MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

HOSPITAL REIMBURSEMENT

MARCH 2026

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

OVERVIEW

- Introduction to the Myers and Stauffer Team
- Outpatient Hospital Cost Settlements

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INTRODUCTION TO THE MYERS AND STAUFFER TEAM

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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LEADERSHIP ON THE PROJECT

- Tara Clark, CPA
  Member
- Nickie Loparo
  Senior Manager
- Helen Hu
  Manager
- Mandy Hager
  Manager
- Alexus Thornton
  Senior Accountant

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OUTPATIENT HOSPITAL COST SETTLEMENTS

MARCH 2026

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
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OVERVIEW

- Outpatient Settlement Provider Types
- Background Information
- Summary of the Myers and Stauffer Process
- Walkthrough of the 23 Page Report
- Regulations and State Plan

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OUTPATIENT SETTLEMENT PROVIDER TYPES

- An outpatient settlement (OPS) is prepared using the Medicare cost report and Medicaid supplemental schedules for any hospital that provides outpatient services. Settlements are prepared for the following provider types:
  - Acute Care Hospital (ACH) – 61 Providers
  - Critical Access Hospital (CAH) – 29 Providers
  - Long-Term Acute Care Hospital (LTAC) – 10 Providers
  - Freestanding Rehabilitation Hospital (Rehab) – 7 Providers

BACKGROUND INFORMATION

- Every hospital that is part of the Medicaid program is required to annually file a Medicare cost report and Medicaid supplemental schedules for the facility's fiscal year.
- Additionally, if a hospital has a change of ownership (CHOW) requiring a new provider number or experiences a change of provider type, the facility must file special cost reports:
  - A close of business cost report for the short period between the beginning of the fiscal year and the date of the change
  - A short period from the date of the change to the facility's fiscal year end (FYE).
- All hospital cost reports are due within five months of the provider's FYE or date of change.

BACKGROUND INFORMATION CONT.

- As a general rule, two settlements are completed for each cost report year.
  - Tentative settlement is completed based on the as-submitted cost report and a paid claims listing (PCL) processed 90 days after the FYE.
  - Final settlement is completed based on the final cost report and a PCL processed at least 14 months after the FYE.
  - If the tentative settlement has not been mailed to the provider by the time the final CR is received, the tentative settlement will be closed and only the final settlement will be mailed.
  - Occasionally, an amended tentative settlement may be issued if changes are material.

BACKGROUND INFORMATION CONT.

- Reimbursement Percentages
  - Critical access hospitals receive 101% of costs
  - All other hospitals (Acute, Rehab, LTAC) receive 95% of costs
- Interim Cost-to-Charge Ratios
  - OP claims are paid in the interim at a percentage of billed charges. Interim cost-to-charge ratios are updated annually as tentative OP settlements are processed (for Acute/Rehab/LTAC) and as Medicare rate notices are received (for CAH).

BACKGROUND INFORMATION CONT.

- Laboratory Exclusion (Acute/Rehab/LTAC)
  - Effective January 1st, 2024, laboratory pathological services are paid on a Medicare fee schedule and therefore will be carved out of the outpatient cost settlement for Acute, Rehab, and LTAC provider types, similar to the treatment for other laboratory services.
  - Critical access hospitals are exempt from the lab fee schedule UPL requirements and are allowed to be paid up to 101% of lab costs.

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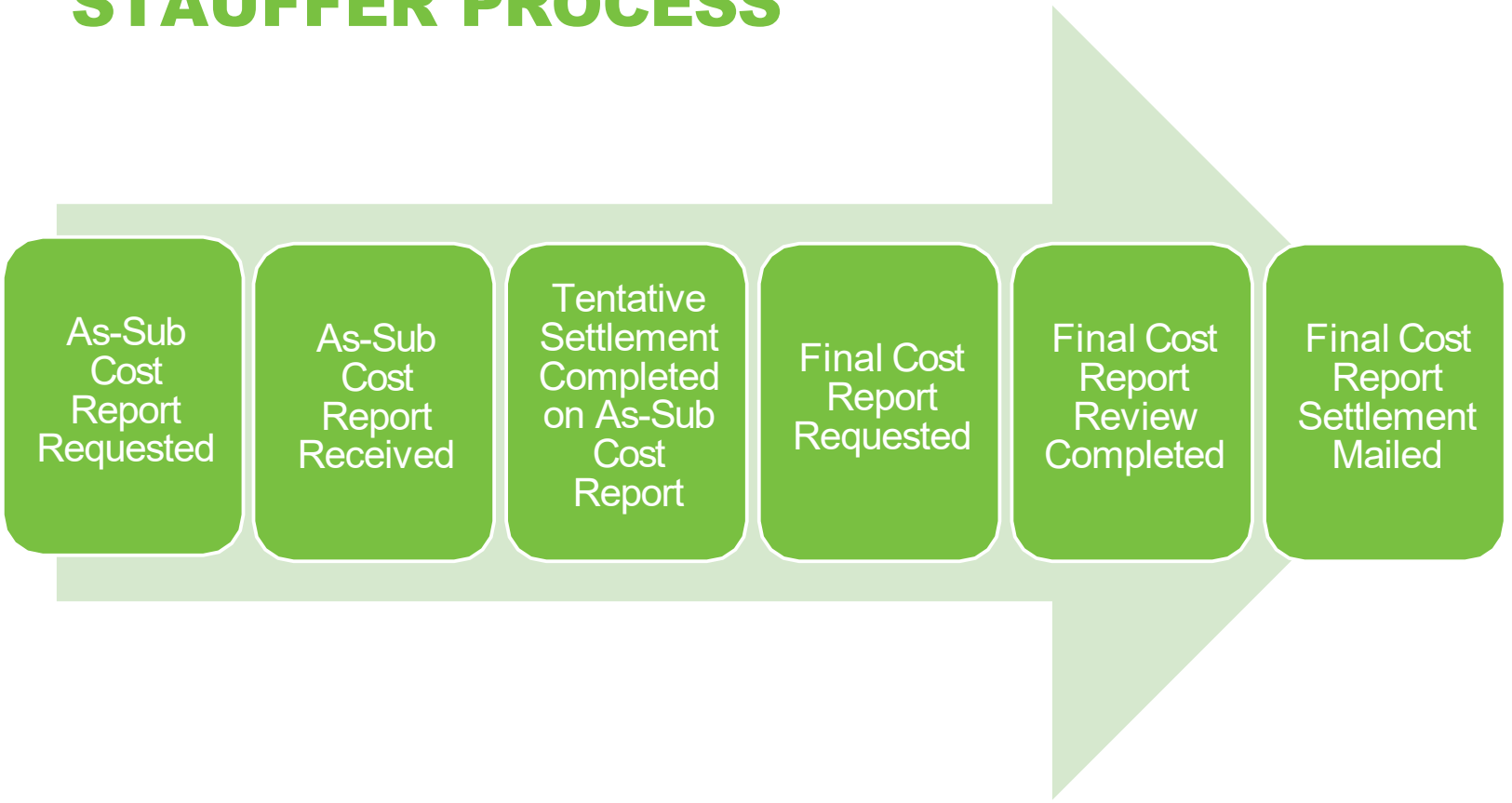
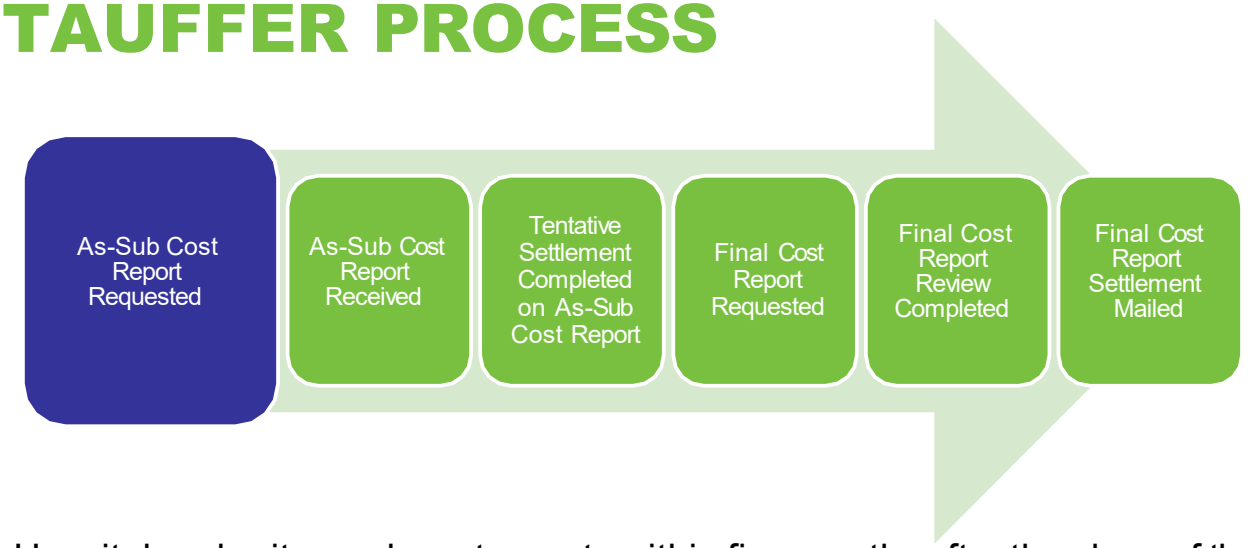
SUMMARY OF THE MYERS AND STAUFFER PROCESS

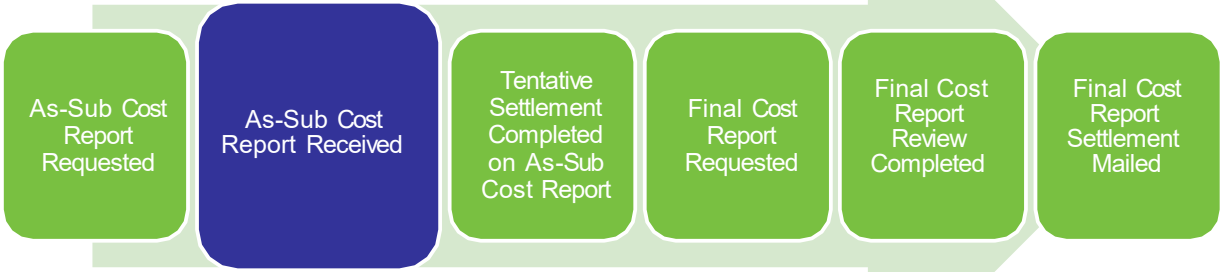


SUMMARY OF THE MYERS AND STAUFFER PROCESS



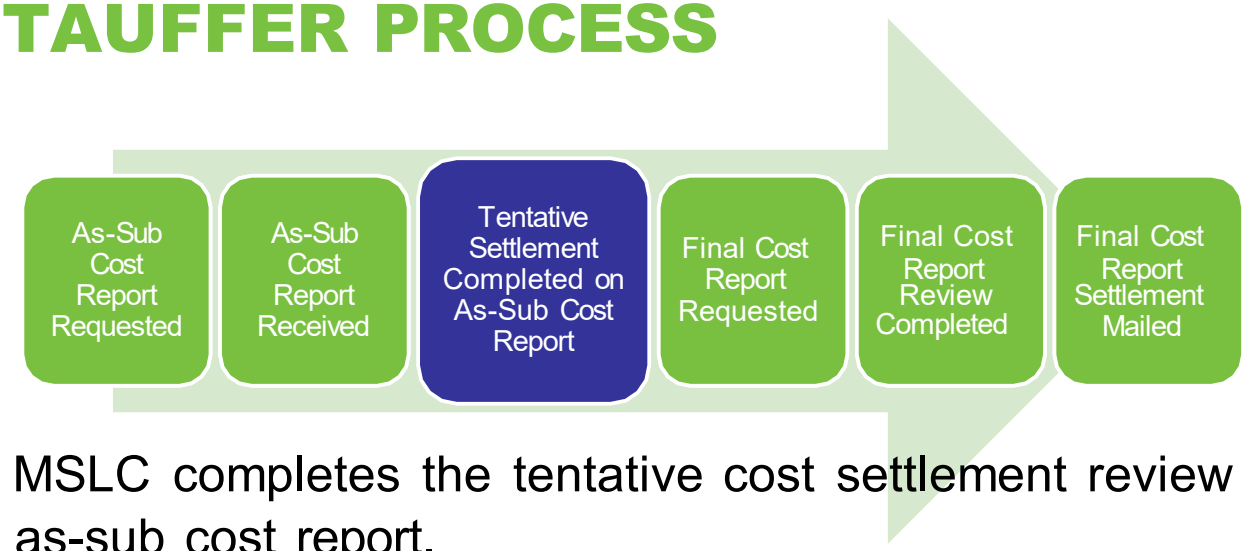
- Hospitals submit as-sub cost reports within five months after the close of the hospital's fiscal year end.
- MSLC sends out request letters the first Wednesday of the month after the provider's FYE.
- MSLC sends out reminder letters 14 days before cost report due date.

SUMMARY OF THE MYERS AND STAUFFER PROCESS



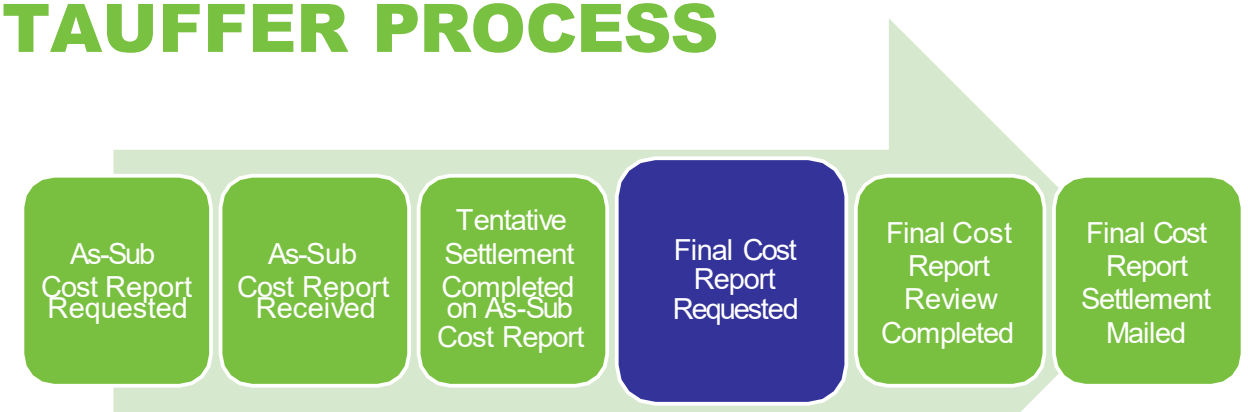
- Each cost report filing includes the Medicaid supplemental schedules, a Medicare cost report, and an electronic Medicare cost report file (ECR).
- If the Medicaid schedules indicate a settlement is due the Department, the provider must pay the amount due at the time the cost report is submitted.
- The Medicaid schedules must have an original signature from a hospital representative.
- If a provider does not submit a cost report by the deadline, DMS can place them in escrow and hold all payments in an escrow account until a cost report is received.

SUMMARY OF THE MYERS AND STAUFFER PROCESS



- MSLC completes the tentative cost settlement review on the as-sub cost report.
- ACH, Rehab, and LTAC providers are only paid 75% of the tentative settlement if due hospital.
- CAH providers are paid 100% of the tentative settlement.
- Hospitals are required to pay 100% if balance is due DMS.

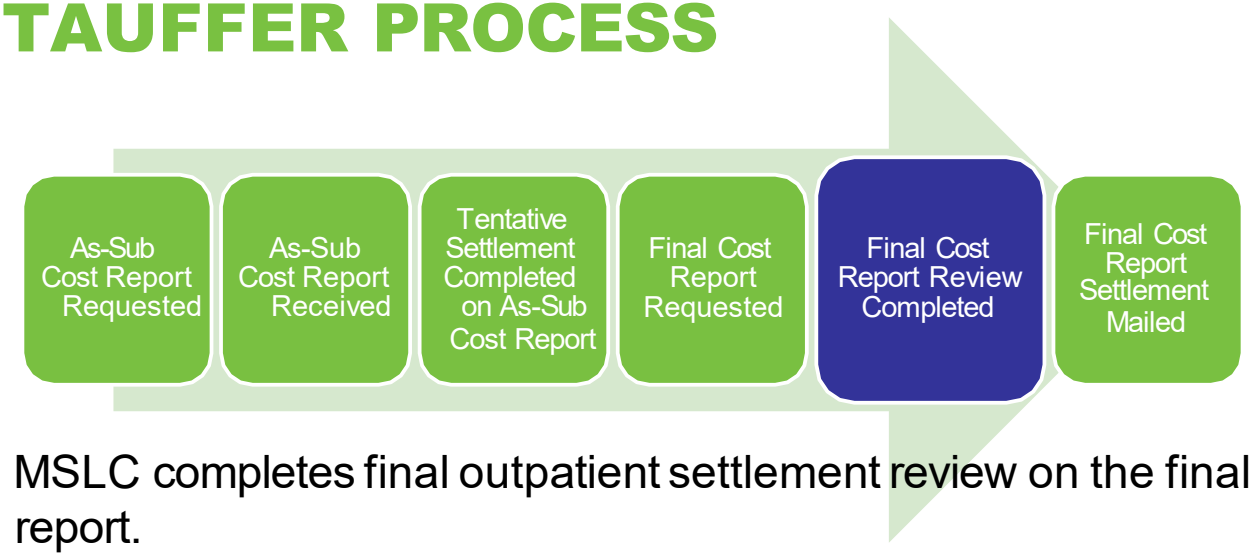
SUMMARY OF THE MYERS AND STAUFFER PROCESS



- Providers, or their consultants, submit a tentative cost report to Medicare. Medicare completes a desk review or audit of the submitted cost report. After completion of the desk review or audit, a draft adjustment letter is sent to the provider with Medicare's proposed adjustments. The provider can accept or dispute the adjustments during a comment window.

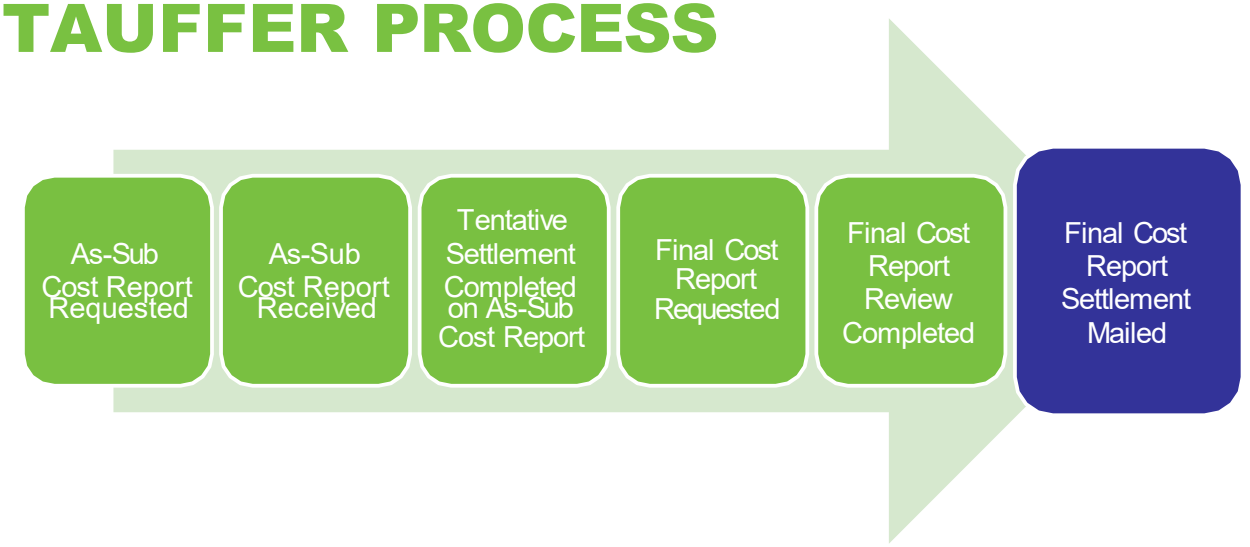
- MSLC sends out request letters for final cost reports 18 months after the hospital's FYE. Hospitals have 70 days to send MSLC the audited cost report after it is received back from Medicare.

SUMMARY OF THE MYERS AND STAUFFER PROCESS



- MSLC completes final outpatient settlement review on the final cost report.
- Payments for all provider types are made at 100% for final settlements.

SUMMARY OF THE MYERS AND STAUFFER PROCESS



- If a facility has been paid more than they should have received, they are required to return 100% of the overpayment.
- If the provider discovers an error in their cost report, they can file an amended cost report to fix the error.

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OUTPATIENT SETTLEMENT TEMPLATE – "23 PAGE REPORT"

MARCH 2026

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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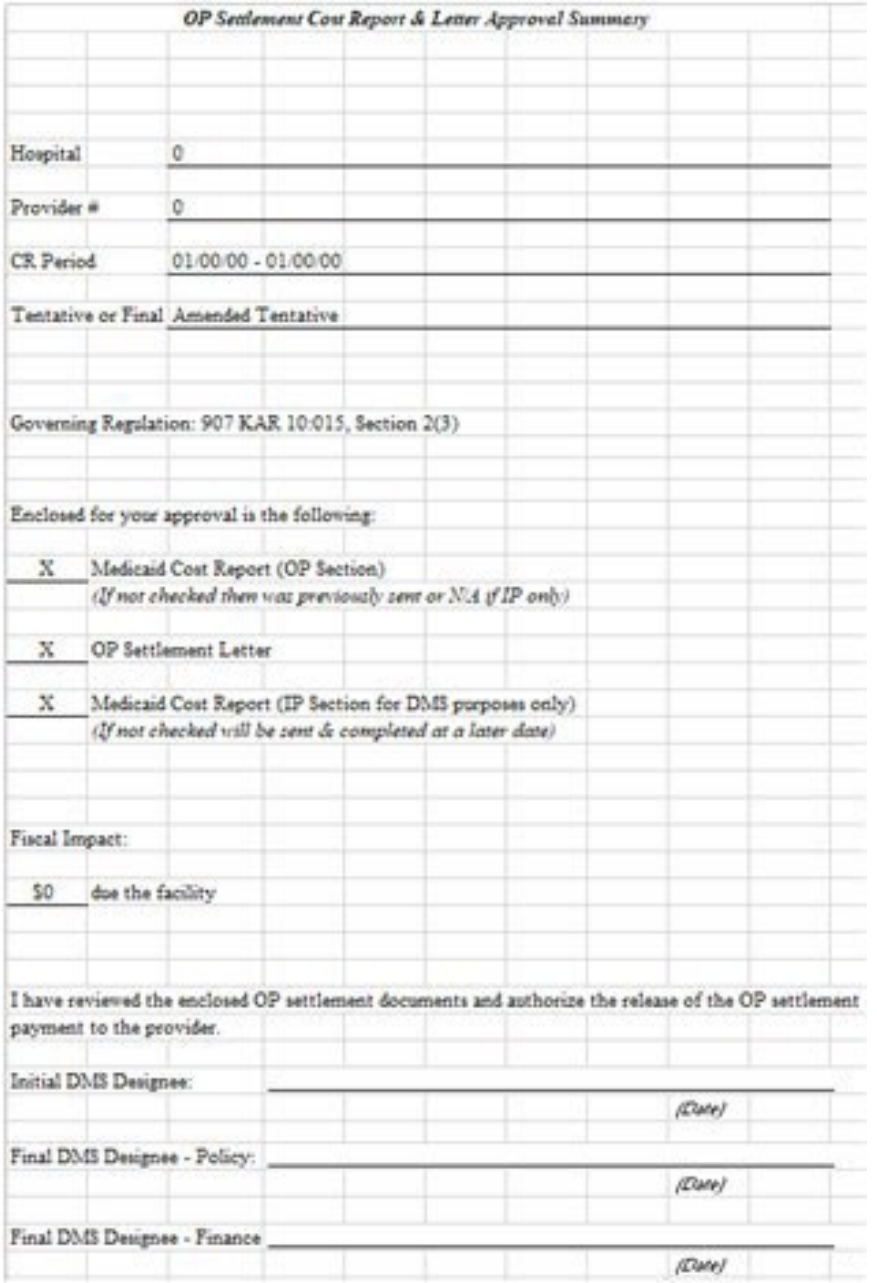
APPROVAL FORM

APPROVAL FORM

- This form is used to summarize deliverables enclosed within the 23 page report and to secure DMS approval of the OP settlement amount and correspondence to the provider.



OP Settlement Cost Report & Letter Approval Summary

Hospital: 0

Provider #: 0

CR Period: 01/00/00 - 01/00/00

Tentative or Final: Amended Tentative

Governing Regulation: 907 KAR 10:015, Section 2(3)

Enclosed for your approval is the following:

X Medicaid Cost Report (OP Section)
(If not checked then was previously sent or N/A if IP only)

X OP Settlement Letter

X Medicaid Cost Report (IP Section for DMS purposes only)
(If not checked will be sent & completed at a later date)

Fiscal Impact:

$0 due the facility

I have reviewed the enclosed OP settlement documents and authorize the release of the OP settlement payment to the provider.

Initial DMS Designee: _____ *(Date)*

Final DMS Designee - Policy: _____ *(Date)*

Final DMS Designee - Finance _____ *(Date)*

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COST-TO-CHARGE RATIO WORKPAPER

COST-TO-CHARGE RATIO WORKPAPER

- The purpose of this worksheet is to revise cost-to-charge ratios to include allowable cost for interns and residents in a teaching hospital, if necessary.

Revised Cost-to-Charge Ratios for Teaching Hospitals

Facility	0
Prov #	0
FYE:	1/0/1900
Revie w	1/0/1900

Cost Center	B Part I, Column 24	C Part I, Column 8	New Cost-to-Charge Ratio	As-Filed Cost-to-Charge Ratio
Line 50 Operating Room	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Line 51 Recovery Room	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Line 52 Delivery and Labor Room	0	0	0.000000	0.000000
Line 53 Anesthesiology	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Line 54 Radiology Diagnostic	0	0	0.000000	0.000000
Line 55 Radiology Therapeutic	0	0	0.000000	0.000000
Line 56 Radioisotope	0	0	0.000000	0.000000
Line 57 Computed Tomography (CT) Scan	0	0	0.000000	0.000000
Line 58 Magnetic Resonance Imaging (MRI)	0	0	0.000000	0.000000
Line 59 Cardiac Catheterization	0	0	0.000000	0.000000
Line 60 Laboratory	0	0	0.000000	0.000000
Line 61 PBP Clinic Lab Service	0	0	0.000000	0.000000
Line 62 Whole/Packed Red Blood	0	0	0.000000	0.000000
Line 63 Blood Storing, Processing	0	0	0.000000	0.000000
Line 64 IV Therapy	0	0	0.000000	0.000000
Line 65 Respiratory Therapy	0	0	0.000000	0.000000
Line 66 Physical Therapy	0	0	0.000000	0.000000
Line 67 Occupational Therapy	0	0	0.000000	0.000000
Line 68 Speech Pathology	0	0	0.000000	0.000000
Line 69 EKG	0	0	0.000000	0.000000
Line 70 EEG	0	0	0.000000	0.000000
Line 71 Med. Supplies Chgd. to Pat.	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Line 72 Implantable Devices Charged to Patients	0	0	0.000000	0.000000
Line 73 Drugs Charged to Patients	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Line 74 Renal Dialysis	0	0	0.000000	0.000000
Line 75 Ambulatory Surgical Center	0	0	0.000000	0.000000
Line 76 Laboratory - Pathological	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Line 90 Clinic	0	0	0.000000	0.000000
Line 91 Emergency	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000
Line 93 Vascular Lab	0	0	0.000000	0.000000
Blank	0	0	0.000000	0.000000

OP (E-3) SUMMARY

- Lines 1-4 summarize the provider's calculated OP Medicaid costs, reducing for non-allowables and applying the cost settlement percentage.
- Lines 5-8 show OP payments from the Paid Claims Listing (PCL) used in the review.
- Line 9 shows any OP interim payments made by either the provider or by DMS, if applicable.
- Line 10 shows the final OP settlement amount due.

OUTPATIENT SETTLEMENT (E-3) SUMMARY

PAGE 1

HOSPITAL	0		
VENDOR NUMBER	0		
PERIOD FROM	1/0/1900	PERIOD TO	1/0/1900
REASON FOR REVISION	0		
PROVIDER TYPE	0		

SETTLEMENT		TITLE XIX OUTPATIENT 1
COSTS		
1. Medicaid medical and other services		0
2. Medicaid non-allowable outpatient cost KMAP-1		0
3. Total reasonable cost (Line 1 - Line 2)		0
4. Reimbursement at 95% Acute or 101% CAH cost (Line 3 x 95% or 101%) *		-
PAYMENTS		
5. KMAP		0
6. Copay/Spenddown		0
7. TPL		0
8. Laboratory Paid***		0
9. Interim payments made (if applicable)**	Date	-
	Date	-
	Date	-
	Date	-
Total Interim payments:		0
10. BALANCE DUE PROVIDER/or (DMS)		-

* Note: Reimbursement at 101% of cost for CAH/ 95% of cost for Acute Care
** Note: Paid by (provider)/DMS
*** Note: Effective January 1, 2024, laboratory pathological services are paid on the Medicare fee schedule and therefore will be carved out of the outpatient cost settlement for Acute, Rehab, and LTAC provider types, similar to the treatment for other laboratory services.

INFORMATIONAL		OP TITLE XIX COST/CHARGE RATIO
TITLE XIX CCR		
1. 95% ACH or 101% CAH reasonable cost		0
2. Total reasonable charges per OP Ancillary Calculation		0
3. Title XIX cost/charge ratio (Line 1/Line 2)		0.000000

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PROVIDER TAX CALC

- Medicaid provider tax is allowable as a cost report expense for Medicaid, but not for Medicare. Therefore, the cost typically has to be added back to the Medicare cost report to give the provider credit for this cost.
- Provider tax cost is allocated amongst all cost centers based on total cost and cost-to-charge ratios are adjusted.

Provider Tax Calculation

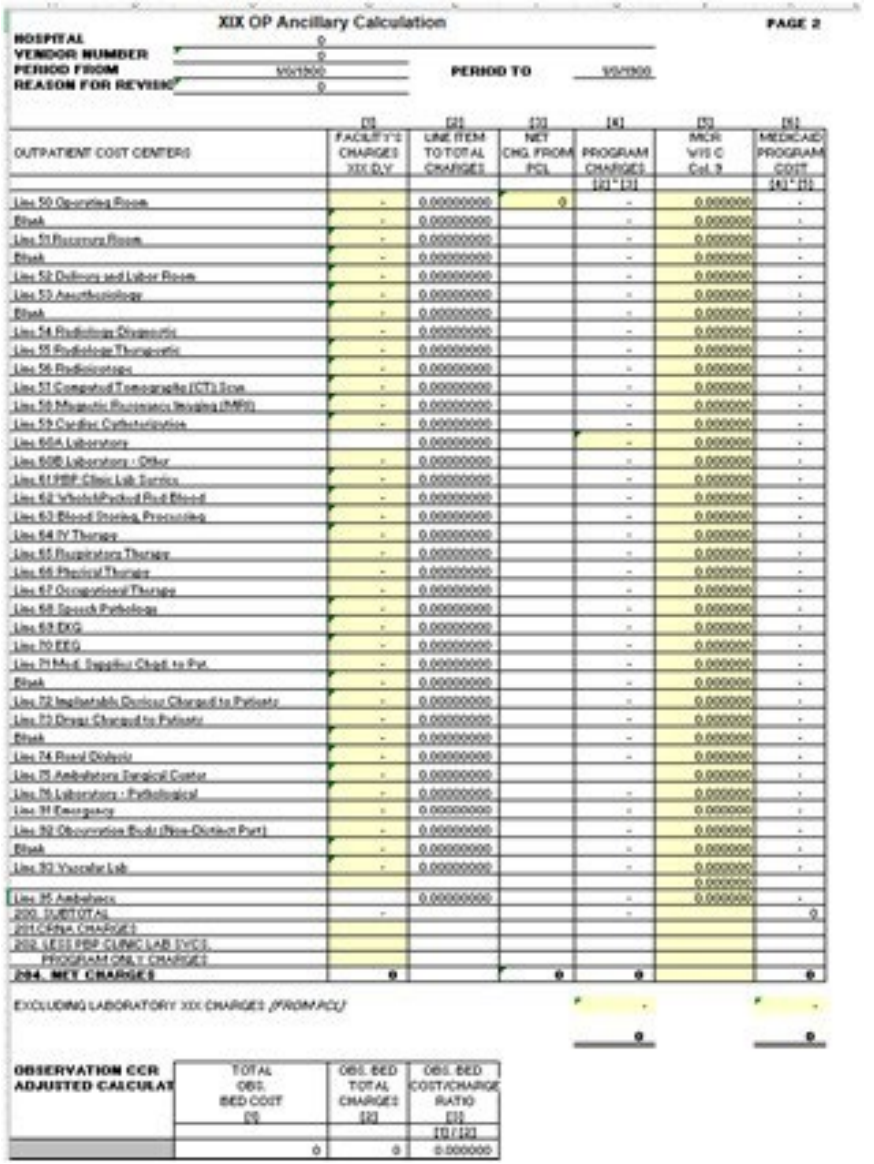
PAGE 2

HOSPITAL
PROVIDER NUMBER
PERIOD FROM MM/YYYY
PERIOD TO MM/YYYY
REASON FOR REVISION

COST CENTERS	[1] FACILITY'S STEP-DOWN COSTS, B Pt. 1	[2] LINE ITEM TO TOTAL COSTS	[3] PROVIDER TAX A-1	[4] PROVIDER TAX SPREAD	[5] COSTS INCLUDING PROVIDER TAX [1]+[4]	[6] CHARGES PER SCHEDULE C	[7] ADJUSTED CCR [5]/[6]
Line 30 Adults and Pediatrics	-	0.00000000	0	-	-		
Line 31 Intensive Care Unit	-	0.00000000		-	-		
Line 32 Coronary Care Unit	-	0.00000000		-	-		
Line 33 Burn Intensive Care Unit	-	0.00000000		-	-		
Line 34 Surgical Intensive Care Unit	-	0.00000000		-	-		
Line 35 Neonatal Intensive Care Unit	-	0.00000000		-	-		
Line 40 Sub Provider 1-DPU Psych	-	0.00000000		-	-		
Line 41 Sub Provider 2-DPU Rehab	-	0.00000000		-	-		
Line 42 Sub Provider (specify)	-	0.00000000		-	-		
Line 43 Nursery	-	0.00000000		-	-		
Line 44 Skilled Nursing Facility	-	0.00000000		-	-		
Line 50 Operating Room	-	0.00000000		-	-	-	-
Blank	-	0.00000000		-	-	-	-
Line 51 Recovery Room	-	0.00000000		-	-	-	-
Blank	-	0.00000000		-	-	-	-
Line 52 Delivery and Labor Room	-	0.00000000		-	-	-	-
Line 53 Anesthesiology	-	0.00000000		-	-	-	-
Blank	-	0.00000000		-	-	-	-
Line 54 Radiology Diagnostic	-	0.00000000		-	-	-	-
Line 55 Radiology Therapeutic	-	0.00000000		-	-	-	-
Line 56 Radioisotopy	-	0.00000000		-	-	-	-
Line 57 Computed Tomography (CT) Scan	-	0.00000000		-	-	-	-
Line 58 Magnetic Resonance Imaging (MRI)	-	0.00000000		-	-	-	-
Line 59 Cardiac Catheterization	-	0.00000000		-	-	-	-
Line 60 Laboratory	-	0.00000000		-	-	-	-
Line 61 PBP Clinic Lab Service	-	0.00000000		-	-	-	-
Line 62 Whole Pooled Red Blood	-	0.00000000		-	-	-	-
Line 63 Blood Storing, Processing	-	0.00000000		-	-	-	-
Line 64 IV Therapy	-	0.00000000		-	-	-	-
Line 65 Respiratory Therapy	-	0.00000000		-	-	-	-
Line 66 Physical Therapy	-	0.00000000		-	-	-	-
Line 67 Occupational Therapy	-	0.00000000		-	-	-	-
Line 68 Speech Pathology	-	0.00000000		-	-	-	-
Line 69 EKG	-	0.00000000		-	-	-	-
Line 70 EEG	-	0.00000000		-	-	-	-
Line 71 Med. Supplies Charged to Pat.	-	0.00000000		-	-	-	-
Blank	-	0.00000000		-	-	-	-
Line 72 Implantable Devices Charged to Patient	-	0.00000000		-	-	-	-
Line 73 Drugs Charged to Patients	-	0.00000000		-	-	-	-
Blank	-	0.00000000		-	-	-	-
Line 74 Renal Dialysis	-	0.00000000		-	-	-	-
Line 75 Ambulatory Surgical Center	-	0.00000000		-	-	-	-
Line 76 Laboratory - Pathological	-	0.00000000		-	-	-	-
Line 90 Clinic	-	0.00000000		-	-	-	-
Line 91 Emergency	-	0.00000000		-	-	-	-
Line 92 Observation Beds	-	0.00000000		-	-	-	-
Blank	-	0.00000000		-	-	-	-
Line 93 Vascular Lab	-	0.00000000		-	-	-	-
Blank	-	0.00000000		-	-	-	-
Line 95 Ambulance	-	0.00000000		-	-		
Line 96 CMHC	-	0.00000000		-	-		
Line 101 Home Health Agency	-	0.00000000		-	-		
Line 190-210 Non-Reimbursable	-	0.00000000		-	-		
202. TOTAL COSTS	-		-	-	-	-	

OP ANCILLARY CALCULATION

- The OP Ancillary Calculation provides the detailed determination of outpatient cost.
- PCL charges are allocated to various cost centers using Medicare cost report info and are multiplied by cost-to-charge ratios to determine cost.



XIX OP Ancillary Calculation — PAGE 2

HOSPITAL: 0
VENDOR NUMBER: 0
PERIOD FROM: 00/00/00 — PERIOD TO: 00/00/00
REASON FOR REVISIO: 0

OUTPATIENT COST CENTER(S)	[1] FACILITY'S CHARGES XIX O/P	[2] LINE ITEM TO TOTAL CHARGES	[3] NET CHG. FROM PCL	[4] PROGRAM CHARGES [2] * [3]	[5] MCR W/S C Col. 9	[6] MEDICAID PROGRAM COST [4] * [5]
Line 50 Operating Room	-	0.00000000	0	-	0.000000	-
Blank	-	0.00000000		-	0.000000	-
Line 51 Recovery Room	-	0.00000000		-	0.000000	-
Blank	-	0.00000000		-	0.000000	-
Line 52 Delivery and Labor Room	-	0.00000000		-	0.000000	-
Line 53 Anesthesiology	-	0.00000000		-	0.000000	-
Blank	-	0.00000000		-	0.000000	-
Line 54 Radiology-Diagnostic	-	0.00000000		-	0.000000	-
Line 55 Radiology-Therapeutic	-	0.00000000		-	0.000000	-
Line 56 Radioisotope	-	0.00000000		-	0.000000	-
Line 57 Computed Tomography (CT) Scan	-	0.00000000		-	0.000000	-
Line 58 Magnetic Resonance Imaging (MRI)	-	0.00000000		-	0.000000	-
Line 59 Cardiac Catheterization	-	0.00000000		-	0.000000	-
Line 60A Laboratory		0.00000000		-	0.000000	-
Line 60B Laboratory - Other	-	0.00000000		-	0.000000	-
Line 61 RHC Clinic Lab Service	-	0.00000000		-	0.000000	-
Line 62 Whole/Packed Red Blood	-	0.00000000		-		-
Line 63 Blood Storing, Processing	-	0.00000000		-	0.000000	-
Line 64 IV Therapy	-	0.00000000		-	0.000000	-
Line 65 Respiratory Therapy	-	0.00000000		-	0.000000	-
Line 66 Physical Therapy	-	0.00000000		-	0.000000	-
Line 67 Occupational Therapy	-	0.00000000		-	0.000000	-
Line 68 Speech Pathology	-	0.00000000		-	0.000000	-
Line 69 EKG	-	0.00000000		-	0.000000	-
Line 70 EEG	-	0.00000000		-	0.000000	-
Line 71 Med. Supplies Chgd. to Pat.	-	0.00000000		-		-
Blank	-	0.00000000		-	0.000000	-
Line 72 Implantable Devices Charged to Patients	-	0.00000000		-	0.000000	-
Line 73 Drugs Charged to Patients	-	0.00000000		-	0.000000	-
Blank	-	0.00000000		-	0.000000	-
Line 74 Renal Dialysis	-	0.00000000		-	0.000000	-
Line 75 Ambulatory Surgical Center	-	0.00000000			0.000000	-
Line 76 Laboratory - Pathological	-	0.00000000		-	0.000000	-
Line 91 Emergency	-	0.00000000		-	0.000000	-
Line 92 Observation Beds (Non-Distinct Part)	-	0.00000000		-	0.000000	-
Blank	-	0.00000000		-	0.000000	-
Line 93 Vascular Lab	-	0.00000000		-	0.000000	-
					0.000000	
Line 95 Ambulance		0.00000000		-	0.000000	-
200. SUBTOTAL	-			-		0
201 Other CHARGES						
202. LESS RHC CLINIC LAB SVCS.						
PROGRAM ONLY CHARGES						
204. NET CHARGES	**0**		**0**	**0**		**0**

EXCLUDING LABORATORY XIX CHARGES (FROM PCL): - — -
0 — 0

OBSERVATION CCR ADJUSTED CALCULAT	TOTAL OBS. BED COST [1]	OBS. BED TOTAL CHARGES [2]	OBS. BED COST/CHARGE RATIO [3] [1] / [2]
	0	0	0.000000

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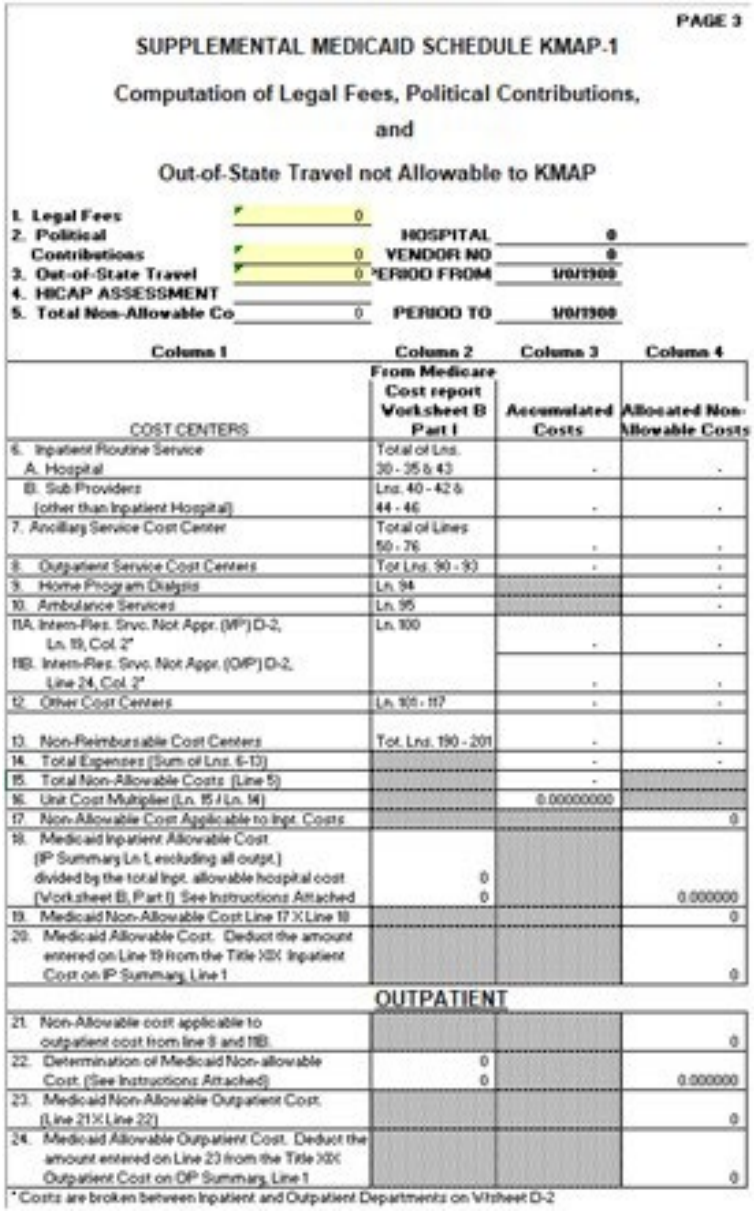
KMAP-1

KMAP-1

- KMAP-1 is a KY-specific schedule that removes non-allowable costs from the OP settlement calculation, including legal fees, political contributions, and out-of-state travel.
- Total non-allowable costs are allocated to Medicaid and offset through the OP settlement.



PAGE 3

SUPPLEMENTAL MEDICAID SCHEDULE KMAP-1

Computation of Legal Fees, Political Contributions, and Out-of-State Travel not Allowable to KMAP

1. Legal Fees	0		
2. Political Contributions	0	HOSPITAL	0
3. Out-of-State Travel	0	VENDOR NO	0
4. HICAP ASSESSMENT		PERIOD FROM	1/0/1900
5. Total Non-Allowable Co	0	PERIOD TO	1/0/1900

Column 1	Column 2	Column 3	Column 4
COST CENTERS	From Medicare Cost report Worksheet B Part I	Accumulated Costs	Allocated Non-Allowable Costs
6. Inpatient Routine Service A. Hospital	Total of Lns. 30 - 35 & 43	-	-
B. Sub Providers (other than Inpatient Hospital)	Lns. 40 - 42 & 44 - 46	-	-
7. Ancillary Service Cost Center	Total of Lines 50 - 76	-	-
8. Outpatient Service Cost Centers	Tot Lns. 90 - 93	-	-
9. Home Program Dialysis	Ln. 94		-
10. Ambulance Services	Ln. 95		-
11A. Intern-Res. Srvc. Not Appr. (IP) D-2, Ln. 19, Col. 2*	Ln. 100	-	-
11B. Intern-Res. Srvc. Not Appr. (OP) D-2, Line 24, Col. 2*		-	-
12. Other Cost Centers	Ln. 101 - 117	-	-
13. Non-Reimbursable Cost Centers	Tot. Lns. 190 - 201	-	-
14. Total Expenses (Sum of Lns. 6-13)		-	-
15. Total Non-Allowable Costs (Line 5)		-	
16. Unit Cost Multiplier (Ln. 15 / Ln. 14)		0.00000000	
17. Non-Allowable Cost Applicable to Inpt. Costs			0
18. Medicaid Inpatient Allowable Cost (IP Summary Ln 1, excluding all outpt.) divided by the total Inpt. allowable hospital cost (Worksheet B, Part I) See Instructions Attached	0 0		0.000000
19. Medicaid Non-Allowable Cost Line 17 X Line 18			0
20. Medicaid Allowable Cost. Deduct the amount entered on Line 19 from the Title XIX Inpatient Cost on IP Summary, Line 1			0
OUTPATIENT			
21. Non-Allowable cost applicable to outpatient cost from line 9 and 11B.			0
22. Determination of Medicaid Non-allowable Cost. (See Instructions Attached)	0 0		0.000000
23. Medicaid Non-Allowable Outpatient Cost. (Line 21 X Line 22)			0
24. Medicaid Allowable Outpatient Cost. Deduct the amount entered on Line 23 from the Title XIX Outpatient Cost on OP Summary, Line 1			0

* Costs are broken between Inpatient and Outpatient Departments on Wksheet D-2

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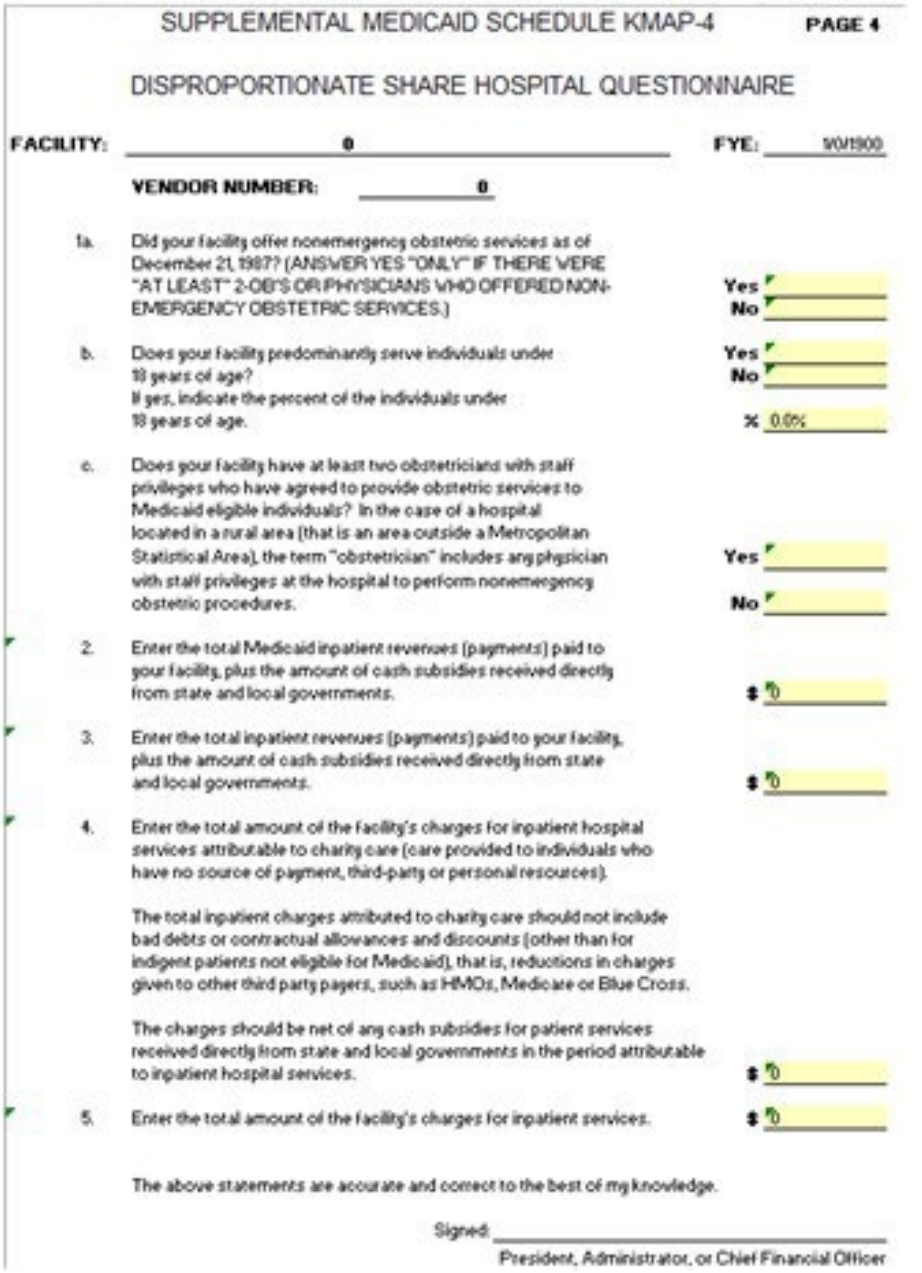
CERTIFIED PUBLIC ACCOUNTANTS

KMAP-4

KMAP-4

- KMAP-4 is a historical DSH questionnaire that was previously used by DMS to gather info on hospital DSH eligibility. This process has been replaced by DSH survey filings.



SUPPLEMENTAL MEDICAID SCHEDULE KMAP-4 PAGE 4

DISPROPORTIONATE SHARE HOSPITAL QUESTIONNAIRE

FACILITY: 0 FYE: 9/1/1900

VENDOR NUMBER: 0

1a. Did your facility offer nonemergency obstetric services as of December 21, 1987? (ANSWER YES "ONLY" IF THERE WERE "AT LEAST" 2 OB'S OR PHYSICIANS WHO OFFERED NON-EMERGENCY OBSTETRIC SERVICES.) Yes / No

b. Does your facility predominantly serve individuals under 18 years of age? Yes / No
If yes, indicate the percent of the individuals under 18 years of age. X 0.0%

c. Does your facility have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medicaid eligible individuals? In the case of a hospital located in a rural area (that is an area outside a Metropolitan Statistical Area), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. Yes / No

2. Enter the total Medicaid inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments. $ 0

3. Enter the total inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments. $ 0

4. Enter the total amount of the Facility's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources).

The total inpatient charges attributed to charity care should not include bad debts or contractual allowances and discounts (other than for indigent patients not eligible for Medicaid), that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.

The charges should be net of any cash subsidies for patient services received directly from state and local governments in the period attributable to inpatient hospital services. $ 0

5. Enter the total amount of the facility's charges for inpatient services. $ 0

The above statements are accurate and correct to the best of my knowledge.

Signed: _____
President, Administrator, or Chief Financial Officer

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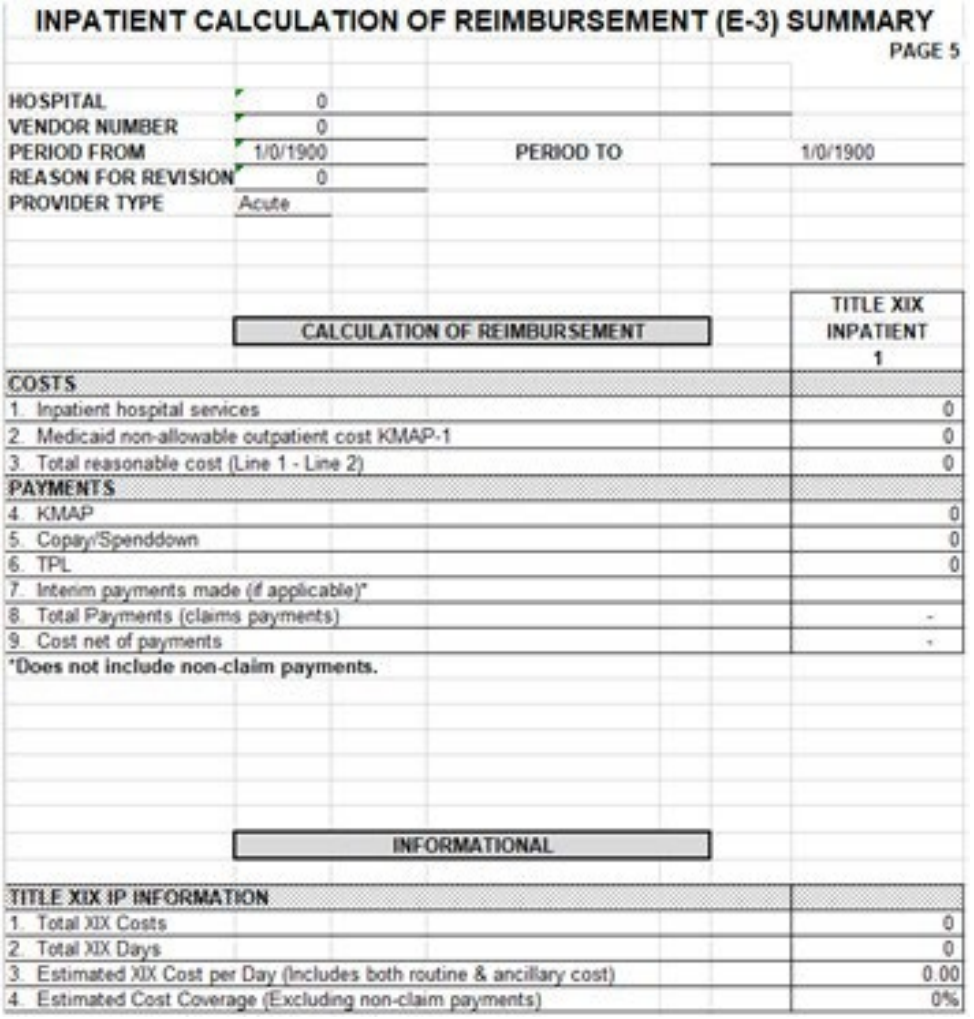
CERTIFIED PUBLIC ACCOUNTANTS

IP (E-3) SUMMARY

IP (E-3) SUMMARY

- The 23-page report also calculates IP Medicaid cost for informational purposes.
- Lines 1-3 of the IP E-3 summarize IP Medicaid costs from the cost report.
- Lines 4-8 summarize payments from the PCL or other interim payments used in the review.
- The bottom section shows estimated cost per day and cost coverage for reference.



INPATIENT CALCULATION OF REIMBURSEMENT (E-3) SUMMARY

PAGE 5

HOSPITAL	0		
VENDOR NUMBER	0		
PERIOD FROM	1/0/1900	PERIOD TO	1/0/1900
REASON FOR REVISION	0		
PROVIDER TYPE	Acute		

CALCULATION OF REIMBURSEMENT	TITLE XIX INPATIENT 1
COSTS	
1. Inpatient hospital services	0
2. Medicaid non-allowable outpatient cost KMAP-1	0
3. Total reasonable cost (Line 1 - Line 2)	0
PAYMENTS	
4. KMAP	0
5. Copay/Spenddown	0
6. TPL	0
7. Interim payments made (if applicable)*	
8. Total Payments (claims payments)	-
9. Cost net of payments	-

*Does not include non-claim payments.

INFORMATIONAL	
TITLE XIX IP INFORMATION	
1. Total XIX Costs	0
2. Total XIX Days	0
3. Estimated XIX Cost per Day (Includes both routine & ancillary cost)	0.00
4. Estimated Cost Coverage (Excluding non-claim payments)	0%

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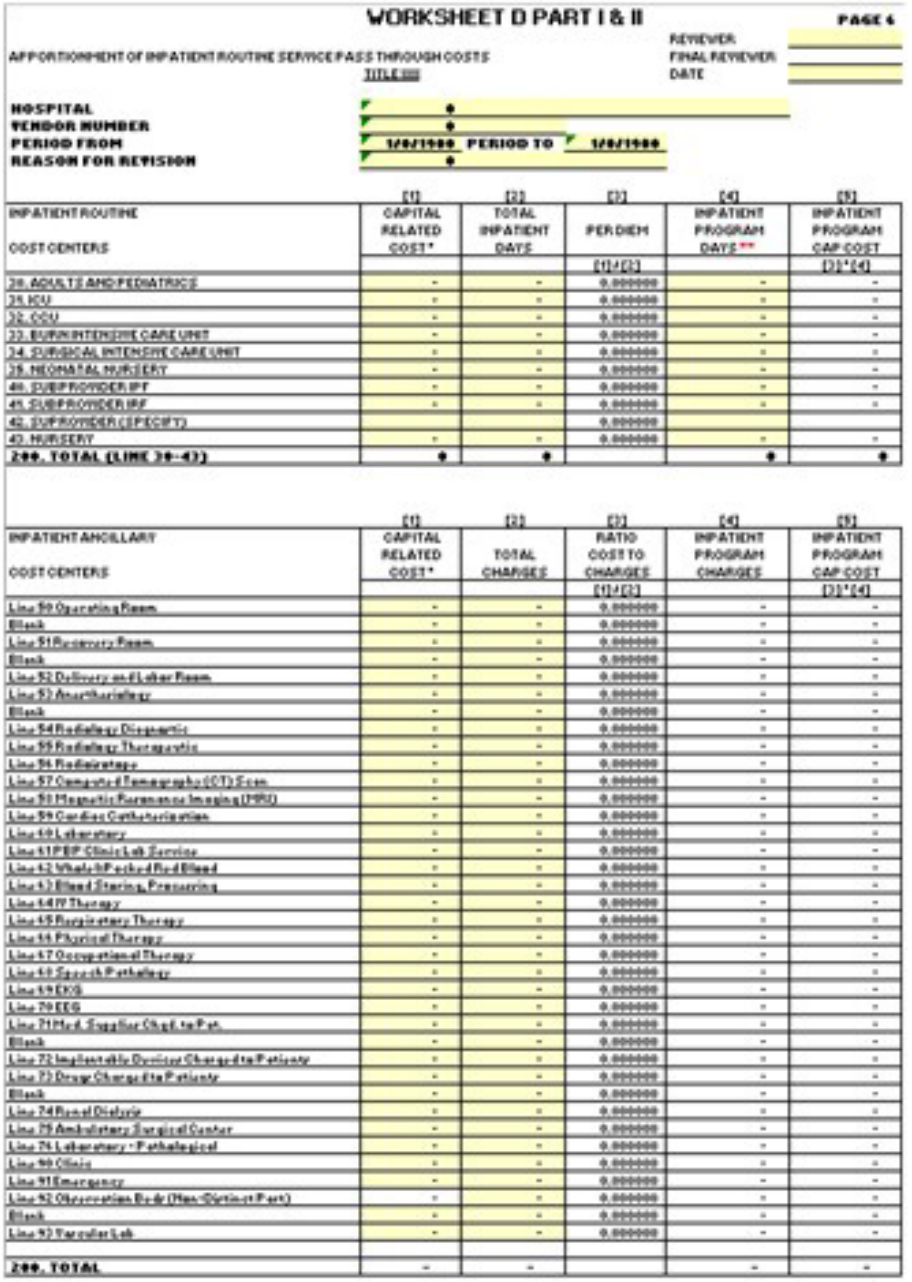
WORKSHEET D PART I

WORKSHEET D PART I & II

- Worksheets D part I and D part II detail the calculation of Medicaid IP capital costs.
- The top section (D Part I) covers capital costs for Medicaid IP routine services.
- The bottom section (D Part II) covers capital costs for Medicaid IP ancillary services.



WORKSHEET D PART I & II

PAGE 6

APPORTIONMENT OF INPATIENT ROUTINE SERVICE PASS THROUGH COSTS
TITLE XIX

REVIEWER:
FINAL REVIEWER:
DATE:

HOSPITAL:
VENDOR NUMBER:
PERIOD FROM: 1/01/1900 PERIOD TO: 1/01/1900
REASON FOR REVISION:

INPATIENT ROUTINE COST CENTERS	[1] CAPITAL RELATED COST*	[2] TOTAL INPATIENT DAYS	[3] PER DIEM [1]/[2]	[4] INPATIENT PROGRAM DAYS**	[5] INPATIENT PROGRAM CAP COST [3]*[4]
30. ADULTS AND PEDIATRICS	-	-	0.000000	-	-
31. ICU	-	-	0.000000	-	-
32. CCU	-	-	0.000000	-	-
33. BURN INTENSIVE CARE UNIT	-	-	0.000000	-	-
34. SURGICAL INTENSIVE CARE UNIT	-	-	0.000000	-	-
35. NEONATAL NURSERY	-	-	0.000000	-	-
40. SUBPROVIDER IPF	-	-	0.000000	-	-
41. SUBPROVIDER IRF	-	-	0.000000	-	-
42. SUPPROVIDER (SPECIFY)			0.000000		
43. NURSERY	-	-	0.000000	-	-
299. TOTAL (LINE 30-43)					

INPATIENT ANCILLARY COST CENTERS	[1] CAPITAL RELATED COST*	[2] TOTAL CHARGES	[3] RATIO COST TO CHARGES [1]/[2]	[4] INPATIENT PROGRAM CHARGES	[5] INPATIENT PROGRAM CAP COST [3]*[4]
Line 50 Operating Room	-	-	0.000000	-	-
Blank	-	-	0.000000	-	-
Line 51 Recovery Room	-	-	0.000000	-	-
Blank	-	-	0.000000	-	-
Line 52 Delivery and Labor Room	-	-	0.000000	-	-
Line 53 Anesthesiology	-	-	0.000000	-	-
Blank	-	-	0.000000	-	-
Line 54 Radiology-Diagnostic	-	-	0.000000	-	-
Line 55 Radiology-Therapeutic	-	-	0.000000	-	-
Line 56 Radioisotope	-	-	0.000000	-	-
Line 57 Computed Tomography (CT) Scan	-	-	0.000000	-	-
Line 58 Magnetic Resonance Imaging (MRI)	-	-	0.000000	-	-
Line 59 Cardiac Catheterization	-	-	0.000000	-	-
Line 60 Laboratory	-	-	0.000000	-	-
Line 61 PEP Clinic Lab Service	-	-	0.000000	-	-
Line 62 Whole Pint of Packed Red Blood	-	-	0.000000	-	-
Line 63 Blood Storing, Processing	-	-	0.000000	-	-
Line 64 IV Therapy	-	-	0.000000	-	-
Line 65 Respiratory Therapy	-	-	0.000000	-	-
Line 66 Physical Therapy	-	-	0.000000	-	-
Line 67 Occupational Therapy	-	-	0.000000	-	-
Line 68 Speech Pathology	-	-	0.000000	-	-
Line 69 EKG	-	-	0.000000	-	-
Line 70 EEG	-	-	0.000000	-	-
Line 71 Med. Supplies Chgd. to Pat.	-	-	0.000000	-	-
Blank	-	-	0.000000	-	-
Line 72 Implantable Devices Charged to Patients	-	-	0.000000	-	-
Line 73 Drugs Charged to Patients	-	-	0.000000	-	-
Blank	-	-	0.000000	-	-
Line 74 Renal Dialysis	-	-	0.000000	-	-
Line 75 Ambulatory Surgical Center	-	-	0.000000	-	-
Line 76 Laboratory - Pathological	-	-	0.000000	-	-
Line 90 Clinic	-	-	0.000000	-	-
Line 91 Emergency	-	-	0.000000	-	-
Line 92 Observation Beds (Non-Distinct Part)	-	-	0.000000	-	-
Blank	-	-	0.000000	-	-
Line 93 Ancillary Lab	-	-	0.000000	-	-
299. TOTAL	-	-		-	-

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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CERTIFIED PUBLIC ACCOUNTANTS

IP ANCILLARY CALCULATION

IP ANCILLARY CALCULATION

- The IP Ancillary Calculation provides the detailed determination of inpatient ancillary cost.
- PCL charges are allocated to various cost centers using Medicare cost report info and are multiplied by cost-to-charge ratios to determine cost.

XIX IP ANCILLARY CALCULATION

PAGE

HOSPITAL 0
VENDOR NUME 0
PERIOD FROM 1/0/1900 PERIOD TO 1/0/1900
REASON FOR REVISION 0

INPATIENT COST CENTERS	[1] FACILITY'S CHARGES XIX, D-3	[2] LINE ITEM TO TOTAL CHARGES	[3] ANCILLARY CHG. FROM PCL	[4] NET PROGRAM CHARGES [2] * [3]	[5] MCR WS C Col. 9	[6] MEDICAID PROGRAM COST [4] * [5]
Line 50 Operating Room	-	0.000000	0	-	0.000000	-
Blank	-	0.000000		-	0.000000	-
Line 51 Recovery Room	-	0.000000		-	0.000000	-
Blank	-	0.000000		-	0.000000	-
Line 52 Delivery and Labor Room	-	0.000000		-	0.000000	-
Line 53 Anesthesiology	-	0.000000		-	0.000000	-
Blank	-	0.000000		-	0.000000	-
Line 54 Radiology Diagnostic	-	0.000000		-	0.000000	-
Line 55 Radiology Therapeutic	-	0.000000		-	0.000000	-
Line 56 Radioisotope	-	0.000000		-	0.000000	-
Line 57 Computed Tomography (CT) Scan	-	0.000000		-	0.000000	-
Line 58 Magnetic Resonance Imaging (MRI)	-	0.000000		-	0.000000	-
Line 59 Cardiac Catheterization	-	0.000000		-	0.000000	-
Line 60 Laboratory	-	0.000000		-	0.000000	-
Line 61 PBP Clinic Lab Service	-	0.000000		-	0.000000	-
Line 62 Whole/Packed Red Blood	-	0.000000		-	0.000000	-
Line 63 Blood Storing, Processing	-	0.000000		-	0.000000	-
Line 64 IV Therapy	-	0.000000		-	0.000000	-
Line 65 Respiratory Therapy	-	0.000000		-	0.000000	-
Line 66 Physical Therapy	-	0.000000		-	0.000000	-
Line 67 Occupational Therapy	-	0.000000		-	0.000000	-
Line 68 Speech Pathology	-	0.000000		-	0.000000	-
Line 69 EKG	-	0.000000		-	0.000000	-
Line 70 EEG	-	0.000000		-	0.000000	-
Line 71 Med. Supplies Chgd. to Pat.	-	0.000000		-	0.000000	-
Blank	-	0.000000		-	0.000000	-
Line 72 Implantable Devices Charged to Patients	-	0.000000		-	0.000000	-
Line 73 Drugs Charged to Patients	-	0.000000		-	0.000000	-
Blank	-	0.000000		-	0.000000	-
Line 74 Renal Dialysis	-	0.000000		-	0.000000	-
Line 75 Ambulatory Surgical Center	-	0.000000		-	0.000000	-
Line 76 Laboratory - Pathological	-	0.000000		-	0.000000	-
Line 90 Clinic		0.000000		-	0.000000	-
Line 91 Emergency	-	0.000000		-	0.000000	-
Line 92 Observation Beds (Non-Distinct Part)	-	0.000000		-	0.000000	-
Blank	-	0.000000		-	0.000000	-
Line 93 Vascular Lab	-	0.000000		-	0.000000	-
200. TOTAL	0		0	0		0

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

D-1 PART I

D-1 PART I

- Worksheet D-1 shows the calculation of Medicaid IP routine cost.
- Part I shows a summary of routine days information, an adjustment to carve out swing bed cost, and an adjustment to carve out extra cost of private rooms, if applicable.

PAGE 8

WORKSHEET D-1, PART I

TITLE XIX COMPUTATION OF INPATIENT OPERATING COST

HOSPITAL	0		
VENDOR NUMBER	0	PERIOD FROM	9/1/1900
REASON FOR REVISION	0	PERIOD TO	9/1/1900

1. INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	0
2. INPATIENT DAYS (including private room days, excluding swing-beds and newborn days)	0
3. PRIVATE ROOM DAYS (excluding swing-bed private room days)	0
4. SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	0
5. SWING-BED SNF Type Inpatient Days (including private room days)	-
6. SWING-BED SNF-Type Inpatient Days (including private room days)	-
7. SWING -BED NF-Type Inpatient Days (including private room days)	-
8. SWING-BED NF-Type Inpatient Days (including private room days)	-
9. Inpatient Days including Private Room Days Applicable to the Program (excluding swing-bed and newborn days)	0
10. SWING-BED SNF-Type Inpatient Days Applicable to the Program (including private rooms) through December 31 of the cost reporting period	-
11. SWING-BED SNF-Type Inpatient Days Applicable to the Program (including private rooms) after December 31 of the cost reporting period	-
12. SWING-BED NF-Type Inpatient Days Applicable to the Program (including private rooms) through December 31 of the cost reporting period	-
13. SWING-BED NF-Type Inpatient Days Applicable to the Program (including private rooms) after December 31 of the cost reporting period	-
14. Medically Necessary Private Room Days Applicable to the Program (excluding swing-bed days)	-
15. TOTAL NURSERY DAYS	0
16. PROGRAM NURSERY DAYS (Title XIX only)	0
SWING-BED ADJUSTMENT	
17. MEDICAID RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DEC. 31 OF COST REPORTING PERIOD	-
18. MEDICAID RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DEC. 31 OF COST REPORTING PERIOD	-
19. MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERV. THROUGH DEC. 31 OF COST REPORTING PERIOD	-
20. MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DEC. 31 OF COST REPORTING PERIOD	-
21. TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	0
22. SWING-BED COST APPLICABLE TO SNF-TYPE SERV. THROUGH DEC. 31 of COST REPORTING PERIOD. (Line 5 X Line 17)	-
23. SWING-BED COST APPLIC. TO SNF-TYPE SERVICE AFTER DEC. 31 of COST REPORTING PERIOD (LINE 6 X LINE 18)	-
24. SWING BED COST APPLIC. TO NF-TYPE SERV. THROUGH DEC. 31 OF COST REPORTING PERIOD (LINE 7 X LINE 19)	-
25. SWING-BED COST APPLICABLE TO NF-TYPE SERV. AFTER DEC. 31 OF COST REPORTING PERIOD (LINE 8 X LINE 20)	-
26. TOTAL SWING-BED COST	-
27. GENERAL INPATIENT ROUTINE SERVICE COST (excluding swing-bed costs)	0
28. GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed charges)	0
29. PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	0
30. SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	0
31. GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	0.000000
32. AVERAGE PRIVATE ROOM PER DIEM CHARGE	0.00
33. AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	0.00
34. AVERAGE PER DIEM PRIVATE ROOM DIFFERENTIAL	0.00
35. AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	0.00
36. PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	0
37. GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	0

MYERS AND STAUFFER LC
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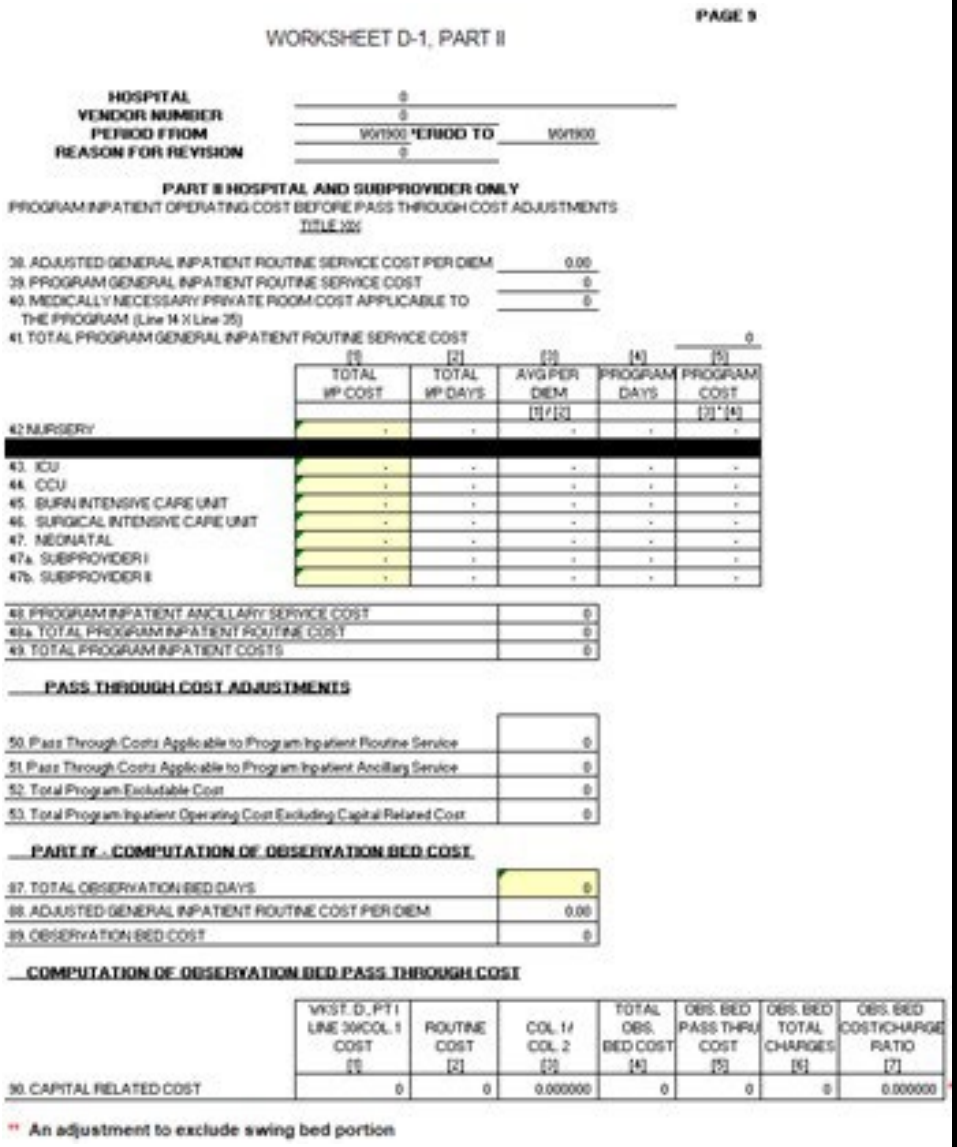
D-1 PART II

D-1 PART II

- Lines 38 – 41 show the IP routine cost per diem and Medicaid IP routine cost
- Lines 42 – 47b summarize Medicaid IP routine cost for specialty cost centers
- Lines 48 – 53 summarize IP cost for Medicaid – in total and for capital
- Lines 87-90 show the computation of observation bed cost



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WORKSHEET D-1, PART II

HOSPITAL
VENDOR NUMBER
PERIOD FROM WW1900 PERIOD TO WW1900
REASON FOR REVISION

PART II HOSPITAL AND SUBPROVIDER ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS
TITLE XIX

38. ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 0.00
39. PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 0
40. MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (Line 14 X Line 35) 0
41. TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 0

	[1] TOTAL I/P COST	[2] TOTAL I/P DAYS	[3] AVG PER DIEM [1]/[2]	[4] PROGRAM DAYS	[5] PROGRAM COST [3]*[4]
42 NURSERY					
43. ICU					
44. CCU					
45. BURN INTENSIVE CARE UNIT					
46. SURGICAL INTENSIVE CARE UNIT					
47. NEONATAL					
47a. SUBPROVIDER I					
47b. SUBPROVIDER II					

48. PROGRAM INPATIENT ANCILLARY SERVICE COST	0
48a. TOTAL PROGRAM INPATIENT ROUTINE COST	0
49. TOTAL PROGRAM INPATIENT COSTS	0

PASS THROUGH COST ADJUSTMENTS

50. Pass Through Costs Applicable to Program Inpatient Routine Service	0
51. Pass Through Costs Applicable to Program Inpatient Ancillary Service	0
52. Total Program Excludable Cost	0
53. Total Program Inpatient Operating Cost Excluding Capital Related Cost	0

PART IV - COMPUTATION OF OBSERVATION BED COST

87. TOTAL OBSERVATION BED DAYS	0
88. ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	0.00
89. OBSERVATION BED COST	0

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	WKST. D_PT I LINE 39/COL. 1 COST [1]	ROUTINE COST [2]	COL. 1 / COL. 2 [3]	TOTAL OBS. BED COST [4]	OBS. BED PASS THRU COST [5]	OBS. BED TOTAL CHARGES [6]	OBS. BED COST/CHARGE RATIO [7]
90. CAPITAL RELATED COST	0	0	0.000000	0	0	0	0.000000

** An adjustment to exclude swing bed portion

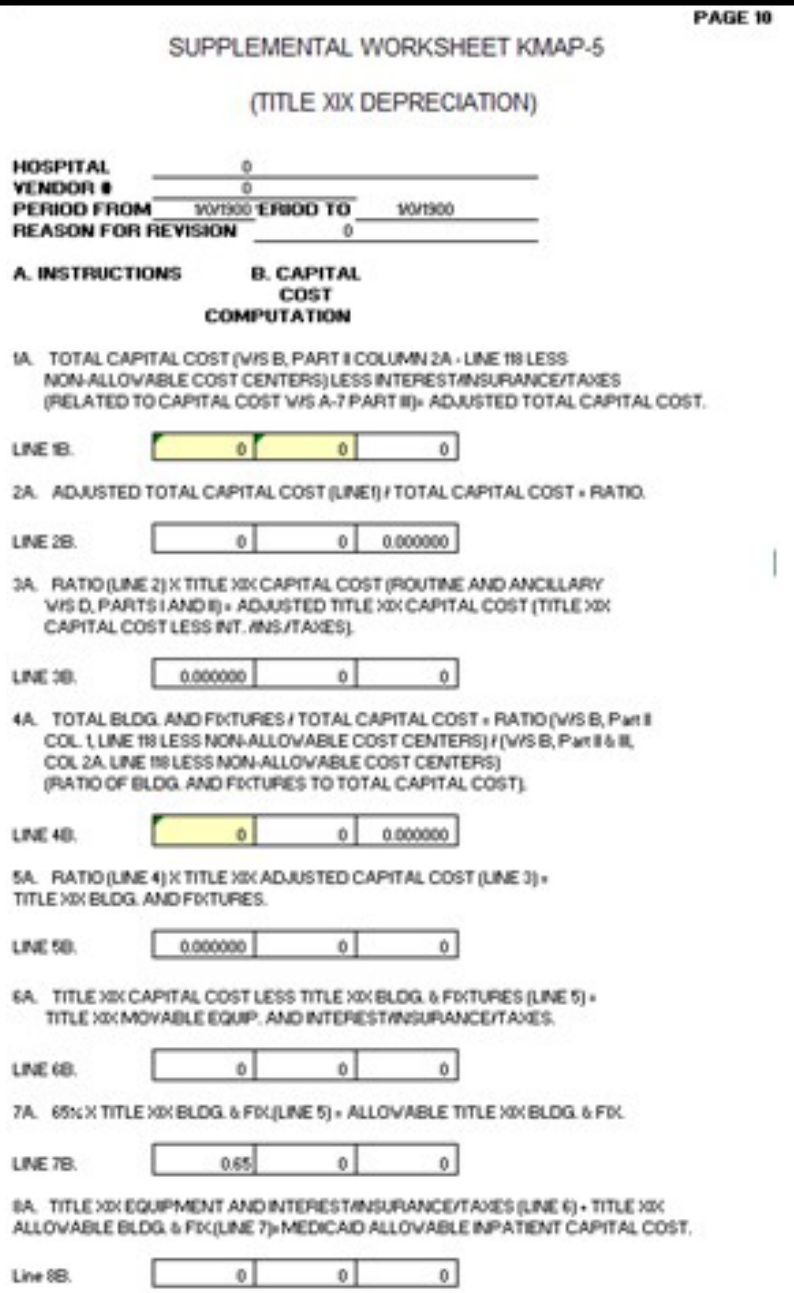
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

KMAP-5

KMAP-5

- The KMAP-5 is a historical schedule that limits allowed capital costs for building and fixtures to 65%, while allowing capital costs for movable equipment at 100%.
- This schedule is only used for freestanding hospital rate-setting currently.



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SUPPLEMENTAL WORKSHEET KMAP-5

(TITLE XIX DEPRECIATION)

HOSPITAL 0
VENDOR # 0
PERIOD FROM 1/0/1900 PERIOD TO 1/0/1900
REASON FOR REVISION 0

A. INSTRUCTIONS

B. CAPITAL COST COMPUTATION

1A. TOTAL CAPITAL COST (W/S B, PART II COLUMN 2A - LINE 118 LESS NON-ALLOWABLE COST CENTERS) LESS INTEREST/INSURANCE/TAXES (RELATED TO CAPITAL COST W/S A-7 PART III)= ADJUSTED TOTAL CAPITAL COST.

LINE 1B. 0 | 0 | 0

2A. ADJUSTED TOTAL CAPITAL COST (LINE1) / TOTAL CAPITAL COST = RATIO.

LINE 2B. 0 | 0 | 0.000000

3A. RATIO (LINE 2) X TITLE XIX CAPITAL COST (ROUTINE AND ANCILLARY W/S D, PARTS I AND II) = ADJUSTED TITLE XIX CAPITAL COST (TITLE XIX CAPITAL COST LESS INT. /INS./TAXES).

LINE 3B. 0.000000 | 0 | 0

4A. TOTAL BLDG. AND FIXTURES / TOTAL CAPITAL COST = RATIO (W/S B, Part II COL. 1, LINE 118 LESS NON-ALLOWABLE COST CENTERS) / (W/S B, Part II & III, COL 2A, LINE 118 LESS NON-ALLOWABLE COST CENTERS) (RATIO OF BLDG. AND FIXTURES TO TOTAL CAPITAL COST).

LINE 4B. 0 | 0 | 0.000000

5A. RATIO (LINE 4) X TITLE XIX ADJUSTED CAPITAL COST (LINE 3) = TITLE XIX BLDG. AND FIXTURES.

LINE 5B. 0.000000 | 0 | 0

6A. TITLE XIX CAPITAL COST LESS TITLE XIX BLDG. & FIXTURES (LINE 5) = TITLE XIX MOVABLE EQUIP. AND INTEREST/INSURANCE/TAXES.

LINE 6B. 0 | 0 | 0

7A. 65% X TITLE XIX BLDG. & FIX.(LINE 5) = ALLOWABLE TITLE XIX BLDG. & FIX.

LINE 7B. 0.65 | 0 | 0

8A. TITLE XIX EQUIPMENT AND INTEREST/INSURANCE/TAXES (LINE 6) + TITLE XIX ALLOWABLE BLDG. & FIX.(LINE 7)= MEDICAID ALLOWABLE INPATIENT CAPITAL COST.

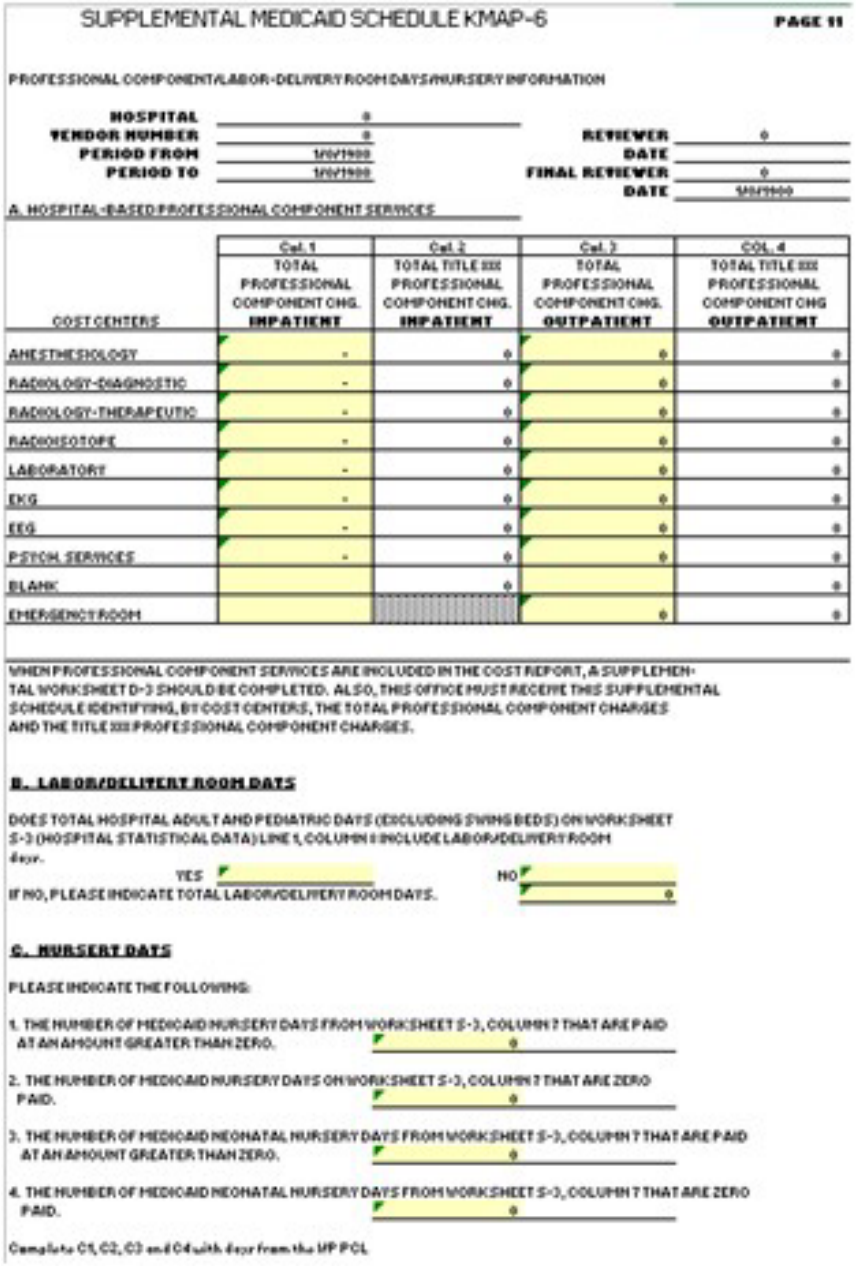
Line 8B. 0 | 0 | 0

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

KMAP-6

KMAP-6

- Section A of the KMAP-6 relates to reimbursement of hospital professional services and is no longer used by DMS.
- Section B shows whether the provider reported labor & delivery days in total routine days on the cost report, which impacts the IP cost per diem.
- Section C reflects the nursery days found on the IP PCL.



SUPPLEMENTAL MEDICAID SCHEDULE KMAP-6 PAGE 11

PROFESSIONAL COMPONENT/LABOR-DELIVERY ROOM DAYS/NURSERY INFORMATION

HOSPITAL 0
VENDOR NUMBER 0
PERIOD FROM 1/0/1900
PERIOD TO 1/0/1900
REVIEWER 0
DATE
FINAL REVIEWER 0
DATE 1/0/1900

A. HOSPITAL-BASED PROFESSIONAL COMPONENT SERVICES

COST CENTERS	Col. 1 TOTAL PROFESSIONAL COMPONENT CHG. IMPATIENT	Col. 2 TOTAL TITLE XIX PROFESSIONAL COMPONENT CHG. IMPATIENT	Col. 3 TOTAL PROFESSIONAL COMPONENT CHG. OUTPATIENT	COL. 4 TOTAL TITLE XIX PROFESSIONAL COMPONENT CHG OUTPATIENT
ANESTHESIOLOGY	-	0	0	0
RADIOLOGY-DIAGNOSTIC	-	0	0	0
RADIOLOGY-THERAPEUTIC	-	0	0	0
RADIOISOTOPE	-	0	0	0
LABORATORY	-	0	0	0
EKG	-	0	0	0
EEG	-	0	0	0
PSYCH. SERVICES	-	0	0	0
BLANK		0		0
EMERGENCY ROOM			0	0

WHEN PROFESSIONAL COMPONENT SERVICES ARE INCLUDED IN THE COST REPORT, A SUPPLEMENTAL WORKSHEET D-3 SHOULD BE COMPLETED. ALSO, THIS OFFICE MUST RECEIVE THIS SUPPLEMENTAL SCHEDULE IDENTIFYING, BY COST CENTERS, THE TOTAL PROFESSIONAL COMPONENT CHARGES AND THE TITLE XIX PROFESSIONAL COMPONENT CHARGES.

B. LABOR/DELIVERY ROOM DATS

DOES TOTAL HOSPITAL ADULT AND PEDIATRIC DAYS (EXCLUDING SWING BEDS) ON WORKSHEET S-3 (HOSPITAL STATISTICAL DATA) LINE 1, COLUMN 6 INCLUDE LABOR/DELIVERY ROOM days.

YES NO

IF NO, PLEASE INDICATE TOTAL LABOR/DELIVERY ROOM DAYS. 0

C. NURSERY DATS

PLEASE INDICATE THE FOLLOWING:

1. THE NUMBER OF MEDICAID NURSERY DAYS FROM WORKSHEET S-3, COLUMN 7 THAT ARE PAID AT AN AMOUNT GREATER THAN ZERO. 0
2. THE NUMBER OF MEDICAID NURSERY DAYS ON WORKSHEET S-3, COLUMN 7 THAT ARE ZERO PAID. 0
3. THE NUMBER OF MEDICAID NEONATAL NURSERY DAYS FROM WORKSHEET S-3, COLUMN 7 THAT ARE PAID AT AN AMOUNT GREATER THAN ZERO. 0
4. THE NUMBER OF MEDICAID NEONATAL NURSERY DAYS FROM WORKSHEET S-3, COLUMN 7 THAT ARE ZERO PAID. 0

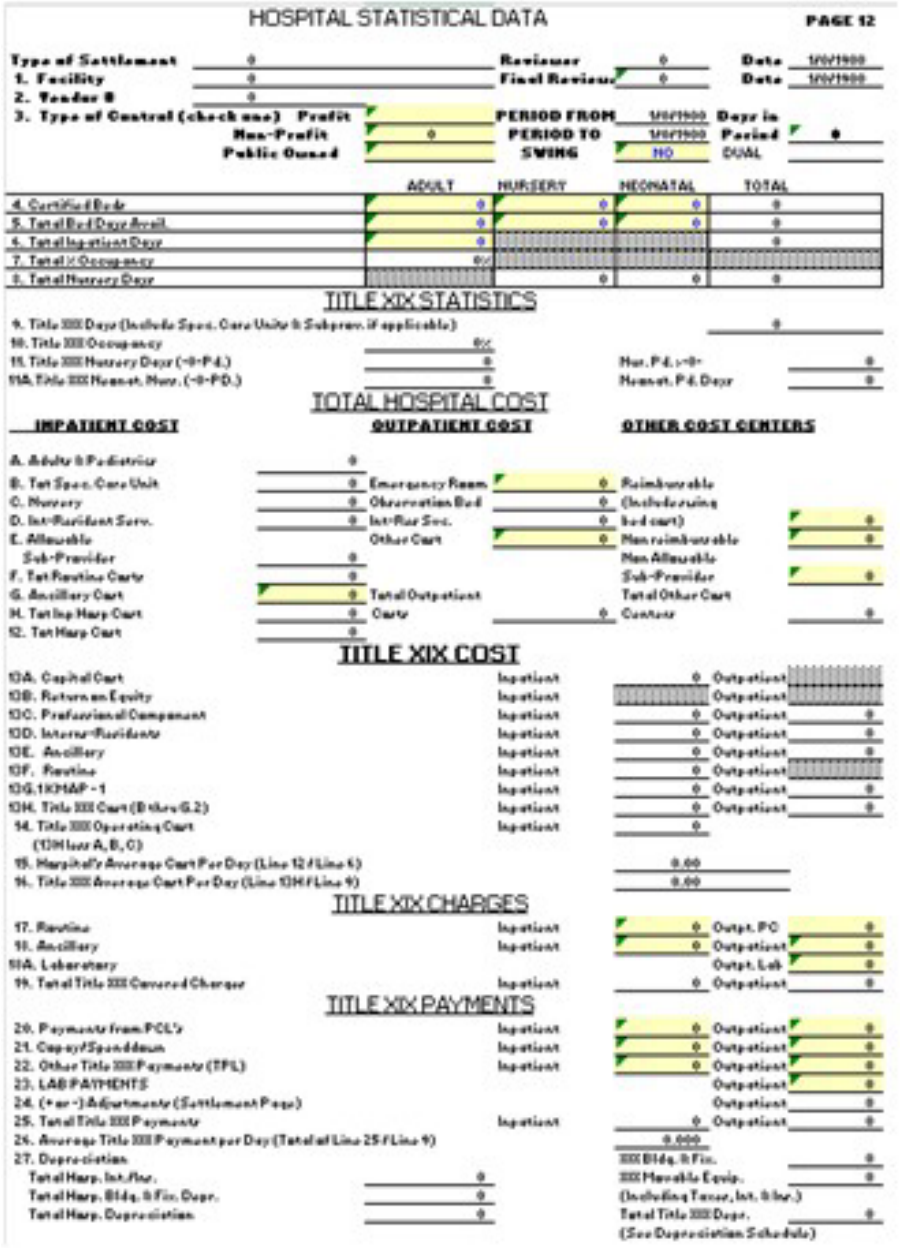
Complete C1, C2, C3 and C4 with days from the IP PCL

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

STATISTICAL DATA SHEET

STATISTICAL DATA SHEET

- The stat page is a summary of various cost, charges, payments, and utilization metrics found in the 23-page report.


HOSPITAL STATISTICAL DATA

PAGE 12

Type of Settlement
1. Facility
2. Vendor #
3. Type of Control (check one) Profit / Non-Profit / Public Owned

Reviewer
Final Review
Date
Date

PERIOD FROM
PERIOD TO
SWING
Days in Period
DUAL

	ADULT	NURSERY	NEONATAL	TOTAL
4. Certified Beds				
5. Total Bed Days Avail.				
6. Total Inpatient Days				
7. Total % Occupancy				
8. Total Nursery Days				

TITLE XIX STATISTICS

9. Title XIX Days (Include Spec. Care Units & Subprov. if applicable)
10. Title XIX Occupancy
11. Title XIX Nursery Days (=8=P4.)
11A. Title XIX Neonat. Nurs. (=8=P3.)
Nur. P4. (=8=
Neonat. P4. Days

TOTAL HOSPITAL COST

IMPATIENT COST		OUTPATIENT COST		OTHER COST CENTERS	
A. Adults & Pediatrics					
B. Tot Spec. Care Unit		Emergency Room		Reimbursable	
C. Nursery		Observation Bed		(Include swing	
D. Int=Resident Serv.		Int=Res Svc.		bed cost)	
E. Allowable		Other Cost		Non reimbursable	
Sub-Provider				Non Allowable	
F. Tot Routine Costs				Sub-Provider	
G. Ancillary Cost		Total Outpatient		Total Other Cost	
H. Tot Inp Hosp Cost		Costs		Centers	
12. Tot Hosp Cost					

TITLE XIX COST

13A. Capital Cost	Inpatient		Outpatient
13B. Return on Equity	Inpatient		Outpatient
13C. Professional Component	Inpatient		Outpatient
13D. Interns=Residents	Inpatient		Outpatient
13E. Ancillary	Inpatient		Outpatient
13F. Routine	Inpatient		Outpatient
13G.1KMAP - 1	Inpatient		Outpatient
13H. Title XIX Cost (B thru G.2)	Inpatient		Outpatient
14. Title XIX Operating Cost (13H Lour A, B, C)	Inpatient		
15. Hospital's Average Cost Per Day (Line 12 / Line 6)		0.00	
16. Title XIX Average Cost Per Day (Line 13H / Line 9)		0.00	

TITLE XIX CHARGES

17. Routine	Inpatient		Outpt. PC
18. Ancillary	Inpatient		Outpatient
18A. Laboratory			Outpt. Lab
19. Total Title XIX Covered Charges	Inpatient		Outpatient

TITLE XIX PAYMENTS

20. Payments from PCL's	Inpatient		Outpatient
21. Copay/Spenddown	Inpatient		Outpatient
22. Other Title XIX Payments (TPL)	Inpatient		Outpatient
23. LAB PAYMENTS			Outpatient
24. (+or-) Adjustments (Settlement Page)			Outpatient
25. Total Title XIX Payments	Inpatient		Outpatient
26. Average Title XIX Payment per Day (Total of Line 25 / Line 9)		0.000	
27. Depreciation			XIX Bldg. & Fix.
Total Hosp. Int./Fur.			XIX Movable Equip.
Total Hosp. Bldg. & Fix. Depr.			(Including Tenor, Int. & Fur.)
Total Hosp. Depreciation			Total Title XIX Depr.
			(See Depreciation Schedule)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DATA FORM

DATA FORM

- The data form is a summary of various cost and days information found in the 23-page report in a format that can be easily input into rate-setting templates.

HOSPITAL DATA FORM — PAGE 13

PROSPECTIVE RATE YEAR		REVIEWER	0	
PERIOD FROM	1/0/1900		DATE	1/0/1900
PERIOD TO	1/0/1900	NAL REVIEWER	0	
EFFECTIVE DATE			DATE	1/0/1900
RECORD NUMBER				
HOSPITAL	0			
REASON FOR REVISION	0		VEN NO.	0
NO. OF DAYS IN REPORT	0	NEWLY PARTICIPATING	NO	
		TYPE	Acute	

	ADULT	NURSERY	NEONATAL	TOTAL
CERTIFIED BEDS (ACUTE, SPECIAL CARE & SUBPROVIDER)	0	0	0	0
TOTAL AVAILABLE BED DAYS (ACUTE, SPECIAL CARE & SUBPROVIDER)	0	0	0	0
TOTAL INPATIENT DAYS (ACUTE,SPECIAL CARE & SUBPROVIDER)	0	0		0
MEDICAID INPATIENT DAYS	0			0
TOTAL MEDICAID NURSERY DAYS		0	0	0
MEDICAID NURS. DAYS PD.> -0-		0		
MEDICAID NURS. DAYS -0- PD.		0		
MED. NEONATAL NURS. DAYS PD.> -0-			0	
MED. NEONATAL NURS. DAYS -0- PD.			0	
MEDICAID INPATIENT COST, NET OF PC, CAPITAL COST AND RETURN ON EQUITY	0			
MEDICAID INPATIENT RETURN ON EQUITY	0			
MEDICAID INPATIENT PROFESSIONAL COMPONENT COST	0			
MEDICAID INPATIENT CAPITAL COST	0			
MEDICAID BUILDING DEPRECIATION	0			

Did your facility offer nonemergency obstetric services as of Dec. 21, 1987 ?	YES		NO	
Does the facility serve mainly children ?	YES		NO	
What is the percent of children served ?			%	
Does the facility have 2 OBs on staff ?	YES		NO	
Total medicaid revenues			0	
Total inpatient revenues			0	
Charity charges			0	
Total inpatient charges			0	

COMPLETE ONLY FOR REVISIONS

ALLOWABLE MEDICAID INPATIENT OPERATING COST INCREASE	
ALLOWABLE MEDICAID PC COST INCREASE	
ALLOWABLE MEDICAID CAPITAL COST INCREASE	
ALLOWABLE MEDICAID RETURN ON EQUITY INCREASE	
ALLOWABLE MEDICAID BUILDING DEPRECIATION INCREASE	

REGULATIONS AND STATE PLAN

- The regulation for OP hospital reimbursement can be found at:
  - 907 KAR 10:015
- The state plan for OP hospital reimbursement can be found at:
  - Attachment 4.19-B