CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2016 To: 04/30/2017	Run Date: 09/26/2017 Run Time: 08:32 Version: 2017.01 (07/27/2017)

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: 09/26/2017 Time: 08:32
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 CRAWFORD MEMORIAL HOSPITAL (14-1343) {(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		452,008	399,500			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		36,300				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		3,950				7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			69,844			10
10.01	HEALTH CLINIC - RHC II			32,711			10.01
10.02	HEALTH CLINIC - RHC III			17,885			10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		492,258	519,940			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: 1000 NORTH ALLEN STREET	P.O. Box:		1
2	City: ROBINSON	State: IL	ZIP Code: 62454 County: CRAWFORD	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	CRAWFORD MEMORIAL HOSPITAL	14-1343	99914	1	05 / 01 / 2005	N	O	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	CRAWFORD MEMORIAL HOSPITAL	14-Z343	99914		05 / 01 / 2005	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF	CRAWFORD MEMORIAL HOSPITAL LTC	14-6150	99914		03 / 29 / 2012	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	CRAWFORD MEMORIAL HHA	14-7175	99914		08 / 01 / 1979	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	CMH RURAL HEALTH CLINIC	14-3429	99914		11 / 11 / 1996	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	PALESTINE RURAL HEALTH CLINIC	14-3486	99914		11 / 21 / 2006	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	OBLONG RURAL HEALTH CLINIC	14-3488	99914		05 / 01 / 2007	N	O	N	15.02
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 05 / 01 / 2016	To: 04 / 30 / 2017	20
21	Type of control (see instructions)	11		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.	3	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.			N		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.	N	N	N	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.			1		118
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:					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	Y	Y	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	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)		05 / 01 / 2016	04 / 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.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/18/2017	Y	09/18/2017	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.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R 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.	N	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's 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.	N	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	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: BRENT	Last name: KOCHEL	Title: SENIOR MANAGER	41
42	Employer: KEB			42
43	Phone number: 6185291040	E-mail Address: BRENTK@KEBCPA.COM		43

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	25	9,125	81,840.00		1,007	385	2,433	1
2	HMO and other (see instructions)									2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						204		230	5
6	Hospital Adults & Peds. Swing Bed NF								21	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	81,840.00		1,211	385	2,684	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						185	352	13
14	Total (see instructions)		25	9,125	81,840.00		1,211	570	3,036	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	35	12,775			1,606		6,496	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					3,079		3,835	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					6,763		27,127	26
26.01	RHC II	88.01					604		4,151	26.01
26.02	RHC III	88.02					812		6,823	26.02
27	Total (sum of lines 14-26)		60							27
28	Observation Bed Days							65	429	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							35	63	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)					290	183	770	1
2	HMO and other (see instructions)								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)		268.36			290	183	770	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		21.46						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		8.20						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		47.88						26
26.01	RHC II		4.20						26.01
26.02	RHC III		5.75						26.02
27	Total (sum of lines 14-26)		355.85						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 14-7175** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA County: CLICK HERE TO ENTER

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		457		20	477	1
2	Unduplicated Census Count (see instructions)						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)	1.01		1.01	4
5	Other Administrative Personnel	1.05		1.05	5
6	Direct Nursing Service	3.91		3.91	6
7	Nursing Supervisor				7
8	Physical Therapy Service	0.35		0.35	8
9	Physical Therapy Supervisor	0.37		0.37	9
10	Occupational Therapy Service	0.14		0.14	10
11	Occupational Therapy Supervisor	0.01		0.01	11
12	Speech Pathology Service	0.01		0.01	12
13	Speech Pathology Supervisor				13
14	Medical Social Service				14
15	Medical Social Service Supervisor				15
16	Home Health Aide	1.28		1.28	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	99914	20

PPS ACTIVITY

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		1	2	3	4	5	
21	Skilled Nursing Visits	1,615	52	27		1,694	21
22	Skilled Nursing Visit Charges	346,236	11,232	5,792		363,260	22
23	Physical Therapy Visits	779		3		782	23
24	Physical Therapy Visit Charges	171,530		666		172,196	24
25	Occupational Therapy Visits	157				157	25
26	Occupational Therapy Visit Charges	34,590				34,590	26
27	Speech Pathology Visits	10				10	27
28	Speech Pathology Visit Charges	2,209				2,209	28
29	Medical Social Service Visits	1				1	29
30	Medical Social Service Visit Charges	306				306	30
31	Home Health Aide Visits	402	32	1		435	31
32	Home Health Aide Visit Charges	40,589	3,264	102		43,955	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,964	84	31		3,079	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	595,460	14,496	6,560		616,516	35
36	Total Number of Episodes (standard/non-outlier)	184		12		196	36
37	Total Number of Ourlier Episodes		2			2	37
38	Total Non-Routine Medical Supply Charges	40,535	2,386	447		43,368	38

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	09/19/1994	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	14		14	8
9	RMX	23		23	9
10	RML				10
11	RLX				11
12	RUC	57		57	12
13	RUB				13
14	RUA				14
15	RVC	19		19	15
16	RVB	14		14	16
17	RVA	43		43	17
18	RHC	264		264	18
19	RHB	163		163	19
20	RHA	584		584	20
21	RMC	34		34	21
22	RMB	30		30	22
23	RMA	185		185	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2	3		3	31
32	HD1	2		2	32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1	34		34	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1	3		3	42
43	LB2				43
44	LB1	1		1	44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	9		9	48
49	CC2				49
50	CC1				50
51	CB2	14		14	51
52	CB1	31		31	52
53	CA2				53
54	CA1	41		41	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	9		9	76
77	PA2				77
78	PA1	28		28	78
199	AAA	1		1	199
200	TOTAL	1,606		1,606	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).	00014	00014	201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each 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	858,154	45.46%		202
203	Recruitment				203
204	Retention of employees				204
205	Training	1,675	0.09%		205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	1,887,650			207

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3429** **WORKSHEET S-8**

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

Clinic Address and Identification:

1	Street: 1000 N ALLEN		1
2	City: ROBINSON State: IL ZIP Code: 62454 County: CRAWFORD		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			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 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-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3486** **WORKSHEET S-8**

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

Clinic Address and Identification:

1	Street: 209 EAST GRAND PRAIRIE		1
2	City: PALESTINE State: IL ZIP Code: 62451 County: CRAWFORD		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			0800	1630	0800	1630	0800	1630	0800	1630	0800	1630			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-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3488** **WORKSHEET S-8**

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

Clinic Address and Identification:

1	Street: 1000 N ALLEN		1
2	City: ROBINSON State: IL ZIP Code: 62454 County: CRAWFORD		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			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 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)	0.454077	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,172,952	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?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	3,865,199	5
6	Medicaid charges	13,120,189	6
7	Medicaid cost (line 1 times line 6)	5,957,576	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.		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)				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	1,210,979	965,970	2,176,949	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	549,878	438,625	988,503	21
22	Partial payment by patients approved for charity care	72,649	57,955	130,604	22
23	Cost of charity care (line 21 minus line 22)	477,229	380,670	857,899	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)	2,145,438	26
27	Medicare bad debts for the entire hospital complex (see instructions)	431,051	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,714,387	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	778,464	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,636,363	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,636,363	31

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		2,194,461	2,194,461	121,746	2,316,207	-59,156	2,257,051	1
2	00200	Cap Rel Costs-Mvble Equip		992,667	992,667	5,417	998,084	-34,206	963,878	2
3	00300	Other Cap Rel Costs		27,373	27,373	-27,373			-0-	3
4	00400	Employee Benefits Department	246,313	3,647,116	3,893,429	2,530	3,895,959	-347,592	3,548,367	4
5.01	00540	NONPATIENT TELEPHONES		2,474	2,474	36,353	38,827		38,827	5.01
5.02	00550	DATA PROCESSING	237,119	696,873	933,992		933,992		933,992	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	158,429	36,084	194,513		194,513		194,513	5.03
5.04	00570	ADMITTING	388,956	105,427	494,383	-37,343	457,040		457,040	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	321,368	376,956	698,324	-20,105	678,219		678,219	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	673,316	4,967,250	5,640,566	-1,168,099	4,472,467	-1,985,480	2,486,987	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	447,519	1,233,726	1,681,245	39,715	1,720,960	-1,252	1,719,708	7
8	00800	Laundry & Linen Service	78,505	51,876	130,381		130,381		130,381	8
9	00900	Housekeeping	310,723	208,213	518,936		518,936		518,936	9
10	01000	Dietary	490,219	409,082	899,301	-448,343	450,958		450,958	10
11	01100	Cafeteria				448,343	448,343	-200,824	247,519	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	585,012	55,514	640,526		640,526		640,526	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	629,031	345,346	974,377		974,377	-14,554	959,823	15
16	01600	Medical Records & Library	524,829	112,223	637,052	-6,304	630,748	-2,917	627,831	16
17	01700	Social Service	86,002	11,635	97,637		97,637		97,637	17
19	01900	Nonphysician Anesthetists								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	2,566,037	392,193	2,958,230	-227,049	2,731,181	-713,604	2,017,577	30
43	04300	Nursery				78,497	78,497		78,497	43
44	04400	Skilled Nursing Facility	858,154	219,907	1,078,061	171,430	1,249,491		1,249,491	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	879,469	455,609	1,335,078	979,429	2,314,507	-804,478	1,510,029	50
52	05200	Delivery Room & Labor Room				148,552	148,552		148,552	52
53	05300	Anesthesiology	873,607	105,822	979,429	-979,429				53
54	05400	Radiology-Diagnostic	675,749	632,031	1,307,780	-12,218	1,295,562	-400	1,295,162	54
54.01	05401	RADIOLOGY-ULTRASOUND		206,425	206,425		206,425		206,425	54.01
60	06000	Laboratory	605,120	998,329	1,603,449	-95,188	1,508,261		1,508,261	60
62	06200	Whole Blood & Packed Red Blood Cells				95,188	95,188		95,188	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	399,509	153,961	553,470		553,470	-22,400	531,070	65
66	06600	Physical Therapy	1,058,925	155,295	1,214,220	-8,652	1,205,568		1,205,568	66
69	06900	Electrocardiology	21,593	3,646	25,239		25,239		25,239	69
71	07100	Medical Supplies Charged to Patients		464,050	464,050		464,050		464,050	71
72	07200	Impl. Dev. Charged to Patients		238,445	238,445		238,445		238,445	72
73	07300	Drugs Charged to Patients		2,062,282	2,062,282	12,218	2,074,500		2,074,500	73
76	03950	CARDIAC REHAB	24,734	3,171	27,905		27,905		27,905	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	3,910,206	190,707	4,100,913	185,804	4,286,717	-159,926	4,126,791	88
88.01	08801	RHC II	273,377	177,713	451,090	6,966	458,056	-15,997	442,059	88.01
88.02	08802	RHC III	514,368	224,394	738,762	99,236	837,998	-4,290	833,708	88.02
90	09000	Clinic	2,063,138	1,320,123	3,383,261	8,482	3,391,743	-2,262,854	1,128,889	90
90.01	09001	PAIN MANAGEMENT CLINIC	139,830	256,530	396,360		396,360	-20,851	375,509	90.01
91	09100	Emergency	809,886	1,904,199	2,714,085		2,714,085	-1,299,865	1,414,220	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	462,892	104,460	567,352	561	567,913	-13,169	554,744	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		552,400	552,400	-553,960	-1,560	1,560		113
118		SUBTOTALS (sum of lines 1-117)	21,313,935	26,295,988	47,609,923	-1,143,596	46,466,327	-7,962,255	38,504,072	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	80,487	156,505	236,992	13,742	250,734		250,734	192
194	07950	NONREIMBURSEABLE								194
194.01	07951	PROFESSIONAL BUILDINGS		223,460	223,460	-65,476	157,984		157,984	194.01
194.02	07952	FOUNDATION SERVICES	28,243	6,110	34,353		34,353		34,353	194.02
194.03	07953	WELLNESS	97,438	21,056	118,494	-829	117,665		117,665	194.03
194.04	07954	RENTED SPACE								194.04

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	
194.05	07955	LITIGATION COSTS				1,196,159	1,196,159		1,196,159	194.05
200		TOTAL (sum of lines 118-199)	21,520,103	26,703,119	48,223,222		48,223,222	-7,962,255	40,260,967	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	R/C HHA MED SUPPLIES	A					1
500	Total reclassifications						500
	Code Letter - A						
1	LITIGATION COSTS	B	LITIGATION COSTS	194.05		1,148,726	1
2			LITIGATION COSTS	194.05	9,252	10,853	2
3			LITIGATION COSTS	194.05	6,554	1,401	3
4			LITIGATION COSTS	194.05	1,102	146	4
5			LITIGATION COSTS	194.05	14,269	3,856	5
500	Total reclassifications				31,177	1,164,982	500
	Code Letter - B						
1	LTC ADMITTING COSTS	D	Skilled Nursing Facility	44	775	215	1
500	Total reclassifications				775	215	500
	Code Letter - D						
1	R/C CAFETERIA COSTS	F	Cafeteria	11	244,397	203,946	1
500	Total reclassifications				244,397	203,946	500
	Code Letter - F						
1	R/C COST OF BLOOD	G	Whole Blood & Packed Red Bloo	62		95,188	1
500	Total reclassifications					95,188	500
	Code Letter - G						
1	PBX COST	H	NONPATIENT TELEPHONES	5.01	28,601	7,752	1
500	Total reclassifications				28,601	7,752	500
	Code Letter - H						
1	R/C DEPR OBLONG CLINIC	I					1
500	Total reclassifications						500
	Code Letter - I						
1	R/C DEPR PROF BLDGS	J	PROFESSIONAL BUILDINGS	194.01		23,803	1
2			Rural Health Clinic	88		166,256	2
3			RHC II	88.01		6,966	3
4			RHC III	88.02		66,283	4
5			Clinic	90		18,160	5
6			Home Health Agency	101		561	6
7			WELLNESS	194.03		1,701	7
500	Total reclassifications					283,730	500
	Code Letter - J						
1	R/C SNF DEPR	K	Skilled Nursing Facility	44		170,440	1
500	Total reclassifications					170,440	500
	Code Letter - K						
1	R/C LABOR/DEL & NB COSTS	L	Nursery	43	66,648	11,849	1
2			Delivery Room & Labor Room	52	126,128	22,424	2
500	Total reclassifications				192,776	34,273	500
	Code Letter - L						
1	R/C TRANSCRIPTION TXFR	N	Medical Records & Library	16		1,651	1
2							2
500	Total reclassifications					1,651	500
	Code Letter - N						
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	O	Drugs Charged to Patients	73		12,218	1
500	Total reclassifications					12,218	500
	Code Letter - O						
1	R/C OR COST	Q	Operating Room	50	873,607	105,822	1
500	Total reclassifications				873,607	105,822	500
	Code Letter - Q						
1	R/C PALESTINE/OBLONG DRS	R					1
2			Physicians' Private Offices	192		13,742	2
3			RHC III	88.02		32,953	3
500	Total reclassifications					46,695	500
	Code Letter - R						
1	HEALTHWORKS COST	U	Employee Benefits Department	4	2,091	439	1
500	Total reclassifications				2,091	439	500
	Code Letter - U						
1	UTILITIES	V	Operation of Plant	7		39,715	1
2							2

RECLASSIFICATIONS **WORKSHEET A-6**

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
3							3
500	Total reclassifications					39,715	500
	Code Letter - V						
1	INTEREST EXPENSE	W	Cap Rel Costs-Bldg & Fixt	1		552,400	1
2			Cap Rel Costs-Bldg & Fixt	1		1,560	2
500	Total reclassifications					553,960	500
	Code Letter - W						
1	RHC UTILITIES & MAINTENANCE	X	Rural Health Clinic	88		66,565	1
500	Total reclassifications					66,565	500
	Code Letter - X						
1	RECLASS PROPERTY TAXES	Z	Physical Therapy	66		22,714	1
500	Total reclassifications					22,714	500
	Code Letter - Z						
	GRAND TOTAL (Increases)				1,373,424	2,810,305	

(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	R/C HHA MED SUPPLIES	A						1
500	Total reclassifications							500
	Code letter - A							
1	LITIGATION COSTS	B	OTHER ADMINISTRATIVE AND GENE	5.06		1,148,726		1
2			CASHIERING/ACCOUNTS RECEIVABL	5.05	9,252	10,853		2
3			Medical Records & Library	16	6,554	1,401		3
4			OTHER ADMINISTRATIVE AND GENE	5.06	1,102	146		4
5			OTHER ADMINISTRATIVE AND GENE	5.06	14,269	3,856		5
500	Total reclassifications				31,177	1,164,982		500
	Code letter - B							
1	LTC ADMITTING COSTS	D	ADMITTING	5.04	775	215		1
500	Total reclassifications				775	215		500
	Code letter - D							
1	R/C CAFETERIA COSTS	F	Dietary	10	244,397	203,946		1
500	Total reclassifications				244,397	203,946		500
	Code letter - F							
1	R/C COST OF BLOOD	G	Laboratory	60		95,188		1
500	Total reclassifications					95,188		500
	Code letter - G							
1	PBX COST	H	ADMITTING	5.04	28,601	7,752		1
500	Total reclassifications				28,601	7,752		500
	Code letter - H							
1	R/C DEPR OBLONG CLINIC	I					9	1
500	Total reclassifications							500
	Code letter - I							
1	R/C DEPR PROF BLDGS	J	Cap Rel Costs-Bldg & Fixt	1		283,730	9	1
2							9	2
3							9	3
4							9	4
5							9	5
6							9	6
7							9	7
500	Total reclassifications					283,730		500
	Code letter - J							
1	R/C SNF DEPR	K	Cap Rel Costs-Bldg & Fixt	1		170,440	9	1
500	Total reclassifications					170,440		500
	Code letter - K							
1	R/C LABOR/DEL & NB COSTS	L	Adults & Pediatrics	30	192,776	34,273		1
2								2
500	Total reclassifications				192,776	34,273		500
	Code letter - L							
1	R/C TRANSCRIPTION TXFR	N	Rural Health Clinic	88		322		1
2			Clinic	90		1,329		2
500	Total reclassifications					1,651		500
	Code letter - N							
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	O	Radiology-Diagnostic	54		12,218		1
500	Total reclassifications					12,218		500
	Code letter - O							
1	R/C OR COST	Q	Anesthesiology	53	873,607	105,822		1
500	Total reclassifications				873,607	105,822		500
	Code letter - Q							
1	R/C PALESTINE/OBLONG DRS	R	Rural Health Clinic	88		46,695		1
2								2
3								3
500	Total reclassifications					46,695		500
	Code letter - R							
1	HEALTHWORKS COST	U	WELLNESS	194.03	2,091	439		1
500	Total reclassifications				2,091	439		500
	Code letter - U							
1	UTILITIES	V						1

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	
2			Physical Therapy	66		31,366		2
3			Clinic	90		8,349		3
500	Total reclassifications					39,715		500
	Code letter - V							
1	INTEREST EXPENSE	W	Interest Expense	113		552,400	11	1
2			Interest Expense	113		1,560	11	2
500	Total reclassifications					553,960		500
	Code letter - W							
1	RHC UTILITIES & MAINTENANCE	X	PROFESSIONAL BUILDINGS	194.01		66,565		1
500	Total reclassifications					66,565		500
	Code letter - X							
1	RECLASS PROPERTY TAXES	Z	PROFESSIONAL BUILDINGS	194.01		22,714		1
500	Total reclassifications					22,714		500
	Code letter - Z							
	GRAND TOTAL (Decreases)				1,373,424	2,810,305		

(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	340,645	150,000		150,000		490,645		1
2	Land Improvements	1,146,066				30,579	1,115,487		2
3	Buildings and Fixtures	50,141,438	4,255,096		4,255,096	928,164	53,468,370		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	12,532,916	1,577,010		1,577,010	523,077	13,586,849		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	64,161,065	5,982,106		5,982,106	1,481,820	68,661,351		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	64,161,065	5,982,106		5,982,106	1,481,820	68,661,351		10

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

		SUMMARY OF CAPITAL							
	Description	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	2,194,461						2,194,461	1
2	Cap Rel Costs-Mvble Equip	992,667						992,667	2
3	Total (sum of lines 1-2)	3,187,128						3,187,128	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

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	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	55,074,502		55,074,502	0.802118			21,956	21,956	1
2	Cap Rel Costs-Mvble Equ	13,586,849		13,586,849	0.197882			5,417	5,417	2
3	Total (sum of lines 1-2)	68,661,351		68,661,351	1.000000			27,373	27,373	3

		SUMMARY OF CAPITAL							
	Description	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	1,740,291	-59,156	553,960			21,956	2,257,051	1
2	Cap Rel Costs-Mvble Equip	958,461					5,417	963,878	2
3	Total (sum of lines 1-2)	2,698,752	-59,156	553,960			27,373	3,220,929	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)	A	-59,156	Cap Rel Costs-Bldg & Fixt	1	10	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-4,236,414				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-200,824	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-2,917	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			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-34,206	Cap Rel Costs-Mvble Equip	2	9	32
33	PHYS RECRUITING	A	-142,053	OTHER ADMINISTRATIVE AND GENERAL	5.06		33
33.11	EMPLOYEE INJURY	A	-3,272	Employee Benefits Department	4		33.11
33.22	EMPLOYEE PHYSICIALS	A	-654	Employee Benefits Department	4		33.22
34	ADVERTISING	A	-133,053	OTHER ADMINISTRATIVE AND GENERAL	5.06		34
35	TV ADMINISTRATION	A	-7,204	OTHER ADMINISTRATIVE AND GENERAL	5.06		35
36	TV UTILITIES & REPAIR	A	-1,252	Operation of Plant	7		36
37							37
38	EMPLOYEE DISCOUNTS	A	-42,298	Employee Benefits Department	4		38
39	OTHER A & G	A	-176,426	OTHER ADMINISTRATIVE AND GENERAL	5.06		39
40	EMPLOYEE SALES - PHARMACY	B	-15,008	Pharmacy	15		40
41							41
42	CONSULTING CLINIC	B	-81,329	Clinic	90		42
42.11	OTHER INCOME ROBINSON RHC	B	-118,463	Rural Health Clinic	88		42.11
42.22	OTHER INCOME PALESTINE RHC	B	-15,997	RHC II	88.01		42.22
43							43
44							44
45							45
46							46
47							47
48							48
48.07	PHYSICIAN MALPRACTICE	A	-9,265	Adults & Pediatrics	30		48.07
48.09	PHYSICIAN MALPRACTICE	A	-85,674	Clinic	90		48.09
48.12	PHYSICIAN HEALTH INSUR	A	-68,386	Employee Benefits Department	4		48.12
48.15	PHYSICIAN BENEFITS	A	-128,181	Employee Benefits Department	4		48.15
48.18	MID LEVEL BENEFITS	A	-23,375	Employee Benefits Department	4		48.18
48.20	MID LEVEL HEALTH INSUR	A	-18,731	Employee Benefits Department	4		48.20
48.25	OUTSIDE PHYSICIAN EXP	A	-66,347	Adults & Pediatrics	30		48.25
48.75	BOND ISSUE COSTS	A	20,208	Interest Expense	113		48.75
48.80	2012 BOND INT NON-DED	A	-18,648	Interest Expense	113		48.80
48.90	LITIGATION SETTLEMENT	A	-1,473,704	OTHER ADMINISTRATIVE AND GENERAL	5.06		48.90
49							49
49.01	NONALLOW CARELINK COST	A	-13,169	Home Health Agency	101		49.01
49.02	MISC INCOME	B	-25,831	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.02

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	
49.03	AHA & IHA DUES	A	-13,099	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.03
49.04	OB LOCUM TENUMS	A	-20,500	Adults & Pediatrics	30		49.04
49.05	NONPATIENT CPR	B	-1,953	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.05
49.07	DONATIONS, PROJECTS	B	-39,748	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.07
49.13	ADMIN CLAIMS FEES	A	34,187	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.13
49.15	PHYSICIAN FEES	A	-649,425	Clinic	90		49.15
49.17	CRNA	A	-62,695	Employee Benefits Department	4		49.17
49.18	NONALLOW ADS	A	-6,596	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.18
49.20	MRI RENT	B	-400	Radiology-Diagnostic	54		49.20
49.23	CMPM RENT	B	-20,851	PAIN MANAGEMENT CLINIC	90.01		49.23
49.25	340B REVENUE	B	454	Pharmacy	15		49.25
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-7,962,255				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	90.01	PAIN MANAGEMENT CLINIC	SALARIES	139,830	139,830			1
2	90.01	PAIN MANAGEMENT CLINIC	OTHER EXPENSES	256,530	256,530			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			396,360	396,360			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			CRAWFORD MEM HOSP PAIN MGMT LL	51.00	PAIN MANAGEMENT SERVICES	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	65	Respiratory Therapy AGGREGATE	22,400	22,400						1
2	91	Emergency AGGREGATE	1,716,220	1,299,865	416,355					2
3	30	Adults & Pediatrics AGGREGATE	617,492	617,492						3
4	90	Clinic AGGREGATE	1,338,533	1,338,533						4
5	88	Rural Health Clinic AGGREGATE	41,463	41,463						5
6	88.02	RHC III AGGREGATE	4,290	4,290						6
7	90	Clinic AGGREGATE	107,893	107,893						7
8	50	Operating Room AGGREGATE	804,478	804,478						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	4,652,769	4,236,414	416,355					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	65	Respiratory Therapy AGGREGATE							22,400	1
2	91	Emergency AGGREGATE							1,299,865	2
3	30	Adults & Pediatrics AGGREGATE							617,492	3
4	90	Clinic AGGREGATE							1,338,533	4
5	88	Rural Health Clinic AGGREGATE							41,463	5
6	88.02	RHC III AGGREGATE							4,290	6
7	90	Clinic AGGREGATE							107,893	7
8	50	Operating Room AGGREGATE							804,478	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							4,236,414	200

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)						35	1
2	Line 1 multiplied by 15 hours per week						525	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						175	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							7
8	Optional travel expense rate							8
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1	2	3	4	5		
9	Total hours worked		1,185.00					9
10	AHSEA (see instructions)		78.66					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)	39.33	39.33					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)	93,212	15
16	Assistants (column 3, line 9 times column 3, line 10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	93,212	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)	93,212	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)	93,212	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)	6,883	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)	6,883	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	6,883	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)	6,883	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	17.00				17.00	47
48	Overtime rate (see instructions)	117.99					48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	2,006					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)	100.00				100.00	50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00				2,080.00	51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)	78.66					52
53	Overtime cost limitation (line 51 times line 52)	163,613					53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)	2,006					54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)	1,337					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.)	669				669	56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	93,212	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	6,883	58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)	669	60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	100,764	63
64	Total cost of outside supplier services (from provider records)	85,546	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	NONPATIENT TELEPHONE S	DATA PROCE SSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,257,051	2,257,051					1
2	Cap Rel Costs-Mvble Equip	963,878		963,878				2
4	Employee Benefits Department	3,548,367	16,308	1,622	3,566,297			4
5.01	NONPATIENT TELEPHONES	38,827			5,567	44,394		5.01
5.02	DATA PROCESSING	933,992	15,649	224,634	46,150	322	1,220,747	5.02
5.03	PURCHASING RECEIVING AND STORES	194,513	41,637	4,959	30,835	643		5.03
5.04	ADMITTING	457,040	13,766	3,333	69,984	965		5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	678,219	22,768	4,799	60,747	1,072	769,437	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	2,486,987	169,486	10,733	128,055	1,716	451,310	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	1,719,708	154,892	47,425	87,100	858		7
8	Laundry & Linen Service	130,381	47,814	3,018	15,279	107		8
9	Housekeeping	518,936	15,593	2,701	60,475	107		9
10	Dietary	450,958	63,087	13,775	47,844	751		10
11	Cafeteria	247,519	37,023		47,566			11
12	Maintenance of Personnel							12
13	Nursing Administration	640,526	19,905		113,860	643		13
14	Central Services & Supply							14
15	Pharmacy	959,823	23,879	44,532	122,427	1,072		15
16	Medical Records & Library	627,831	58,529	13,311	100,871	1,716		16
17	Social Service	97,637	942	238	16,738	214		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	2,017,577	210,013	69,995	341,722	4,825		30
43	Nursery	78,497	7,853		12,972	214		43
44	Skilled Nursing Facility	1,249,491		10,129	167,172	3,002		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,510,029	371,268	172,271	182,391	2,466		50
52	Delivery Room & Labor Room	148,552	23,559		24,548			52
53	Anesthesiology							53
54	Radiology-Diagnostic	1,295,162	63,972	151,769	131,520	1,716		54
54.01	RADIOLOGY-ULTRASOUND	206,425	9,133	2,135				54.01
60	Laboratory	1,508,261	32,165	22,829	117,773	751		60
62	Whole Blood & Packed Red Blood Cells	95,188	2,072					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	531,070	21,657	24,052	73,396	643		65
66	Physical Therapy	1,205,568	188,751	9,581	206,096	751		66
69	Electrocardiology	25,239	5,122	531	4,203	214		69
71	Medical Supplies Charged to Patients	464,050	28,530					71
72	Impl. Dev. Charged to Patients	238,445	9,962					72
73	Drugs Charged to Patients	2,074,500						73
76	CARDIAC REHAB	27,905	43,276	12,706	4,814	214		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	4,126,791		17,051	752,959	7,295		88
88.01	RHC II	442,059		1,005	53,207	751		88.01
88.02	RHC III	833,708		9,483	99,275	2,788		88.02
90	Clinic	1,128,889	254,493	16,651	120,031	5,576		90
90.01	PAIN MANAGEMENT CLINIC	375,509	14,199	3,581	27,215			90.01
91	Emergency	1,414,220	180,786	38,182	157,626	1,287		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	554,744		787	90,092	965		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	38,504,072	2,168,089	937,818	3,520,510	43,644	1,220,747	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		13,182					190
192	Physicians' Private Offices	250,734			15,665			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	157,984		4,025		536		194.01
194.02	FOUNDATION SERVICES	34,353	942		5,497	107		194.02
194.03	WELLNESS	117,665		22,035	18,557	107		194.03
194.04	RENTED SPACE		74,838					194.04
194.05	LITIGATION COSTS	1,196,159			6,068			194.05
200	Cross Foot Adjustments							200

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	NONPATIENT TELEPHONES	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	40,260,967	2,257,051	963,878	3,566,297	44,394	1,220,747	202

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

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES	272,587						5.03
5.04	ADMITTING	1,154	546,242					5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	288		1,537,330				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	3,173			3,251,460	3,251,460		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	6,923			2,016,906	177,195	2,194,101	7
8	Laundry & Linen Service	4,904			201,503	17,703	51,975	8
9	Housekeeping	10,384			608,196	53,433	16,950	9
10	Dietary	7,788			584,203	51,325	68,577	10
11	Cafeteria				332,108	29,177	40,246	11
12	Maintenance of Personnel							12
13	Nursing Administration	288			775,222	68,107	21,638	13
14	Central Services & Supply							14
15	Pharmacy	17,019			1,168,752	102,681	25,957	15
16	Medical Records & Library	1,154			803,412	70,584	63,623	16
17	Social Service	577			116,346	10,222	1,024	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	9,807	124,999	59,122	2,838,060	249,338	228,290	30
43	Nursery		18,032	8,004	125,572	11,032	8,536	43
44	Skilled Nursing Facility	7,788			1,437,582	126,299	222,845	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	24,807	73,619	227,503	2,564,354	225,291	403,582	50
52	Delivery Room & Labor Room		47,922	21,273	265,854	23,357	25,609	52
53	Anesthesiology							53
54	Radiology-Diagnostic	12,115	40,523	346,644	2,043,421	179,525	69,539	54
54.01	RADIOLOGY-ULTRASOUND		10,224	61,344	289,261	25,413	9,928	54.01
60	Laboratory	53,366	60,669	334,408	2,130,222	187,151	34,964	60
62	Whole Blood & Packed Red Blood Cells		7,403	7,490	112,153	9,853	2,252	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,327	22,676	35,273	713,094	62,649	23,541	65
66	Physical Therapy	3,461	46,245	82,589	1,743,042	153,135	205,179	66
69	Electrocardiology		3,030	14,002	52,341	4,598	5,568	69
71	Medical Supplies Charged to Patients	52,787	28,723	29,791	603,881	53,054	31,013	71
72	Impl. Dev. Charged to Patients		4,812	6,990	260,209	22,861	10,829	72
73	Drugs Charged to Patients		46,665	116,169	2,237,334	196,561		73
76	CARDIAC REHAB	288	4	3,197	92,404	8,118	47,042	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	23,942			4,928,038	432,941		88
88.01	RHC II	2,596			499,618	43,894		88.01
88.02	RHC III	4,038			949,292	83,400		88.02
90	Clinic	7,788		30,796	1,564,224	137,425	276,642	90
90.01	PAIN MANAGEMENT CLINIC	865		4,202	425,571	37,389	15,435	90.01
91	Emergency	6,923	10,696	131,819	1,941,539	170,574	196,520	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,154		16,714	664,456	58,376		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	269,704	546,242	1,537,330	38,339,630	3,082,661	2,107,304	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				13,182	1,158	14,330	190
192	Physicians' Private Offices	288			266,687	23,430		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	1,442			163,987	14,407		194.01
194.02	FOUNDATION SERVICES	288			41,187	3,618	1,024	194.02
194.03	WELLNESS	865			159,229	13,989	71,443	194.03
194.04	RENTED SPACE				74,838	6,575		194.04
194.05	LITIGATION COSTS				1,202,227	105,622		194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	272,587	546,242	1,537,330	40,260,967	3,251,460	2,194,101	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	271,181						8
9	Housekeeping		678,579					9
10	Dietary	7,066	18,254	729,425				10
11	Cafeteria		10,713		412,244			11
12	Maintenance of Personnel							12
13	Nursing Administration		5,760		14,723	885,450		13
14	Central Services & Supply							14
15	Pharmacy		6,909		12,883	52,381	1,369,563	15
16	Medical Records & Library		16,935		20,244			16
17	Social Service		272		3,681	13,340		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	72,387	60,767	235,309	62,570	226,783		30
43	Nursery	1,555	2,272		3,681	15,104		43
44	Skilled Nursing Facility	74,155	59,317	447,230	38,648	161,511		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	36,571	107,426	23,648	36,808	150,445		50
52	Delivery Room & Labor Room	4,298	6,817		7,362	28,581		52
53	Anesthesiology							53
54	Radiology-Diagnostic	18,670	18,510		22,085			54
54.01	RADIOLOGY-ULTRASOUND		2,643					54.01
60	Laboratory	245	9,307		22,085			60
62	Whole Blood & Packed Red Blood Cells		599					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,390	6,266		12,883	55,988		65
66	Physical Therapy		54,615		31,286			66
69	Electrocardiology		1,482					69
71	Medical Supplies Charged to Patients		8,255					71
72	Impl. Dev. Charged to Patients		2,882					72
73	Drugs Charged to Patients						1,369,563	73
76	CARDIAC REHAB		12,522					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	7,692	99,569					88
88.01	RHC II	507						88.01
88.02	RHC III	210						88.02
90	Clinic	3,021	73,637		31,286			90
90.01	PAIN MANAGEMENT CLINIC		4,109		5,521			90.01
91	Emergency	38,914	52,310	23,238	29,446	119,706		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,452		14,723	61,611		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	267,681	644,600	729,425	369,915	885,450	1,369,563	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		3,814					190
192	Physicians' Private Offices				7,362			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		10,876					194.01
194.02	FOUNDATION SERVICES		272		1,840			194.02
194.03	WELLNESS	3,500	19,017		5,521			194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS				27,606			194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	271,181	678,579	729,425	412,244	885,450	1,369,563	202

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	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
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	974,798						16
17	Social Service		144,885					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	38,684	75,340	4,087,528		4,087,528		30
43	Nursery	5,237		172,989		172,989		43
44	Skilled Nursing Facility		65,198	2,632,785		2,632,785		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	148,858		3,696,983		3,696,983		50
52	Delivery Room & Labor Room	13,919		375,797		375,797		52
53	Anesthesiology							53
54	Radiology-Diagnostic	226,804		2,578,554		2,578,554		54
54.01	RADIOLOGY-ULTRASOUND	40,138		367,383		367,383		54.01
60	Laboratory	218,807		2,602,781		2,602,781		60
62	Whole Blood & Packed Red Blood Cells	4,901		129,758		129,758		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	23,080		899,891		899,891		65
66	Physical Therapy	54,039		2,241,296		2,241,296		66
69	Electrocardiology	9,162		73,151		73,151		69
71	Medical Supplies Charged to Patients	19,493		715,696		715,696		71
72	Impl. Dev. Charged to Patients	4,574		301,355		301,355		72
73	Drugs Charged to Patients	76,010		3,879,468		3,879,468		73
76	CARDIAC REHAB	2,092		162,178		162,178		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			5,468,240		5,468,240		88
88.01	RHC II			544,019		544,019		88.01
88.02	RHC III			1,032,902		1,032,902		88.02
90	Clinic			2,086,235		2,086,235		90
90.01	PAIN MANAGEMENT CLINIC	2,749		490,774		490,774		90.01
91	Emergency	86,251	2,898	2,661,396		2,661,396		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,449	803,067		803,067		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	974,798	144,885	38,004,226		38,004,226		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			32,484		32,484		190
192	Physicians' Private Offices			297,479		297,479		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS			189,270		189,270		194.01
194.02	FOUNDATION SERVICES			47,941		47,941		194.02
194.03	WELLNESS			272,699		272,699		194.03
194.04	RENTED SPACE			81,413		81,413		194.04
194.05	LITIGATION COSTS			1,335,455		1,335,455		194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	974,798	144,885	40,260,967		40,260,967		202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2016 To: 04/30/2017	Run Date: 09/26/2017 Run Time: 08:32 Version: 2017.01 (07/27/2017)

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	NONPATIENT TELEPHONES	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		16,308	1,622	17,930	17,930		4
5.01	NONPATIENT TELEPHONES					28	28	5.01
5.02	DATA PROCESSING		15,649	224,634	240,283	232		5.02
5.03	PURCHASING RECEIVING AND STORES		41,637	4,959	46,596	155		5.03
5.04	ADMITTING		13,766	3,333	17,099	352	1	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		22,768	4,799	27,567	306	1	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		169,486	10,733	180,219	644	1	5.06
6	Maintenance & Repairs							6
7	Operation of Plant		154,892	47,425	202,317	438	1	7
8	Laundry & Linen Service		47,814	3,018	50,832	77		8
9	Housekeeping		15,593	2,701	18,294	304		9
10	Dietary		63,087	13,775	76,862	241		10
11	Cafeteria		37,023		37,023	239		11
12	Maintenance of Personnel							12
13	Nursing Administration		19,905		19,905	573		13
14	Central Services & Supply							14
15	Pharmacy		23,879	44,532	68,411	616	1	15
16	Medical Records & Library		58,529	13,311	71,840	507	1	16
17	Social Service		942	238	1,180	84		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	15,497	210,013	69,995	295,505	1,719	3	30
43	Nursery		7,853		7,853	65		43
44	Skilled Nursing Facility	10,516		10,129	20,645	841	2	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	50,155	371,268	172,271	593,694	917	2	50
52	Delivery Room & Labor Room		23,559		23,559	123		52
53	Anesthesiology							53
54	Radiology-Diagnostic		63,972	151,769	215,741	662	1	54
54.01	RADIOLOGY-ULTRASOUND		9,133	2,135	11,268			54.01
60	Laboratory		32,165	22,829	54,994	592		60
62	Whole Blood & Packed Red Blood Cells		2,072		2,072			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		21,657	24,052	45,709	369		65
66	Physical Therapy		188,751	9,581	198,332	1,037		66
69	Electrocardiology		5,122	531	5,653	21		69
71	Medical Supplies Charged to Patients		28,530		28,530			71
72	Impl. Dev. Charged to Patients		9,962		9,962			72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB		43,276	12,706	55,982	24		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			17,051	17,051	3,779	6	88
88.01	RHC II			1,005	1,005	268		88.01
88.02	RHC III	12,600		9,483	22,083	499	2	88.02
90	Clinic		254,493	16,651	271,144	604	4	90
90.01	PAIN MANAGEMENT CLINIC		14,199	3,581	17,780	137		90.01
91	Emergency		180,786	38,182	218,968	793	1	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			787	787	453	1	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	88,768	2,168,089	937,818	3,194,675	17,699	28	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		13,182		13,182			190
192	Physicians' Private Offices	1,500			1,500	79		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS			4,025	4,025			194.01
194.02	FOUNDATION SERVICES		942		942	28		194.02
194.03	WELLNESS			22,035	22,035	93		194.03
194.04	RENTED SPACE		74,838		74,838			194.04
194.05	LITIGATION COSTS					31		194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	90,268	2,257,051	963,878	3,311,197	17,930	28	202

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

	COST CENTER DESCRIPTIONS	DATA PROCE SSING	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING	240,515						5.02
5.03	PURCHASING RECEIVING AND STORES		46,751					5.03
5.04	ADMITTING		198	17,650				5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	151,597	49		179,520			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	88,918	544			270,326		5.06
6	Maintenance & Repairs							6
7	Operation of Plant		1,187			14,731	218,674	7
8	Laundry & Linen Service		841			1,472	5,180	8
9	Housekeeping		1,781			4,442	1,689	9
10	Dietary		1,336			4,267	6,835	10
11	Cafeteria					2,426	4,011	11
12	Maintenance of Personnel							12
13	Nursing Administration		49			5,662	2,157	13
14	Central Services & Supply							14
15	Pharmacy		2,919			8,537	2,587	15
16	Medical Records & Library		198			5,868	6,341	16
17	Social Service		99			850	102	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		1,682	4,045	6,903	20,729	22,752	30
43	Nursery			582	935	917	851	43
44	Skilled Nursing Facility		1,336			10,500	22,210	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		4,255	2,378	26,563	18,730	40,224	50
52	Delivery Room & Labor Room			1,548	2,484	1,942	2,552	52
53	Anesthesiology							53
54	Radiology-Diagnostic		2,078	1,309	40,498	14,925	6,931	54
54.01	RADIOLOGY-ULTRASOUND			330	7,162	2,113	990	54.01
60	Laboratory		9,155	1,960	39,045	15,559	3,485	60
62	Whole Blood & Packed Red Blood Cells			239	874	819	224	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		742	732	4,118	5,208	2,346	65
66	Physical Therapy		594	1,494	9,643	12,731	20,449	66
69	Electrocardiology			98	1,635	382	555	69
71	Medical Supplies Charged to Patients		9,053	928	3,478	4,411	3,091	71
72	Impl. Dev. Charged to Patients			155	816	1,901	1,079	72
73	Drugs Charged to Patients			1,507	13,564	16,341		73
76	CARDIAC REHAB		49		373	675	4,688	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		4,106			36,004		88
88.01	RHC II		445			3,649		88.01
88.02	RHC III		693			6,934		88.02
90	Clinic		1,336		3,596	11,425	27,571	90
90.01	PAIN MANAGEMENT CLINIC		148		491	3,108	1,538	90.01
91	Emergency		1,187	345	15,391	14,181	19,586	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		198		1,951	4,853		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	240,515	46,258	17,650	179,520	256,292	210,024	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					96	1,428	190
192	Physicians' Private Offices		49			1,948		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		247			1,198		194.01
194.02	FOUNDATION SERVICES		49			301	102	194.02
194.03	WELLNESS		148			1,163	7,120	194.03
194.04	RENTED SPACE					547		194.04
194.05	LITIGATION COSTS					8,781		194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	240,515	46,751	17,650	179,520	270,326	218,674	202

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	58,402						8
9	Housekeeping		26,510					9
10	Dietary	1,522	713	91,776				10
11	Cafeteria		419		44,118			11
12	Maintenance of Personnel							12
13	Nursing Administration		225		1,576	30,147		13
14	Central Services & Supply							14
15	Pharmacy		270		1,379	1,783	86,503	15
16	Medical Records & Library		662		2,167			16
17	Social Service		11		394	454		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	15,589	2,374	29,606	6,696	7,722		30
43	Nursery	335	89		394	514		43
44	Skilled Nursing Facility	15,968	2,317	56,271	4,136	5,499		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,876	4,193	2,975	3,939	5,122		50
52	Delivery Room & Labor Room	926	266		788	973		52
53	Anesthesiology							53
54	Radiology-Diagnostic	4,021	723		2,363			54
54.01	RADIOLOGY-ULTRASOUND		103					54.01
60	Laboratory	53	364		2,363			60
62	Whole Blood & Packed Red Blood Cells		23					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	515	245		1,379	1,906		65
66	Physical Therapy		2,134		3,348			66
69	Electrocardiology		58					69
71	Medical Supplies Charged to Patients		323					71
72	Impl. Dev. Charged to Patients		113					72
73	Drugs Charged to Patients						86,503	73
76	CARDIAC REHAB		489					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	1,657	3,890					88
88.01	RHC II	109						88.01
88.02	RHC III	45						88.02
90	Clinic	651	2,877		3,348			90
90.01	PAIN MANAGEMENT CLINIC		161		591			90.01
91	Emergency	8,381	2,044	2,924	3,151	4,076		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		96		1,576	2,098		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	57,648	25,182	91,776	39,588	30,147	86,503	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		149					190
192	Physicians' Private Offices				788			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		425					194.01
194.02	FOUNDATION SERVICES		11		197			194.02
194.03	WELLNESS	754	743		591			194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS				2,954			194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	58,402	26,510	91,776	44,118	30,147	86,503	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	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
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	87,584						16
17	Social Service		3,174					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	3,475	1,651	420,451		420,451		30
43	Nursery	470		13,005		13,005		43
44	Skilled Nursing Facility		1,428	141,153		141,153		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	13,370		724,238		724,238		50
52	Delivery Room & Labor Room	1,250		36,411		36,411		52
53	Anesthesiology							53
54	Radiology-Diagnostic	20,400		309,652		309,652		54
54.01	RADIOLOGY-ULTRASOUND	3,605		25,571		25,571		54.01
60	Laboratory	19,653		147,223		147,223		60
62	Whole Blood & Packed Red Blood Cells	440		4,691		4,691		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,073		65,342		65,342		65
66	Physical Therapy	4,854		254,616		254,616		66
69	Electrocardiology	823		9,225		9,225		69
71	Medical Supplies Charged to Patients	1,751		51,565		51,565		71
72	Impl. Dev. Charged to Patients	411		14,437		14,437		72
73	Drugs Charged to Patients	6,827		124,742		124,742		73
76	CARDIAC REHAB	188		62,468		62,468		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			66,493		66,493		88
88.01	RHC II			5,476		5,476		88.01
88.02	RHC III			30,256		30,256		88.02
90	Clinic			322,556		322,556		90
90.01	PAIN MANAGEMENT CLINIC	247		24,201		24,201		90.01
91	Emergency	7,747	63	298,838		298,838		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		32	12,045		12,045		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	87,584	3,174	3,164,655		3,164,655		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			14,855		14,855		190
192	Physicians' Private Offices			4,364		4,364		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS			5,895		5,895		194.01
194.02	FOUNDATION SERVICES			1,630		1,630		194.02
194.03	WELLNESS			32,647		32,647		194.03
194.04	RENTED SPACE			75,385		75,385		194.04
194.05	LITIGATION COSTS			11,766		11,766		194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	87,584	3,174	3,311,197		3,311,197		202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2016 To: 04/30/2017	Run Date: 09/26/2017 Run Time: 08:32 Version: 2017.01 (07/27/2017)

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	119,853						1
2	Cap Rel Costs-Mvble Equip		1,081,570					2
4	Employee Benefits Department	866	1,820	18,323,687				4
5.01	NONPATIENT TELEPHONES			28,601	414			5.01
5.02	DATA PROCESSING	831	252,061	237,119	3	10,000		5.02
5.03	PURCHASING RECEIVING AND STORES	2,211	5,564	158,429	6		945	5.03
5.04	ADMITTING	731	3,740	359,580	9		4	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,209	5,385	312,116	10	6,303	1	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,000	12,043	657,945	16	3,697	11	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	8,225	53,216	447,519	8		24	7
8	Laundry & Linen Service	2,539	3,387	78,505	1		17	8
9	Housekeeping	828	3,031	310,723	1		36	9
10	Dietary	3,350	15,457	245,822	7		27	10
11	Cafeteria	1,966		244,397				11
12	Maintenance of Personnel							12
13	Nursing Administration	1,057		585,012	6		1	13
14	Central Services & Supply							14
15	Pharmacy	1,268	49,969	629,031	10		59	15
16	Medical Records & Library	3,108	14,936	518,275	16		4	16
17	Social Service	50	267	86,002	2		2	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	11,152	78,542	1,755,769	45		34	30
43	Nursery	417		66,648	2			43
44	Skilled Nursing Facility		11,366	858,929	28		27	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,715	193,306	937,125	23		86	50
52	Delivery Room & Labor Room	1,251		126,128				52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,397	170,300	675,749	16		42	54
54.01	RADIOLOGY-ULTRASOUND	485	2,396					54.01
60	Laboratory	1,708	25,617	605,120	7		185	60
62	Whole Blood & Packed Red Blood Cells	110						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,150	26,989	377,109	6		15	65
66	Physical Therapy	10,023	10,751	1,058,925	7		12	66
69	Electrocardiology	272	596	21,593	2			69
71	Medical Supplies Charged to Patients	1,515					183	71
72	Impl. Dev. Charged to Patients	529						72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	2,298	14,257	24,734	2		1	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		19,133	3,868,743	68		83	88
88.01	RHC II		1,128	273,377	7		9	88.01
88.02	RHC III		10,641	510,078	26		14	88.02
90	Clinic	13,514	18,684	616,722	52		27	90
90.01	PAIN MANAGEMENT CLINIC	754	4,018	139,830			3	90.01
91	Emergency	9,600	42,844	809,886	12		24	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		883	462,892	9		4	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	115,129	1,052,327	18,088,433	407	10,000	935	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	700						190
192	Physicians' Private Offices			80,487			1	192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		4,517		5		5	194.01
194.02	FOUNDATION SERVICES	50		28,243	1		1	194.02
194.03	WELLNESS		24,726	95,347	1		3	194.03
194.04	RENTED SPACE	3,974						194.04
194.05	LITIGATION COSTS			31,177				194.05
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,257,051	963,878	3,566,297	44,394	1,220,747	272,587	202

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	
		1	2	4	5.01	5.02	5.03	
203	Unit Cost Multiplier (Wkst. B, Part I)	18.831827	0.891184	0.194628	107.231884	122.074700	288.451852	203
204	Cost to be allocated (Per Wkst. B, Part II)			17,930	28	240,515	46,751	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000979	0.067633	24.051500	49.471958	205

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

	COST CENTER DESCRIPTIONS	ADMITTING INPATIENT REVENUE	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON-CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	
		5.04	5.05	5A.06	5.06	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING	11,826,080						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		74,977,247					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-3,251,460	37,009,507			5.06
6	Maintenance & Repairs							6
7	Operation of Plant				2,016,906	107,182		7
8	Laundry & Linen Service				201,503	2,539	222,165	8
9	Housekeeping				608,196	828		9
10	Dietary				584,203	3,350	5,789	10
11	Cafeteria				332,108	1,966		11
12	Maintenance of Personnel							12
13	Nursing Administration				775,222	1,057		13
14	Central Services & Supply							14
15	Pharmacy				1,168,752	1,268		15
16	Medical Records & Library				803,412	3,108		16
17	Social Service				116,346	50		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	2,706,312	2,883,426		2,838,060	11,152	59,303	30
43	Nursery	390,381	390,381		125,572	417	1,274	43
44	Skilled Nursing Facility				1,437,582	10,886	60,752	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,593,822	11,095,528		2,564,354	19,715	29,961	50
52	Delivery Room & Labor Room	1,037,503	1,037,487		265,854	1,251	3,521	52
53	Anesthesiology							53
54	Radiology-Diagnostic	877,302	16,906,409		2,043,421	3,397	15,295	54
54.01	RADIOLOGY-ULTRASOUND	221,356	2,991,801		289,261	485		54.01
60	Laboratory	1,313,475	16,309,402		2,130,222	1,708	201	60
62	Whole Blood & Packed Red Blood Cells	160,267	365,278		112,153	110		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	490,937	1,720,314		713,094	1,150	1,958	65
66	Physical Therapy	1,001,194	4,027,927		1,743,042	10,023		66
69	Electrocardiology	65,595	682,892		52,341	272		69
71	Medical Supplies Charged to Patients	621,850	1,452,950		603,881	1,515		71
72	Impl. Dev. Charged to Patients	104,174	340,918		260,209	529		72
73	Drugs Charged to Patients	1,010,280	5,665,652		2,237,334			73
76	CARDIAC REHAB	76	155,897		92,404	2,298		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				4,928,038		6,302	88
88.01	RHC II				499,618		415	88.01
88.02	RHC III				949,292		172	88.02
90	Clinic		1,501,942		1,564,224	13,514	2,475	90
90.01	PAIN MANAGEMENT CLINIC		204,935		425,571	754		90.01
91	Emergency	231,556	6,428,946		1,941,539	9,600	31,880	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		815,162		664,456			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	11,826,080	74,977,247	-3,251,460	35,088,170	102,942	219,298	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				13,182	700		190
192	Physicians' Private Offices				266,687			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS				163,987			194.01
194.02	FOUNDATION SERVICES				41,187	50		194.02
194.03	WELLNESS				159,229	3,490	2,867	194.03
194.04	RENTED SPACE				74,838			194.04
194.05	LITIGATION COSTS				1,202,227			194.05
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	546,242	1,537,330		3,251,460	2,194,101	271,181	202

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

	COST CENTER DESCRIPTIONS	ADMITTING INPATIENT REVENUE	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	
		5.04	5.05	5A.06	5.06	7	8	
203	Unit Cost Multiplier (Wkst. B, Part I)	0.046190	0.020504		0.087855	20.470797	1.220629	203
204	Cost to be allocated (Per Wkst. B, Part II)	17,650	179,520		270,326	218,674	58,402	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.001492	0.002394		0.007304	2.040212	0.262877	205

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINIS-TRATION NURSING HOURS	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	124,534						9
10	Dietary	3,350	39,142					10
11	Cafeteria	1,966		224				11
12	Maintenance of Personnel							12
13	Nursing Administration	1,057		8	244,992			13
14	Central Services & Supply							14
15	Pharmacy	1,268		7	14,493	629,031		15
16	Medical Records & Library	3,108		11			72,660,142	16
17	Social Service	50		2	3,691			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	11,152	12,627	34	62,748		2,883,425	30
43	Nursery	417		2	4,179		390,381	43
44	Skilled Nursing Facility	10,886	23,999	21	44,688			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,715	1,269	20	41,626		11,095,528	50
52	Delivery Room & Labor Room	1,251		4	7,908		1,037,487	52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,397		12			16,906,409	54
54.01	RADIOLOGY-ULTRASOUND	485					2,991,801	54.01
60	Laboratory	1,708		12			16,309,402	60
62	Whole Blood & Packed Red Blood Cells	110					365,278	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,150		7	15,491		1,720,314	65
66	Physical Therapy	10,023		17			4,027,927	66
69	Electrocardiology	272					682,892	69
71	Medical Supplies Charged to Patients	1,515					1,452,950	71
72	Impl. Dev. Charged to Patients	529					340,918	72
73	Drugs Charged to Patients					629,031	5,665,652	73
76	CARDIAC REHAB	2,298					155,897	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	18,273						88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic	13,514		17				90
90.01	PAIN MANAGEMENT CLINIC	754		3			204,935	90.01
91	Emergency	9,600	1,247	16	33,121		6,428,946	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	450		8	17,047			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	118,298	39,142	201	244,992	629,031	72,660,142	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	700						190
192	Physicians' Private Offices			4				192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	1,996						194.01
194.02	FOUNDATION SERVICES	50		1				194.02
194.03	WELLNESS	3,490		3				194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS			15				194.05
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	678,579	729,425	412,244	885,450	1,369,563	974,798	202

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINIS-TRATION NURSING HOURS	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	15	16	
203	Unit Cost Multiplier (Wkst. B, Part I)	5.448946	18.635353	1,840.375000	3.614200	2.177258	0.013416	203
204	Cost to be allocated (Per Wkst. B, Part II)	26,510	91,776	44,118	30,147	86,503	87,584	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.212874	2.344694	196.955357	0.123053	0.137518	0.001205	205

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME						
		17						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
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	100						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	52						30
43	Nursery							43
44	Skilled Nursing Facility	45						44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency	2						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS							194.01
194.02	FOUNDATION SERVICES							194.02
194.03	WELLNESS							194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross foot adjustments							200

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME						
		17						
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	144,885						202
203	Unit Cost Multiplier (Wkst. B, Part I)	1,448.850000						203
204	Cost to be allocated (Per Wkst. B, Part II)	3,174						204
205	Unit Cost Multiplier (Wkst. B, Part II)	31.740000						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	4,087,528		4,087,528		4,087,528	30
43	Nursery	172,989		172,989		172,989	43
44	Skilled Nursing Facility	2,632,785		2,632,785		2,632,785	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,696,983		3,696,983		3,696,983	50
52	Delivery Room & Labor Room	375,797		375,797		375,797	52
53	Anesthesiology						53
54	Radiology-Diagnostic	2,578,554		2,578,554		2,578,554	54
54.01	RADIOLOGY-ULTRASOUND	367,383		367,383		367,383	54.01
60	Laboratory	2,602,781		2,602,781		2,602,781	60
62	Whole Blood & Packed Red Blood Cells	129,758		129,758		129,758	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	899,891		899,891		899,891	65
66	Physical Therapy	2,241,296		2,241,296		2,241,296	66
69	Electrocardiology	73,151		73,151		73,151	69
71	Medical Supplies Charged to Patients	715,696		715,696		715,696	71
72	Impl. Dev. Charged to Patients	301,355		301,355		301,355	72
73	Drugs Charged to Patients	3,879,468		3,879,468		3,879,468	73
76	CARDIAC REHAB	162,178		162,178		162,178	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	5,468,240		5,468,240		5,468,240	88
88.01	RHC II	544,019		544,019		544,019	88.01
88.02	RHC III	1,032,902		1,032,902		1,032,902	88.02
90	Clinic	2,086,235		2,086,235		2,086,235	90
90.01	PAIN MANAGEMENT CLINIC	490,774		490,774		490,774	90.01
91	Emergency	2,661,396		2,661,396		2,661,396	91
92	Observation Beds (Non-Distinct Part)	566,700		566,700		566,700	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	803,067		803,067		803,067	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	38,570,926		38,570,926		38,570,926	200
201	Less Observation Beds	566,700		566,700		566,700	201
202	Total (line 200 minus line 201)	38,004,226		38,004,226		38,004,226	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	2,807,888		2,807,888				30
43	Nursery	390,381		390,381				43
44	Skilled Nursing Facility	1,109,019		1,109,019				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,593,822	9,501,706	11,095,528	0.333196	0.333196	0.333196	50
52	Delivery Room & Labor Room	1,017,715	19,772	1,037,487	0.362219	0.362219	0.362219	52
53	Anesthesiology							53
54	Radiology-Diagnostic	877,302	16,029,107	16,906,409	0.152519	0.152519	0.152519	54
54.01	RADIOLOGY-ULTRASOUND	221,356	2,770,445	2,991,801	0.122797	0.122797	0.122797	54.01
60	Laboratory	1,313,475	14,995,927	16,309,402	0.159588	0.159588	0.159588	60
62	Whole Blood & Packed Red Blood Cells	160,267	205,011	365,278	0.355231	0.355231	0.355231	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	490,937	1,229,377	1,720,314	0.523097	0.523097	0.523097	65
66	Physical Therapy	1,001,194	3,026,733	4,027,927	0.556439	0.556439	0.556439	66
69	Electrocardiology	65,595	617,297	682,892	0.107119	0.107119	0.107119	69
71	Medical Supplies Charged to Patients	621,850	831,100	1,452,950	0.492581	0.492581	0.492581	71
72	Impl. Dev. Charged to Patients	104,174	236,744	340,918	0.883952	0.883952	0.883952	72
73	Drugs Charged to Patients	1,010,280	4,655,372	5,665,652	0.684735	0.684735	0.684735	73
76	CARDIAC REHAB	76	155,821	155,897	1.040289	1.040289	1.040289	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		5,451,953	5,451,953				88
88.01	RHC II		609,552	609,552				88.01
88.02	RHC III		1,123,134	1,123,134				88.02
90	Clinic	144,131	1,357,811	1,501,942	1.389025	1.389025	1.389025	90
90.01	PAIN MANAGEMENT CLINIC		204,935	204,935	2.394779	2.394779	2.394779	90.01
91	Emergency	231,556	6,197,390	6,428,946	0.413971	0.413971	0.413971	91
92	Observation Beds (Non-Distinct Part)	8,503	491,693	500,196	1.132956	1.132956	1.132956	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		815,162	815,162				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	13,169,521	70,526,042	83,695,563				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	13,169,521	70,526,042	83,695,563				202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1343** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P
[XX] Title XVIII, Part B
[ ] Title XIX - O/P
[XX] Hospital
[ ] IPF
[ ] IRF
[ ] SUB (Other)
[ ] SNF
[ ] NF
[ ] Swing Bed SNF
[ ] Swing Bed 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	0.333196		2,795,151			931,333		50
52	Delivery Room & Labor Room	0.362219							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.152519		5,723,452			872,935		54
54.01	RADIOLOGY-ULTRASOUND	0.122797		944,425			115,973		54.01
60	Laboratory	0.159588		6,391,355			1,019,984		60
62	Whole Blood & Packed Red Blood	0.355231		117,937			41,895		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.523097		473,554			247,715		65
66	Physical Therapy	0.556439		988,956			550,294		66
69	Electrocardiology	0.107119		287,924			30,842		69
71	Medical Supplies Charged to Pat	0.492581		121,518			59,857		71
72	Impl. Dev. Charged to Patients	0.883952		155,909			137,816		72
73	Drugs Charged to Patients	0.684735		2,515,757			1,722,627		73
76	CARDIAC REHAB	1.040289		30,120			31,334		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
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.389025		717,068			996,025		90
90.01	PAIN MANAGEMENT CLINIC	2.394779		72,311			173,169		90.01
91	Emergency	0.413971		1,900,765			786,862		91
92	Observation Beds (Non-Distinct	1.132956		152,745			173,053		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			23,388,947			7,891,714		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			23,388,947			7,891,714		202

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z343** **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	0.333196							50
52	Delivery Room & Labor Room	0.362219							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.152519							54
54.01	RADIOLOGY-ULTRASOUND	0.122797							54.01
60	Laboratory	0.159588							60
62	Whole Blood & Packed Red Blood	0.355231							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.523097							65
66	Physical Therapy	0.556439							66
69	Electrocardiology	0.107119							69
71	Medical Supplies Charged to Pat	0.492581							71
72	Impl. Dev. Charged to Patients	0.883952							72
73	Drugs Charged to Patients	0.684735							73
76	CARDIAC REHAB	1.040289							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
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.389025							90
90.01	PAIN MANAGEMENT CLINIC	2.394779							90.01
91	Emergency	0.413971							91
92	Observation Beds (Non-Distinct	1.132956							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/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-6150** **WORKSHEET D PART IV**

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

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total Cost (sum of col. 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-6150** **WORKSHEET D PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8) 7	Ratio of Cost to Charges (col. 5÷ col. 7) 8	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7) 9	Inpatient Program Charges 10	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11	Outpatient Program Charges 12	Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	11,095,528							50
52	Delivery Room & Labor Room	1,037,487							52
53	Anesthesiology								53
54	Radiology-Diagnostic	16,906,409			31,989				54
54.01	RADIOLOGY-ULTRASOUND	2,991,801			17,357				54.01
60	Laboratory	16,309,402			68,155				60
62	Whole Blood & Packed Red Blood	365,278			3,549				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,720,314			107,763				65
66	Physical Therapy	4,027,927			672,399				66
69	Electrocardiology	682,892			2,136				69
71	Medical Supplies Charged to Pat	1,452,950			12,343				71
72	Impl. Dev. Charged to Patients	340,918							72
73	Drugs Charged to Patients	5,665,652			46,265				73
76	CARDIAC REHAB	155,897							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	5,451,953							88
88.01	RHC II	609,552							88.01
88.02	RHC III	1,123,134							88.02
90	Clinic	1,501,942			3,085				90
90.01	PAIN MANAGEMENT CLINIC	204,935							90.01
91	Emergency	6,428,946							91
92	Observation Beds (Non-Distinct	500,196							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	78,573,113			965,041				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-6150** **WORKSHEET D PART V**

```
Check        [  ] Title V - O/P           [  ] Hospital    [  ] SUB (Other)        [  ] Swing Bed SNF
Applicable   [XX] Title XVIII, Part B     [  ] IPF         [XX] 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	0.333196							50
52	Delivery Room & Labor Room	0.362219							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.152519							54
54.01	RADIOLOGY-ULTRASOUND	0.122797							54.01
60	Laboratory	0.159588							60
62	Whole Blood & Packed Red Blood	0.355231							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.523097							65
66	Physical Therapy	0.556439							66
69	Electrocardiology	0.107119							69
71	Medical Supplies Charged to Pat	0.492581							71
72	Impl. Dev. Charged to Patients	0.883952							72
73	Drugs Charged to Patients	0.684735							73
76	CARDIAC REHAB	1.040289							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
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.389025							90
90.01	PAIN MANAGEMENT CLINIC	2.394779							90.01
91	Emergency	0.413971							91
92	Observation Beds (Non-Distinct	1.132956							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                 [XX] PPS
Applicable     [  ] Title XVIII, Part A     [  ] TEFRA
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)	420,451	31,567	388,884	2,862	135.88	385	52,314	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	13,005		13,005	352	36.95	185	6,836	43
44	Skilled Nursing Facility	141,153		141,153	6,496	21.73			44
45	Nursing Facility								45
200	Total (lines 30-199)	574,609		543,042	9,710		570	59,150	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1343** **WORKSHEET D PART II**

```
Check        [  ] Title V                [XX] Hospital     [  ] SUB (Other)          [XX] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF                                    [  ] TEFRA
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	724,238	11,095,528	0.065273	582,455	38,019	50
52	Delivery Room & Labor Room	36,411	1,037,487	0.035095	423,144	14,850	52
53	Anesthesiology						53
54	Radiology-Diagnostic	309,652	16,906,409	0.018316	148,865	2,727	54
54.01	RADIOLOGY-ULTRASOUND	25,571	2,991,801	0.008547	41,791	357	54.01
60	Laboratory	147,223	16,309,402	0.009027	371,278	3,352	60
62	Whole Blood & Packed Red Blood	4,691	365,278	0.012842			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	65,342	1,720,314	0.037983	30,698	1,166	65
66	Physical Therapy	254,616	4,027,927	0.063213	44,984	2,844	66
69	Electrocardiology	9,225	682,892	0.013509	4,520	61	69
71	Medical Supplies Charged to Pat	51,565	1,452,950	0.035490	70,449	2,500	71
72	Impl. Dev. Charged to Patients	14,437	340,918	0.042347	22,996	974	72
73	Drugs Charged to Patients	124,742	5,665,652	0.022017	160,881	3,542	73
76	CARDIAC REHAB	62,468	155,897	0.400700			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	66,493	5,451,953	0.012196			88
88.01	RHC II	5,476	609,552	0.008984			88.01
88.02	RHC III	30,256	1,123,134	0.026939			88.02
90	Clinic	322,556	1,501,942	0.214759	3,410	732	90
90.01	PAIN MANAGEMENT CLINIC	24,201	204,935	0.118091			90.01
91	Emergency	298,838	6,428,946	0.046483	63,600	2,956	91
92	Observation Beds (Non-Distinct	58,292	500,196	0.116538	6,660	776	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,636,293	78,573,113		1,975,731	74,856	200

(A) Worksheet A line numbers

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

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

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	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                 [XX] PPS
Applicable     [  ] Title XVIII, Part A     [  ] TEFRA
Boxes:         [XX] Title XIX               [  ] Other
```

(A)	Cost Center Description	Total Patient Days 6	Per Diem (col. 5÷ col. 6) 7	Inpatient Program Days 8	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,862		385		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	352		185		43
44	Skilled Nursing Facility	6,496				44
45	Nursing Facility					45
200	Total (lines 30-199)	9,710		570		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS — **COMPONENT CCN: 14-1343** — **WORKSHEET D PART IV**

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

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total Cost (sum of col. 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-1343** **WORKSHEET D PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8) 7	Ratio of Cost to Charges (col. 5÷ col. 7) 8	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7) 9	Inpatient Program Charges 10	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11	Outpatient Program Charges 12	Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	11,095,528			582,455				50
52	Delivery Room & Labor Room	1,037,487			423,144				52
53	Anesthesiology								53
54	Radiology-Diagnostic	16,906,409			148,865				54
54.01	RADIOLOGY-ULTRASOUND	2,991,801			41,791				54.01
60	Laboratory	16,309,402			371,278				60
62	Whole Blood & Packed Red Blood	365,278							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,720,314			30,698				65
66	Physical Therapy	4,027,927			44,984				66
69	Electrocardiology	682,892			4,520				69
71	Medical Supplies Charged to Pat	1,452,950			70,449				71
72	Impl. Dev. Charged to Patients	340,918			22,996				72
73	Drugs Charged to Patients	5,665,652			160,881				73
76	CARDIAC REHAB	155,897							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	5,451,953							88
88.01	RHC II	609,552							88.01
88.02	RHC III	1,123,134							88.02
90	Clinic	1,501,942			3,410				90
90.01	PAIN MANAGEMENT CLINIC	204,935							90.01
91	Emergency	6,428,946			63,600				91
92	Observation Beds (Non-Distinct	500,196			6,660				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	78,573,113			1,975,731				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1343** **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
```

			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	0.333196		1,353,653			451,032		50
52	Delivery Room & Labor Room	0.362219		19,722			7,144		52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.152519		2,804,475			427,736		54
54.01	RADIOLOGY-ULTRASOUND	0.122797		497,493			61,091		54.01
60	Laboratory	0.159588		2,408,804			384,416		60
62	Whole Blood & Packed Red Blood	0.355231							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.523097		88,437			46,261		65
66	Physical Therapy	0.556439		589,362			327,944		66
69	Electrocardiology	0.107119		154,914			16,594		69
71	Medical Supplies Charged to Pat	0.492581		120,582			59,396		71
72	Impl. Dev. Charged to Patients	0.883952		4,706			4,160		72
73	Drugs Charged to Patients	0.684735		682,877			467,590		73
76	CARDIAC REHAB	1.040289							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
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.389025		209,546			291,065		90
90.01	PAIN MANAGEMENT CLINIC	2.394779		59,394			142,236		90.01
91	Emergency	0.413971		1,441,317			596,663		91
92	Observation Beds (Non-Distinct	1.132956		29,832			33,798		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			10,465,114			3,317,126		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			10,465,114			3,317,126		202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1343** **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

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,113	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,862	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)	2,433	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	153	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)	77	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	14	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)	7	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,007	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)	136	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)	68	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	144.67	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20
21	Total general inpatient routine service cost (see instructions)	4,087,528	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)	2,025	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,033	25
26	Total swing-bed cost (see instructions)	306,883	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,780,645	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)	3,780,645	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1343** **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)	1,320.98	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,330,227	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)	1,330,227	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)	1,272,879	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,603,106	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)	179,653	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	89,827	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	269,480	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: 14-1343** **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)					429	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,320.98	88
89	Observation bed cost (line 87 x line 88) (see instructions)					566,700	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	420,451	4,087,528	0.102862	566,700	58,292	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-6150** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,496	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,496	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)	6,496	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (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)	1,606	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		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	2,632,785	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,632,785	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)	2,632,785	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-6150** **WORKSHEET D-1 PARTS III & IV**

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

PART III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,632,785	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	405.29	71
72	Program routine service cost (line 9 x line 71)	650,896	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	650,896	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	650,896	83
84	Program inpatient ancillary services (see instructions)	491,941	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	1,142,837	86

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1343** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,113	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,862	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)	2,433	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	153	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)	77	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	14	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)	7	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	385	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)	352	15
16	Nursery days (title V or XIX only)	185	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	144.67	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20
21	Total general inpatient routine service cost (see instructions)	4,087,528	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)	2,025	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,033	25
26	Total swing-bed cost (see instructions)	306,883	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,780,645	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)	3,780,645	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1343** **WORKSHEET D-1 PART II**

```
Check        [  ] Title V - I/P          [XX] Hospital     [  ] SUB (Other)          [XX] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF                                    [  ] TEFRA
Boxes:       [XX] Title XIX - I/P        [  ] IRF                                    [  ] 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)	1,320.98	38
39	Program general inpatient routine service cost (line 9 x line 38)	508,577	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)	508,577	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)	172,989	352	491.45	185	90,918	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)	679,806	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,279,301	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	59,150	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	74,856	51
52	Total Program excludable cost (sum of lines 50 and 51)	134,006	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,145,295	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: 14-1343** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					429	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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2016 To: 04/30/2017	Run Date: 09/26/2017 Run Time: 08:32 Version: 2017.01 (07/27/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1343** **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		1,121,904		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.333196	475,298	158,367	50
52	Delivery Room & Labor Room	0.362219			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.152519	408,574	62,315	54
54.01	RADIOLOGY-ULTRASOUND	0.122797	113,649	13,956	54.01
60	Laboratory	0.159588	617,219	98,501	60
62	Whole Blood & Packed Red Blood Cells	0.355231	83,649	29,715	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.523097	269,761	141,111	65
66	Physical Therapy	0.556439	127,683	71,048	66
69	Electrocardiology	0.107119	43,604	4,671	69
71	Medical Supplies Charged to Patients	0.492581	295,780	145,696	71
72	Impl. Dev. Charged to Patients	0.883952	58,961	52,119	72
73	Drugs Charged to Patients	0.684735	463,257	317,208	73
76	CARDIAC REHAB	1.040289			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
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.389025	127,479	177,072	90
90.01	PAIN MANAGEMENT CLINIC	2.394779			90.01
91	Emergency	0.413971	350	145	91
92	Observation Beds (Non-Distinct Part)	1.132956	843	955	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,086,107	1,272,879	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,086,107		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z343** **WORKSHEET D-3**

Check Applicable Boxes:

- [ ] Title V
- [XX] Title XVIII, Part A
- [ ] Title XIX
- [ ] Hospital
- [ ] IPF
- [ ] IRF
- [ ] SUB (Other)
- [ ] SNF
- [ ] NF
- [XX] Swing Bed SNF
- [ ] Swing Bed NF
- [ ] ICF/IID
- [ ] PPS
- [ ] TEFRA
- [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	0.333196			50
52	Delivery Room & Labor Room	0.362219			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.152519	17,681	2,697	54
54.01	RADIOLOGY-ULTRASOUND	0.122797	2,021	248	54.01
60	Laboratory	0.159588	27,740	4,427	60
62	Whole Blood & Packed Red Blood Cells	0.355231	2,317	823	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.523097	24,490	12,811	65
66	Physical Therapy	0.556439	71,942	40,031	66
69	Electrocardiology	0.107119	801	86	69
71	Medical Supplies Charged to Patients	0.492581	18,568	9,146	71
72	Impl. Dev. Charged to Patients	0.883952			72
73	Drugs Charged to Patients	0.684735	41,800	28,622	73
76	CARDIAC REHAB	1.040289			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
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.389025	9,157	12,719	90
90.01	PAIN MANAGEMENT CLINIC	2.394779			90.01
91	Emergency	0.413971			91
92	Observation Beds (Non-Distinct Part)	1.132956			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		216,517	111,610	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		216,517		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-6150** **WORKSHEET D-3**

```
Check         [  ] Title V                [  ] Hospital    [  ] SUB (Other)       [  ] Swing Bed SNF    [XX] PPS
Applicable    [XX] Title XVIII, Part A    [  ] IPF         [XX] SNF               [  ] Swing Bed NF     [  ] TEFRA
Boxes:        [  ] Title XIX              [  ] IRF         [  ] NF                [  ] ICF/IID          [  ] 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	0.333196			50
52	Delivery Room & Labor Room	0.362219			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.152519	31,989	4,879	54
54.01	RADIOLOGY-ULTRASOUND	0.122797	17,357	2,131	54.01
60	Laboratory	0.159588	68,155	10,877	60
62	Whole Blood & Packed Red Blood Cells	0.355231	3,549	1,261	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.523097	107,763	56,371	65
66	Physical Therapy	0.556439	672,399	374,149	66
69	Electrocardiology	0.107119	2,136	229	69
71	Medical Supplies Charged to Patients	0.492581	12,343	6,080	71
72	Impl. Dev. Charged to Patients	0.883952			72
73	Drugs Charged to Patients	0.684735	46,265	31,679	73
76	CARDIAC REHAB	1.040289			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
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.389025	3,085	4,285	90
90.01	PAIN MANAGEMENT CLINIC	2.394779			90.01
91	Emergency	0.413971			91
92	Observation Beds (Non-Distinct Part)	1.132956			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		965,041	491,941	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		965,041		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1343** **WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		464,534		30
43	Nursery		214,812		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.333196	582,455	194,072	50
52	Delivery Room & Labor Room	0.362219	423,144	153,271	52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.152519	148,865	22,705	54
54.01	RADIOLOGY-ULTRASOUND	0.122797	41,791	5,132	54.01
60	Laboratory	0.159588	371,278	59,252	60
62	Whole Blood & Packed Red Blood Cells	0.355231			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.523097	30,698	16,058	65
66	Physical Therapy	0.556439	44,984	25,031	66
69	Electrocardiology	0.107119	4,520	484	69
71	Medical Supplies Charged to Patients	0.492581	70,449	34,702	71
72	Impl. Dev. Charged to Patients	0.883952	22,996	20,327	72
73	Drugs Charged to Patients	0.684735	160,881	110,161	73
76	CARDIAC REHAB	1.040289			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
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.389025	3,410	4,737	90
90.01	PAIN MANAGEMENT CLINIC	2.394779			90.01
91	Emergency	0.413971	63,600	26,329	91
92	Observation Beds (Non-Distinct Part)	1.132956	6,660	7,545	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,975,731	679,806	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,975,731		202

(A) Worksheet A line numbers

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1343** **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)	7,891,714			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)	7,891,714			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)	7,970,631			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)	76,026			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,339,648			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)	4,554,957			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)	4,554,957			30
31	Primary payer payments	743			31
32	Subtotal (line 30 minus line 31)	4,554,214			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)	537,501			34
35	Adjusted reimbursable bad debts (see instructions)	349,376			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	402,976			36
37	Subtotal (see instructions)	4,903,590			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)	4,903,590			40
40.01	Sequestration adjustment (see instructions)	98,072			40.01
41	Interim payments	4,406,018			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	399,500			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

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-6150** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 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)				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)	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)				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)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				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)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				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)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				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: 14-1343** **WORKSHEET E-1 PART I**

```
Check        [XX] Hospital     [  ] SUB (Other)
Applicable   [  ] IPF          [  ] SNF
Boxes:       [  ] IRF          [  ] 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				1,820,786		4,457,271	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	12/06/2016	77,300			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			12/06/2016	51,253	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		77,300		-51,253	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)				1,898,086		4,406,018	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		452,008		399,500	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				2,350,094		4,805,518	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-Z343** **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				316,401			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	12/06/2016	19,072			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		19,072			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)				335,473			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		36,300			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				371,773			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: 14-6150** **WORKSHEET E-1 PART I**

```
Check        [  ] Hospital     [  ] SUB (Other)
Applicable   [  ] IPF          [XX] SNF
Boxes:       [  ] IRF          [  ] 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				511,848			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)				511,848			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		3,950			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				515,798			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)	770	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,007	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	2,433	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	83,695,563	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,176,949	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-Z343** **WORKSHEET E-2**

```
Check         [  ] Title V                [XX] Swing Bed - SNF
Applicable    [XX] Title XVIII            [  ] Swing Bed - NF
Boxes:        [  ] Title XIX
```

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	272,175		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)	112,726		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	204		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)	384,901		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	384,901		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	384,901		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,541		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)	379,360		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)	379,360		19
19.01	Sequestration adjustment (see instructions)	7,587		19.01
20	Interim payments	335,473		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	36,300		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	2,603,106	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,603,106	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,629,137	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)	2,629,137	19
20	Deductibles (exclude professional component)	266,199	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,362,938	22
23	Coinsurance	329	23
24	Subtotal (line 22 minus line 23)	2,362,609	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	54,533	25
26	Adjusted reimbursable bad debts (see instructions)	35,446	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	45,040	27
28	Subtotal (sum of lines 24 and 26)	2,398,055	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,398,055	30
30.01	Sequestration adjustment (see instructions)	47,961	30.01
31	Interim payments	1,898,086	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	452,008	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

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

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	634,371	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	634,371	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	112,077	7
8	Allowable bad debts (see instructions)	6,201	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)	4,031	10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	526,325	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	526,325	15
15.01	Sequestration adjustment (see instructions)	10,527	15.01
16	Interim payments	511,848	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)	3,950	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1343** **WORKSHEET E-3 PART VII**

```
Check        [  ] Title V          [XX] Hospital        [  ] NF         [XX] PPS
Applicable   [XX] Title XIX        [  ] SUB (Other)     [  ] ICF/IID    [  ] TEFRA
Boxes:                             [  ] SNF                             [  ] Other
```

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services		3,317,126	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)		3,317,126	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)		3,317,126	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	679,346		8
9	Ancillary service charges	1,975,731	10,465,114	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)	2,655,077	10,465,114	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)	2,655,077	10,465,114	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)		3,317,126	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)		3,317,126	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)		3,317,126	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)		3,317,126	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)		3,317,126	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)		3,317,126	40
41	Interim payments		3,317,126	41
42	Balance due provider/program (line 40 minus line 41)			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	993,330				1
2	Temporary investments	1,036,111				2
3	Notes receivable					3
4	Accounts receivable	14,207,984				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-3,380,000				6
7	Inventory	1,062,157				7
8	Prepaid expenses	734,249				8
9	Other current assets	252,464				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	14,906,295				11
	FIXED ASSETS					
12	Land	490,645				12
13	Land improvements	1,115,487				13
14	Accumulated depreciation	-588,382				14
15	Buildings	53,468,370				15
16	Accumulated depreciation	-21,784,557				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	13,586,849				23
24	Accumulated depreciation	-9,422,258				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	36,866,154				30
	OTHER ASSETS					
31	Investments	17,155,378				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	3,384,413				34
35	Total other assets (sum of lines 31-34)	20,539,791				35
36	Total assets (sum of lines 11, 30 and 35)	72,312,240				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	1,176,375				37
38	Salaries, wages and fees payable	3,042,516				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	961,485				40
41	Deferred income	10,266				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	2,928,650				44
45	Total current liabilities (sum of lines 37 thru 44)	8,119,292				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	12,175,439				47
48	Unsecured loans					48
49	Other long term liabilities	3,384,413				49
50	Total long term liabilities (sum of lines 46 thru 49)	15,559,852				50
51	Total liabilities (sum of lines 45 and 50)	23,679,144				51
	CAPITAL ACCOUNTS					
52	General fund balance	48,633,096				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)	48,633,096				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	72,312,240				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		49,959,468			1
2	Net income (loss) (from Worksheet G-3, line 29)		-1,323,893			2
3	Total (sum of line 1 and line 2)		48,635,575			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		48,635,575			11
12	Deductions (debit adjustments) (specify)					12
13	TRANSFER PERM RESTRICTED	2,479				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		2,479			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		48,633,096			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						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	TRANSFER PERM RESTRICTED					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

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

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	2,286,964		2,286,964	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	120,982		120,982	5
6	Swing Bed - NF				6
7	Skilled nursing facility	1,887,650		1,887,650	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	4,295,596		4,295,596	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	4,295,596		4,295,596	17
18	Ancillary services	9,522,221	51,474,742	60,996,963	18
19	Outpatient services		18,129,685	18,129,685	19
20	Rural Health Clinic (RHC)		5,495,428	5,495,428	20
20.01	RHC II		609,553	609,553	20.01
20.02	RHC III		1,123,135	1,123,135	20.02
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		815,163	815,163	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHYSICIAN PRIVATE OFFICE		1,266,872	1,266,872	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	13,817,817	78,914,578	92,732,395	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		48,223,222	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				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		48,223,222	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	92,732,395	1
2	Less contractual allowances and discounts on patients' accounts	46,911,886	2
3	Net patient revenues (line 1 minus line 2)	45,820,509	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	48,223,222	4
5	Net income from service to patients (line 3 minus line 4)	-2,402,713	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	45,803	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	200,824	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	15,008	17
18	Revenue from sale of medical records and abstracts		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		21
22	Rental of hosptial space	242,521	22
23	Governmental appropriations	127,706	23
24	Other (CONSULTING CLINIC)	68,780	24
24.01	Other (WELLNESS)	58,549	24.01
24.02	Other (GRANTS)	13,550	24.02
24.03	Other (340B INCOME)		24.03
24.04	Other (FOUNDATION REIMBURSEMENT)		24.04
24.05	Other (DONATIONS)		24.05
24.06	Other (OTHER INCOME)	306,079	24.06
25	Total other income (sum of lines 6-24)	1,078,820	25
26	Total (line 5 plus line 25)	-1,323,893	26
29	Net income (or loss) for the period (line 26 minus line 28)	-1,323,893	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7175** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	112,770	7,330	296	25,767	44,576	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	254,186	16,522	13,935			6
7	Physical Therapy	50,607	3,289	5,886			7
8	Occupational Therapy	11,324	688	1,309			8
9	Speech Pathology	459		72			9
10	Medical Social Services						10
11	Home Health Aide	33,546	2,180	4,381			11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	462,892	30,009	25,879	25,767	44,576	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7175** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	190,739	-21,210	169,529	-13,169	156,360	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	284,643		284,643		284,643	6
7	Physical Therapy	59,782		59,782		59,782	7
8	Occupational Therapy	13,321		13,321		13,321	8
9	Speech Pathology	531		531		531	9
10	Medical Social Services						10
11	Home Health Aide	40,107		40,107		40,107	11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	589,123	-21,210	567,913	-13,169	554,744	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7175** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	156,360				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	284,643				6
7	Physical Therapy	59,782				7
8	Occupational Therapy	13,321				8
9	Speech Pathology	531				9
10	Medical Social Services					10
11	Home Health Aide	40,107				11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	554,744				24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7175** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		156,360	156,360		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		284,643	111,719	396,362	6
7	Physical Therapy		59,782	23,464	83,246	7
8	Occupational Therapy		13,321	5,228	18,549	8
9	Speech Pathology		531	208	739	9
10	Medical Social Services					10
11	Home Health Aide		40,107	15,741	55,848	11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		554,744		554,744	24

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 14-7175** **WORKSHEET H-1 PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-156,360	398,384	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						284,643	6
7	Physical Therapy						59,782	7
8	Occupational Therapy						13,321	8
9	Speech Pathology						531	9
10	Medical Social Services							10
11	Home Health Aide						40,107	11
12	Supplies (see instructions)							12
13	Drugs							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-156,360	398,384	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						156,360	25
26	Unit Cost Multiplier						0.392486	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7175** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	DATA PROCE SSING	
		0	1	2	4	5.01	5.02	
1	Administrative and General			787	21,948	965		1
2	Skilled Nursing Care	396,362			49,472			2
3	Physical Therapy	83,246			9,850			3
4	Occupational Therapy	18,549			2,204			4
5	Speech Pathology	739			89			5
6	Medical Social Services							6
7	Home Health Aide	55,848			6,529			7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	554,744		787	90,092	965		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7175** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	MAIN-TENANCE & REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
1	Administrative and General	1,154		16,714	41,568	3,652		1
2	Skilled Nursing Care				445,834	39,169		2
3	Physical Therapy				93,096	8,179		3
4	Occupational Therapy				20,753	1,823		4
5	Speech Pathology				828	73		5
6	Medical Social Services							6
7	Home Health Aide				62,377	5,480		7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	1,154		16,714	664,456	58,376		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7175** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General			2,452		14,723		1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)			2,452		14,723		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7175** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	
		13	14	15	16	17	19	
1	Administrative and General	61,611				1,449		1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	61,611				1,449		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7175** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP-DOWN ADJS	
		20	21	22	23	24	25	
1	Administrative and General					125,455		1
2	Skilled Nursing Care					485,003		2
3	Physical Therapy					101,275		3
4	Occupational Therapy					22,576		4
5	Speech Pathology					901		5
6	Medical Social Services							6
7	Home Health Aide					67,857		7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)					803,067		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7175** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS				
		26	27	28				
1	Administrative and General	125,455						1
2	Skilled Nursing Care	485,003	89,795	574,798				2
3	Physical Therapy	101,275	18,750	120,025				3
4	Occupational Therapy	22,576	4,180	26,756				4
5	Speech Pathology	901	167	1,068				5
6	Medical Social Services							6
7	Home Health Aide	67,857	12,563	80,420				7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	803,067	125,455	803,067				20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.185143					21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7175** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	
		1	2	4	5.01	5.02	5.03	
1	Administrative and General		883	112,770	9		4	1
2	Skilled Nursing Care			254,186				2
3	Physical Therapy			50,607				3
4	Occupational Therapy			11,324				4
5	Speech Pathology			459				5
6	Medical Social Services							6
7	Home Health Aide			33,546				7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		883	462,892	9		4	20
21	Total cost to be allocated		787	90,092	965		1,154	21
22	Unit Cost Multiplier			0.194629				22
22	Unit Cost Multiplier		0.891280		107.222222		288.500000	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7175** **WORKSHEET H-2 PART II**

	HHA COST CENTER	ADMITTING INPATIENT REVENUE	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.04	5.05	4A.06	5.06	6	7	
1	Administrative and General		815,162		41,568			1
2	Skilled Nursing Care				445,834			2
3	Physical Therapy				93,096			3
4	Occupational Therapy				20,753			4
5	Speech Pathology				828			5
6	Medical Social Services							6
7	Home Health Aide				62,377			7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		815,162		664,456			20
21	Total cost to be allocated		16,714		58,376			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		0.020504		0.087855			22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7175** **WORKSHEET H-2 PART II**

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS-TRATION NURSING HOURS	
		8	9	10	11	12	13	
1	Administrative and General		450		8		17,047	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		450		8		17,047	20
21	Total cost to be allocated		2,452		14,723		61,611	21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		5.448889		1,840.375000		3.614184	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7175** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	
		14	15	16	17	19	20	
1	Administrative and General				1			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)				1			20
21	Total cost to be allocated				1,449			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				1,449.000000			22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7175** **WORKSHEET H-2 PART II**

	HHA COST CENTER	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME				
		21	22	23				
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7175** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	574,798		574,798	2,193	262.11	1
2	Physical Therapy	3	120,025		120,025	938	127.96	2
3	Occupational Therapy	4	26,756		26,756	196	136.51	3
4	Speech Pathology	5	1,068		1,068	26	41.08	4
5	Medical Social Services	6				5		5
6	Home Health Aide	7	80,420		80,420	477	168.60	6
7	Total (sum of lines 1-6)		803,067		803,067	3,835		7

Limitation Cost Comoputation			Program Visits			
				PART B		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	99914		1,694		8
9	Physical Therapy	99914		782		9
10	Occupational Therapy	99914		157		10
11	Speech Pathology	99914		10		11
12	Medical Social Services	99914		1		12
13	Home Health Aide	99914		435		13
14	Total (sum of lines 8-13)			3,079		14

Supplies and Drugs Cost Computations								
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8		21,362	21,362	41,514	0.514573	15
16	Cost of Drugs	9						16

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.556439			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.492581	43,368	21,362	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.684735			col. 2, line 16	5

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7175** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
			Part B			Part B			
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		1,694			444,014		444,014	1
2	Physical Therapy		782			100,065		100,065	2
3	Occupational Therapy		157			21,432		21,432	3
4	Speech Pathology		10			411		411	4
5	Medical Social Services		1						5
6	Home Health Aide		435			73,341		73,341	6
7	Total (sum of lines 1-6)		3,079			639,263		639,263	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6	7	8	9	10	11	
15	Cost of Medical Supplies							15
16	Cost of Drugs							16

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7175** **WORKSHEET H-4 PARTS I & II**

`Check applicable box:    [ ] Title V    [XX] Title XVIII    [ ] Title XIX`

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

			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to excced 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		451,891	11
12	Total PPS Reimbursement - Full Episodes with Outliers		4,685	12
13	Total PPS Reimbursement - LUPA Episodes		4,571	13
14	Total PPS Reimbursement - PEP Episodes			14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		804	15
16	Total PPS Outlier Reimbursement - PSP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		461,951	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		461,951	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		461,951	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		461,951	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		461,951	31
31.01	Sequestration adjustment (see instructions)		9,239	31.01
32	Interim payments (see instructions)		452,712	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7175** **WORKSHEET H-5**

				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider						452,712	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.							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. H-4, Part II, column as appropriate, line 32)						452,712	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	Determine net settlement amount (balance due)		.01					6.01
	based on the cost report (see instructions)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						452,712	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 CAPITAL PAYMENT **COMPONENT CCN: 14-1343** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)		12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

ALLOCATION OF ALLOWABLE 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
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
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
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS							194.01
194.02	FOUNDATION SERVICES							194.02
194.03	WELLNESS							194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
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: 14-3429** **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	1,985,946		1,985,946	-55,574	1,930,372	-159,926	1,770,446	1
2	Physician Assistant								2
3	Nurse Practitioner	98,748		98,748		98,748		98,748	3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techinician								8
9	Other Facility Health Care Staff Costs	771,344	215,500	986,844		986,844		986,844	9
10	Subtotal (sum of lines 1 through 9)	2,856,038	215,500	3,071,538	-55,574	3,015,964	-159,926	2,856,038	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		108,973	108,973		108,973		108,973	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment				166,256	166,256		166,256	17
18	Professional Liability Insurance		134,461	134,461		134,461		134,461	18
19	Other Health Care Costs		64,090	64,090		64,090		64,090	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		307,524	307,524	166,256	473,780		473,780	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,856,038	523,024	3,379,062	110,682	3,489,744	-159,926	3,329,818	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								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		183,040	183,040	75,122	258,162		258,162	29
30	Administrative Costs	913,392	-374,581	538,811		538,811		538,811	30
31	Total Facility Overhead (sum of lines 29 and 30)	913,392	-191,541	721,851	75,122	796,973		796,973	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	3,769,430	331,483	4,100,913	185,804	4,286,717	-159,926	4,126,791	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: 14-3429** **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	4.67	23,049	4,200	19,614		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.91	4,078	2,100	1,911		3
4	Subtotal (sum of lines 1 through 3)	5.58	27,127		21,525	27,127	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						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)	5.58	27,127			27,127	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	3,329,818	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	3,329,818	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	796,973	14
15	Parent provider overhead allocated to facility (see instructions)	1,341,449	15
16	Total overhead (sum of lines 14 and 15)	2,138,422	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	2,138,422	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	2,138,422	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	5,468,240	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: 14-3429** **WORKSHEET M-3**

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	5,468,240	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	185,072	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	5,283,168	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	27,127	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	27,127	6
7	Adjusted cost per visit (line 3 divided by line 6)	194.76	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)				8
9	Rate for program covered visits (see instructions)	194.76	194.76	194.76	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		7,326		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,426,812		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,426,812		16
16.01	Total program charges (see instructions)(from contractor's records)		1,137,338		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		133,306		16.02
16.03	Total program preventive costs (see instructions)		167,235		16.03
16.04	Total program non-preventive costs (see instructions)		900,164		16.04
16.05	Total program cost (see instructions)		1,067,399		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		134,372		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		173,932		19
20	Net Medicare cost excluding vaccines (see instructions)		1,067,399		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		144,089		21
22	Total reimbursable Program cost (line 20 plus line 21)		1,211,488		22
23	Allowable bad debts (see instructions)		53,486		23
23.01	Adjusted reimbursable bad debts (see instructions)		34,766		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		53,486		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		1,246,254		26
26.01	Sequestration adjustment (see instructions)		24,925		26.01
27	Interim payments		1,151,485		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		69,844		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: 14-3429** **WORKSHEET M-4**

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,856,038	2,856,038	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000972	0.001418	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,776	4,050	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	92,234	13,637	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	95,010	17,687	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	3,329,818	3,329,818	6
7	Total overhead (from Wkst. M-2, line 16)	2,138,422	2,138,422	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.028533	0.005312	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	61,016	11,359	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	156,026	29,046	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	581	847	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	268.55	34.29	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	469	529	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	125,950	18,139	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)		185,072	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)		144,089	16

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2016 To: 04/30/2017	Run Date: 09/26/2017 Run Time: 08:32 Version: 2017.01 (07/27/2017)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES — **COMPONENT CCN: 14-3429** — **WORKSHEET M-5**

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

	DESCRIPTION			Part B mm/dd/yyyy 1	Part B Amount 2	
1	Total interim payments paid to provider				1,132,906	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	12/06/2016	18,579	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			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		18,579	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				1,151,485	
	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		69,844	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				1,221,329	
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.

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 14-3486** **WORKSHEET M-1**

Check applicable box: [XX] RHC II [ ] 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								1
2	Physician Assistant								2
3	Nurse Practitioner	134,727		134,727		134,727		134,727	3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techinician								8
9	Other Facility Health Care Staff Costs	106,409	19,464	125,873		125,873	-15,997	109,876	9
10	Subtotal (sum of lines 1 through 9)	241,136	19,464	260,600		260,600	-15,997	244,603	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		9,267	9,267		9,267		9,267	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment				6,966	6,966		6,966	17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		9,267	9,267	6,966	16,233		16,233	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	241,136	28,731	269,867	6,966	276,833	-15,997	260,836	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								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		21,067	21,067		21,067		21,067	29
30	Administrative Costs	32,241	127,915	160,156		160,156		160,156	30
31	Total Facility Overhead (sum of lines 29 and 30)	32,241	148,982	181,223		181,223		181,223	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	273,377	177,713	451,090	6,966	458,056	-15,997	442,059	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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2016 To: 04/30/2017	Run Date: 09/26/2017 Run Time: 08:32 Version: 2017.01 (07/27/2017)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3486** **WORKSHEET M-2**

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

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel 1	Total Visits 2	Productivity Standard (1) 3	Minimum Visits (col. 1 x col. 3) 4	Greater of col. 2 or col. 4 5	
1	Physicians			4,200			1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.80	4,151	2,100	1,680		3
4	Subtotal (sum of lines 1 through 3)	0.80	4,151		1,680	4,151	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						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)	0.80	4,151			4,151	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	260,836	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	260,836	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	181,223	14
15	Parent provider overhead allocated to facility (see instructions)	101,960	15
16	Total overhead (sum of lines 14 and 15)	283,183	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	283,183	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	283,183	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	544,019	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: 14-3486** **WORKSHEET M-3**

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	544,019	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	35,310	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	508,709	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	4,151	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	4,151	6
7	Adjusted cost per visit (line 3 divided by line 6)	122.55	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)				8
9	Rate for program covered visits (see instructions)	122.55	122.55	122.55	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		653		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		80,025		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		80,025		16
16.01	Total program charges (see instructions)(from contractor's records)		94,525		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,589		16.02
16.03	Total program preventive costs (see instructions)		9,811		16.03
16.04	Total program non-preventive costs (see instructions)		45,769		16.04
16.05	Total program cost (see instructions)		55,580		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		13,003		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		13,986		19
20	Net Medicare cost excluding vaccines (see instructions)		55,580		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		27,438		21
22	Total reimbursable Program cost (line 20 plus line 21)		83,018		22
23	Allowable bad debts (see instructions)		7,660		23
23.01	Adjusted reimbursable bad debts (see instructions)		4,979		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,660		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		87,997		26
26.01	Sequestration adjustment (see instructions)		1,760		26.01
27	Interim payments		53,526		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		32,711		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: 14-3486** **WORKSHEET M-4**

Check applicable boxes:	[XX] RHC II	[ ] 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)	244,603	244,603	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001857	0.002667	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	454	652	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	13,811	2,013	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	14,265	2,665	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	260,836	260,836	6
7	Total overhead (from Wkst. M-2, line 16)	283,183	283,183	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.054690	0.010217	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	15,487	2,893	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	29,752	5,558	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	87	125	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	341.98	44.46	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	71	71	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	24,281	3,157	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)		35,310	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)		27,438	16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **COMPONENT CCN: 14-3486** **WORKSHEET M-5**

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

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				53,526	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			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			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				53,526	
	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		32,711	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				86,237	
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.

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 14-3488** **WORKSHEET M-1**

Check applicable box: [XX] RHC III [ ] 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	198,618		198,618	32,953	231,571	-4,290	227,281	1
2	Physician Assistant								2
3	Nurse Practitioner	139,553		139,553		139,553		139,553	3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techinician								8
9	Other Facility Health Care Staff Costs	143,821	24,528	168,349		168,349		168,349	9
10	Subtotal (sum of lines 1 through 9)	481,992	24,528	506,520	32,953	539,473	-4,290	535,183	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		18,702	18,702		18,702		18,702	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment				66,283	66,283		66,283	17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		18,702	18,702	66,283	84,985		84,985	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	481,992	43,230	525,222	99,236	624,458	-4,290	620,168	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								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		26,933	26,933		26,933		26,933	29
30	Administrative Costs	32,377	154,230	186,607		186,607		186,607	30
31	Total Facility Overhead (sum of lines 29 and 30)	32,377	181,163	213,540		213,540		213,540	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	514,369	224,393	738,762	99,236	837,998	-4,290	833,708	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: 14-3488** **WORKSHEET M-2**

Check applicable box: [XX] RHC III [ ] 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	0.51	2,815	4,200	2,142		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.80	4,008	2,100	1,680		3
4	Subtotal (sum of lines 1 through 3)	1.31	6,823		3,822	6,823	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						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)	1.31	6,823			6,823	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	620,168	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	620,168	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	213,540	14
15	Parent provider overhead allocated to facility (see instructions)	199,194	15
16	Total overhead (sum of lines 14 and 15)	412,734	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	412,734	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	412,734	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	1,032,902	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: 14-3488** **WORKSHEET M-3**

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	1,032,902	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	15,716	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,017,186	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	6,823	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	6,823	6
7	Adjusted cost per visit (line 3 divided by line 6)	149.08	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)				8
9	Rate for program covered visits (see instructions)	149.08	149.08	149.08	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		683		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		101,822		11
12	Program covered visits for mental health services (from contractor records)		194		12
13	Program covered cost from mental health services (line 9 x line 12)		28,922		13
14	Limit adjustment for mental health services (see instructions)		28,922		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		130,744		16
16.01	Total program charges (see instructions)(from contractor's records)		136,960		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,690		16.02
16.03	Total program preventive costs (see instructions)		14,023		16.03
16.04	Total program non-preventive costs (see instructions)		83,668		16.04
16.05	Total program cost (see instructions)		97,691		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		12,136		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		22,027		19
20	Net Medicare cost excluding vaccines (see instructions)		97,691		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,123		21
22	Total reimbursable Program cost (line 20 plus line 21)		107,814		22
23	Allowable bad debts (see instructions)		3,774		23
23.01	Adjusted reimbursable bad debts (see instructions)		2,453		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,774		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		110,267		26
26.01	Sequestration adjustment (see instructions)		2,205		26.01
27	Interim payments		90,177		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		17,885		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: 14-3488** **WORKSHEET M-4**

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	535,183	535,183	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000563	0.001420	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	301	760	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,668	1,707	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,969	2,467	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	620,168	620,168	6
7	Total overhead (from Wkst. M-2, line 16)	412,734	412,734	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.011237	0.003978	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,638	1,642	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	11,607	4,109	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	42	106	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	276.36	38.76	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	32	33	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	8,844	1,279	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		15,716	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)		10,123	16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **COMPONENT CCN: 14-3488** **WORKSHEET M-5**

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

	DESCRIPTION			Part B mm/dd/yyyy 1	Part B Amount 2	
1	Total interim payments paid to provider				90,177	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			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			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				90,177	
	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		17,885	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				108,062	
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.