,250	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	8,375	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	2,210,035	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,891,457	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	1,891,457	37

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

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	2,096.95	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,027,506	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)	1,027,506	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)					249,714	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,277,220	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					1,377,696	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)					1,377,696	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)	108	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	2,096.96	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	226,472	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	1,100,597	1,891,457	0.581878	226,472	131,779	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1301)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		830,120		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.918892	33,796	31,055	50
53	ANESTHESIOLOGY	0.622354	1,264	787	53
54	RADIOLOGY-DIAGNOSTIC	0.421538	21,973	9,262	54
56.10	ULTRASOUND	0.183467	14,195	2,604	56.10
60	LABORATORY	0.278193	201,874	56,160	60
66	PHYSICAL THERAPY	0.592998	31,293	18,557	66
67	OCCUPATIONAL THERAPY	1.077722	13,717	14,783	67
68	SPEECH PATHOLOGY	0.376378	3,691	1,389	68
69	ELECTROCARDIOLOGY	0.118289	14,100	1,668	69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.151478	170,356	25,805	71
73	DRUGS CHARGED TO PATIENTS	0.265945	329,556	87,644	73
74	RENAL DIALYSIS				74
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
91	EMERGENCY	1.310491			91
92	OBSERVATION BEDS (NON-DISTINCT	0.624112			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		835,815	249,714	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		835,815		202

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-3

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

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.918892			50
53	ANESTHESIOLOGY	0.622354			53
54	RADIOLOGY-DIAGNOSTIC	0.421538	7,403	3,121	54
56.10	ULTRASOUND	0.183467	704	129	56.10
60	LABORATORY	0.278193	113,907	31,688	60
66	PHYSICAL THERAPY	0.592998	96,419	57,176	66
67	OCCUPATIONAL THERAPY	1.077722	76,527	82,475	67
68	SPEECH PATHOLOGY	0.376378	5,039	1,897	68
69	ELECTROCARDIOLOGY	0.118289	4,562	540	69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.151478	95,268	14,431	71
73	DRUGS CHARGED TO PATIENTS	0.265945	359,749	95,673	73
74	RENAL DIALYSIS				74
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
91	EMERGENCY	1.310491			91
92	OBSERVATION BEDS (NON-DISTINCT	0.624112			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		759,578	287,130	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		759,578		202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,175,922	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)	4,175,922	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	4,217,681	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)	16,765	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,045,103	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	3,155,813	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)	3,155,813	30
31	PRIMARY PAYER PAYMENTS	2,678	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	3,153,135	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)	118,119	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	118,119	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	3,271,254	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	3,271,254	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	16,356	40.01
41	INTERIM PAYMENTS	3,588,485	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	-333,587	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 (14-1301) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,859,464		3,588,485	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	.03					3.03
		.04					3.04
	PROVIDER	.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER TO	.52					3.52
		.53					3.53
	PROGRAM	.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				1,859,464		3,588,485	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	.01					5.01
		.02					5.02
	PROVIDER	.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER	.50					5.50
	TO	.51					5.51
	PROGRAM	.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)							7

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

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

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

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	INPATIENT PART B MM/DD/YYYY 3	INPATIENT PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				2,534,190			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE		NONE	3.01
		.02					3.02
	PROGRAM	.03					3.03
	TO	.04					3.04
	PROVIDER	.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER	.52					3.52
	TO	.53					3.53
	PROGRAM	.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				2,534,190			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					5.01
	TO	.02					5.02
	PROVIDER	.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER	.50					5.50
	TO	.51					5.51
	PROGRAM	.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)							7

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

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

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	430	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	490	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	194	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	794	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	35,071,292	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,188,255	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	2,829,185	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	2,829,185	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	56,584	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)	2,772,601	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,698,579	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	1,074,022	32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS — WORKSHEET E-2

CHECK	[ ]	TITLE V	[XX]	SWING BED - SNF (14-Z301)	
APPLICABLE	[XX]	TITLE XVIII	[ ]	SWING BED - NF	
BOXES	[ ]	TITLE XIX			

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	1,391,473		1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)			2
3	ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	290,001		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			4
5	PROGRAM DAYS	657		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	1,681,474		8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	1,681,474		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)	17,070		11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	1,664,404		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)			13
14	80% OF PART B COSTS (LINE 12 x 80%)			14
15	SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	1,664,404		15
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			16
17	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			17
17.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			17.01
18	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			18
19	TOTAL (SEE INSTRUCTIONS)	1,664,404		19
19.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	8,322		19.01
20	INTERIM PAYMENTS	2,534,190		20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS LINES 19.01, 20 AND 21)	-878,108		22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART V

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

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

1	INPATIENT SERVICES	1,277,220	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,277,220	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	1,289,992	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6 AND 17)	1,289,992	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	117,424	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,172,568	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,172,568	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	10,691	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	10,691	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,183,259	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,183,259	30
30.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	5,916	30.01
31	INTERIM PAYMENTS	1,859,464	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS LINES 30.01, 31 AND 32)	-682,121	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,799,768				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	5,133,943				4
5	OTHER RECEIVABLES	160,820				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY					7
8	PREPAID EXPENSES	860,597				8
9	OTHER CURRENT ASSETS	275,255				9
10	DUE FROM OTHER FUNDS	1,698,694				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	10,929,077				11
	FIXED ASSETS					
12	LAND	5,122,890				12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	15,743,095				15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	18,071,194				19
20	ACCUMULATED DEPRECIATION	-6,482,672				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
24	ACCUMULATED DEPRECIATION					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)	32,454,507				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS	191,479				33
34	OTHER ASSETS	23,672,720				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	23,864,199				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	67,247,783				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,309,207				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)	292,140				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS	145,302				42
43	DUE TO OTHER FUNDS	2,805,427				43
44	OTHER CURRENT LIABILITIES	1,636,522				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	6,188,598				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	32,754				47
48	UNSECURED LOANS	28,875,803				48
49	OTHER LONG TERM LIABILITIES	1,067,411				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	29,975,968				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	36,164,566				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	31,083,217				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)	31,083,217				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	67,247,783				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	27,926,832								1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	3,156,385								2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	31,083,217								3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5										5
6										6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	31,083,217								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)	31,083,217								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	2,428,050		2,428,050	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	2,428,050		2,428,050	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)	2,428,050		2,428,050	17
18	ANCILLARY SERVICES	2,687,871	32,656,107	35,343,978	18
19	OUTPATIENT SERVICES				19
20	RHC				20
20.01	RHC II				20.01
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES	-7		-7	27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	5,115,914	32,656,107	37,772,021	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		25,657,324	29
30	ADD (SPECIFY)			30
31	AUXILIARY	28,203		31
32	ROUNDING VARIANCE	231		32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)		28,434	36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		25,685,758	43

STATEMENT OF REVENUES AND EXPENSES — WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	37,772,021	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	14,498,150	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	23,273,871	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	25,685,758	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-2,411,887	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,423,442	6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GRANT REVENUE)	158,726	24
24.01	OTHER (OTHER)	2,946,780	24.01
24.02	OTHER (INVESTMENT RETURN)	832,805	24.02
24.03	OTHER (ASSETS RELEASED)	226,254	24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	5,588,007	25
26	TOTAL (LINE 5 PLUS LINE 25)	3,176,120	26
27	OTHER EXPENSES (LOSS ON SALE OF EQUIPMENT)	19,735	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	19,735	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	3,156,385	29

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS | COMPONENT NO: - | WORKSHEET I-1

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

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

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES COMPONENT NO: - WORKSHEET I-2

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

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

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES COMPONENT NO: - WORKSHEET I-2 (CONTINUED)

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

		MEDICAL SUPPLIES 7	ROUTINE ANCILLARY SERVICES 8	SUBTOTAL (SUM OF COLS.1-8) 9	OVERHEAD 10	TOTAL (COL.9 + COL.10) 11	
1	TOTAL RENAL DEPT COSTS						1
	MAINTENANCE						
2	HEMODIALYSIS						2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS						4
5	INTERMITTENT PERITONEAL						5
6	CAPD						6
7	CCPD						7
	HOME						
8	HEMODIALYSIS						8
9	INTERMITTENT PERITONEAL						9
10	CAPD						10
11	CCPD						11
	OTHER BILLABLE SERVICES						
12	INPATIENT DIALYSIS						12
13	METHOD II HOME PATIENT						13
14	EPO (INCL IN RENAL DEPT)						14
15	ARANESP (INCL IN RENAL DEPT)						15
16	OTHER						16
17	TOTAL (SUM OF LINES 2-16)						17
18	MEDICAL EDUC PGM COSTS						18
19	TOTAL RENAL COSTS (LINES 17+18)						19

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS | COMPONENT NO: - | WORKSHEET I-3

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

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

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS | COMPONENT NO: - | WORKSHEET I-3 (CONTINUED)

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

		DRUGS (REQUIST.) 6	MEDICAL SUPPLIES (REQUIST.) 7	ROUTINE ANCILLARY SERVICES (CHARGES) 8	SUBTOTAL 9	OVERHEAD (ACCUM. COST) 10	
1	TOTAL RENAL DEPT COSTS						1
	MAINTENANCE						
2	HEMODIALYSIS						2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS						4
5	INTERMITTENT PERITONEAL						5
6	CAPD						6
7	CCPD						7
	HOME						
8	HEMODIALYSIS						8
9	INTERMITTENT PERITONEAL						9
10	CAPD						10
11	CCPD						11
	OTHER BILLABLE SERVICES						
12	INPT DIAL TRTMNTS						
13	METHOD II HOME PATIENT						13
14	EPO						14
15	ARANESP						15
16	OTHER						16
17	TOTAL STATISTICAL BASIS						17
18	UNIT COST MULTIPLIER (LINE 1 ÷ LINE 17)						18

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS COMPONENT NO: - WORKSHEET I-4

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

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

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS | COMPONENT NO: - | WORKSHEET I-4 (CONTINUED)

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

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

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B COMPONENT NO: - WORKSHEET I-5

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

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE RATE PERCENTAGE

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

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

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
56.10	ULTRASOUND						56.10
60	LABORATORY						60
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PA						71
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
88	RURAL HEALTH CLINIC						88
88.01	RHC II						88.01
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES						95
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CA						190
190.01	FOUNDATION						190.01
192	PHYSICIANS' PRIVATE OFFICES						192
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: 14-3438

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	36,647		36,647		36,647		36,647	1
2	PHYSICIAN ASSISTANT	100,547		100,547		100,547		100,547	2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE	86,657		86,657		86,657		86,657	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)	223,851		223,851		223,851		223,851	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		55,384	55,384		55,384		55,384	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		55,384	55,384		55,384		55,384	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	223,851	55,384	279,235		279,235		279,235	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
	FACILITY OVERHEAD								
29	FACILITY COSTS		14,350	14,350		14,350		14,350	29
30	ADMINISTRATIVE COSTS	65,763	102,428	168,191		168,191		168,191	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	65,763	116,778	182,541		182,541		182,541	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	289,614	172,162	461,776		461,776		461,776	32

RHC I WORKSHEET M-2

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

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.23	880	4,200	966		1
2	PHYSICIAN ASSISTANTS	0.87	3,703	2,100	1,827		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	1.10	4,583		2,793	4,583	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.10	4,583			4,583	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)	279,235	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)	279,235	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)	182,541	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	192,836	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	375,377	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	375,377	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	375,377	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	654,612	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES | RHC I COMPONENT NO: 14-3438 | WORKSHEET M-3

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)	654,612	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)		2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	654,612	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	4,583	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,583	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	142.83	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)	142.83	142.83	142.83	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	535	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	76,414	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)	76,414	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		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%)	47,083	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	47,083	16.05
17	PRIMARY PAYOR PAYMENTS	8,871	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR	17,560	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)	38,212	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	38,212	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	516	23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)	38,728	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	194	26.01
27	INTERIM PAYMENTS	60,593	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)	-22,059	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.

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I
COMPONENT NO: 14-3438

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	223,851	223,851	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME			2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)			5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	279,235	279,235	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	375,377	375,377	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES			13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)			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)			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)			16

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

RHC I COMPONENT NO: 14-3438

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				60,593	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE	3.01
			.02			3.02
		PROGRAM	.03			3.03
		TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50		NONE	3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				60,593	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01			5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER	.50			5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99			5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO	.01			6.01
		PROVIDER TO	.02			6.02
		PROGRAM				
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

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

RHC II WORKSHEET M-1

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

COMPONENT NO: 14-3495

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	576,700		576,700		576,700		576,700	1
2	PHYSICIAN ASSISTANT	108,852		108,852		108,852		108,852	2
3	NURSE PRACTITIONER	104,486		104,486		104,486		104,486	3
4	VISITING NURSE								4
5	OTHER NURSE	304,796		304,796		304,796		304,796	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS								9
10	SUBTOTAL (SUM OF LINES 1-9)	1,094,834		1,094,834		1,094,834		1,094,834	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		303,978	303,978		303,978		303,978	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		303,978	303,978		303,978		303,978	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,094,834	303,978	1,398,812		1,398,812		1,398,812	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		13,693	13,693		13,693		13,693	29
30	ADMINISTRATIVE COSTS	333,581	434,022	767,603		767,603		767,603	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	333,581	447,715	781,296		781,296		781,296	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,428,415	751,693	2,180,108		2,180,108		2,180,108	32

RHC II WORKSHEET M-2

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

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	2.79	9,957	4,200	11,718		1
2	PHYSICIAN ASSISTANTS	1.00	2,425	2,100	2,100		2
3	NURSE PRACTITIONERS	1.02	2,712	2,100	2,142		3
4	SUBTOTAL (SUM OF LINES 1-3)	4.81	15,094		15,960	15,960	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER	0.15	332			332	7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	4.96	15,426			16,292	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)	1,398,812	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	1,398,812	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)	781,296	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	1,540,499	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	2,321,795	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	2,321,795	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	2,321,795	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	3,720,607	20

RHC II WORKSHEET M-3

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

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	3,720,607	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)		2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	3,720,607	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	16,292	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	16,292	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	228.37	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)	228.37	228.37	228.37	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	2,960		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	675,975		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)	675,975		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)			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%)	500,198		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	500,198		16.05
17	PRIMARY PAYOR PAYMENTS	193		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR	50,728		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	88,600		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)	500,005		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)			21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	500,005		22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	3,927		23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)	503,932		26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	2,520		26.01
27	INTERIM PAYMENTS	583,304		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)	-81,892		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: 14-3495

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,094,834	1,094,834	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME			2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)			5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,398,812	1,398,812	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	2,321,795	2,321,795	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES			13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)			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)			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)			16

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

RHC II COMPONENT NO: 14-3495

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				583,304	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE	3.01
			.02			3.02
		PROGRAM	.03			3.03
		TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50		NONE	3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				583,304	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01			5.01
		TO	.02			5.02
		PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER	.50			5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99			5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO	.01			6.01
		PROVIDER TO	.02			6.02
		PROGRAM				
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

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

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

	COST CENTERS	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX INPATIENT	TITLE XIX OUTPATIENT	TITLE V INPATIENT	TITLE V OUTPATIENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
UTILIZATION PERCENTAGES BASED ON DAYS									
30	ADULTS & PEDIATRICS	54.32						54.32	30
UTILIZATION PERCENTAGES BASED ON CHARGES									
50	OPERATING ROOM	1.38	26.96					28.34	50
53	ANESTHESIOLOGY	0.53	30.82					31.35	53
54	RADIOLOGY-DIAGNOSTIC	0.41	28.13					28.54	54
56.10	ULTRASOUND	2.57	17.29					19.86	56.10
60	LABORATORY	2.21	30.68					32.89	60
66	PHYSICAL THERAPY	1.36	29.61					30.97	66
67	OCCUPATIONAL THERAPY	5.21	8.64					13.85	67
68	SPEECH PATHOLOGY	2.85	3.44					6.29	68
69	ELECTROCARDIOLOGY	2.82	39.93					42.75	69
71	MEDICAL SUPPLIES CHARGED TO PAT	16.11	18.35					34.46	71
73	DRUGS CHARGED TO PATIENTS	12.53	24.40					36.93	73
91	EMERGENCY		31.10					31.10	91
92	OBSERVATION BEDS (NON-DISTINCT		33.19					33.19	92
200	TOTAL CHARGES	2.55	24.55					27.10	200

***** REPORT 97 ***** UTILIZATION STATISTICS ***** SWING-BED SNF / NF

	COST CENTERS	---- TITLE XVIII ---- PART A 1	PART B 2	----- TITLE XIX ----- INPATIENT 3	OUTPATIENT 4	------ TITLE V ------ INPATIENT 5	OUTPATIENT 6	TOTAL THIRD PARTY UTIL 7	
UTILIZATION PERCENTAGES BASED ON CHARGES									
54	RADIOLOGY-DIAGNOSTIC	0.14						0.14	54
56.10	ULTRASOUND	0.13						0.13	56.10
60	LABORATORY	1.25						1.25	60
66	PHYSICAL THERAPY	4.20						4.20	66
67	OCCUPATIONAL THERAPY	29.05						29.05	67
68	SPEECH PATHOLOGY	3.89						3.89	68
69	ELECTROCARDIOLOGY	0.91						0.91	69
71	MEDICAL SUPPLIES CHARGED TO PAT	9.01						9.01	71
73	DRUGS CHARGED TO PATIENTS	13.67						13.67	73
200	TOTAL CHARGES	2.32						2.32	200

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	3,753,985	16.03	-3,753,985	-32.00			1
2	CAP REL COSTS-MVBLE EQUIP	784,549	3.35	-784,549	-6.69			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	106,625	0.46	-106,625	-0.91			4
5	ADMINISTRATIVE & GENERAL	4,578,525	19.55	-4,578,525	-39.03			5
6	MAINTENANCE & REPAIRS	365,629	1.56	-365,629	-3.12			6
7	OPERATION OF PLANT	360,340	1.54	-360,340	-3.07			7
8	LAUNDRY & LINEN SERVICE	91,871	0.39	-91,871	-0.78			8
9	HOUSEKEEPING	372,247	1.59	-372,247	-3.17			9
10	DIETARY	104,848	0.45	-104,848	-0.89			10
11	CAFETERIA	232,009	0.99	-232,009	-1.98			11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	89,422	0.38	-89,422	-0.76			14
15	PHARMACY	228,241	0.97	-228,241	-1.95			15
16	MEDICAL RECORDS & LIBRARY	663,963	2.84	-663,963	-5.66			16
17	SOCIAL SERVICE							17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,548,338	6.61	2,553,154	21.76	4,101,492	17.51	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	786,514	3.36	1,460,419	12.45	2,246,933	9.59	50
53	ANESTHESIOLOGY	113,109	0.48	34,827	0.30	147,936	0.63	53
54	RADIOLOGY-DIAGNOSTIC	975,502	4.17	1,308,028	11.15	2,283,530	9.75	54
56.10	ULTRASOUND	9,458	0.04	91,950	0.78	101,408	0.43	56.10
60	LABORATORY	1,532,969	6.55	1,003,658	8.55	2,536,627	10.83	60
66	PHYSICAL THERAPY	607,445	2.59	752,888	6.42	1,360,333	5.81	66
67	OCCUPATIONAL THERAPY	209,665	0.90	74,275	0.63	283,940	1.21	67
68	SPEECH PATHOLOGY	35,436	0.15	13,259	0.11	48,695	0.21	68
69	ELECTROCARDIOLOGY	45,937	0.20	13,157	0.11	59,094	0.25	69
71	MEDICAL SUPPLIES CHARGED TO PAT	109,151	0.47	50,994	0.43	160,145	0.68	71
73	DRUGS CHARGED TO PATIENTS	190,037	0.81	509,636	4.34	699,673	2.99	73
74	RENAL DIALYSIS							74
88	RURAL HEALTH CLINIC	461,776	1.97	192,836	1.64	654,612	2.80	88
88.01	RHC II	2,180,108	9.31	1,540,499	13.13	3,720,607	15.89	88.01
91	EMERGENCY	2,532,062	10.81	1,836,183	15.65	4,368,245	18.65	91
92	OBSERVATION BEDS (NON-DISTINCT							92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
95	AMBULANCE SERVICES	243,257	1.04	230,104	1.96	473,361	2.02	95
	OUTPATIENT SERVICE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CAN			36,967	0.32	36,967	0.16	190
190.01	FOUNDATION	94,398	0.40	26,119	0.22	120,517	0.51	190.01
192	PHYSICIANS' PRIVATE OFFICES	12,287	0.05	3,301	0.03	15,588	0.07	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	23,419,703	100.00			23,419,703	100.00	202

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

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

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

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