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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 09/14/2017 Time: 16:41 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 6. Date Received: __________ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: __________ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE 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 certification 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 WARNER HOSPITAL AND HEALTH SERVICES (14-1303) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 05/01/2016 and ending 04/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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 XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		149,897	85,117		48,121	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		45,408				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			130,213			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		195,305	215,330		48,121	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 resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

Hospital and Hospital Health Care Complex Address:

1	Street: 422 WEST WHITE STREET	P.O. Box:			1
2	City: CLINTON	State: IL	ZIP Code: 61727	County: DEWITT	2

Hospital and Hospital-Based Component Identification:

							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	WARNER HOSPITAL AND HEALTH SERVICES	14-1303	99914	1	03 / 01 / 2000	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	SWING BED	14-Z303	99914		03 / 01 / 2000	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	RURAL HEALTH CENTER	14-3404	99914		07 / 03 / 1995	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 05 / 01 / 2016	To: 04 / 30 / 2017	20
21	Type of control (see instructions)	12		21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
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	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							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 is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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

		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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		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 Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 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, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline 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 osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs 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	

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.

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 reseived 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 Nonprovider Settings					
63	Has your facility trained residents in nonprovider 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 HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 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. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

	Inpatient Psychiatric Faciltiy PPS	1	2	3	
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, indicate which program year began during this cost reporting period. (see instructions)				71

	Inpatient Rehabilitation Facility PPS	1	2	3	
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, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

	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.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

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

		V	XIX	
Title V and XIX 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/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers					1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?				Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				N		106
107	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. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.				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
			Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		Y	Y	Y	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.					N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 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 Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	115,989	11,090		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 high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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

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 (see instructions)	Y		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

		1	2	
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	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, chapter 40, §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	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					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. (see instructions)						166
	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10 / 01 / 2016	09 / 30 / 2017	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

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

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/27/2017	Y	06/27/2017	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.	Y		Y		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 Reoprt 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 HOSPITAL 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.	Y	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 capitalization 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.	Y	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	Y	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are 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.	N		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information				
41	First name: AMBER	Last name: HALSTEAD	Title: PARTNER	41
42	Employer: KERBER, ECK & BRAECKEL			42
43	Phone number: 618-529-1040	E-mail Address: AMBERH@KEBCPA.COM		43

	In Lieu of Form	Period :	Run Date: 09/14/2017
WARNER HOSPITAL AND HEALTH SERVICES	**CMS-2552-10**	From: 05/01/2016	Run Time: 16:41
Provider CCN: 14-1303		To: 04/30/2017	Version: 2017.01 (07/27/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 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	14	5,554	13,745.00		417	18	587	1
2	HMO and other (see instructions)						85			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						46		68	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		14	5,554	13,745.00		463	18	655	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)		14	5,554	13,745.00		463	18	655	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					4,821		14,231	26
27	Total (sum of lines 14-26)		14							27
28	Observation Bed Days							16	169	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

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

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 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)					136	5	201	1
2	HMO and other (see instructions)					24			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		91.80			136	5	201	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		21.33						26
27	Total (sum of lines 14-26)		113.13						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	03/01/2000	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	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
69	PE2				69
70	PE1				70
71	PD2				71

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			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 catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)				207

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3404** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 422 W WHITE STREET		1
2	City: CLINTON State: IL ZIP Code: 61727 County: DEWITT		2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban		3

Source of Federal Funds:

		Grant Award	Date	
		1	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 the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	OTHER			9

		1	2	
10	Does this facility operate as other than a hospital-based 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)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0730	1700	0730	1700	0730	1800	0730	1800	0730	1700	0900	1200	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. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	RHC/FQHC name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

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

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)			0.548233	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,707,186	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	5,800,473	6
7	Medicaid cost (line 1 times line 6)	3,180,011	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.	472,825	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 fundnig 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)			472,825	19
		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	97,422	103,160	200,582	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	53,410	56,556	109,966	21
22	Partial payment by patients approved for charity care		3,221	3,221	22
23	Cost of charity care (line 21 minus line 22)	53,410	53,335	106,745	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	895,589	26
27	Medicare bad debts for the entire hospital complex (see instructions)	121,465	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	774,124	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	424,400	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	531,145	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,003,970	31

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2016 To: 04/30/2017	Run Date: 09/14/2017 Run Time: 16:41 Version: 2017.01 (07/27/2017)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		371,017	371,017	54,484	425,501	-20,462	405,039	1
2	00200	Cap Rel Costs-Mvble Equip		823,724	823,724	9,616	833,340	-391,615	441,725	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		2,078,149	2,078,149		2,078,149	486,212	2,564,361	4
5	00500	Administrative & General	1,034,404	1,337,247	2,371,651	133,544	2,505,195	-17,393	2,487,802	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	182,779	668,201	850,980		850,980		850,980	7
8	00800	Laundry & Linen Service		92,804	92,804		92,804		92,804	8
9	00900	Housekeeping	100,733	33,178	133,911		133,911		133,911	9
10	01000	Dietary	133,237	148,947	282,184	-87,383	194,801	-63,953	130,848	10
11	01100	Cafeteria				87,383	87,383	-33,067	54,316	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	137,569	15,044	152,613		152,613	-55	152,558	13
14	01400	Central Services & Supply	23,583	114,486	138,069	-113,891	24,178		24,178	14
15	01500	Pharmacy	136,349	588,099	724,448	-204,268	520,180	-104,299	415,881	15
16	01600	Medical Records & Library	161,538	81,564	243,102	3,000	246,102	-7,297	238,805	16
17	01700	Social Service	60,581	2,877	63,458		63,458		63,458	17
19	01900	Nonphysician Anesthetists				144,610	144,610		144,610	19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	630,836	149,124	779,960	-39,826	740,134	-122,520	617,614	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	170,409	128,769	299,178		299,178	-91,900	207,278	50
53	05300	Anesthesiology		144,992	144,992	-144,610	382		382	53
54	05400	Radiology-Diagnostic	292,767	570,528	863,295		863,295		863,295	54
60	06000	Laboratory	359,272	472,674	831,946	5,091	837,037		837,037	60
62	06200	Whole Blood & Packed Red Blood Cells				4,425	4,425		4,425	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy				88,895	88,895		88,895	64
65	06500	Respiratory Therapy	203,278	60,345	263,623	-24,397	239,226	-550	238,676	65
66	06600	Physical Therapy		475,450	475,450	-9,074	466,376	-7,799	458,577	66
69	06900	Electrocardiology	55,489	13,714	69,203		69,203	-25,469	43,734	69
71	07100	Medical Supplies Charged to Patients				138,288	138,288	-191	138,097	71
72	07200	Impl. Dev. Charged to Patients		58,171	58,171		58,171		58,171	72
73	07300	Drugs Charged to Patients				204,268	204,268	-4,128	200,140	73
76	03950	CARDIAC REHAB	74,320	4,197	78,517		78,517		78,517	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	1,531,045	324,534	1,855,579	-182,271	1,673,308	-54,172	1,619,136	88
90	09000	Clinic				471	471		471	90
90.01	09001	PROVIDER BASED CLINIC								90.01
91	09100	Emergency	733,689	1,024,044	1,757,733	-47,617	1,710,116		1,710,116	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		34,393	34,393	-34,393				113
118		SUBTOTALS (sum of lines 1-117)	6,021,878	9,816,272	15,838,150	-13,655	15,824,495	-458,658	15,365,837	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices	61,028	3,105	64,133		64,133		64,133	192
192.01	19201	LIFELINE								192.01
192.02	19202	HOME MEDICAL EQUIPMENT								192.02
192.03	19203	COMMUNITY BENEFIT				13,655	13,655		13,655	192.03
192.04	19204	RENTAL PROPERTIES								192.04
200		TOTAL (sum of lines 118-199)	6,082,906	9,819,377	15,902,283		15,902,283	-458,658	15,443,625	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA COSTS FROM DIET	A	Cafeteria	11	41,259	46,124	1
500	Total reclassifications				41,259	46,124	500
	Code Letter - A						
1	TO RECLASS DRUGS SOLD TO PATIENTS	B	Drugs Charged to Patients	73		204,268	1
500	Total reclassifications					204,268	500
	Code Letter - B						
1	TO RECLASS INTEREST EXPENSE	C	Cap Rel Costs-Bldg & Fixt	1		34,393	1
500	Total reclassifications					34,393	500
	Code Letter - C						
1	TO RECLASS SUPPLIES CHARGED TO PTS	D	Medical Supplies Charged to P	71		113,891	1
500	Total reclassifications					113,891	500
	Code Letter - D						
1	TO RECLASS ER PHYSICIAN CONTRACTED	E	Administrative & General	5		4,910	1
500	Total reclassifications					4,910	500
	Code Letter - E						
1	TO RECLSS PROPERTY INS EXP	F	Other Cap Rel Costs	3		29,707	1
500	Total reclassifications					29,707	500
	Code Letter - F						
1	TO RECLASS RHC ADMIN EXPENSES	G	Administrative & General	5		54,553	1
500	Total reclassifications					54,553	500
	Code Letter - G						
1	TO RECLASS OXYGEN SUPPLIES	H	Medical Supplies Charged to P	71		24,397	1
500	Total reclassifications					24,397	500
	Code Letter - H						
1	TO RECLASS NURSING COST	I	Intravenous Therapy	64	88,895		1
2			Whole Blood & Packed Red Bloo	62	4,425		2
3			Clinic	90	471		3
500	Total reclassifications				93,791		500
	Code Letter - I						
1	TO RECLASS GRANT EXPENSES	J	Medical Records & Library	16		3,000	1
2			Adults & Pediatrics	30		2,460	2
3			Rural Health Clinic	88		11,946	3
4			Emergency	91		8,798	4
500	Total reclassifications					26,204	500
	Code Letter - J						
1	TO RECLASS RHC PHYSICIAN ADMIN	K	Administrative & General	5	134,573		1
500	Total reclassifications				134,573		500
	Code Letter - K						
1	TO RECLASS ATHLETIC TRAINER COM BEN	L	COMMUNITY BENEFIT	192.03		13,655	1
500	Total reclassifications					13,655	500
	Code Letter - L						
1	TO RECLASS CRNA EXPENSE	M	Nonphysician Anesthetists	19		144,610	1
500	Total reclassifications					144,610	500
	Code Letter - M						
1	TO RECLASS RHC LAB TESTS	N	Laboratory	60		5,091	1
500	Total reclassifications					5,091	500
	Code Letter - N						
1	TO RECLASS RESTRICTED DONATIONS	O	Physical Therapy	66		4,581	1
500	Total reclassifications					4,581	500
	Code Letter - O						
	GRAND TOTAL (Increases)				269,623	706,384	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	TO RECLASS CAFETERIA COSTS FROM DIET	A	Dietary	10	41,259	46,124		1
500	Total reclassifications				41,259	46,124		500
	Code letter - A							
1	TO RECLASS DRUGS SOLD TO PATIENTS	B	Pharmacy	15		204,268		1
500	Total reclassifications					204,268		500
	Code letter - B							
1	TO RECLASS INTEREST EXPENSE	C	Interest Expense	113		34,393	11	1
500	Total reclassifications					34,393		500
	Code letter - C							
1	TO RECLASS SUPPLIES CHARGED TO PTS	D	Central Services & Supply	14		113,891		1
500	Total reclassifications					113,891		500
	Code letter - D							
1	TO RECLASS ER PHYSICIAN CONTRACTED	E	Emergency	91		4,910		1
500	Total reclassifications					4,910		500
	Code letter - E							
1	TO RECLSS PROPERTY INS EXP	F	Administrative & General	5		29,707	12	1
500	Total reclassifications					29,707		500
	Code letter - F							
1	TO RECLASS RHC ADMIN EXPENSES	G	Rural Health Clinic	88		54,553		1
500	Total reclassifications					54,553		500
	Code letter - G							
1	TO RECLASS OXYGEN SUPPLIES	H	Respiratory Therapy	65		24,397		1
500	Total reclassifications					24,397		500
	Code letter - H							
1	TO RECLASS NURSING COST	I	Adults & Pediatrics	30	42,286			1
2			Emergency	91	51,505			2
3								3
500	Total reclassifications				93,791			500
	Code letter - I							
1	TO RECLASS GRANT EXPENSES	J	Administrative & General	5		26,204		1
2								2
3								3
4								4
500	Total reclassifications					26,204		500
	Code letter - J							
1	TO RECLASS RHC PHYSICIAN ADMIN	K	Rural Health Clinic	88	134,573			1
500	Total reclassifications				134,573			500
	Code letter - K							
1	TO RECLASS ATHLETIC TRAINER COM BEN	L	Physical Therapy	66		13,655		1
500	Total reclassifications					13,655		500
	Code letter - L							
1	TO RECLASS CRNA EXPENSE	M	Anesthesiology	53		144,610		1
500	Total reclassifications					144,610		500
	Code letter - M							
1	TO RECLASS RHC LAB TESTS	N	Rural Health Clinic	88		5,091		1
500	Total reclassifications					5,091		500
	Code letter - N							
1	TO RECLASS RESTRICTED DONATIONS	O	Administrative & General	5		4,581		1
500	Total reclassifications					4,581		500
	Code letter - O							
	GRAND TOTAL (Decreases)				269,623	706,384		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	343,588					343,588		1
2	Land Improvements								2
3	Buildings and Fixtures	10,775,494	169,764		169,764		10,945,258		3
4	Building Improvements								4
5	Fixed Equipment	125,772					125,772		5
6	Movable Equipment	4,759,517	756,229		756,229	276,981	5,238,765		6
7	HIT-designated Assets	1,056,607	47,736		47,736		1,104,343		7
8	Subtotal (sum of lines 1-7)	17,060,978	973,729		973,729	276,981	17,757,726		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	17,060,978	973,729		973,729	276,981	17,757,726		10

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

	Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	371,017						371,017	1
2	Cap Rel Costs-Mvble Equip	823,724						823,724	2
3	Total (sum of lines 1-2)	1,194,741						1,194,741	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	10,945,258		10,945,258	0.676300	20,091			20,091	1
2	Cap Rel Costs-Mvble Equ	5,238,765		5,238,765	0.323700	9,616			9,616	2
3	Total (sum of lines 1-2)	16,184,023		16,184,023	1.000000	29,707			29,707	3

	Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	371,017		13,931	20,091			405,039	1
2	Cap Rel Costs-Mvble Equip	432,109			9,616			441,725	2
3	Total (sum of lines 1-2)	803,126		13,931	29,707			846,764	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-20,462	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)	B	-8,165	Administrative & General	5	11	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	-264,134				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	62,662				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-33,067	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-191	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients	B	-4,128	Drugs Charged to Patients	73		17
18	Sale of medical records and abstracts	B	-7,297	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 overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment	A	-363,585	Cap Rel Costs-Mvble Equip	2	9	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						32
33	OTHER INCOME	B	-8,565	Administrative & General	5		33
34	OUTSIDE DIETARY SERVICES	B	-63,953	Dietary	10		34
35							35
36	FITNESS MGMT	B	-7,005	Physical Therapy	66		36
37	NON-ALLOW AMORTIZATION	A	-29,167	Rural Health Clinic	88		37
38	EHR DEPRECIATION - CAPITAL LEASE	A	-24,996	Cap Rel Costs-Mvble Equip	2	9	38
39	OTHER REVENUE - RHC	B	-760	Rural Health Clinic	88		39
40	RESTING METABOLIC	B	-550	Respiratory Therapy	65		40
41	LOBBYING EXPENSE	A	-6,492	Administrative & General	5		41
42	ADVERTISING EXPENSE	A	-55,998	Administrative & General	5		42
43	MARKETING OTHER EXPENSE	A	-835	Administrative & General	5		43
44	CLINICAL TRAINING CLASSES	A	-55	Nursing Administration	13		44
45	PENSION DIFFERENTIAL	A	486,212	Employee Benefits Department	4		45
46	NON-ALLOW PURCH SVC - CABLE TV	A	-794	Physical Therapy	66		46
47	DEPRECIATION ON NON-ALLOW CABLE TV	A	-3,034	Cap Rel Costs-Mvble Equip	2	9	47
48	340B PROGRAM	A	-104,299	Pharmacy	15		48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-458,658				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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 CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	ADMINISTRATION & GENERAL	62,662		62,662		1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			62,662		62,662		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors 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	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			CITY OF CLINTON		CITY GOVERNMENT	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 PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	60	Laboratory	2,126		2,126					1
2	69	Electrocardiology AGGREGATE	25,469	25,469						2
3	91	Emergency CORE	876,393		876,393					3
4	88	Rural Health Clinic AGGREGATE	683,068	24,245	658,823					4
5	50	Operating Room AGGREGATE	91,900	91,900						5
6	30	Adults & Pediatrics HOSPITALIST	122,520	122,520						6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,801,476	264,134	1,537,342					200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	60	Laboratory								1
2	69	Electrocardiology AGGREGATE							25,469	2
3	91	Emergency CORE								3
4	88	Rural Health Clinic AGGREGATE							24,245	4
5	50	Operating Room AGGREGATE							91,900	5
6	30	Adults & Pediatrics HOSPITALIST							122,520	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							264,134	200

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

Line	Description						
1	Total number of weeks worked (excluding aides) (see instructions)					4	1
2	Line 1 multiplied by 15 hours per week					60	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					1	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					20	4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.35	7
8	Optional travel expense rate					0.54	8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		1.50	26.00			9
10	AHSEA (see instructions)		45.31	57.07			10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	22.66	22.66	28.54			11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

Line	Description	Amount	
14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	68	15
16	Assistants (column 3, line 9 times column 3, line 10)	1,484	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	1,552	17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	1,552	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	56.44	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	3,386	22
23	Total salary equivalency (see instructions)	3,386	23

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

Line	Description	Amount	
	Standard Travel Allowance		
24	Therapists (line 3 times column 2, line 11)	23	24
25	Assistants (line 4 times column 3, line 11)	571	25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	594	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	112	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	706	28
	Optional Travel Allowance and Optional Travel Expense		
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)	706	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

Line	Description	Amount	
	Standard Travel Expense		
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
	Optional Travel Allowance and Optional Travel Expense		
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
	Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.		
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
	CALCULATION OF LIMIT						
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	3,386	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	706	58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	4,092	63
64	Total cost of outside supplier services (from provider records)	901	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					12	1
2	Line 1 multiplied by 15 hours per week					180	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					278	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.35	7
8	Optional travel expense rate					0.54	8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		3,940.50	1,975.33	1,284.00		9
10	AHSEA (see instructions)		80.29	60.22	13.78		10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	40.15	40.15	30.11			11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	316,383	15
16	Assistants (column 3, line 9 times column 3, line 10)	118,954	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	435,337	17
18	Aides (column 4, line 9 times column 4, line 10)	17,694	18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	453,031	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	453,031	23

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

	Standard Travel Allowance		
24	Therapists (line 3 times column 2, line 11)	11,162	24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	11,162	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,487	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	12,649	28
	Optional Travel Allowance and Optional Travel Expense		
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)	12,649	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

	Standard Travel Expense		
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
	Optional Travel Allowance and Optional Travel Expense		
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
	Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.		
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	453,031	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	12,649	58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	465,680	63
64	Total cost of outside supplier services (from provider records)	244,831	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	405,039	405,039					1
2	Cap Rel Costs-Mvble Equip	441,725		441,725				2
4	Employee Benefits Department	2,564,361	2,431	2,651	2,569,443			4
5	Administrative & General	2,487,802	45,048	49,128	493,781	3,075,759	3,075,759	5
6	Maintenance & Repairs							6
7	Operation of Plant	850,980	78,765	85,901	77,207	1,092,853	271,782	7
8	Laundry & Linen Service	92,804	4,798	5,232		102,834	25,574	8
9	Housekeeping	133,911	2,379	2,594	42,550	181,434	45,121	9
10	Dietary	130,848	12,550	13,687	38,852	195,937	48,728	10
11	Cafeteria	54,316			17,428	71,744	17,842	11
12	Maintenance of Personnel							12
13	Nursing Administration	152,558	2,111	2,302	58,110	215,081	53,488	13
14	Central Services & Supply	24,178	8,183	8,924	9,962	51,247	12,745	14
15	Pharmacy	415,881	6,979	7,611	57,594	488,065	121,377	15
16	Medical Records & Library	238,805	9,037	9,856	68,234	325,932	81,056	16
17	Social Service	63,458			25,590	89,048	22,145	17
19	Nonphysician Anesthetists	144,610				144,610	35,963	19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	617,614	47,531	51,836	248,606	965,587	240,132	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	207,278	27,915	30,443	71,981	337,617	83,962	50
53	Anesthesiology	382	1,041	1,135		2,558	636	53
54	Radiology-Diagnostic	863,295	28,101	30,646	123,666	1,045,708	260,057	54
60	Laboratory	837,037	9,735	10,617	151,758	1,009,147	250,965	60
62	Whole Blood & Packed Red Blood Cells	4,425			1,869	6,294	1,565	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	88,895	762	831	37,550	128,038	31,842	64
65	Respiratory Therapy	238,676	2,390	2,607	85,865	329,538	81,953	65
66	Physical Therapy	458,577	14,615	15,938		489,130	121,642	66
69	Electrocardiology	43,734	1,431	1,560	23,439	70,164	17,449	69
71	Medical Supplies Charged to Patients	138,097				138,097	34,343	71
72	Impl. Dev. Charged to Patients	58,171				58,171	14,467	72
73	Drugs Charged to Patients	200,140				200,140	49,773	73
76	CARDIAC REHAB	78,517	1,861	2,030	31,393	113,801	28,301	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,619,136	49,927	54,449	589,874	2,313,386	575,309	88
90	Clinic	471			199	670	167	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	1,710,116	20,878	22,769	288,157	2,041,920	507,805	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	15,365,837	378,468	412,747	2,543,665	15,284,510	3,036,189	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	64,133	26,571	28,978	25,778	145,460	36,174	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT	13,655				13,655	3,396	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	15,443,625	405,039	441,725	2,569,443	15,443,625	3,075,759	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	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	1,364,635						7
8	Laundry & Linen Service	23,485	151,893					8
9	Housekeeping	11,643		238,198				9
10	Dietary	61,430		11,006	317,101			10
11	Cafeteria					89,586		11
12	Maintenance of Personnel							12
13	Nursing Administration	10,333		1,851		2,740	283,493	13
14	Central Services & Supply	40,052		7,176		470		14
15	Pharmacy	34,159		6,120		2,716		15
16	Medical Records & Library	44,236		7,925		3,218		16
17	Social Service					1,207	9,855	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	232,653	151,893	41,683	317,101	11,724	100,909	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	136,637		24,480		3,395	17,243	50
53	Anesthesiology	5,095		913				53
54	Radiology-Diagnostic	137,548		24,643		5,832		54
60	Laboratory	47,652		8,537		7,157		60
62	Whole Blood & Packed Red Blood Cells					88		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	3,729		668		1,771		64
65	Respiratory Therapy	11,700		2,096		4,049		65
66	Physical Therapy	71,535		12,816				66
69	Electrocardiology	7,003		1,255		1,105		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	9,109		1,632		1,480	12,064	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	244,382		43,786		27,820	37,281	88
90	Clinic					9		90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	102,193		18,309		13,589	106,141	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,234,574	151,893	214,896	317,101	88,370	283,493	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	130,061		23,302		1,216		192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,364,635	151,893	238,198	317,101	89,586	283,493	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	
		14	15	16	17	19	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							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	111,690						14
15	Pharmacy	597	653,034					15
16	Medical Records & Library	9		462,376				16
17	Social Service				122,255			17
19	Nonphysician Anesthetists					180,573		19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,936		15,001	122,255		2,202,874	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,183		14,671			622,188	50
53	Anesthesiology	60		7,347		180,573	197,182	53
54	Radiology-Diagnostic	7,940		114,102			1,595,830	54
60	Laboratory	35,328		83,597			1,442,383	60
62	Whole Blood & Packed Red Blood Cells			760			8,707	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			21,125			187,173	64
65	Respiratory Therapy	751		11,490			441,577	65
66	Physical Therapy	681		45,289			741,093	66
69	Electrocardiology	308		8,966			106,250	69
71	Medical Supplies Charged to Patients	29,597		7,538			209,575	71
72	Impl. Dev. Charged to Patients	15,117		1,523			89,278	72
73	Drugs Charged to Patients		653,034	18,663			921,610	73
76	CARDIAC REHAB	378		4,116			170,881	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	4,292		45,109			3,291,365	88
90	Clinic	189		68			1,103	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	8,324		63,011			2,861,292	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	111,690	653,034	462,376	122,255	180,573	15,090,361	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices						336,213	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						17,051	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	111,690	653,034	462,376	122,255	180,573	15,443,625	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	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
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,202,874					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		622,188					50
53	Anesthesiology		197,182					53
54	Radiology-Diagnostic		1,595,830					54
60	Laboratory		1,442,383					60
62	Whole Blood & Packed Red Blood Cells		8,707					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		187,173					64
65	Respiratory Therapy		441,577					65
66	Physical Therapy		741,093					66
69	Electrocardiology		106,250					69
71	Medical Supplies Charged to Patients		209,575					71
72	Impl. Dev. Charged to Patients		89,278					72
73	Drugs Charged to Patients		921,610					73
76	CARDIAC REHAB		170,881					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		3,291,365					88
90	Clinic		1,103					90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		2,861,292					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		15,090,361					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		336,213					192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT		17,051					192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		15,443,625					202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		2,431	2,651	5,082	5,082		4
5	Administrative & General		45,048	49,128	94,176	976	95,152	5
6	Maintenance & Repairs							6
7	Operation of Plant		78,765	85,901	164,666	153	8,407	7
8	Laundry & Linen Service		4,798	5,232	10,030		791	8
9	Housekeeping		2,379	2,594	4,973	84	1,396	9
10	Dietary		12,550	13,687	26,237	77	1,507	10
11	Cafeteria					34	552	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,111	2,302	4,413	115	1,655	13
14	Central Services & Supply		8,183	8,924	17,107	20	394	14
15	Pharmacy		6,979	7,611	14,590	114	3,755	15
16	Medical Records & Library		9,037	9,856	18,893	135	2,507	16
17	Social Service					51	685	17
19	Nonphysician Anesthetists						1,112	19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		47,531	51,836	99,367	491	7,428	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		27,915	30,443	58,358	142	2,597	50
53	Anesthesiology		1,041	1,135	2,176		20	53
54	Radiology-Diagnostic		28,101	30,646	58,747	244	8,045	54
60	Laboratory		9,735	10,617	20,352	300	7,763	60
62	Whole Blood & Packed Red Blood Cells					4	48	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		762	831	1,593	74	985	64
65	Respiratory Therapy		2,390	2,607	4,997	170	2,535	65
66	Physical Therapy		14,615	15,938	30,553		3,763	66
69	Electrocardiology		1,431	1,560	2,991	46	540	69
71	Medical Supplies Charged to Patients						1,062	71
72	Impl. Dev. Charged to Patients						448	72
73	Drugs Charged to Patients						1,540	73
76	CARDIAC REHAB		1,861	2,030	3,891	62	875	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		49,927	54,449	104,376	1,169	17,805	88
90	Clinic						5	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		20,878	22,769	43,647	570	15,708	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		378,468	412,747	791,215	5,031	93,928	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		26,571	28,978	55,549	51	1,119	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						105	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		405,039	441,725	846,764	5,082	95,152	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	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	173,226						7
8	Laundry & Linen Service	2,981	13,802					8
9	Housekeeping	1,478		7,931				9
10	Dietary	7,798		366	35,985			10
11	Cafeteria					586		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,312		62		18	7,575	13
14	Central Services & Supply	5,084		239		3		14
15	Pharmacy	4,336		204		18		15
16	Medical Records & Library	5,615		264		21		16
17	Social Service					8	263	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	29,533	13,802	1,388	35,985	77	2,697	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,345		815		22	461	50
53	Anesthesiology	647		30				53
54	Radiology-Diagnostic	17,460		821		38		54
60	Laboratory	6,049		284		47		60
62	Whole Blood & Packed Red Blood Cells					1		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	473		22		12		64
65	Respiratory Therapy	1,485		70		26		65
66	Physical Therapy	9,081		427				66
69	Electrocardiology	889		42		7		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	1,156		54		10	322	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	31,022		1,457		181	996	88
90	Clinic							90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	12,972		610		89	2,836	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	156,716	13,802	7,155	35,985	578	7,575	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	16,510		776		8		192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	173,226	13,802	7,931	35,985	586	7,575	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	
		14	15	16	17	19	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							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	22,847						14
15	Pharmacy	122	23,139					15
16	Medical Records & Library	2		27,437				16
17	Social Service				1,007			17
19	Nonphysician Anesthetists					1,112		19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	805		890	1,007		193,470	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	856		871			81,467	50
53	Anesthesiology	12		436			3,321	53
54	Radiology-Diagnostic	1,624		6,767			93,746	54
60	Laboratory	7,227		4,962			46,984	60
62	Whole Blood & Packed Red Blood Cells			45			98	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			1,254			4,413	64
65	Respiratory Therapy	154		682			10,119	65
66	Physical Therapy	139		2,688			46,651	66
69	Electrocardiology	63		532			5,110	69
71	Medical Supplies Charged to Patients	6,054		447			7,563	71
72	Impl. Dev. Charged to Patients	3,092		90			3,630	72
73	Drugs Charged to Patients		23,139	1,108			25,787	73
76	CARDIAC REHAB	77		244			6,691	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	878		2,677			160,561	88
90	Clinic	39		4			48	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	1,703		3,740			81,875	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	22,847	23,139	27,437	1,007		771,534	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices						74,013	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						105	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments					1,112	1,112	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	22,847	23,139	27,437	1,007	1,112	846,764	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	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
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		193,470					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		81,467					50
53	Anesthesiology		3,321					53
54	Radiology-Diagnostic		93,746					54
60	Laboratory		46,984					60
62	Whole Blood & Packed Red Blood Cells		98					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		4,413					64
65	Respiratory Therapy		10,119					65
66	Physical Therapy		46,651					66
69	Electrocardiology		5,110					69
71	Medical Supplies Charged to Patients		7,563					71
72	Impl. Dev. Charged to Patients		3,630					72
73	Drugs Charged to Patients		25,787					73
76	CARDIAC REHAB		6,691					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		160,561					88
90	Clinic		48					90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		81,875					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		771,534					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		74,013					192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT		105					192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments		1,112					200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		846,764					202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2016 To: 04/30/2017	Run Date: 09/14/2017 Run Time: 16:41 Version: 2017.01 (07/27/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	69,647						1
2	Cap Rel Costs-Mvble Equip		69,647					2
4	Employee Benefits Department	418	418	6,082,906				4
5	Administrative & General	7,746	7,746	1,168,977	-3,075,759	12,367,866		5
6	Maintenance & Repairs							6
7	Operation of Plant	13,544	13,544	182,779		1,092,853	47,939	7
8	Laundry & Linen Service	825	825			102,834	825	8
9	Housekeeping	409	409	100,733		181,434	409	9
10	Dietary	2,158	2,158	91,978		195,937	2,158	10
11	Cafeteria			41,259		71,744		11
12	Maintenance of Personnel							12
13	Nursing Administration	363	363	137,569		215,081	363	13
14	Central Services & Supply	1,407	1,407	23,583		51,247	1,407	14
15	Pharmacy	1,200	1,200	136,349		488,065	1,200	15
16	Medical Records & Library	1,554	1,554	161,538		325,932	1,554	16
17	Social Service			60,581		89,048		17
19	Nonphysician Anesthetists					144,610		19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,173	8,173	588,550		965,587	8,173	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,800	4,800	170,409		337,617	4,800	50
53	Anesthesiology	179	179			2,558	179	53
54	Radiology-Diagnostic	4,832	4,832	292,767		1,045,708	4,832	54
60	Laboratory	1,674	1,674	359,272		1,009,147	1,674	60
62	Whole Blood & Packed Red Blood Cells			4,425		6,294		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	131	131	88,895		128,038	131	64
65	Respiratory Therapy	411	411	203,278		329,538	411	65
66	Physical Therapy	2,513	2,513			489,130	2,513	66
69	Electrocardiology	246	246	55,489		70,164	246	69
71	Medical Supplies Charged to Patients					138,097		71
72	Impl. Dev. Charged to Patients					58,171		72
73	Drugs Charged to Patients					200,140		73
76	CARDIAC REHAB	320	320	74,320		113,801	320	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	8,585	8,585	1,396,472		2,313,386	8,585	88
90	Clinic			471		670		90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	3,590	3,590	682,184		2,041,920	3,590	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	65,078	65,078	6,021,878	-3,075,759	12,208,751	43,370	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	4,569	4,569	61,028		145,460	4,569	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT					13,655		192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	405,039	441,725	2,569,443		3,075,759	1,364,635	202
203	Unit Cost Multiplier (Wkst. B, Part I)	5.815599	6.342341	0.422404		0.248690	28.466071	203
204	Cost to be allocated (Per Wkst. B, Part II)			5,082		95,152	173,226	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000835		0.007693	3.613467	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	NURSING ADMINIS-TRATION DIRECT NRSG SALAR	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	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	587						8
9	Housekeeping		46,705					9
10	Dietary		2,158	587				10
11	Cafeteria				4,497,180			11
12	Maintenance of Personnel							12
13	Nursing Administration		363		137,569	1,737,125		13
14	Central Services & Supply		1,407		23,583		429,785	14
15	Pharmacy		1,200		136,349		2,299	15
16	Medical Records & Library		1,554		161,538		34	16
17	Social Service				60,581	60,390		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	587	8,173	587	588,550	618,325	15,147	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		4,800		170,409	105,657	16,097	50
53	Anesthesiology		179				231	53
54	Radiology-Diagnostic		4,832		292,767		30,554	54
60	Laboratory		1,674		359,272		135,937	60
62	Whole Blood & Packed Red Blood Cells				4,425			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		131		88,895			64
65	Respiratory Therapy		411		203,278		2,891	65
66	Physical Therapy		2,513				2,619	66
69	Electrocardiology		246		55,489		1,187	69
71	Medical Supplies Charged to Patients						113,891	71
72	Impl. Dev. Charged to Patients						58,171	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB		320		74,320	73,924	1,453	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		8,585		1,396,472	228,442	16,516	88
90	Clinic				471		728	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		3,590		682,184	650,387	32,030	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	587	42,136	587	4,436,152	1,737,125	429,785	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		4,569		61,028			192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	151,893	238,198	317,101	89,586	283,493	111,690	202
203	Unit Cost Multiplier (Wkst. B, Part I)	258.761499	5.100054	540.206133	0.019920	0.163197	0.259874	203
204	Cost to be allocated (Per Wkst. B, Part II)	13,802	7,931	35,985	586	7,575	22,847	204
205	Unit Cost Multiplier (Wkst. B, Part II)	23.512777	0.169811	61.303237	0.000130	0.004361	0.053159	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	NONPHYSIC. ANESTHET. ASSIGNED TIME			
		15	16	17	19			
	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
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	483,800						15
16	Medical Records & Library		27,525,464					16
17	Social Service			587				17
19	Nonphysician Anesthetists				100			19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		893,025	587				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		873,360					50
53	Anesthesiology		437,357		100			53
54	Radiology-Diagnostic		6,792,407					54
60	Laboratory		4,976,598					60
62	Whole Blood & Packed Red Blood Cells		45,223					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		1,257,605					64
65	Respiratory Therapy		684,034					65
66	Physical Therapy		2,696,100					66
69	Electrocardiology		533,736					69
71	Medical Supplies Charged to Patients		448,746					71
72	Impl. Dev. Charged to Patients		90,665					72
73	Drugs Charged to Patients	483,800	1,111,032					73
76	CARDIAC REHAB		245,024					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		2,685,389					88
90	Clinic		4,045					90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		3,751,118					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	483,800	27,525,464	587	100			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	653,034	462,376	122,255	180,573			202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.349802	0.016798	208.270869	1,805.730000			203
204	Cost to be allocated (Per Wkst. B, Part II)	23,139	27,437	1,007	1,112			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.047828	0.000997	1.715503	11.120000			205

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,202,874		2,202,874			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	622,188		622,188			50
53	Anesthesiology	197,182		197,182			53
54	Radiology-Diagnostic	1,595,830		1,595,830			54
60	Laboratory	1,442,383		1,442,383			60
62	Whole Blood & Packed Red Blood Cells	8,707		8,707			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	187,173		187,173			64
65	Respiratory Therapy	441,577		441,577			65
66	Physical Therapy	741,093		741,093			66
69	Electrocardiology	106,250		106,250			69
71	Medical Supplies Charged to Patients	209,575		209,575			71
72	Impl. Dev. Charged to Patients	89,278		89,278			72
73	Drugs Charged to Patients	921,610		921,610			73
76	CARDIAC REHAB	170,881		170,881			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	3,291,365		3,291,365			88
90	Clinic	1,103		1,103			90
90.01	PROVIDER BASED CLINIC						90.01
91	Emergency	2,861,292		2,861,292			91
92	Observation Beds (Non-Distinct Part)	451,803		451,803			92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	15,542,164		15,542,164			200
201	Less Observation Beds	451,803		451,803			201
202	Total (line 200 minus line 201)	15,090,361		15,090,361			202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	684,737		684,737				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	76,372	796,988	873,360	0.712407			50
53	Anesthesiology	44,008	393,349	437,357	0.450849			53
54	Radiology-Diagnostic	600,913	6,191,494	6,792,407	0.234943			54
60	Laboratory	550,188	4,426,410	4,976,598	0.289833			60
62	Whole Blood & Packed Red Blood Cells		45,223	45,223	0.192535			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	110,314	1,147,291	1,257,605	0.148833			64
65	Respiratory Therapy	248,472	435,562	684,034	0.645548			65
66	Physical Therapy	18,709	2,677,391	2,696,100	0.274876			66
69	Electrocardiology	76,437	457,299	533,736	0.199068			69
71	Medical Supplies Charged to Patients	168,363	280,383	448,746	0.467024			71
72	Impl. Dev. Charged to Patients		90,665	90,665	0.984702			72
73	Drugs Charged to Patients	301,383	809,649	1,111,032	0.829508			73
76	CARDIAC REHAB		245,024	245,024	0.697405			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	126,035	2,559,354	2,685,389				88
90	Clinic		4,045	4,045	0.272682			90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	235,879	3,515,239	3,751,118	0.762784			91
92	Observation Beds (Non-Distinct Part)	15,624	192,664	208,288	2.169126			92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	3,257,434	24,268,030	27,525,464				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	3,257,434	24,268,030	27,525,464				202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1303** **WORKSHEET D PART V**

```
Check        [  ] Title V - O/P          [XX] Hospital    [  ] SUB (Other)        [  ] Swing Bed SNF
Applicable   [XX] Title XVIII, Part B    [  ] IPF         [  ] SNF                [  ] Swing Bed NF
Boxes:       [  ] Title XIX - O/P        [  ] IRF         [  ] NF                 [  ] ICF/IID
```

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.712407		222,577			158,565		50
53	Anesthesiology	0.450849		108,044			48,712		53
54	Radiology-Diagnostic	0.234943		2,283,036			536,383		54
60	Laboratory	0.289833		1,886,010			546,628		60
62	Whole Blood & Packed Red Blood	0.192535		28,383			5,465		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.148833		639,167			95,129		64
65	Respiratory Therapy	0.645548		171,769			110,885		65
66	Physical Therapy	0.274876		675,613			185,710		66
69	Electrocardiology	0.199068		209,808			41,766		69
71	Medical Supplies Charged to Pat	0.467024		100,364			46,872		71
72	Impl. Dev. Charged to Patients	0.984702		4,115			4,052		72
73	Drugs Charged to Patients	0.829508		349,036			289,528		73
76	CARDIAC REHAB	0.697405		144,216			100,577		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.272682		3,036			828		90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	0.762784		1,146,399			874,455		91
92	Observation Beds (Non-Distinct	2.169126		122,051			264,744		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			8,093,624			3,310,299		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			8,093,624			3,310,299		202

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z303** **WORKSHEET D PART V**

```
Check         [  ] Title V - O/P            [  ] Hospital     [  ] SUB (Other)          [XX] Swing Bed SNF
Applicable    [XX] Title XVIII, Part B      [  ] IPF          [  ] SNF                  [  ] Swing Bed NF
Boxes:        [  ] Title XIX - O/P          [  ] IRF          [  ] NF                   [  ] ICF/IID
```

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.712407							50
53	Anesthesiology	0.450849							53
54	Radiology-Diagnostic	0.234943							54
60	Laboratory	0.289833							60
62	Whole Blood & Packed Red Blood	0.192535							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.148833							64
65	Respiratory Therapy	0.645548							65
66	Physical Therapy	0.274876							66
69	Electrocardiology	0.199068							69
71	Medical Supplies Charged to Pat	0.467024							71
72	Impl. Dev. Charged to Patients	0.984702							72
73	Drugs Charged to Patients	0.829508							73
76	CARDIAC REHAB	0.697405							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.272682							90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	0.762784							91
92	Observation Beds (Non-Distinct	2.169126							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS **WORKSHEET D PART I**

```
Check        [  ] Title V
Applicable   [  ] Title XVIII, Part A
Boxes:       [XX] Title XIX
```

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26) 1	Swing Bed Adjust-ment 2	Reduced Capital Related Cost (col. 1 minus col. 2) 3	Total Patient Days 4	Per Diem (col. 3 ÷ col. 4) 5	Inpatient Program Days 6	Inpatient Program Capital Cost (col. 5 x col. 6) 7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	193,470	15,966	177,504	756	234.79	18	4,226	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	193,470		177,504	756		18	4,226	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1303** **WORKSHEET D PART II**

```
Check         [  ] Title V                [XX] Hospital     [  ] SUB (Other)
Applicable    [  ] Title XVIII, Part A    [  ] IPF
Boxes:        [XX] Title XIX              [  ] IRF
```

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	81,467	873,360	0.093280			50
53	Anesthesiology	3,321	437,357	0.007593			53
54	Radiology-Diagnostic	93,746	6,792,407	0.013802			54
60	Laboratory	46,984	4,976,598	0.009441			60
62	Whole Blood & Packed Red Blood	98	45,223	0.002167			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	4,413	1,257,605	0.003509			64
65	Respiratory Therapy	10,119	684,034	0.014793			65
66	Physical Therapy	46,651	2,696,100	0.017303			66
69	Electrocardiology	5,110	533,736	0.009574			69
71	Medical Supplies Charged to Pat	7,563	448,746	0.016854			71
72	Impl. Dev. Charged to Patients	3,630	90,665	0.040038			72
73	Drugs Charged to Patients	25,787	1,111,032	0.023210			73
76	CARDIAC REHAB	6,691	245,024	0.027308			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	160,561	2,685,389	0.059791			88
90	Clinic	48	4,045	0.011867			90
90.01	PROVIDER BASED CLINIC						90.01
91	Emergency	81,875	3,751,118	0.021827			91
92	Observation Beds (Non-Distinct	39,680	208,288	0.190505			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	617,744	26,840,727				200

(A) Worksheet A line numbers

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

```
Check          [  ] Title V                [  ] PPS
Applicable     [  ] Title XVIII, Part A    [  ] TEFRA
Boxes:         [XX] Title XIX              [XX] Other
```

(A)	Cost Center Description	Nursing School 1	Allied Health Cost 2	All Other Medical Education Cost 3	Swing-Bed Adjust-ment Amount (see instruct-ions) 4	Total Costs (sum of cols. 1 through 3 minus col 4.) 5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

```
Check        [  ] Title V               [  ] PPS
Applicable   [  ] Title XVIII, Part A   [  ] TEFRA
Boxes:       [XX] Title XIX             [XX] Other
```

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	756		18		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	756		18		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1303

WORKSHEET D PART IV

```
Check        [  ] Title V                [XX] Hospital    [  ] SUB (Other)       [  ] ICF/IID     [  ] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF         [  ] SNF                                [  ] TEFRA
Boxes:       [XX] Title XIX              [  ] IRF         [  ] NF                                 [XX] Other
```

(A)	Cost Center Description	Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology	180,573				180,573		53
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)	180,573				180,573		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-1303** **WORKSHEET D PART IV**

```
Check        [  ] Title V               [XX] Hospital     [  ] SUB (Other)        [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A   [  ] IPF          [  ] SNF                                  [  ] TEFRA
Boxes:       [XX] Title XIX             [  ] IRF          [  ] NF                                   [XX] Other
```

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	873,360							50
53	Anesthesiology	437,357	0.412873						53
54	Radiology-Diagnostic	6,792,407							54
60	Laboratory	4,976,598							60
62	Whole Blood & Packed Red Blood	45,223							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,257,605							64
65	Respiratory Therapy	684,034							65
66	Physical Therapy	2,696,100							66
69	Electrocardiology	533,736							69
71	Medical Supplies Charged to Pat	448,746							71
72	Impl. Dev. Charged to Patients	90,665							72
73	Drugs Charged to Patients	1,111,032							73
76	CARDIAC REHAB	245,024							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	2,685,389							88
90	Clinic	4,045							90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	3,751,118							91
92	Observation Beds (Non-Distinct	208,288							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	26,840,727							200

(A) Worksheet A line numbers

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2016 To: 04/30/2017	Run Date: 09/14/2017 Run Time: 16:41 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1303** **WORKSHEET D PART V**

```
Check       [  ] Title V - O/P          [XX] Hospital    [  ] SUB (Other)         [  ] Swing Bed SNF
Applicable  [  ] Title XVIII, Part B    [  ] IPF         [  ] SNF                 [  ] Swing Bed NF
Boxes:      [XX] Title XIX - O/P        [  ] IRF         [  ] NF                  [  ] ICF/IID
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			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.712407							50
53	Anesthesiology	0.450849							53
54	Radiology-Diagnostic	0.234943							54
60	Laboratory	0.289833							60
62	Whole Blood & Packed Red Blood	0.192535							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.148833							64
65	Respiratory Therapy	0.645548							65
66	Physical Therapy	0.274876							66
69	Electrocardiology	0.199068							69
71	Medical Supplies Charged to Pat	0.467024							71
72	Impl. Dev. Charged to Patients	0.984702							72
73	Drugs Charged to Patients	0.829508							73
76	CARDIAC REHAB	0.697405							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.272682							90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	0.762784							91
92	Observation Beds (Non-Distinct	2.169126							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1 PART I**

```
Check        [  ] Title V - I/P          [XX] Hospital    [  ] SUB (Other)        [  ] ICF/IID     [  ] PPS
Applicable   [XX] Title XVIII, Part A    [  ] IPF         [  ] SNF                                 [  ] TEFRA
Boxes:       [  ] Title XIX - I/P        [  ] IRF         [  ] NF                                  [XX] Other
```

PART I - ALL PROVIDER COMPONENTS

	Description	Amount	
	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	824	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	756	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	587	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	45	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)	23	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	417	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)	31	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)	15	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 XIX only)		15
16	Nursery days (title V or 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	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,202,874	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	181,791	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,021,083	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	2,021,083	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1 PART II**

```
Check         [  ] Title V - I/P           [XX] Hospital     [  ] SUB (Other)          [  ] PPS
Applicable    [XX] Title XVIII, Part A     [  ] IPF                                    [  ] TEFRA
Boxes:        [  ] Title XIX - I/P         [  ] IRF                                    [XX] Other
```

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	2,673.39	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,114,804	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)	1,114,804	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	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

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	498,916	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,613,720	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 (sum of lines 50 and 51)		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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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)	82,875	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	40,101	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	122,976	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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1 PARTS III & IV**

```
Check        [  ] Title V - I/P         [XX] Hospital    [  ] SUB (Other)      [  ] ICF/IID    [  ] PPS
Applicable   [XX] Title XVIII, Part A   [  ] IPF         [  ] SNF                              [  ] TEFRA
Boxes:       [  ] Title XIX - I/P       [  ] IRF         [  ] NF                               [XX] Other
```

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					169	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,673.39	88
89	Observation bed cost (line 87 x line 88) (see instructions)					451,803	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	193,470	2,202,874	0.087826	451,803	39,680	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1 PART I**

```
Check        [  ] Title V - I/P            [XX] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A      [  ] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [XX] Title XIX - I/P          [  ] IRF          [  ] NF                                     [XX] Other
```

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	824	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	756	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	587	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	45	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)	23	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	18	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or 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	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,202,874	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	181,791	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,021,083	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	2,021,083	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1 PART II**

```
Check        [  ] Title V - I/P           [XX] Hospital    [  ] SUB (Other)          [  ] PPS
Applicable   [  ] Title XVIII, Part A     [  ] IPF                                   [  ] TEFRA
Boxes:       [XX] Title XIX - I/P         [  ] IRF                                   [XX] Other
```

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	2,673.39	38
39	Program general inpatient routine service cost (line 9 x line 38)	48,121	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)	48,121	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	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

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	48,121	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	4,226	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 (sum of lines 50 and 51)	4,226	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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1 PARTS III & IV**

```
Check        [  ] Title V - I/P          [XX] Hospital    [  ] SUB (Other)        [  ] ICF/IID    [  ] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF         [  ] SNF                                [  ] TEFRA
Boxes:       [XX] Title XIX - I/P        [  ] IRF         [  ] NF                                 [XX] Other
```

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)	169	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		88
89	Observation bed cost (line 87 x line 88) (see instructions)		89

		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1303** **WORKSHEET D-3**

```
Check        [  ] Title V                [XX] Hospital    [  ] SUB (Other)    [  ] Swing Bed SNF    [  ] PPS
Applicable   [XX] Title XVIII, Part A    [  ] IPF         [  ] SNF            [  ] Swing Bed NF     [  ] TEFRA
Boxes:       [  ] Title XIX              [  ] IRF         [  ] NF             [  ] ICF/IID          [XX] Other
```

(A)	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		446,955		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.712407	42,910	30,569	50
53	Anesthesiology	0.450849	23,818	10,738	53
54	Radiology-Diagnostic	0.234943	225,550	52,991	54
60	Laboratory	0.289833	229,826	66,611	60
62	Whole Blood & Packed Red Blood Cells	0.192535			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.148833	12,835	1,910	64
65	Respiratory Therapy	0.645548	184,553	119,138	65
66	Physical Therapy	0.274876	12,993	3,571	66
69	Electrocardiology	0.199068	27,335	5,442	69
71	Medical Supplies Charged to Patients	0.467024	113,325	52,925	71
72	Impl. Dev. Charged to Patients	0.984702			72
73	Drugs Charged to Patients	0.829508	184,364	152,931	73
76	CARDIAC REHAB	0.697405			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.272682			90
90.01	PROVIDER BASED CLINIC				90.01
91	Emergency	0.762784	206	157	91
92	Observation Beds (Non-Distinct Part)	2.169126	891	1,933	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,058,606	498,916	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,058,606		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z303** **WORKSHEET D-3**

```
Check        [  ] Title V                [  ] Hospital   [  ] SUB (Other)     [XX] Swing Bed SNF   [  ] PPS
Applicable   [XX] Title XVIII, Part A    [  ] IPF        [  ] SNF             [  ] Swing Bed NF    [  ] TEFRA
Boxes:       [  ] Title XIX              [  ] IRF        [  ] NF              [  ] ICF/IID         [XX] Other
```

(A)	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	0.712407			50
53	Anesthesiology	0.450849			53
54	Radiology-Diagnostic	0.234943	4,845	1,138	54
60	Laboratory	0.289833	9,905	2,871	60
62	Whole Blood & Packed Red Blood Cells	0.192535			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.148833			64
65	Respiratory Therapy	0.645548	27,499	17,752	65
66	Physical Therapy	0.274876	5,716	1,571	66
69	Electrocardiology	0.199068			69
71	Medical Supplies Charged to Patients	0.467024	9,229	4,310	71
72	Impl. Dev. Charged to Patients	0.984702			72
73	Drugs Charged to Patients	0.829508	21,653	17,961	73
76	CARDIAC REHAB	0.697405			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.272682			90
90.01	PROVIDER BASED CLINIC				90.01
91	Emergency	0.762784			91
92	Observation Beds (Non-Distinct Part)	2.169126			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		78,847	45,603	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		78,847		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1303** **WORKSHEET D-3**

```
Check        [  ] Title V               [XX] Hospital    [  ] SUB (Other)        [  ] Swing Bed SNF    [  ] PPS
Applicable   [  ] Title XVIII, Part A   [  ] IPF         [  ] SNF                [  ] Swing Bed NF     [  ] TEFRA
Boxes:       [XX] Title XIX             [  ] IRF         [  ] NF                 [  ] ICF/IID          [XX] Other
```

(A)	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	0.712407			50
53	Anesthesiology	0.450849			53
54	Radiology-Diagnostic	0.234943			54
60	Laboratory	0.289833			60
62	Whole Blood & Packed Red Blood Cells	0.192535			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.148833			64
65	Respiratory Therapy	0.645548			65
66	Physical Therapy	0.274876			66
69	Electrocardiology	0.199068			69
71	Medical Supplies Charged to Patients	0.467024			71
72	Impl. Dev. Charged to Patients	0.984702			72
73	Drugs Charged to Patients	0.829508			73
76	CARDIAC REHAB	0.697405			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.272682			90
90.01	PROVIDER BASED CLINIC				90.01
91	Emergency	0.762784			91
92	Observation Beds (Non-Distinct Part)	2.169126			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1303** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	3,310,299			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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	3,310,299			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, col. 4, line 69)				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 ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	3,343,402			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	16,347			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,245,829			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,081,226			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,081,226			30
31	Primary payer payments	1,276			31
32	Subtotal (line 30 minus line 31)	2,079,950			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)	100,205			34
35	Adjusted reimbursable bad debts (see instructions)	65,133			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	100,205			36
37	Subtotal (see instructions)	2,145,083			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,145,083			40
40.01	Sequestration adjustment (see instructions)	42,902			40.01
41	Interim payments	2,017,064			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	85,117			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse 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 **COMPONENT CCN: 14-1303** **WORKSHEET E-1 PART I**

```
Check         [XX] Hospital     [  ] SUB (Other)
Applicable    [  ] IPF          [  ] SNF
Boxes:        [  ] IRF          [  ] Swing Bed SNF
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	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				1,299,291		2,163,796	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	11/17/2016	76,745	11/17/2016	34,297	3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	04/17/2017	30,735	04/17/2017	181,029	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		46,010		-146,732	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,345,301		2,017,064	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.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	Determined net settlement amount (balance due)		.01		149,897		85,117	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,495,198		2,102,181	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z303** **WORKSHEET E-1 PART I**

```
Check        [  ] Hospital    [  ] SUB (Other)
Applicable   [  ] IPF         [  ] SNF
Boxes:       [  ] IRF         [XX] Swing Bed SNF
```

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				118,769			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					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 Wkst. E-3, line and column as appropriate)				118,769			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.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	Determined net settlement amount (balance due)		.01		45,408			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				164,177			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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

Check applicable box: [XX] Hospital [ ] 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 (Wkst. S-3, Pt. I, col. 15, line 14)	201	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	417	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	85	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	587	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	27,525,464	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	200,582	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1	7
8	Calculation of the HIT incentive payment (see instructions)	1	8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	1	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z303** **WORKSHEET E-2**

```
Check         [  ] Title V              [XX] Swing Bed - SNF
Applicable    [XX] Title XVIII          [  ] Swing Bed - NF
Boxes:        [  ] Title XIX
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COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	124,206		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, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	46,059		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	46		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 through 3 plus lines 6 and 7)	170,265		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	170,265		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	170,265		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,737		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)	167,528		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
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)	167,528		19
19.01	Sequestration adjustment (see instructions)	3,351		19.01
20	Interim payments	118,769		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	45,408		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3 PART V**

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

1	Inpatient services	1,613,720	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,613,720	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,629,857	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)	0.000000	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 instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	1,629,857	19
20	Deductibles (exclude professional component)	128,324	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,501,533	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,501,533	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,199	25
26	Adjusted reimbursable bad debts (see instructions)	24,179	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,199	27
28	Subtotal (sum of lines 24 and 26)	1,525,712	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,525,712	30
30.01	Sequestration adjustment (see instructions)	30,514	30.01
31	Interim payments	1,345,301	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	149,897	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1303** **WORKSHEET E-3 PART VII**

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Check        [  ] Title V       [XX] Hospital       [  ] NF        [  ] PPS
Applicable   [XX] Title XIX     [  ] SUB (Other)    [  ] ICF/IID   [  ] TEFRA
Boxes:                          [  ] SNF                           [XX] Other
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PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	48,121		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	48,121		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	48,121		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	48,121		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	48,121		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	48,121		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	48,121		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	48,121		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	48,121		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	48,121		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	2,623,782				1
2	Temporary investments	5,618,815				2
3	Notes receivable					3
4	Accounts receivable	4,496,765				4
5	Other receivables	312,138				5
6	Allowances for uncollectible notes and accounts receivable	-2,336,647				6
7	Inventory	286,894				7
8	Prepaid expenses	231,308				8
9	Other current assets	89,000				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	11,322,055				11
	FIXED ASSETS					
12	Land	343,588				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	10,945,258				15
16	Accumulated depreciation	-8,096,485				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	125,772				19
20	Accumulated depreciation	-83,154				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	5,238,765				23
24	Accumulated depreciation	-3,873,525				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	1,104,343				27
28	Accumulated depreciation	-1,090,755				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	4,613,807				30
	OTHER ASSETS					
31	Investments	1,385,949				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	771,843				34
35	Total other assets (sum of lines 31-34)	2,157,792				35
36	Total assets (sum of lines 11, 30 and 35)	18,093,654				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	581,516				37
38	Salaries, wages and fees payable	765,259				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	71,764				40
41	Deferred income	97,137				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	37,345				44
45	Total current liabilities (sum of lines 37 thru 44)	1,553,021				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	700,815				47
48	Unsecured loans					48
49	Other long term liabilities	2,679,353				49
50	Total long term liabilities (sum of lines 46 thru 49)	3,380,168				50
51	Total liabilities (sum of lines 45 and 50)	4,933,189				51
	CAPITAL ACCOUNTS					
52	General fund balance	13,160,465				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					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 thru 58)	13,160,465				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	18,093,654				60

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		10,890,874			1
2	Net income (loss) (from Worksheet G-3, line 29)		2,250,321			2
3	Total (sum of line 1 and line 2)		13,141,195			3
4	Additions (credit adjustments) (specify)					4
5	CAPITAL GRANTS	19,516				5
6	RESTRICTED DONATIONS	100				6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		19,616			10
11	Subtotal (line 3 plus line 10)		13,160,811			11
12	Deductions (debit adjustments) (specify)					12
13	UNREALIZED LOSS	346				13
14	PRIOR PERIOD ADJUSTMENT					14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		346			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,160,465			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	CAPITAL GRANTS					5
6	RESTRICTED DONATIONS					6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	UNREALIZED LOSS					13
14	PRIOR PERIOD ADJUSTMENT					14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

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	797,780		797,780	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)	797,780		797,780	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)	797,780		797,780	17
18	Ancillary services	2,437,256		2,437,256	18
19	Outpatient services		21,868,333	21,868,333	19
20	Rural Health Clinic (RHC)	126,035	2,559,354	2,685,389	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	3,361,071	24,427,687	27,788,758	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		15,902,283	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38	INTEREST EXPENSE	-34,393		38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-34,393	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		15,867,890	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	27,788,758	1
2	Less contractual allowances and discounts on patients' accounts	11,166,074	2
3	Net patient revenues (line 1 minus line 2)	16,622,684	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	15,867,890	4
5	Net income from service to patients (line 3 minus line 4)	754,794	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	166,833	6
7	Income from investments	31,577	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	33,067	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	191	16
17	Revenue from sale of drugs to other than patients	4,128	17
18	Revenue from sale of medical records and abstracts	8,057	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	1,101	21
22	Rental of hosptial space	38,128	22
23	Governmental appropriations	254,003	23
24	Other (OTHER DIETARY REVENUE)	63,953	24
24.01	Other (SALE: MINOR EQUIPMENT/SUPPLIES)	2,515	24.01
24.02	Other (FITNESS CENTER)	7,005	24.02
24.03	Other (PHARM 340B RETAIL/CONTRACT REV)	378,278	24.03
24.04	Other (MISC OTHER)	10,266	24.04
24.05	Other (CRNA PASS THROUGH AND OTHER)		24.05
24.06	Other (MEDICAID EHR)	127,500	24.06
24.07	Other (MEDICARE EHR)	403,810	24.07
25	Total other income (sum of lines 6-24)	1,530,412	25
26	Total (line 5 plus line 25)	2,285,206	26
27	Other expenses (INTEREST EXPENSE)	34,393	27
27.01	Other expenses (LOSS ON DISPOSAL OF ASSET)	492	27.01
28	Total other expenses (sum of line 27 and subscripts)	34,885	28
29	Net income (or loss) for the period (line 26 minus line 28)	2,250,321	29

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1 PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	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
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 14-3404** **WORKSHEET M-1**

Check applicable box: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	660,088		660,088	-134,573	525,515	-24,245	501,270	1
2	Physician Assistant								2
3	Nurse Practitioner	309,109		309,109		309,109		309,109	3
4	Visiting Nurse								4
5	Other Nurse	229,771		229,771		229,771		229,771	5
6	Clinical Psychologist								6
7	Clinical Social Worker		58,785	58,785		58,785		58,785	7
8	Laboratory Techinician								8
9	Other Facility Health Care Staff Costs	316,597		316,597		316,597		316,597	9
10	Subtotal (sum of lines 1 through 9)	1,515,565	58,785	1,574,350	-134,573	1,439,777	-24,245	1,415,532	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement	15,480	7,500	22,980		22,980		22,980	11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement		10,000	10,000		10,000		10,000	13
14	Subtotal (sum of lines 11 through 13)	15,480	17,500	32,980		32,980		32,980	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		41,682	41,682		41,682		41,682	15
16	Transportation (Health Care Staff)		28,458	28,458		28,458		28,458	16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		51,163	51,163	-51,163				18
19	Other Health Care Costs		41,283	41,283	-3,390	37,893		37,893	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		162,586	162,586	-54,553	108,033		108,033	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,531,045	238,871	1,769,916	-189,126	1,580,790	-24,245	1,556,545	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs				-5,091	-5,091		-5,091	26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)				-5,091	-5,091		-5,091	28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs		85,663	85,663	11,946	97,609	-29,927	67,682	30
31	Total Facility Overhead (sum of lines 29 and 30)		85,663	85,663	11,946	97,609	-29,927	67,682	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,531,045	324,534	1,855,579	-182,271	1,673,308	-54,172	1,619,136	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3404** **WORKSHEET M-2**

Check applicable box: [XX] RHC I [ ] FQHC

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1	2	3	4	5	
1	Physicians	1.63	8,243	4,200	6,846		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.28	4,908	2,100	2,688		3
4	Subtotal (sum of lines 1 through 3)	2.91	13,151		9,534	13,151	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker		900			900	7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	2.91	14,051			14,051	8
9	Physician Services Under Agreements		180			180	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)	1,556,545	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	-5,091	11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,551,454	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.003281	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	67,682	14
15	Parent provider overhead allocated to facility (see instructions)	1,672,229	15
16	Total overhead (sum of lines 14 and 15)	1,739,911	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,739,911	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,745,620	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	3,302,165	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3404** **WORKSHEET M-3**

```
Check                  [XX] RHC I            [  ] Title V          [  ] Title XIX
applicable boxes:      [  ] FQHC             [XX] Title XVIII
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DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	3,302,165	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	52,646	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	3,249,519	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	14,051	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	180	5
6	Total adjusted visits (line 4 plus line 5)	14,231	6
7	Adjusted cost per visit (line 3 divided by line 6)	228.34	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8
9	Rate for program covered visits (see instructions)	228.34	228.34	228.34	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		4,683		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,069,316		11
12	Program covered visits for mental health services (from contractor records)		138		12
13	Program covered cost from mental health services (line 9 x line 12)		31,511		13
14	Limit adjustment for mental health services (see instructions)		31,511		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,100,827		16
16.01	Total program charges (see instructions)(from contractor's records)		805,079		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		15,611		16.02
16.03	Total program preventive costs (see instructions)		21,346		16.03
16.04	Total program non-preventive costs (see instructions)		787,658		16.04
16.05	Total program cost (see instructions)		809,004		16.05
17	Primary payer payments		25		17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		94,908		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		142,034		19
20	Net Medicare cost excluding vaccines (see instructions)		808,979		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		28,359		21
22	Total reimbursable Program cost (line 20 plus line 21)		837,338		22
23	Allowable bad debts (see instructions)		49,466		23
23.01	Adjusted reimbursable bad debts (see instructions)		32,153		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		49,466		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		869,491		26
26.01	Sequestration adjustment (see instructions)		17,390		26.01
27	Interim payments		721,888		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		130,213		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3404** **WORKSHEET M-4**

Check applicable boxes:	[XX] RHC I	[ ] Title V	[ ] Title XIX
	[ ] FQHC	[XX] Title XVIII	

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,415,532	1,415,532	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000450	0.002400	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	637	3,397	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	11,600	9,182	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	12,237	12,579	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,556,545	1,556,545	6
7	Total overhead (from Wkst. M-2, line 16)	1,745,620	1,745,620	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.007862	0.008081	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	13,724	14,106	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	25,961	26,685	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	77	412	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	337.16	64.77	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	43	214	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	14,498	13,861	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)		52,646	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)		28,359	16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **COMPONENT CCN: 14-3404** **WORKSHEET M-5**

Check applicable box: [XX] RHC I [ ] FQHC

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				827,544	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 zero					2
3	List separately each retroactive lump sum adjustment		.01	11/15/2016	6,007	3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51	04/17/2017	111,663	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		-105,656	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				721,888	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.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)		.01		130,213	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				852,101	
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.