

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. ELECTRONICALLY FILED COST REPORT
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.
- DATE: _____ TIME: _____
- CONTRACTOR USE ONLY
5. COST REPORT STATUS
 6. DATE RECEIVED: _____
 7. AS SUBMITTED
 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.
 13. SETTLED WITHOUT AUDIT
 14. SETTLED WITH AUDIT
 15. REOPENED
 16. AMENDED

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY SWEDISHAMERICAN HOSPITAL (14-0228) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 06/01/2010 AND ENDING 05/31/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL	-878	347,050	39,958		32,354,756	1
2 SUBPROVIDER - IPF		2,539	15		719,692	2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9

10 HEALTH CLINIC - RHC
11 HEALTH CLINIC - FQHC

10
11

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

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

WORKSHEET S
PARTS I, II & III

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII PART A 2	TITLE XVIII PART B 3	HIT 4	TITLE XIX 5	
12						12
200	OUTPATIENT REHABILITATION PROVIDER					
	TOTAL	-878	349,589	39,973	33,074,448	200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID 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.

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1401 EAST STATE ST. P.O. BOX: 1
 2 CITY: ROCKFORD STATE: IL ZIP CODE: 61104 COUNTY: WINNEBAGO 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N) V XVIII XIX				
						6	7	8		
3	HOSPITAL	SWEDISHAMERICAN HOSPITAL	14-0228	40420	1	06/30/1966	O	P	O	3
4	SUBPROVIDER - IPF	SWEISHAMERICAN HOSPITAL PSYCH	14-S228	40420	4	05/31/1986	N	P	O	4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	SWEDISHAMERICAN HOME HEALTH	14-7448	40420		03/24/1986	N	P	O	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 06/01/2010			TO: 05/31/2011					20
21	TYPE OF CONTROL				2					21

INPATIENT PPS INFORMATION

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

		IN-STATE	IN-STATE	OUT-OF	OUT-OF	MEDICAID	OTHER	
		MEDICAID	MEDICAID	STATE	STATE			
		PAID	ELIGIBLE	PAID	ELIGIBLE	HMO	MEDICAID	
		DAYS	DAYS	DAYS	DAYS	DAYS	DAYS	
		1	2	3	4	5	6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	16,031	1,481	217			3,209	24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25

26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.	1	26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.	1	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:
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.		37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:
			38

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

	V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL	1	2	3	
45 DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46 IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47 IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48 IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS	1	2	3	
56 IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			56
57 IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58 IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.	N			58
59 ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60 ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	Y			60
61 DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)				
62 ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01 ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS				
63 HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

64 ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT
 FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS.
 ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT
 FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF
 (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
---	--------------------------------------	------------------------------------

64

ENTER IN LINES 65-65.49, 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
1	2

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
3	4	5

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

66 ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT
 FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS.
 ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT
 FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF
 (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
---	--------------------------------------	------------------------------------

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
1	2

UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
3	4	5

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

INPATIENT PSYCHIATRIC FACILITY PPS

70 IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? Y 70
ENTER 'Y' FOR YES OR 'N' FOR NO.

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

INPATIENT REHABILITATION FACILITY PPS

75 IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? N 75
ENTER 'Y' FOR YES OR 'N' FOR NO.

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

LONG TERM CARE HOSPITAL PPS

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

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)? N 86
ENTER 'Y' FOR YES, OR 'N' FOR NO.

TITLE V AND XIX INPATIENT SERVICES

90 DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' N Y 90
FOR NO IN APPLICABLE COLUMN.

91 IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N N 91
ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.

92 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR N 92
'N' FOR NO IN THE APPLICABLE COLUMN.

93 DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR N N 93
'N' FOR NO IN THE APPLICABLE COLUMN.

94 DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE N N 94
COLUMN.

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 N N 96
COLUMN.

97 IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN. 97

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

RURAL PROVIDERS

		1	2					
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N						105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.							106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.							107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N						108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	N	N			109
MISCELLANEOUS COST REPORTING INFORMATION								
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.					N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.					N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.					Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.					1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.					2,000,000	4,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.					N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.					N		121

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TRANSPLANT CENTER INFORMATION

	1	2
125		N 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.		
126		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.		
127		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.		
128		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.		
129		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.		
130		130
IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		
131		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.		
132		132
IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		
133		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.		
134		134
IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.		

ALL PROVIDERS

	1	2
140	Y	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.		

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

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

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B.
 SEE 42 CFR §413.13)

	PART A	PART B
155	1	2
156	N	N 155
157	N	N 156
158	N	N 157
159	N	N 158
160	N	N 159
161	N	N 160
		N 161

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

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

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

NAME	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. N 167

168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),
ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168

169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH
(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE	
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	2	1
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 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
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE
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	3 4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N	Y/N
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	1 2	6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	Y		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11
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				Y/N
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			Y 15

PS&R REPORT DATA	PART A		PART B		
	Y/N	DATE	Y/N	DATE	
16	1	2	3	4	16
16	N		N		
17	Y	11/15/2011	Y	11/15/2011	17
18	N		N		18
19	N		N		19
20	N		N		20
21	N		N		21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

22	HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	27

INTEREST EXPENSE

28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	31

PURCHASED SERVICES

32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	33

PROVIDER-BASED PHYSICIANS

34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	35

HOME OFFICE COSTS

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

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	158,461,085	940,114	159,401,199	5,454,594.64	29.22	1
2							2
3							3
4							4
5		2,004,740		2,004,740	23,316.80	85.98	5
6							6
7	21						7
8							8
9	44						9
10		50,535,709	-1,780,259	48,755,450	1,204,944.00	40.46	10
11		350,256		350,256	4,707.00	74.41	11
12							12
13		6,041,327		6,041,327	89,294.50	67.66	13
14							14
15							15
16							16
17		36,348,411		36,348,411			17
18							18
19		11,442,325		11,442,325			19
20							20
21							21
22							22
23		297,316		297,316			23
24							24
25							25
26		1,884,856	115,744	2,000,600	61,503.00	32.53	26
27		20,939,266	-372,221	20,567,045	737,265.00	27.90	27
28		3,182,433		3,182,433	33,655.79	94.56	28
29		578,569		578,569	23,088.00	25.06	29
30		703,537		703,537	32,489.60	21.65	30
31		65,642		65,642	6,178.00	10.63	31
32		2,630,490		2,630,490	198,848.00	13.23	32
33							33
34		2,007,018		2,007,018	147,513.00	13.61	34
35		262,138		262,138	8,320.00	31.51	35
36							36
37							37
38		1,234,588		1,234,588	37,606.00	32.83	38
39		549,231		549,231	35,277.00	15.57	39
40		4,190,289		4,190,289	107,120.00	39.12	40
41		1,702,250		1,702,250	92,664.00	18.37	41
42							42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	159,900,916	940,114	160,841,030	5,473,253.6	29.39	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	50,535,709	-1,780,259	48,755,450	1,204,944.0	40.46	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	109,365,207	2,720,373	112,085,580	4,268,309.6	26.26	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	6,391,583		6,391,583	94,001.50	67.99	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	36,348,411		36,348,411		32.43%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	152,105,201	2,720,373	154,825,574	4,362,311.1	35.49	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	39,930,307	-256,477	39,673,830	1,521,527.3	26.08	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	6,892,519	2
3	QUALIFIED AND NON-QUALIFIED PENSION PLAN COST		3
4	PRIOR YEAR PENSION SERVICE COST		4
	PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5	401K/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	2,038,291	6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	24,113,661	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	396,468	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	1,086,776	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	1,632,033	15
16	RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	10,810,455	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	349,627	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	768,222	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	48,088,052	24
	PART B - OTHER THAN CORE RELATED COST		
25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT	
0		LABOR	COST	
		1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	1,143,916	47,647,686	1
2	HOSPITAL	1,143,916	45,617,852	2
3	SUBPROVIDER - IPF		508,888	3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA		1,520,946	11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7448

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		1,380	92	68	1,540	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION		1,133.00	229.00	488.00	1,850.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			
	STAFF 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)		3.00	3.00	3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)		1.00	1.00	4
5 OTHER ADMINISTRATIVE PERSONNEL		17.81	17.81	5
6 DIRECT NURSING SERVICE		20.96	20.96	6
7 NURSING SUPERVISOR				7
8 PHYSICAL THERAPY SERVICE		6.49	6.49	8
9 PHYSICAL THERAPY SUPERVISOR		0.57	0.57	9
10 OCCUPATIONAL THERAPY SERVICE		2.64	2.64	10
11 OCCUPATIONAL THERAPY SUPERVISOR		0.43	0.43	11
12 SPEECH PATHOLOGY SERVICE		0.96	0.96	12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE		1.07	1.07	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE		1.41	1.41	16
17 HOME HEALTH AIDE SUPERVISOR				17
18 PHARMACY TECH				18

HOME HEALTH AGENCY CBSA CODES

19 ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	4	19
20 LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).	16974	20
20.01	40420	20.01
20.02	99904	20.02
20.03	99914	20.03

PPS ACTIVITY

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2				
21 SKILLED NURSING VISITS	8,565	18	325	65	8,973	21
22 SKILLED NURSING VISIT CHARGES	1,368,450	2,775	55,350	10,545	1,437,120	22
23 PHYSICAL THERAPY VISITS	3,893	23	55	52	4,023	23
24 PHYSICAL THERAPY VISIT CHARGES	604,800	3,510	9,300	8,130	625,740	24

25	OCCUPATIONAL THERAPY VISITS	1,719	12	7	3	1,741	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	269,730	1,830	1,260	540	273,360	26
27	SPEECH PATHOLOGY VISITS	471	19	1	9	500	27
28	SPEECH PATHOLOGY VISIT CHARGES	72,330	2,880	180	1,380	76,770	28
29	MEDICAL SOCIAL SERVICE VISITS	167	1	5	3	176	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	30,060	180	900	540	31,680	30
31	HOME HEALTH AIDE VISITS	1,123	15	2	6	1,146	31
32	HOME HEALTH AIDE VISIT CHARGES	101,070	1,350	180	540	103,140	32
33	TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	15,938	88	395	138	16,559	33
34	OTHER CHARGES	422,282	372	23,574	1,968	448,196	34
35	TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	2,868,722	12,897	90,744	23,643	2,996,006	35
36	TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	15,938		395	138	16,471	36
37	TOTAL NUMBER OF OUTLIER EPISODES		88			88	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES						38

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.246614	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				45,712,567	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				223,046,497	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				55,006,389	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 2 PLUS LINE 5 MINUS LINE 7)				9,293,822	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 9 MINUS LINE 11)					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 13 MINUS LINE 15)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				752,513	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				9,293,822	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	36,103,310	5,709,089	41,812,399		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES	8,903,582	1,407,941	10,311,523		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE					22
23	COST OF CHARITY CARE	8,903,582	1,407,941	10,311,523		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)				33,586,325	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				1,849,942	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				31,736,383	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				7,826,636	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				18,138,159	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				27,431,981	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		17,939,808	17,939,808	-4,432,471	1
2	00200				13,225,554	2
3	00300					3
4	00400	1,884,856	2,933,534	4,818,390	-16,784	4
5	00500	20,939,266	42,951,560	63,890,826	-9,168,124	5
6	00600	578,569	703,868	1,282,437	833,807	6
7	00700	703,537	3,940,426	4,643,963	-4,175	7
8	00800	65,642	1,316,629	1,382,271	-54	8
9	00900	2,630,490	1,518,909	4,149,399	-17,046	9
10	01000	2,007,018	3,190,754	5,197,772	-133,786	10
11	01100					11
12	01200					12
13	01300	1,234,588	630,303	1,864,891	-4,706	13
14	01400	549,231	6,518,191	7,067,422	-4,020,039	14
15	01500	4,190,289	11,116,879	15,307,168	-9,499,935	15
16	01600	1,702,250	1,323,908	3,026,158	-217,561	16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200		4,709,045	4,709,045	-54	22
23	02300					23
23.10	02304	70,326	24,167	94,493		23.10
23.20	02301	157,740	89,585	247,325	-2,318	23.20
23.30	02302	148,152	98,193	246,345	-3,235	23.30
23.40	02303	420,554	614,476	1,035,030	-25,994	23.40
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	22,489,422	11,096,670	33,586,092	-483,081	30
31	03100	5,849,116	2,340,373	8,189,489	-3,367	31
31.01	03101					31.01
40	04000	2,617,115	975,031	3,592,146	-1,141,121	40
43	04300	1,342,834	1,551,870	2,894,704	1,113,483	43
ANCILLARY SERVICE COST CENTERS						
50	05000	6,990,096	25,026,816	32,016,912	-1,436,799	50
50.20	03340	556,589	344,776	901,365	-505	50.20
52	05200	2,591,117	1,284,354	3,875,471	-1,470	52
53	05300		284,138	284,138	1,425,000	53
54	05400	8,756,232	15,723,909	24,480,141	-542,915	54
54.10	03480	2,113,248	1,174,043	3,287,291	11,347,259	54.10
54.20	05401	911,002	1,824,940	2,735,942	-222,518	54.20
54.30	05402	15,000	45,691	60,691		54.30
60	06000	3,058,678	9,574,673	12,633,351	-608,967	60
62.30	06250					62.30
65	06500	2,127,910	1,525,094	3,653,004	-388,234	65
66	06600	3,159,434	2,173,999	5,333,433	-8,529	66
69	06900	698,905	466,351	1,165,256	-2,145	69
69.10	03140					69.10

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
70	07000 ELECTROENCEPHALOGRAPHY	651,001	623,845	1,274,846	-6,941	70
70.10	03370 APNEA MONITORING					70.10
71	07100 MEDICAL SUPPLIES CHRGED TO PATIENTS				3,982,391	71
73	07300 DRUGS CHARGED TO PATIENTS				9,492,226	73
75.10	03950 NUTRITIONAL SUPPORT				119,810	75.10
75.20	03951 HEMODIALYSIS		656,831	656,831		75.20
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						
90	09000 CLINIC	1,300,891	1,420,259	2,721,150	-8,417	90
90.01	09001 CHILDRENS CLINIC					90.01
91	09100 EMERGENCY	7,708,870	5,912,844	13,621,714	-93,711	91
91.05	09101 AMBULATORY CARE	32,095	15,018	47,113	-1,655	91.05
91.10	09102 PSYCHIATRIC PARTIAL	1,087,200	776,411	1,863,611	429,369	91.10
92	09200 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF					99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY					99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY					99.40
101	10100 HOME HEALTH AGENCY	4,735,472	4,437,198	9,172,670	-773,211	101
SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	116,074,735	188,875,369	304,950,104	8,699,031	118
NONREIMBURSABLE COST CENTERS						
190	19000 GIFT, FLOWER, COFFEE SHOP & CANTEN	221,972	481,090	703,062		190
190.10	19001 MCC WORD PROCESSING					190.10
192	19200 PHYSICIANS' PRIVATE OFFICES					192
192.01	19201 SPECIALISTS/PCP'S	41,242,506	46,535,923	87,778,429	-11,351,517	192.01
192.02	19202 MEDWORKS					192.02
192.03	19203 SWEDISHAMERICAN ER	25,000	2,571,383	2,596,383		192.03
192.20	19204 IDLE SPACE					192.20
193	19300 NONPAID WORKERS	18,882	18,869	37,751		193
193.10	19301 HOTEL					193.10
193.30	19302 PHYSICIAN BILLING					193.30
193.40	19303 MEALS ON WHEELS					193.40
193.50	19304 WEE CARE					193.50
193.60	19305 PHYSICIAN RELATED AREAS	314,361	1,014,462	1,328,823		193.60
193.70	19306 WOMEN'S CENTER					193.70
193.80	19307 MARKETING EXPENSES				2,652,486	193.80
193.90	19308 COMPLIMENTARY MEDICINE	563,629	254,531	818,160		193.90
200	TOTAL (SUM OF LINES 118-199)	158,461,085	239,751,627	398,212,712		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	13,507,337	-5,051,632	8,455,705	1
2	00200	CAP REL COSTS-MVBLE EQUIP	13,225,554	198,884	13,424,438	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	4,801,606	-1,047,178	3,754,428	4
5	00500	ADMINISTRATIVE & GENERAL	54,722,702	-1,109,269	53,613,433	5
6	00600	MAINTENANCE & REPAIRS	2,116,244	-92,448	2,023,796	6
7	00700	OPERATION OF PLANT	4,639,788	-7,393	4,632,395	7
8	00800	LAUNDRY & LINEN SERVICE	1,382,217	-14,138	1,368,079	8
9	00900	HOUSEKEEPING	4,132,353	-464	4,131,889	9
10	01000	DIETARY	5,063,986	-243	5,063,743	10
11	01100	CAFETERIA		-1,361,232	-1,361,232	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	1,860,185	-93,763	1,766,422	13
14	01400	CENTRAL SERVICES & SUPPLY	3,047,383		3,047,383	14
15	01500	PHARMACY	5,807,233	-1,800	5,805,433	15
16	01600	MEDICAL RECORDS & LIBRARY	2,808,597	-211,690	2,596,907	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	4,708,991	-140,386	4,568,605	22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
23.10	02304	PARAMED ED - LAB	94,493		94,493	23.10
23.20	02301	PARAMED ED PRGM - RADIOLOGY	245,007	-126,163	118,844	23.20
23.30	02302	PARAMED ED - RADIATION ONCOLOGY	243,110	-78,681	164,429	23.30
23.40	02303	PARAMED ED - PARAMEDICAL TECHS	1,009,036	-151,209	857,827	23.40
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	33,103,011	-227,323	32,875,688	30
31	03100	INTENSIVE CARE UNIT	8,186,122	-77,743	8,108,379	31
31.01	03101	PEDIATRIC ICU				31.01
40	04000	SUBPROVIDER - IPF	2,451,025	-378,253	2,072,772	40
43	04300	NURSERY	4,008,187	-27,027	3,981,160	43
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	30,580,113	-3,807,259	26,772,854	50
50.20	03340	GASTROENTEROLOGY	900,860		900,860	50.20
52	05200	DELIVERY ROOM & LABOR ROOM	3,874,001		3,874,001	52
53	05300	ANESTHESIOLOGY	1,709,138	-1,377,217	331,921	53
54	05400	RADIOLOGY-DIAGNOSTIC	23,937,226	-324,917	23,612,309	54
54.10	03480	RADIATION ONCOLOGY	14,634,550	-1,096,057	13,538,493	54.10
54.20	05401	CT	2,513,424	-6,900	2,506,524	54.20
54.30	05402	MRI	60,691	1,940,995	2,001,686	54.30
60	06000	LABORATORY	12,024,384	-304,675	11,719,709	60
62.30	06250	BLOOD CLOTTING FACTORS ADMIN COSTS				62.30
65	06500	RESPIRATORY THERAPY	3,264,770		3,264,770	65
66	06600	PHYSICAL THERAPY	5,324,904	-52,777	5,272,127	66
69	06900	ELECTROCARDIOLOGY	1,163,111		1,163,111	69
69.10	03140	PEDIATRIC CARDIOLOGY				69.10

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
70	07000 ELECTROENCEPHALOGRAPHY	1,267,905	-63,663	1,204,242	70
70.10	03370 APNEA MONITORING				70.10
71	07100 MEDICAL SUPPLIES CHRGED TO PATIENTS	3,982,391		3,982,391	71
73	07300 DRUGS CHARGED TO PATIENTS	9,492,226		9,492,226	73
75.10	03950 NUTRITIONAL SUPPORT	119,810		119,810	75.10
75.20	03951 HEMODIALYSIS	656,831		656,831	75.20
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					
90	09000 CLINIC	2,712,733	-355,942	2,356,791	90
90.01	09001 CHILDRENS CLINIC				90.01
91	09100 EMERGENCY	13,528,003	-1,508,329	12,019,674	91
91.05	09101 AMBULATORY CARE	45,458		45,458	91.05
91.10	09102 PSYCHIATRIC PARTIAL	2,292,980	-1,095,676	1,197,304	91.10
92	09200 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
101	10100 HOME HEALTH AGENCY	8,399,459	-13,142	8,386,317	101
SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	313,649,135	-18,064,710	295,584,425	118
NONREIMBURSABLE COST CENTERS					
190	19000 GIFT, FLOWER, COFFEE SHOP & CANTEN	703,062	-1,249	701,813	190
190.10	19001 MCC WORD PROCESSING				190.10
192	19200 PHYSICIANS' PRIVATE OFFICES				192
192.01	19201 SPECIALISTS/PCP'S	76,426,912	-225,929	76,200,983	192.01
192.02	19202 MEDWORKS				192.02
192.03	19203 SWEDISHAMERICAN ER	2,596,383		2,596,383	192.03
192.20	19204 IDLE SPACE				192.20
193	19300 NONPAID WORKERS	37,751		37,751	193
193.10	19301 HOTEL				193.10
193.30	19302 PHYSICIAN BILLING				193.30
193.40	19303 MEALS ON WHEELS				193.40
193.50	19304 WEE CARE				193.50
193.60	19305 PHYSICIAN RELATED AREAS	1,328,823	-7,783	1,321,040	193.60
193.70	19306 WOMEN'S CENTER				193.70
193.80	19307 MARKETING EXPENSES	2,652,486		2,652,486	193.80
193.90	19308 COMPLIMENTARY MEDICINE	818,160		818,160	193.90
200	TOTAL (SUM OF LINES 118-199)	398,212,712	-18,299,671	379,913,041	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE				
		COST CENTER	LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 INTEREST EXPENSE	B	CAP REL COSTS-BLDG & FIXT	1		5,069,530	1
2 MEDICAL MAINTENANCE	C	MAINTENANCE & REPAIRS	6		835,125	2
3 MEDICAL SUPPLIES CHARGED TO PATIENTS	D	MEDICAL SUPPLIES CHRGED TO PA	71		3,982,391	3
4 DRUGS CHARGED TO PATIENTS	E	DRUGS CHARGED TO PATIENTS	73		9,492,226	4
5 MEDICAL SUPPLIES	F	ADULTS & PEDIATRICS	30		8,725	5
6 PUBLIC RELATIONS EXP	G	ADMINISTRATIVE & GENERAL	5		25,896	6
7	G					7
8	G					8
9 ANESTHESIA PHYSICIANS	H	ANESTHESIOLOGY	53		1,425,000	9
10 CAPITAL RELATED COSTS	I	CAP REL COSTS-MVBLE EQUIP	2		3,723,553	10
11	I					11
12	I					12
13	I					13
14	I					14
15	I					15
16	I					16
17	I					17
18	I					18
19	I					19
20	I					20
21	I					21
22	I					22
23	I					23
24	I					24
25	I					25
26	I					26
27	I					27
28	I					28
29	I					29
30	I					30
31	I					31
32	I					32
33	I					33
34	I					34
35	I					35
36	I					36
37	I					37
38	I					38
39	I					39
40	I					40
41	I					41
42	I					42
43	I					43
44 SPLIT OF PSYCHIATRIC	J	ADULTS & PEDIATRICS	30	516,301	189,936	44
45	J	PSYCHIATRIC PARTIAL	91.10	313,894	115,475	45
46 SPLIT OF FAMILY BIRTHPLACE	K	NURSERY	43	778,677	335,231	46
47 DEPRECIATION ADJUSTMENT	L	CAP REL COSTS-MVBLE EQUIP	2		9,502,001	47
48 DIETARY NUTRITIONAL SUPPLIMENT	N	NUTRITIONAL SUPPORT	75.10		119,810	48

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST REF.	A-7
	1	6	7	8	9	10	
1 INTEREST EXPENSE	B	ADMINISTRATIVE & GENERAL	5		5,069,530	11	1
2 MEDICAL MAINTENANCE	C	ADMINISTRATIVE & GENERAL	5		835,125		2
3 MEDICAL SUPPLIES CHARGED TO PATIENTS	D	CENTRAL SERVICES & SUPPLY	14		3,982,391		3
4 DRUGS CHARGED TO PATIENTS	E	PHARMACY	15		9,492,226		4
5 MEDICAL SUPPLIES	F	DIETARY	10		8,725		5
6 PUBLIC RELATIONS EXP	G	PARAMED ED PRGM - RADIOLOGY	23.20		1,786		6
7	G	PARAMED ED - RADIATION ONCOLO	23.30		2,454		7
8	G	PARAMED ED - PARAMEDICAL TECH	23.40		21,656		8
9 ANESTHESIA PHYSICIANS	H	OPERATING ROOM	50		1,425,000		9
10 CAPITAL RELATED COSTS	I	EMPLOYEE BENEFITS	4		16,784	10	10
11	I	ADMINISTRATIVE & GENERAL	5		636,879		11
12	I	MAINTENANCE & REPAIRS	6		1,318		12
13	I	OPERATION OF PLANT	7		4,175		13
14	I	LAUNDRY & LINEN SERVICE	8		54		14
15	I	HOUSEKEEPING	9		17,046		15
16	I	DIETARY	10		5,251		16
17	I	NURSING ADMINISTRATION	13		4,706		17
18	I	CENTRAL SERVICES & SUPPLY	14		37,648		18
19	I	PHARMACY	15		7,709		19
20	I	MEDICAL RECORDS & LIBRARY	16		217,561		20
21	I	I&R SRVCES-OTHER PRGM COSTS A	22		54		21
22	I	PARAMED ED PRGM - RADIOLOGY	23.20		532		22
23	I	PARAMED ED - RADIATION ONCOLO	23.30		781		23
24	I	PARAMED ED - PARAMEDICAL TECH	23.40		4,338		24
25	I	ADULTS & PEDIATRICS	30		84,135		25
26	I	INTENSIVE CARE UNIT	31		3,367		26
27	I	SUBPROVIDER - IPF	40		5,515		27
28	I	NURSERY	43		425		28
29	I	OPERATING ROOM	50		11,799		29
30	I	GASTROENTEROLOGY	50.20		505		30
31	I	DELIVERY ROOM & LABOR ROOM	52		1,470		31
32	I	RADIOLOGY-DIAGNOSTIC	54		542,915		32
33	I	RADIATION ONCOLOGY	54.10		4,258		33
34	I	CT	54.20		222,518		34
35	I	LABORATORY	60		608,967		35
36	I	RESPIRATORY THERAPY	65		388,234		36
37	I	PHYSICAL THERAPY	66		8,529		37
38	I	ELECTROCARDIOLOGY	69		2,145		38
39	I	ELECTROENCEPHALOGRAPHY	70		6,941		39
40	I	CLINIC	90		8,417		40
41	I	EMERGENCY	91		93,711		41
42	I	AMBULATORY CARE	91.05		1,655		42
43	I	HOME HEALTH AGENCY	101		773,211		43
44 SPLIT OF PSYCHIATRIC	J	SUBPROVIDER - IPF	40	830,195	305,411		44
45	J						45
46 SPLIT OF FAMILY BIRTHPLACE	K	ADULTS & PEDIATRICS	30	778,677	335,231		46
47 DEPRECIATION ADJUSTMENT	L	CAP REL COSTS-BLDG & FIXT	1		9,502,001	9	47
48 DIETARY NUTRITIONAL SUPPLIMENT	N	DIETARY	10		119,810		48

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----				
		COST CENTER	LINE #	SALARY	OTHER	
	1	2	3	4	5	
49 MARKETING EXPENSES	O	MARKETING EXPENSES	193.80	372,221	2,280,265	49
50 CHEMO EXPENSES	Q	RADIATION ONCOLOGY	54.10	1,322,285	10,029,232	50
51 RECRUITMENT BONUS	R	EMPLOYEE BENEFITS	4	115,744		51
52 RECLASS OF MRI SALARIES	S	MRI	54.30	824,370		52
500 TOTAL RECLASSIFICATIONS (SUM OF COLS. 4 & 5 MUST EQUAL SUM OF COLS. 8 & 9)				4,243,492	47,134,396	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
49 MARKETING EXPENSES	O	ADMINISTRATIVE & GENERAL	5	372,221	2,280,265	49
50 CHEMO EXPENSES	Q	SPECIALISTS/PCP'S	192.01	1,322,285	10,029,232	50
51 RECRUITMENT BONUS	R	EMPLOYEE BENEFITS	4		115,744	51
52 RECLASS OF MRI SALARIES	S	MRI	54.30		824,370	52
500 TOTAL RECLASSIFICATIONS (SUM OF COLS. 4 & 5 MUST EQUAL SUM OF COLS. 8 & 9)				3,303,378	48,074,510	500

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	1,593,952	10,277		10,277		1,604,229		1
2 LAND IMPROVEMENTS	6,018,998	127,970		127,970	24,183	6,122,785		2
3 BUILDINGS AND FIXTURES	90,308,787	2,468,725		2,468,725	508,879	92,268,633		3
4 BUILDING IMPROVEMENTS	85,459,940	1,903,674		1,903,674	246,040	87,117,574		4
5 FIXED EQUIPMENT	5,794,454	878,734		878,734	600,911	6,072,277		5
6 MOVABLE EQUIPMENT	113,974,232	13,823,951		13,823,951	1,521,387	126,276,796		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	303,150,363	19,213,331		19,213,331	2,901,400	319,462,294		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	303,150,363	19,213,331		19,213,331	2,901,400	319,462,294		10

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

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)	
							(SUM OF COLS. 9-14) 15	
1 CAP REL COSTS-BLDG & FIXT	17,939,808						17,939,808	1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)	17,939,808						17,939,808	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

----- COMPUTATION OF RATIOS ----- ALLOCATION OF OTHER CAPITAL -----

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

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC-	INSURANCE	TAXES (SEE	OTHER CAPITAL- RELATED COSTS (SEE	TOTAL(2)
					(SUM OF COLS.

		IATION	LEASE	INTEREST (SEE INSTR.)	INSTR.)	INSTR.)	INSTR.)	9-14)
		9	10	11	12	13	14	15
1	CAP REL COSTS-BLDG & FIXT	8,440,570		15,135				8,455,705 1
2	CAP REL COSTS-MVBLE EQUIP	9,558,884	3,865,554					13,424,438 2
3	TOTAL	17,999,454	3,865,554	15,135				21,880,143 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
DESCRIPTION	BASIS	AMOUNT	COST CENTER	LINE NO.	WKST A-7 REF	
	1	2	3	4	5	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-6,739,858	CAP REL COSTS-BLDG & FIXT	1	11 1	
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2	
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					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)	A	-150,690	ADMINISTRATIVE & GENERAL	5	7	
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8	
9 PARKING LOT (CHAPTER 21)					9	
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-10,323,837			10	
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11	
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	1,242,281			12	
13 LAUNDRY AND LINEN SERVICE					13	
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-1,361,232	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					18	
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19	
20 VENDING MACHINES					20	
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21	
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22	
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23	
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24	
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25	
26 DEPRECIATION--BUILDINGS & FIXTURES	A	-3,646	CAP REL COSTS-BLDG & FIXT	1	9 26	
27 DEPRECIATION--MOVABLE EQUIPMENT	A	23,537	CAP REL COSTS-MVBLE EQUIP	2	9 27	
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28	
29 PHYSICIANS' ASSISTANT					29	
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				30	
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31	
32 CAH HIT ADJ FOR DEPRECIATION AND					32	

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
DESCRIPTION	BASIS	AMOUNT	COST CENTER	LINE NO.	WKST A-7 REF	
	1	2	3	4	5	
33 CUDDLE CARE	B	-356	ADULTS & PEDIATRICS	30	33	
34 OTHER REVENUE	B	-1,384	SUBPROVIDER - IPF	40	34	
35					35	
35.10 OTHER REVENUE	B	-49,412	PSYCHIATRIC PARTIAL	91.10	35.10	
36 PROFESSIONAL EDUCATION	B	-600	ADMINISTRATIVE & GENERAL	5	36	
37 RECYCLING	B	-4,037	ADULTS & PEDIATRICS	30	37	
38 MEDICAL REC TRANSCRIPTS	B	-85	CLINIC	90	38	
39 WOMEN CENTER RESEARCH	B	-2,400	CLINIC	90	39	
40 BABY PICTURES	B	-2,019	NURSERY	43	40	
41 EMS EDUCATION FEES	B	-117,050	PARAMED ED - PARAMEDICAL TECHS	23.40	41	
42 OTHER REVENUE	B	-49,469	EMERGENCY	91	42	
43 OTHER REVENUE	B	-71,547	RADIOLOGY-DIAGNOSTIC	54	43	
44 OTHER REVENUE	B	-130	ADMINISTRATIVE & GENERAL	5	44	
45 TUITION	B	-110,663	PARAMED ED PRGM - RADIOLOGY	23.20	45	
46 ADMISSION FEES	B	-13,217	PARAMED ED PRGM - RADIOLOGY	23.20	46	
47 RECLAIMED SILVER	B	-1,763	RADIOLOGY-DIAGNOSTIC	54	47	
48 MED REC TRANSCRIPTS	B	-3,994	RADIOLOGY-DIAGNOSTIC	54	48	
49 OTHER REVENUE	B	-6,550	RADIOLOGY-DIAGNOSTIC	54	49	
49.02 RECLAIMED WIRE	B	-1,462	RADIOLOGY-DIAGNOSTIC	54	49.02	
49.04 TUITION	B	-73,272	PARAMED ED - RADIATION ONCOLOGY	23.30	49.04	
49.06 BOOK FEES	B	-3,126	PARAMED ED - RADIATION ONCOLOGY	23.30	49.06	
49.08 OTHER REVENUE	B	-46,562	RADIATION ONCOLOGY	54.10	49.08	
49.10 OTHER REVENUE	B	-594	PHYSICAL THERAPY	66	49.10	
49.12 HEART SCAN REVENUE	B	-6,900	CT	54.20	49.12	
49.14 GROSS REVENUE	B	-20	EMPLOYEE BENEFITS	4	49.14	
49.16 EMPLOYEE HEALTH	B	-902,657	EMPLOYEE BENEFITS	4	49.16	
49.18 OTHER REVENUE	B	-211,023	MEDICAL RECORDS & LIBRARY	16	49.18	
49.20 OTHER REVENUE	B	-1,800	PHARMACY	15	49.20	
49.21 PHOTO	B	-1,839	ADMINISTRATIVE & GENERAL	5	49.21	
49.22 VENDING MACHINES	B	-464	HOUSEKEEPING	9	49.22	
49.24 NON PATIENT LINEN	B	-14,138	LAUNDRY & LINEN SERVICE	8	49.24	
49.26 GUEST ROOM RENTAL	B	-10,140	ADMINISTRATIVE & GENERAL	5	49.26	
49.28 INSURANCE AUDIT	B	-1,695	ADMINISTRATIVE & GENERAL	5	49.28	
49.30 COMPUTER SERVICE REVENUE	B	52,993	ADMINISTRATIVE & GENERAL	5	49.30	
49.31 COMMUNICATIONS	B	-7,892	ADMINISTRATIVE & GENERAL	5	49.31	
49.32 PHYSICIAN PAGING AND ANSWERING	B	-379,950	ADMINISTRATIVE & GENERAL	5	49.32	
49.33 WORD PROCESSING	B	-77,243	ADMINISTRATIVE & GENERAL	5	49.33	
49.34 OTHER REVENUE	B	-1,265,476	ADMINISTRATIVE & GENERAL	5	49.34	
49.35 OTHER REVENUE/TRANSCRIPTS	B	-2,593	EMPLOYEE BENEFITS	4	49.35	
49.36 OTHER REVENUE	B	-536,121	ADMINISTRATIVE & GENERAL	5	49.36	
49.38 INVESTMENT PREMIUM DISCOUNT	B	-403,985	CAP REL COSTS-BLDG & FIXT	1	11 49.38	
49.40 INVESTMENT MANAGEMENT	A	578,952	ADMINISTRATIVE & GENERAL	5	49.40	
49.42 MRI COSTS	A	-31,551	MRI	54.30	49.42	
49.44 PRIOR YEARS ADJUSTMENT	A	17,269	CAP REL COSTS-MVBLE EQUIP	2	9 49.44	
49.46 COURIER FEES TO SAHMC	B	-311,640	ADMINISTRATIVE & GENERAL	5	49.46	
49.48 MALPRACTICE EXPENSE	A	1,427,325	ADMINISTRATIVE & GENERAL	5	49.48	
49.50 UNNECESSARY BOND INTEREST EXPENSE	A	-453,115	CAP REL COSTS-BLDG & FIXT	1	11 49.50	
49.52 BOND FUND INCOME	B	-5	CAP REL COSTS-BLDG & FIXT	1	11 49.52	

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
49.54 T.V. REPAIR SALARY	A	-6,256	ADMINISTRATIVE & GENERAL	5	49.54
49.56 T.V. ELECTRICITY COST	A	-7,393	OPERATION OF PLANT	7	49.56
49.58 DUES RELATED TO LOBBYING	A	-39,762	ADMINISTRATIVE & GENERAL	5	49.58
49.60 LOSS ON DEFEASANCE	A	406,135	CAP REL COSTS-BLDG & FIXT	1	11 49.60
49.62 CORPORATE SPONSORSHIP	A	-94,798	ADMINISTRATIVE & GENERAL	5	49.62
49.64 SITTEERS COST	A	-183	ADMINISTRATIVE & GENERAL	5	49.64
49.66 SITTEERS COST	A	-571	NURSING ADMINISTRATION	13	49.66
49.68 SITTEERS COST	A	-207,930	ADULTS & PEDIATRICS	30	49.68
49.70 SITTEERS COST	A	-28,675	INTENSIVE CARE UNIT	31	49.70
49.72 SITTEERS COST	A	-60,396	SUBPROVIDER - IPF	40	49.72
49.74 SITTEERS COST	A	-10	EMERGENCY	91	49.74
49.76 ALCOHOL COSTS	A	-2,887	EMPLOYEE BENEFITS	4	49.76
49.78 ALCOHOL COSTS	A	-3,919	ADMINISTRATIVE & GENERAL	5	49.78
49.80 ALCOHOL COSTS	A	-318	RADIOLOGY-DIAGNOSTIC	54	49.80
49.81 ALCOHOL COSTS	A	-3,938	PHYSICIAN RELATED AREAS	193.60	49.81
49.82 CASUALTY LOSS	B	-25,000	ADMINISTRATIVE & GENERAL	5	49.82
49.83 RESTRICTED REVENUE REALIZED	B	-37,507	ADMINISTRATIVE & GENERAL	5	49.83
49.84 EXTERNAL RENT REVENUE	B	-7,060	ADMINISTRATIVE & GENERAL	5	49.84
49.85 MISC PATIENT REVENUE	B	-16,445	ADMINISTRATIVE & GENERAL	5	49.85
49.86 MISC PATIENT REVENUE	B	116,771	ADMINISTRATIVE & GENERAL	5	49.86
49.88 DEPR ADD BACK	A	6,409	CAP REL COSTS-BLDG & FIXT	1	9 49.88
49.90 INTEREST EXPENSE ADD BACK	A	2,130,907	CAP REL COSTS-BLDG & FIXT	1	11 49.90
50 TOTAL (SUM OF LINES 1 THRU 49)		-18,299,671			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	PARKING LOTS	33,996	294,876	-260,880	1
2	6	MAINTENANCE & REPAIRS	MEDICAL MAINTENANCE	742,677	835,125	-92,448	2
3	4	EMPLOYEE BENEFITS	RENTAL ADJUSTMENT	118,930	119,577	-647	3
4	5	ADMINISTRATIVE & GENERAL	RENTAL ADJUSTMENT	1,003,203	1,021,200	-17,997	4
4.01	22	I&R SRVCS-OTHER PRGM COSTS APP	RENTAL ADJUSTMENT	280,454	420,840	-140,386	4.01
4.02	23.40	PARAMED ED - PARAMEDICAL TECHS	RENTAL ADJUSTMENT	90,749	124,908	-34,159	4.02
4.03	50	OPERATING ROOM	RENTAL ADJUSTMENT	14,564	12,000	2,564	4.03
4.04	54	RADIOLOGY-DIAGNOSTIC	RENTAL ADJUSTMENT	426,088	445,001	-18,913	4.04
4.05	66	PHYSICAL THERAPY	RENTAL ADJUSTMENT	406,664	439,187	-32,523	4.05
4.06	70	ELECTROENCEPHALOGRAPHY	RENTAL ADJUSTMENT	190,283	205,501	-15,218	4.06
4.07	90	CLINIC	RENTAL ADJUSTMENT	286,370	290,282	-3,912	4.07
4.08	101	HOME HEALTH AGENCY	RENTAL ADJUSTMENT	177,221	190,363	-13,142	4.08
4.09	192.01	SPECIALISTS/PCP'S	RENTAL ADJUSTMENT	2,043,598	2,269,527	-225,929	4.09
4.10	193.60	PHYSICIAN RELATED AREAS	RENTAL ADJUSTMENT	51,847	55,692	-3,845	4.10
4.15	2	CAP REL COSTS-MVBLE EQUIP	MRI DEPRECIATION	16,077		16,077	9 4.15
4.16	1	CAP REL COSTS-BLDG & FIXT	MRI INTEREST	5,526		5,526	11 4.16
4.17	2	CAP REL COSTS-MVBLE EQUIP	MRI LEASED EQUIPMENT	142,001		142,001	10 4.17
4.18	54.30	MRI	MRI EXPENSES	1,972,546		1,972,546	4.18
4.19	10	DIETARY	RENTAL ADJUSTMENT	44,736	44,979	-243	4.19
4.20	16	MEDICAL RECORDS & LIBRARY	RENTAL ADJUSTMENT	122,633	123,300	-667	4.20
4.21	23.20	PARAMED ED PRGM - RADIOLOGY	RENTAL ADJUSTMENT	5,517	7,800	-2,283	4.21
4.22	23.30	PARAMED ED - RADIATION ONCOLOGY	RENTAL ADJUSTMENT	5,517	7,800	-2,283	4.22
4.23	91.10	PSYCHIATRIC PARTIAL	RENTAL ADJUSTMENT	94,288	94,800	-512	4.23
4.24	190	GIFT, FLOWER, COFFEE SHOP & CAN	RENTAL ADJUSTMENT	68,251	69,500	-1,249	4.24
4.26	54.10	RADIATION ONCOLOGY	RENTAL ADJUSTMENT	365,090	394,287	-29,197	4.26
5		TOTALS (SUM OF LINES 1-4)		8,708,826	7,466,545	1,242,281	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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

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

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

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----

SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6						6
7	C		IL IMAGING	50.00		7
8						8
9						9
10						10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.	2		3	4	5	6	7	8	9
1	4	EMPLOYEE BENEFITS	138,374	138,374					
2	5	ADMINISTRATIVE & GENERAL	72,218	22,218	50,000	171,400	487	40,131	2,007
3	13	NURSING ADMINISTRATION	125,000		125,000	171,400	386	31,808	1,590
4	30	ADULTS & PEDIATRICS	21,000	15,000	6,000	171,400	89	7,334	367
5	31	INTENSIVE CARE UNIT	62,500		62,500	171,400	163	13,432	672
6	40	SUBPROVIDER - IPF	344,820	292,320	52,500	171,400	344	28,347	1,417
7	43	NURSERY	25,008	25,008					
8	50	OPERATING ROOM	3,862,594	3,772,594	90,000	200,300	548	52,771	2,639
9	53	ANESTHESIOLOGY	1,425,000	1,365,000	60,000	194,500	511	47,783	2,389
10	54	RADIOLOGY-DIAGNOSTIC	484,749	29,680	455,069	142,500	3,859	264,379	13,219
11	54.10	RADIATION ONCOLOGY	1,035,850	1,010,850	25,000	142,500	227	15,552	778
12	60	LABORATORY	304,675	304,675					
13	66	PHYSICAL THERAPY	19,660	19,660					
14	70	ELECTROENCEPHALOGRAPHY	55,945	48,445	7,500	171,400	128	10,548	527
15	90	CLINIC	361,576	344,376	17,200	171,400	146	12,031	602
16	91	EMERGENCY	1,576,523	1,404,523	172,000	171,400	1,428	117,673	5,884
17	91.10	PSYCHIATRIC PARTIAL	1,045,752	1,045,752					
200		TOTAL	10,961,244	9,838,475	1,122,769		8,316	641,789	32,091

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO. 10	11	12	13	14	15	16	17	18
1 4	EMPLOYEE BENEFITS	AGGREGATE						138,374
2 5	ADMINISTRATIVE & GENERAL	AGGREGATE				40,131	9,869	32,087
3 13	NURSING ADMINISTRATION	AGGREGATE				31,808	93,192	93,192
4 30	ADULTS & PEDIATRICS	AGGREGATE				7,334		15,000
5 31	INTENSIVE CARE UNIT	AGGREGATE				13,432	49,068	49,068
6 40	SUBPROVIDER - IPF	AGGREGATE				28,347	24,153	316,473
7 43	NURSERY	AGGREGATE						25,008
8 50	OPERATING ROOM	AGGREGATE				52,771	37,229	3,809,823
9 53	ANESTHESIOLOGY	AGGREGATE				47,783	12,217	1,377,217
10 54	RADIOLOGY-DIAGNOSTIC	AGGREGATE				264,379	190,690	220,370
11 54.10	RADIATION ONCOLOGY	AGGREGATE				15,552	9,448	1,020,298
12 60	LABORATORY	AGGREGATE						304,675
13 66	PHYSICAL THERAPY	AGGREGATE						19,660
14 70	ELECTROENCEPHALOGRAPHY	AGGREGATE				10,548		48,445
15 90	CLINIC	AGGREGATE				12,031	5,169	349,545
16 91	EMERGENCY	AGGREGATE				117,673	54,327	1,458,850
17 91.10	PSYCHIATRIC PARTIAL	AGGREGATE						1,045,752
200	TOTAL					641,789	485,362	10,323,837

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	8,455,705	8,455,705				1
2 CAP REL COSTS-MVBLE EQUIP	13,424,438		13,424,438			2
4 EMPLOYEE BENEFITS	3,754,428	3,794	6,358	3,764,580		4
5 ADMINISTRATIVE & GENERAL	53,613,433	509,904	854,533	517,922	55,495,792	5
6 MAINTENANCE & REPAIRS	2,023,796	209,075	350,382	16,041	2,599,294	6
7 OPERATION OF PLANT	4,632,395	434,534	728,223	22,574	5,817,726	7
8 LAUNDRY & LINEN SERVICE	1,368,079	28,976	48,560	4,292	1,449,907	8
9 HOUSEKEEPING	4,131,889	265,034	444,162	138,159	4,979,244	9
10 DIETARY	5,063,743	390,960	655,198	102,492	6,212,393	10
11 CAFETERIA	-1,361,232				-1,361,232	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,766,422	22,215	37,230	26,085	1,851,952	13
14 CENTRAL SERVICES & SUPPLY	3,047,383	139,683	234,091	24,510	3,445,667	14
15 PHARMACY	5,805,433	67,354	112,877	74,427	6,060,091	15
16 MEDICAL RECORDS & LIBRARY	2,596,907	22,201	37,205	64,816	2,721,129	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	4,568,605				4,568,605	22
23 PARAMED ED PRGM-(SPECIFY)						23
23.10 PARAMED ED - LAB	94,493			1,445	95,938	23.10
23.20 PARAMED ED PRGM - RADIOLOGY	118,844			2,948	121,792	23.20
23.30 PARAMED ED - RADIATION ONCOLOGY	164,429			2,890	167,319	23.30
23.40 PARAMED ED - PARAMEDICAL TECHS	857,827			13,093	870,920	23.40
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	32,875,688	2,095,588	3,511,940	577,506	39,060,722	30
31 INTENSIVE CARE UNIT	8,108,379	356,434	597,337	135,962	9,198,112	31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF	2,072,772	246,494	413,092	38,601	2,770,959	40
43 NURSERY	3,981,160	68,904	115,475	46,318	4,211,857	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	26,772,854	566,645	949,624	177,598	28,466,721	50
50.20 GASTROENTEROLOGY	900,860	83,355	139,693	13,194	1,137,102	50.20
52 DELIVERY ROOM & LABOR ROOM	3,874,001	405,972	680,356	60,697	5,021,026	52
53 ANESTHESIOLOGY	331,921	19,868	33,297		385,086	53
54 RADIOLOGY-DIAGNOSTIC	23,612,309	891,299	1,493,701	212,860	26,210,169	54
54.10 RADIATION ONCOLOGY	13,538,493	121,335	203,342	57,937	13,921,107	54.10
54.20 CT	2,506,524	42,482	71,195	20,391	2,640,592	54.20
54.30 MRI	2,001,686	44,918	75,276	21,056	2,142,936	54.30
60 LABORATORY	11,719,709	213,488	357,779	103,532	12,394,508	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	3,264,770	54,749	91,751	56,564	3,467,834	65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
66 PHYSICAL THERAPY	5,272,127	53,081	88,956	76,406	5,490,570	66
69 ELECTROCARDIOLOGY	1,163,111	54,675	91,628	15,998	1,325,412	69
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	1,204,242	61,229	102,611	19,423	1,387,505	70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	3,982,391				3,982,391	71
73 DRUGS CHARGED TO PATIENTS	9,492,226				9,492,226	73
75.10 NUTRITIONAL SUPPORT	119,810				119,810	75.10
75.20 HEMODIALYSIS	656,831	32,947	55,214		744,992	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
90 OUTPATIENT SERVICE COST CENTERS CLINIC	2,356,791			26,129	2,382,920	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	12,019,674	340,020	569,829	183,711	13,113,234	91
91.05 AMBULATORY CARE	45,458	54,247	90,910	737	191,352	91.05
91.10 PSYCHIATRIC PARTIAL	1,197,304	50,409	84,479	28,961	1,361,153	91.10
92 OBSERVATION BEDS OTHER REIMBURSABLE COST CENTERS						92
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	8,386,317	2,214	3,711	115,412	8,507,654	101
118 SUBTOTALS (SUM OF LINES 1-117)	295,584,425	7,954,083	13,330,015	3,000,687	294,224,487	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	701,813	37,670	63,130	10,983	813,596	190
190.10 MCC WORD PROCESSING						190.10
192 PHYSICIANS' PRIVATE OFFICES		38,984			38,984	192
192.01 SPECIALISTS/PCP'S	76,200,983	85,023		706,780	76,992,786	192.01
192.02 MEDWORKS						192.02
192.03 SWEDISHAMERICAN ER	2,596,383				2,596,383	192.03
192.20 IDLE SPACE		321,273			321,273	192.20
193 NONPAID WORKERS	37,751			751	38,502	193
193.10 HOTEL						193.10
193.30 PHYSICIAN BILLING						193.30
193.40 MEALS ON WHEELS						193.40
193.50 WEE CARE						193.50
193.60 PHYSICIAN RELATED AREAS	1,321,040			18,440	1,339,480	193.60
193.70 WOMEN'S CENTER						193.70
193.80 MARKETING EXPENSES	2,652,486	4,797	8,040	8,079	2,673,402	193.80
193.90 COMPLIMENTARY MEDICINE	818,160	13,875	23,253	18,860	874,148	193.90

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	379,913,041	8,455,705	13,424,438	3,764,580	379,913,041	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAINT- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	55,495,792					5
6 MAINTENANCE & REPAIRS	586,791	3,186,085				6
7 OPERATION OF PLANT	1,313,352	186,795	7,317,873			7
8 LAUNDRY & LINEN SERVICE	327,317	12,456	29,053	1,818,733		8
9 HOUSEKEEPING	1,124,064	113,931	265,741	114	6,483,094	9
10 DIETARY	1,402,448	168,064	392,003	11,128	379,259	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	418,078	9,550	22,275		21,550	13
14 CENTRAL SERVICES & SUPPLY	777,859	60,046	140,056	40,857	135,503	14
15 PHARMACY	1,368,066	28,954	67,534		65,339	15
16 MEDICAL RECORDS & LIBRARY	614,295	9,543	22,260		21,536	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	1,031,363					22
23 PARAMED ED PRGM-(SPECIFY)						23
23.10 PARAMED ED - LAB	21,658					23.10
23.20 PARAMED ED PRGM - RADIOLOGY	27,495					23.20
23.30 PARAMED ED - RADIATION ONCOLOGY	37,772					23.30
23.40 PARAMED ED - PARAMEDICAL TECHS	196,610					23.40
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	8,817,836	900,843	2,101,181	805,818	2,032,868	30
31 INTENSIVE CARE UNIT	2,076,474	153,222	357,385	122,460	345,766	31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF	625,544	105,962	247,152	17,821	239,116	40
43 NURSERY	950,827	29,620	69,088	30,969	66,842	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,426,362	243,586	568,157	129,653	549,686	50
50.20 GASTROENTEROLOGY	256,701	35,832	83,578	25,765	80,861	50.20
52 DELIVERY ROOM & LABOR ROOM	1,133,497	174,517	407,055		393,821	52
53 ANESTHESIOLOGY	86,933	8,541	19,921		19,274	53
54 RADIOLOGY-DIAGNOSTIC	5,916,946	383,147	893,677	92,717	864,623	54
54.10 RADIATION ONCOLOGY	3,142,690	52,159	121,659	13,552	117,704	54.10
54.20 CT	596,114	18,262	42,596		41,211	54.20
54.30 MRI	483,768	19,309	45,038	8,389	43,573	54.30
60 LABORATORY	2,798,060	91,773	214,058		207,099	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	782,864	23,535	54,895	703	53,110	65
66 PHYSICAL THERAPY	1,239,496	22,818	53,222		51,492	66
69 ELECTROCARDIOLOGY	299,212	23,503	54,821	11,001	53,038	69

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAINT- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	313,229	26,321	61,392	2,395	59,396	70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	899,025					71
73 DRUGS CHARGED TO PATIENTS	2,142,870					73
75.10 NUTRITIONAL SUPPORT	27,047					75.10
75.20 HEMODIALYSIS	168,182	14,163	33,034	3,351	31,960	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	537,944					90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	2,960,313	146,166	340,927	489,888	329,843	91
91.05 AMBULATORY CARE	43,198	23,319	54,391	8,468	52,623	91.05
91.10 PSYCHIATRIC PARTIAL	307,280	21,669	50,543	3,684	48,900	91.10
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,920,603	952	2,220		2,148	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	54,200,183	3,108,558	6,814,912	1,818,733	6,308,141	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	183,669	16,193	37,771		36,543	190
190.10 MCC WORD PROCESSING						190.10
192 PHYSICIANS' PRIVATE OFFICES		16,758	39,088		37,817	192
192.01 SPECIALISTS/PCP'S		36,549	85,250		82,479	192.01
192.02 MEDWORKS						192.02
192.03 SWEDISHAMERICAN ER						192.03
192.20 IDLE SPACE			322,130			192.20
193 NONPAID WORKERS	8,692					193
193.10 HOTEL						193.10
193.30 PHYSICIAN BILLING						193.30
193.40 MEALS ON WHEELS						193.40
193.50 WEE CARE						193.50
193.60 PHYSICIAN RELATED AREAS	302,388					193.60
193.70 WOMEN'S CENTER						193.70
193.80 MARKETING EXPENSES	603,521	2,062	4,810		4,654	193.80
193.90 COMPLIMENTARY MEDICINE	197,339	5,965	13,912		13,460	193.90
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	55,495,792	3,186,085	7,317,873	1,818,733	6,483,094	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY 10	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES * SUPPLY 14	PHARMACY 15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	8,565,295					10
11 CAFETERIA	5,281,573	3,920,341				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		45,178	2,368,583			13
14 CENTRAL SERVICES & SUPPLY		42,449		4,642,437		14
15 PHARMACY		128,900		15,188	7,734,072	15
16 MEDICAL RECORDS & LIBRARY		112,256		12		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
23.10 PARAMED ED - LAB		2,503				23.10
23.20 PARAMED ED PRGM - RADIOLOGY		5,106		3		23.20
23.30 PARAMED ED - RADIATION ONCOLOGY		5,006				23.30
23.40 PARAMED ED - PARAMEDICAL TECHS			51	3,261	18,024	23.40
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,869,978	1,000,192	1,004,016	150,450	545	30
31 INTENSIVE CARE UNIT	225,335	235,474	316,635	46,349	351	31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF	188,409	66,853	41,084	2,418	2	40
43 NURSERY		80,218	120,901	12,965	290	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		307,583	266,413	2,436,278	435	50
50.20 GASTROENTEROLOGY		22,852	21,801	13,262	68	50.20
52 DELIVERY ROOM & LABOR ROOM		105,122	139,864	20,676		52
53 ANESTHESIOLOGY				1,056		53
54 RADIOLOGY-DIAGNOSTIC		368,654	94,830	863,448	21,814	54
54.10 RADIATION ONCOLOGY		100,342	12,907	39,937	3,616,041	54.10
54.20 CT		35,316		43,154	116,217	54.20
54.30 MRI		36,467		40		54.30
60 LABORATORY		179,309		17,758	148	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		97,964		31,378	23,001	65
66 PHYSICAL THERAPY		132,329		8,504	109	66
69 ELECTROCARDIOLOGY		27,707	14,523	16,854	64	69

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY 10	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES * SUPPLY 14	PHARMACY 15	
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY		33,639		6,346		70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS				692,339		71
73 DRUGS CHARGED TO PATIENTS					3,896,953	73
75.10 NUTRITIONAL SUPPORT						75.10
75.20 HEMODIALYSIS				1,178	223	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		45,253	18,771	18,912	34,060	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY		318,171	308,295	199,776	552	91
91.05 AMBULATORY CARE		1,276		195		91.05
91.10 PSYCHIATRIC PARTIAL		50,158	8,492	511		91.10
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY						101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	8,565,295	3,586,277	2,368,583	4,642,248	7,728,897	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		19,022				190
190.10 MCC WORD PROCESSING						190.10
192 PHYSICIANS' PRIVATE OFFICES						192
192.01 SPECIALISTS/PCP'S		250,216				192.01
192.02 MEDWORKS						192.02
192.03 SWEDISHAMERICAN ER						192.03
192.20 IDLE SPACE						192.20
193 NONPAID WORKERS		1,302			5,170	193
193.10 HOTEL						193.10
193.30 PHYSICIAN BILLING						193.30
193.40 MEALS ON WHEELS						193.40
193.50 WEE CARE						193.50
193.60 PHYSICIAN RELATED AREAS		16,870		13	5	193.60
193.70 WOMEN'S CENTER						193.70
193.80 MARKETING EXPENSES		13,991		3		193.80
193.90 COMPLIMENTARY MEDICINE		32,663		173		193.90
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	8,565,295	3,920,341	2,368,583	4,642,437	7,734,072	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	PARAMED ED LAB	PARAMED ED PRGM RADIOLOGY	PARAMED ED PRGM RAD ONC	
	16	22	23.10	23.20	23.30	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	3,501,031					16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD		5,599,968				22
23 PARAMED ED PRGM-(SPECIFY)						23
23.10 PARAMED ED - LAB			120,099			23.10
23.20 PARAMED ED PRGM - RADIOLOGY				154,396		23.20
23.30 PARAMED ED - RADIATION ONCOLOGY					210,097	23.30
23.40 PARAMED ED - PARAMEDICAL TECHS						23.40
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	268,050	3,113,082				30
31 INTENSIVE CARE UNIT	112,257	214,695				31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF	19,773	214,695				40
43 NURSERY	27,376	286,260				43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	594,732	536,738				50
50.20 GASTROENTEROLOGY	23,008	214,695				50.20
52 DELIVERY ROOM & LABOR ROOM	54,846					52
53 ANESTHESIOLOGY	31,020					53
54 RADIOLOGY-DIAGNOSTIC	510,290			154,396		54
54.10 RADIATION ONCOLOGY	228,882				210,097	54.10
54.20 CT	151,289					54.20
54.30 MRI	68,833					54.30
60 LABORATORY	427,342		120,099			60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	71,532					65
66 PHYSICAL THERAPY	75,571					66
69 ELECTROCARDIOLOGY	82,026	250,478				69

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	PARAMED ED LAB	PARAMED ED PRGM RADIOLOGY	PARAMED ED PRGM RAD ONC	
	16	22	23.10	23.20	23.30	
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	31,356					70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	132,495					71
73 DRUGS CHARGED TO PATIENTS	347,280					73
75.10 NUTRITIONAL SUPPORT	1,687					75.10
75.20 HEMODIALYSIS	7,092	268,369				75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	11,508					90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	218,062	500,956				91
91.05 AMBULATORY CARE	637					91.05
91.10 PSYCHIATRIC PARTIAL	4,087					91.10
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY						101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	3,501,031	5,599,968	120,099	154,396	210,097	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.10 MCC WORD PROCESSING						190.10
192 PHYSICIANS' PRIVATE OFFICES						192
192.01 SPECIALISTS/PCP'S						192.01
192.02 MEDWORKS						192.02
192.03 SWEDISHAMERICAN ER						192.03
192.20 IDLE SPACE						192.20
193 NONPAID WORKERS						193
193.10 HOTEL						193.10
193.30 PHYSICIAN BILLING						193.30
193.40 MEALS ON WHEELS						193.40
193.50 WEE CARE						193.50
193.60 PHYSICIAN RELATED AREAS						193.60
193.70 WOMEN'S CENTER						193.70
193.80 MARKETING EXPENSES						193.80
193.90 COMPLIMENTARY MEDICINE						193.90
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	3,501,031	5,599,968	120,099	154,396	210,097	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	PARAMED ED PRGM PARAMEDICS 23.40	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
23.10 PARAMED ED - LAB					23.10
23.20 PARAMED ED PRGM - RADIOLOGY					23.20
23.30 PARAMED ED - RADIATION ONCOLOGY					23.30
23.40 PARAMED ED - PARAMEDICAL TECHS	1,088,866				23.40
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS		62,125,581	-3,113,082	59,012,499	30
31 INTENSIVE CARE UNIT		13,404,515	-214,695	13,189,820	31
31.01 PEDIATRIC ICU					31.01
40 SUBPROVIDER - IPF		4,539,788	-214,695	4,325,093	40
43 NURSERY		5,887,213	-286,260	5,600,953	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		40,526,344	-536,738	39,989,606	50
50.20 GASTROENTEROLOGY		1,915,525	-214,695	1,700,830	50.20
52 DELIVERY ROOM & LABOR ROOM		7,450,424		7,450,424	52
53 ANESTHESIOLOGY		551,831		551,831	53
54 RADIOLOGY-DIAGNOSTIC		36,374,711		36,374,711	54
54.10 RADIATION ONCOLOGY		21,577,077		21,577,077	54.10
54.20 CT		3,684,751		3,684,751	54.20
54.30 MRI		2,848,353		2,848,353	54.30
60 LABORATORY		16,450,154		16,450,154	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY		4,606,816		4,606,816	65
66 PHYSICAL THERAPY		7,074,111		7,074,111	66
69 ELECTROCARDIOLOGY		2,158,639	-250,478	1,908,161	69

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	PARAMED ED PRGM PARAMEDICS 23.40	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
69.10 PEDIATRIC CARDIOLOGY					69.10
70 ELECTROENCEPHALOGRAPHY		1,921,579		1,921,579	70
70.10 APNEA MONITORING					70.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS		5,706,250		5,706,250	71
73 DRUGS CHARGED TO PATIENTS		15,879,329		15,879,329	73
75.10 NUTRITIONAL SUPPORT		148,544		148,544	75.10
75.20 HEMODIALYSIS		1,272,544	-268,369	1,004,175	75.20
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		3,049,368		3,049,368	90
90.01 CHILDRENS CLINIC					90.01
91 EMERGENCY	1,088,866	20,015,049	-500,956	19,514,093	91
91.05 AMBULATORY CARE		375,459		375,459	91.05
91.10 PSYCHIATRIC PARTIAL		1,856,477		1,856,477	91.10
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY		10,433,577		10,433,577	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	1,088,866	291,834,009	-5,599,968	286,234,041	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,106,794		1,106,794	190
190.10 MCC WORD PROCESSING					190.10
192 PHYSICIANS' PRIVATE OFFICES		132,647		132,647	192
192.01 SPECIALISTS/PCP'S		77,447,280		77,447,280	192.01
192.02 MEDWORKS					192.02
192.03 SWEDISHAMERICAN ER		2,596,383		2,596,383	192.03
192.20 IDLE SPACE		643,403		643,403	192.20
193 NONPAID WORKERS		53,666		53,666	193
193.10 HOTEL					193.10
193.30 PHYSICIAN BILLING					193.30
193.40 MEALS ON WHEELS					193.40
193.50 WEE CARE					193.50
193.60 PHYSICIAN RELATED AREAS		1,658,756		1,658,756	193.60
193.70 WOMEN'S CENTER					193.70
193.80 MARKETING EXPENSES		3,302,443		3,302,443	193.80
193.90 COMPLIMENTARY MEDICINE		1,137,660		1,137,660	193.90
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	1,088,866	379,913,041	-5,599,968	374,313,073	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		3,794	6,358	10,152	10,152	4
5 ADMINISTRATIVE & GENERAL		509,904	854,533	1,364,437	1,397	5
6 MAINTENANCE & REPAIRS		209,075	350,382	559,457	43	6
7 OPERATION OF PLANT		434,534	728,223	1,162,757	61	7
8 LAUNDRY & LINEN SERVICE		28,976	48,560	77,536	12	8
9 HOUSEKEEPING		265,034	444,162	709,196	373	9
10 DIETARY		390,960	655,198	1,046,158	276	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		22,215	37,230	59,445	70	13
14 CENTRAL SERVICES & SUPPLY		139,683	234,091	373,774	66	14
15 PHARMACY		67,354	112,877	180,231	201	15
16 MEDICAL RECORDS & LIBRARY		22,201	37,205	59,406	175	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
23.10 PARAMED ED - LAB					4	23.10
23.20 PARAMED ED PRGM - RADIOLOGY					8	23.20
23.30 PARAMED ED - RADIATION ONCOLOGY					8	23.30
23.40 PARAMED ED - PARAMEDICAL TECHS					35	23.40
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		2,095,588	3,511,940	5,607,528	1,557	30
31 INTENSIVE CARE UNIT		356,434	597,337	953,771	367	31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF		246,494	413,092	659,586	104	40
43 NURSERY		68,904	115,475	184,379	125	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		566,645	949,624	1,516,269	479	50
50.20 GASTROENTEROLOGY		83,355	139,693	223,048	36	50.20
52 DELIVERY ROOM & LABOR ROOM		405,972	680,356	1,086,328	164	52
53 ANESTHESIOLOGY		19,868	33,297	53,165		53
54 RADIOLOGY-DIAGNOSTIC		891,299	1,493,701	2,385,000	574	54
54.10 RADIATION ONCOLOGY		121,335	203,342	324,677	156	54.10
54.20 CT		42,482	71,195	113,677	55	54.20
54.30 MRI		44,918	75,276	120,194	57	54.30
60 LABORATORY		213,488	357,779	571,267	279	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		54,749	91,751	146,500	153	65
66 PHYSICAL THERAPY		53,081	88,956	142,037	206	66
69 ELECTROCARDIOLOGY		54,675	91,628	146,303	43	69

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY		61,229	102,611	163,840	52	70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
75.10 NUTRITIONAL SUPPORT						75.10
75.20 HEMODIALYSIS		32,947	55,214	88,161		75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC					70	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY		340,020	569,829	909,849	495	91
91.05 AMBULATORY CARE		54,247	90,910	145,157	2	91.05
91.10 PSYCHIATRIC PARTIAL		50,409	84,479	134,888	78	91.10
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		2,214	3,711	5,925	311	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)		7,954,083	13,330,015	21,284,098	8,092	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		37,670	63,130	100,800	30	190
190.10 MCC WORD PROCESSING						190.10
192 PHYSICIANS' PRIVATE OFFICES		38,984		38,984		192
192.01 SPECIALISTS/PCP'S		85,023		85,023	1,905	192.01
192.02 MEDWORKS						192.02
192.03 SWEDISHAMERICAN ER						192.03
192.20 IDLE SPACE		321,273		321,273		192.20
193 NONPAID WORKERS					2	193
193.10 HOTEL						193.10
193.30 PHYSICIAN BILLING						193.30
193.40 MEALS ON WHEELS						193.40
193.50 WEE CARE						193.50
193.60 PHYSICIAN RELATED AREAS					50	193.60
193.70 WOMEN'S CENTER						193.70
193.80 MARKETING EXPENSES		4,797	8,040	12,837	22	193.80
193.90 COMPLIMENTARY MEDICINE		13,875	23,253	37,128	51	193.90
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		8,455,705	13,424,438	21,880,143	10,152	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAINT- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	1,365,834					5
6 MAINTENANCE & REPAIRS	14,442	573,942				6
7 OPERATION OF PLANT	32,323	33,649	1,228,790			7
8 LAUNDRY & LINEN SERVICE	8,056	2,244	4,878	92,726		8
9 HOUSEKEEPING	27,665	20,524	44,622	6	802,386	9
10 DIETARY	34,516	30,275	65,824	567	46,939	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	10,289	1,720	3,740		2,667	13
14 CENTRAL SERVICES & SUPPLY	19,144	10,817	23,518	2,083	16,771	14
15 PHARMACY	33,670	5,216	11,340		8,087	15
16 MEDICAL RECORDS & LIBRARY	15,119	1,719	3,738		2,665	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	25,383					22
23 PARAMED ED PRGM-(SPECIFY)						23
23.10 PARAMED ED - LAB	533					23.10
23.20 PARAMED ED PRGM - RADIOLOGY	677					23.20
23.30 PARAMED ED - RADIATION ONCOLOGY	930					23.30
23.40 PARAMED ED - PARAMEDICAL TECHS	4,839					23.40
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	217,026	162,278	352,822	41,083	251,601	30
31 INTENSIVE CARE UNIT	51,105	27,601	60,011	6,243	42,794	31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF	15,395	19,088	41,501	909	29,594	40
43 NURSERY	23,401	5,336	11,601	1,579	8,273	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	158,161	43,880	95,403	6,610	68,032	50
50.20 GASTROENTEROLOGY	6,318	6,455	14,034	1,314	10,008	50.20
52 DELIVERY ROOM & LABOR ROOM	27,897	31,438	68,351		48,742	52
53 ANESTHESIOLOGY	2,140	1,539	3,345		2,385	53
54 RADIOLOGY-DIAGNOSTIC	145,624	69,020	150,063	4,727	107,011	54
54.10 RADIATION ONCOLOGY	77,346	9,396	20,429	691	14,568	54.10
54.20 CT	14,671	3,290	7,152		5,100	54.20
54.30 MRI	11,906	3,478	7,563	428	5,393	54.30
60 LABORATORY	68,864	16,532	35,944		25,632	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	19,267	4,240	9,218	36	6,573	65
66 PHYSICAL THERAPY	30,506	4,110	8,937		6,373	66
69 ELECTROCARDIOLOGY	7,364	4,234	9,205	561	6,564	69

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAINT- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	7,709	4,741	10,309	122	7,351	70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	22,126					71
73 DRUGS CHARGED TO PATIENTS	52,739					73
75.10 NUTRITIONAL SUPPORT	666					75.10
75.20 HEMODIALYSIS	4,139	2,551	5,547	171	3,956	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	13,240					90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	72,857	26,330	57,247	24,976	40,823	91
91.05 AMBULATORY CARE	1,063	4,201	9,133	432	6,513	91.05
91.10 PSYCHIATRIC PARTIAL	7,563	3,904	8,487	188	6,052	91.10
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	47,269	171	373		266	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,333,948	559,977	1,144,335	92,726	780,733	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,520	2,917	6,342		4,523	190
190.10 MCC WORD PROCESSING						190.10
192 PHYSICIANS' PRIVATE OFFICES		3,019	6,563		4,680	192
192.01 SPECIALISTS/PCP'S		6,584	14,315		10,208	192.01
192.02 MEDWORKS						192.02
192.03 SWEDISHAMERICAN ER						192.03
192.20 IDLE SPACE			54,091			192.20
193 NONPAID WORKERS	214					193
193.10 HOTEL						193.10
193.30 PHYSICIAN BILLING						193.30
193.40 MEALS ON WHEELS						193.40
193.50 WEE CARE						193.50
193.60 PHYSICIAN RELATED AREAS	7,442					193.60
193.70 WOMEN'S CENTER						193.70
193.80 MARKETING EXPENSES	14,853	371	808		576	193.80
193.90 COMPLIMENTARY MEDICINE	4,857	1,074	2,336		1,666	193.90
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,365,834	573,942	1,228,790	92,726	802,386	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY 10	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES * SUPPLY 14	PHARMACY 15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	1,224,555					10
11 CAFETERIA	755,091	560,479				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		6,459	84,390			13
14 CENTRAL SERVICES & SUPPLY		6,069		452,242		14
15 PHARMACY		18,428		1,480	258,653	15
16 MEDICAL RECORDS & LIBRARY		16,049		1		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
23.10 PARAMED ED - LAB		358				23.10
23.20 PARAMED ED PRGM - RADIOLOGY		730				23.20
23.30 PARAMED ED - RADIATION ONCOLOGY		716				23.30
23.40 PARAMED ED - PARAMEDICAL TECHS			2	318	603	23.40
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	410,312	142,992	35,772	14,656	18	30
31 INTENSIVE CARE UNIT	32,216	33,665	11,281	4,515	12	31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF	26,936	9,558	1,464	236		40
43 NURSERY		11,469	4,307	1,263	10	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		43,974	9,492	237,327	15	50
50.20 GASTROENTEROLOGY		3,267	777	1,292	2	50.20
52 DELIVERY ROOM & LABOR ROOM		15,029	4,983	2,014		52
53 ANESTHESIOLOGY				103		53
54 RADIOLOGY-DIAGNOSTIC		52,705	3,379	84,114	730	54
54.10 RADIATION ONCOLOGY		14,346	460	3,890	120,934	54.10
54.20 CT		5,049		4,204	3,887	54.20
54.30 MRI		5,214		4		54.30
60 LABORATORY		25,635		1,730	5	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		14,006		3,057	769	65
66 PHYSICAL THERAPY		18,919		828	4	66
69 ELECTROCARDIOLOGY		3,961	517	1,642	2	69

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY 10	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES * SUPPLY 14	PHARMACY 15	
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY		4,809		618		70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS				67,445		71
73 DRUGS CHARGED TO PATIENTS					130,325	73
75.10 NUTRITIONAL SUPPORT						75.10
75.20 HEMODIALYSIS				115	7	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		6,470	669	1,842	1,139	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY		45,488	10,984	19,461	18	91
91.05 AMBULATORY CARE		182		19		91.05
91.10 PSYCHIATRIC PARTIAL		7,171	303	50		91.10
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY						101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,224,555	512,718	84,390	452,224	258,480	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,720				190
190.10 MCC WORD PROCESSING						190.10
192 PHYSICIANS' PRIVATE OFFICES						192
192.01 SPECIALISTS/PCP'S		35,773				192.01
192.02 MEDWORKS						192.02
192.03 SWEDISHAMERICAN ER						192.03
192.20 IDLE SPACE						192.20
193 NONPAID WORKERS		186			173	193
193.10 HOTEL						193.10
193.30 PHYSICIAN BILLING						193.30
193.40 MEALS ON WHEELS						193.40
193.50 WEE CARE						193.50
193.60 PHYSICIAN RELATED AREAS		2,412		1		193.60
193.70 WOMEN'S CENTER						193.70
193.80 MARKETING EXPENSES		2,000				193.80
193.90 COMPLIMENTARY MEDICINE		4,670		17		193.90
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER		194,612				201
202 TOTAL (SUM OF LINES 118-201)	1,224,555	755,091	84,390	452,242	258,653	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	PARAMED ED LAB	PARAMED ED PRGM RADIOLOGY	PARAMED ED PRGM RAD ONC
	16	22	23.10	23.20	23.30
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	98,872				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD		25,383			22
23 PARAMED ED PRGM-(SPECIFY)					23
23.10 PARAMED ED - LAB			895		23.10
23.20 PARAMED ED PRGM - RADIOLOGY				1,415	23.20
23.30 PARAMED ED - RADIATION ONCOLOGY					1,654
23.40 PARAMED ED - PARAMEDICAL TECHS					23.40
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	7,578				30
31 INTENSIVE CARE UNIT	3,174				31
31.01 PEDIATRIC ICU					31.01
40 SUBPROVIDER - IPF	559				40
43 NURSERY	774				43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	16,708				50
50.20 GASTROENTEROLOGY	650				50.20
52 DELIVERY ROOM & LABOR ROOM	1,551				52
53 ANESTHESIOLOGY	877				53
54 RADIOLOGY-DIAGNOSTIC	14,426				54
54.10 RADIATION ONCOLOGY	6,471				54.10
54.20 CT	4,277				54.20
54.30 MRI	1,946				54.30
60 LABORATORY	12,081				60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY	2,022				65
66 PHYSICAL THERAPY	2,136				66
69 ELECTROCARDIOLOGY	2,319				69

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	PARAMED ED LAB	PARAMED ED PRGM RADIOLOGY	PARAMED ED PRGM RAD ONC	
	16	22	23.10	23.20	23.30	
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	886					70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	3,746					71
73 DRUGS CHARGED TO PATIENTS	9,818					73
75.10 NUTRITIONAL SUPPORT	48					75.10
75.20 HEMODIALYSIS	201					75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	325					90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	6,165					91
91.05 AMBULATORY CARE	18					91.05
91.10 PSYCHIATRIC PARTIAL	116					91.10
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY						101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	98,872					118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.10 MCC WORD PROCESSING						190.10
192 PHYSICIANS' PRIVATE OFFICES						192
192.01 SPECIALISTS/PCP'S						192.01
192.02 MEDWORKS						192.02
192.03 SWEDISHAMERICAN ER						192.03
192.20 IDLE SPACE						192.20
193 NONPAID WORKERS						193
193.10 HOTEL						193.10
193.30 PHYSICIAN BILLING						193.30
193.40 MEALS ON WHEELS						193.40
193.50 WEE CARE						193.50
193.60 PHYSICIAN RELATED AREAS						193.60
193.70 WOMEN'S CENTER						193.70
193.80 MARKETING EXPENSES						193.80
193.90 COMPLIMENTARY MEDICINE						193.90
200 CROSS FOOT ADJUSTMENTS		25,383	895	1,415	1,654	200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	98,872	25,383	895	1,415	1,654	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	PARAMED ED PRGM PARAMEDICS 23.40	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
23.10 PARAMED ED - LAB					23.10
23.20 PARAMED ED PRGM - RADIOLOGY					23.20
23.30 PARAMED ED - RADIATION ONCOLOGY					23.30
23.40 PARAMED ED - PARAMEDICAL TECHS	5,797				23.40
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS		7,245,223		7,245,223	30
31 INTENSIVE CARE UNIT		1,226,755		1,226,755	31
31.01 PEDIATRIC ICU					31.01
40 SUBPROVIDER - IPF		804,930		804,930	40
43 NURSERY		252,517		252,517	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		2,196,350		2,196,350	50
50.20 GASTROENTEROLOGY		267,201		267,201	50.20
52 DELIVERY ROOM & LABOR ROOM		1,286,497		1,286,497	52
53 ANESTHESIOLOGY		63,554		63,554	53
54 RADIOLOGY-DIAGNOSTIC		3,017,373		3,017,373	54
54.10 RADIATION ONCOLOGY		593,364		593,364	54.10
54.20 CT		161,362		161,362	54.20
54.30 MRI		156,183		156,183	54.30
60 LABORATORY		757,969		757,969	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY		205,841		205,841	65
66 PHYSICAL THERAPY		214,056		214,056	66
69 ELECTROCARDIOLOGY		182,715		182,715	69

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	PARAMED ED PRGM PARAMEDICS 23.40	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
69.10 PEDIATRIC CARDIOLOGY					69.10
70 ELECTROENCEPHALOGRAPHY		200,437		200,437	70
70.10 APNEA MONITORING					70.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS		93,317		93,317	71
73 DRUGS CHARGED TO PATIENTS		192,882		192,882	73
75.10 NUTRITIONAL SUPPORT		714		714	75.10
75.20 HEMODIALYSIS		104,848		104,848	75.20
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		23,755		23,755	90
90.01 CHILDRENS CLINIC					90.01
91 EMERGENCY		1,214,693		1,214,693	91
91.05 AMBULATORY CARE		166,720		166,720	91.05
91.10 PSYCHIATRIC PARTIAL		168,800		168,800	91.10
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY		54,315		54,315	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)		20,852,371		20,852,371	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		121,852		121,852	190
190.10 MCC WORD PROCESSING					190.10
192 PHYSICIANS' PRIVATE OFFICES		53,246		53,246	192
192.01 SPECIALISTS/PCP'S		153,808		153,808	192.01
192.02 MEDWORKS					192.02
192.03 SWEDISHAMERICAN ER					192.03
192.20 IDLE SPACE		375,364		375,364	192.20
193 NONPAID WORKERS		575		575	193
193.10 HOTEL					193.10
193.30 PHYSICIAN BILLING					193.30
193.40 MEALS ON WHEELS					193.40
193.50 WEE CARE					193.50
193.60 PHYSICIAN RELATED AREAS		9,905		9,905	193.60
193.70 WOMEN'S CENTER					193.70
193.80 MARKETING EXPENSES		31,467		31,467	193.80
193.90 COMPLIMENTARY MEDICINE		51,799		51,799	193.90
200 CROSS FOOT ADJUSTMENTS	5,797	35,144		35,144	200
201 NEGATIVE COST CENTER		194,612		194,612	201
202 TOTAL (SUM OF LINES 118-201)	5,797	21,880,143		21,880,143	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP	CAP	EMPLOYEE	RECON-	ADMINIS-
	BLDGS & FIXTURES SQUARE FEET	MOVABLE EQUIPMENT SQUARE FEET	BENEFITS FTE'S		
	1	2	4	5A	5
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT	572,841				1
2 CAP REL COSTS-MVBLE EQUIP		542,675			2
4 EMPLOYEE BENEFITS	257	257	260,493		4
5 ADMINISTRATIVE & GENERAL	34,544	34,544	35,838	-55,495,792	245,829,055
6 MAINTENANCE & REPAIRS	14,164	14,164	1,110		2,599,294
7 OPERATION OF PLANT	29,438	29,438	1,562		5,817,726
8 LAUNDRY & LINEN SERVICE	1,963	1,963	297		1,449,907
9 HOUSEKEEPING	17,955	17,955	9,560		4,979,244
10 DIETARY	26,486	26,486	7,092		6,212,393
11 CAFETERIA				1,361,232	
12 MAINTENANCE OF PERSONNEL					
13 NURSING ADMINISTRATION	1,505	1,505	1,805		1,851,952
14 CENTRAL SERVICES & SUPPLY	9,463	9,463	1,696		3,445,667
15 PHARMACY	4,563	4,563	5,150		6,060,091
16 MEDICAL RECORDS & LIBRARY	1,504	1,504	4,485		2,721,129
17 SOCIAL SERVICE					
19 NONPHYSICIAN ANESTHETISTS					
20 NURSING SCHOOL					
21 I&R SRVCES-SALARY & FRINGES APPRVD					
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					4,568,605
23 PARAMED ED PRGM-(SPECIFY)					
23.10 PARAMED ED - LAB			100		95,938
23.20 PARAMED ED PRGM - RADIOLOGY			204		121,792
23.30 PARAMED ED - RADIATION ONCOLOGY			200		167,319
23.40 PARAMED ED - PARAMEDICAL TECHS			906		870,920
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	141,968	141,968	39,961		39,060,722
31 INTENSIVE CARE UNIT	24,147	24,147	9,408		9,198,112
31.01 PEDIATRIC ICU					
40 SUBPROVIDER - IPF	16,699	16,699	2,671		2,770,959
43 NURSERY	4,668	4,668	3,205		4,211,857
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	38,388	38,388	12,289		28,466,721
50.20 GASTROENTEROLOGY	5,647	5,647	913		1,137,102
52 DELIVERY ROOM & LABOR ROOM	27,503	27,503	4,200		5,021,026
53 ANESTHESIOLOGY	1,346	1,346			385,086
54 RADIOLOGY-DIAGNOSTIC	60,382	60,382	14,729		26,210,169
54.10 RADIATION ONCOLOGY	8,220	8,220	4,009		13,921,107
54.20 CT	2,878	2,878	1,411		2,640,592
54.30 MRI	3,043	3,043	1,457		2,142,936
60 LABORATORY	14,463	14,463	7,164		12,394,508
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					
65 RESPIRATORY THERAPY	3,709	3,709	3,914		3,467,834
66 PHYSICAL THERAPY	3,596	3,596	5,287		5,490,570

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS FTE'S	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
69 ELECTROCARDIOLOGY	3,704	3,704	1,107		1,325,412	69
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	4,148	4,148	1,344		1,387,505	70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					3,982,391	71
73 DRUGS CHARGED TO PATIENTS					9,492,226	73
75.10 NUTRITIONAL SUPPORT					119,810	75.10
75.20 HEMODIALYSIS	2,232	2,232			744,992	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC			1,808		2,382,920	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	23,035	23,035	12,712		13,113,234	91
91.05 AMBULATORY CARE	3,675	3,675	51		191,352	91.05
91.10 PSYCHIATRIC PARTIAL	3,415	3,415	2,004		1,361,153	91.10
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	150	150	7,986		8,507,654	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	538,858	538,858	207,635	-54,134,560	240,089,927	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,552	2,552	760		813,596	190
190.10 MCC WORD PROCESSING						190.10
192 PHYSICIANS' PRIVATE OFFICES	2,641			-38,984		192
192.01 SPECIALISTS/PCP'S	5,760		48,906	-76,992,786		192.01
192.02 MEDWORKS						192.02
192.03 SWEDISHAMERICAN ER				-2,596,383		192.03
192.20 IDLE SPACE	21,765			-321,273		192.20
193 NONPAID WORKERS			52		38,502	193
193.10 HOTEL						193.10
193.30 PHYSICIAN BILLING						193.30
193.40 MEALS ON WHEELS						193.40
193.50 WEE CARE						193.50
193.60 PHYSICIAN RELATED AREAS			1,276		1,339,480	193.60
193.70 WOMEN'S CENTER						193.70
193.80 MARKETING EXPENSES	325	325	559		2,673,402	193.80
193.90 COMPLIMENTARY MEDICINE	940	940	1,305		874,148	193.90

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS FTE'S 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	8,455,705	13,424,438	3,764,580		55,495,792	202
203 UNIT COST MULT-WS B PT I	14.760998	24.737528	14.451751		0.225750	203
204 COST TO BE ALLOC PER B PT II			10,152		1,365,834	204
205 UNIT COST MULT-WS B PT II			0.038972		0.005556	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAINT- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	
	6	7	8	9	10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	502,111					6
7 OPERATION OF PLANT	29,438	494,438				7
8 LAUNDRY & LINEN SERVICE	1,963	1,963	1,752,091			8
9 HOUSEKEEPING	17,955	17,955	110	452,755		9
10 DIETARY	26,486	26,486	10,720	26,486	539,761	10
11 CAFETERIA					332,830	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,505	1,505		1,505		13
14 CENTRAL SERVICES & SUPPLY	9,463	9,463	39,360	9,463		14
15 PHARMACY	4,563	4,563		4,563		15
16 MEDICAL RECORDS & LIBRARY	1,504	1,504		1,504		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
23.10 PARAMED ED - LAB						23.10
23.20 PARAMED ED PRGM - RADIOLOGY						23.20
23.30 PARAMED ED - RADIATION ONCOLOGY						23.30
23.40 PARAMED ED - PARAMEDICAL TECHS						23.40
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	141,968	141,968	776,292	141,968	180,858	30
31 INTENSIVE CARE UNIT	24,147	24,147	117,973	24,147	14,200	31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF	16,699	16,699	17,168	16,699	11,873	40
43 NURSERY	4,668	4,668	29,834	4,668		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	38,388	38,388	124,902	38,388		50
50.20 GASTROENTEROLOGY	5,647	5,647	24,821	5,647		50.20
52 DELIVERY ROOM & LABOR ROOM	27,503	27,503		27,503		52
53 ANESTHESIOLOGY	1,346	1,346		1,346		53
54 RADIOLOGY-DIAGNOSTIC	60,382	60,382	89,320	60,382		54
54.10 RADIATION ONCOLOGY	8,220	8,220	13,055	8,220		54.10
54.20 CT	2,878	2,878		2,878		54.20
54.30 MRI	3,043	3,043	8,082	3,043		54.30
60 LABORATORY	14,463	14,463		14,463		60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	3,709	3,709	677	3,709		65
66 PHYSICAL THERAPY	3,596	3,596		3,596		66

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MAINT- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED
		6	7	8	9	10
69	ELECTROCARDIOLOGY	3,704	3,704	10,598	3,704	69
69.10	PEDIATRIC CARDIOLOGY					69.10
70	ELECTROENCEPHALOGRAPHY	4,148	4,148	2,307	4,148	70
70.10	APNEA MONITORING					70.10
71	MEDICAL SUPPLIES CHRGD TO PATIENTS					71
73	DRUGS CHARGED TO PATIENTS					73
75.10	NUTRITIONAL SUPPORT					75.10
75.20	HEMODIALYSIS	2,232	2,232	3,228	2,232	75.20
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC					90
90.01	CHILDRENS CLINIC					90.01
91	EMERGENCY	23,035	23,035	471,937	23,035	91
91.05	AMBULATORY CARE	3,675	3,675	8,158	3,675	91.05
91.10	PSYCHIATRIC PARTIAL	3,415	3,415	3,549	3,415	91.10
92	OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
101	HOME HEALTH AGENCY	150	150		150	101
SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	489,893	460,455	1,752,091	440,537	539,761 118
NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,552	2,552		2,552	190
190.10	MCC WORD PROCESSING					190.10
192	PHYSICIANS' PRIVATE OFFICES	2,641	2,641		2,641	192
192.01	SPECIALISTS/PCP'S	5,760	5,760		5,760	192.01
192.02	MEDWORKS					192.02
192.03	SWEDISHAMERICAN ER					192.03
192.20	IDLE SPACE		21,765			192.20
193	NONPAID WORKERS					193
193.10	HOTEL					193.10
193.30	PHYSICIAN BILLING					193.30
193.40	MEALS ON WHEELS					193.40
193.50	WEE CARE					193.50
193.60	PHYSICIAN RELATED AREAS					193.60
193.70	WOMEN'S CENTER					193.70
193.80	MARKETING EXPENSES	325	325		325	193.80
193.90	COMPLIMENTARY MEDICINE	940	940		940	193.90

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAINT- TENANCE & REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE- KEEPING SQUARE FEET 9	DIETARY MEALS SERVED 10	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	3,186,085	7,317,873	1,818,733	6,483,094	8,565,295	202
203 UNIT COST MULT-WS B PT I	6.345380	14.800385	1.038036	14.319210	15.868681	203
204 COST TO BE ALLOC PER B PT II	573,942	1,228,790	92,726	802,386	1,224,555	204
205 UNIT COST MULT-WS B PT II	1.143058	2.485226	0.052923	1.772230	2.268699	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA FTE'S	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES * SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
	11	13	14	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	156,631					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,805	35,817,896				13
14 CENTRAL SERVICES & SUPPLY	1,696		26,556,186			14
15 PHARMACY	5,150		86,880	18,838,719		15
16 MEDICAL RECORDS & LIBRARY	4,485		70		1,150,835,716	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
23.10 PARAMED ED - LAB	100					23.10
23.20 PARAMED ED PRGM - RADIOLOGY	204		16			23.20
23.30 PARAMED ED - RADIATION ONCOLOGY	200					23.30
23.40 PARAMED ED - PARAMEDICAL TECHS		769	18,654	43,904		23.40
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	39,961	15,182,670	860,621	1,327	88,116,403	30
31 INTENSIVE CARE UNIT	9,408	4,788,221	265,131	856	36,902,527	31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF	2,671	621,281	13,831	5	6,500,114	40
43 NURSERY	3,205	1,828,289	74,161	706	8,999,340	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,289	4,028,740	13,936,291	1,059	195,444,303	50
50.20 GASTROENTEROLOGY	913	329,686	75,862	165	7,563,335	50.20
52 DELIVERY ROOM & LABOR ROOM	4,200	2,115,050	118,275		18,029,553	52
53 ANESTHESIOLOGY			6,042		10,197,207	53
54 RADIOLOGY-DIAGNOSTIC	14,729	1,434,034	4,939,181	53,135	167,748,118	54
54.10 RADIATION ONCOLOGY	4,009	195,182	228,449	8,807,989	75,240,759	54.10
54.20 CT	1,411		246,855	283,083	49,733,401	54.20
54.30 MRI	1,457		228		22,627,487	54.30
60 LABORATORY	7,164		101,580	360	140,480,716	60
62.30 BLOOD CLOTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	3,914		179,491	56,025	23,514,682	65
66 PHYSICAL THERAPY	5,287		48,647	266	24,842,617	66

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA FTE'S	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES * SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
	11	13	14	15	16	
69 ELECTROCARDIOLOGY	1,107	219,612	96,411	155	26,964,453	69
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	1,344		36,300		10,307,616	70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			3,960,387		43,555,089	71
73 DRUGS CHARGED TO PATIENTS				9,492,226	114,161,893	73
75.10 NUTRITIONAL SUPPORT					554,718	75.10
75.20 HEMODIALYSIS			6,739	543	2,331,501	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,808	283,854	108,183	82,964	3,783,044	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	12,712	4,662,088	1,142,776	1,345	71,683,830	91
91.05 AMBULATORY CARE	51		1,118		209,424	91.05
91.10 PSYCHIATRIC PARTIAL	2,004	128,420	2,922	1	1,343,586	91.10
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY						101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	143,284	35,817,896	26,555,101	18,826,114	1,150,835,716	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	760					190
190.10 MCC WORD PROCESSING						190.10
192 PHYSICIANS' PRIVATE OFFICES						192
192.01 SPECIALISTS/PCP'S	9,997					192.01
192.02 MEDWORKS						192.02
192.03 SWEDISHAMERICAN ER						192.03
192.20 IDLE SPACE						192.20
193 NONPAID WORKERS	52			12,594		193
193.10 HOTEL						193.10
193.30 PHYSICIAN BILLING						193.30
193.40 MEALS ON WHEELS						193.40
193.50 WEE CARE						193.50
193.60 PHYSICIAN RELATED AREAS	674		76	11		193.60
193.70 WOMEN'S CENTER						193.70
193.80 MARKETING EXPENSES	559		17			193.80
193.90 COMPLIMENTARY MEDICINE	1,305		992			193.90

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA FTE'S 11	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES * SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	3,920,341	2,368,583	4,642,437	7,734,072	3,501,031	202
203 UNIT COST MULT-WS B PT I	25.029151	0.066128	0.174816	0.410541	0.003042	203
204 COST TO BE ALLOC PER B PT II	560,479	84,390	452,242	258,653	98,872	204
205 UNIT COST MULT-WS B PT II	3.578340	0.002356	0.017030	0.013730	0.000086	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED ED LAB DIRECT	PARAMED ED PRGM RADIOLOGY ASSIGNED TIME	PARAMED ED PRGM RAD ONC ASSIGNED TIME	PARAMED ED PRGM PARAMEDICS ASSIGNED TIME
	22	23.10	23.20	23.30	23.40
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	1,565				22
23 PARAMED ED PRGM-(SPECIFY)					23
23.10 PARAMED ED - LAB		100			23.10
23.20 PARAMED ED PRGM - RADIOLOGY			100		23.20
23.30 PARAMED ED - RADIATION ONCOLOGY				100	23.30
23.40 PARAMED ED - PARAMEDICAL TECHS					100 23.40
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	870				30
31 INTENSIVE CARE UNIT	60				31
31.01 PEDIATRIC ICU					31.01
40 SUBPROVIDER - IPF	60				40
43 NURSERY	80				43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	150				50
50.20 GASTROENTEROLOGY	60				50.20
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC			100		54
54.10 RADIATION ONCOLOGY				100	54.10
54.20 CT					54.20
54.30 MRI					54.30
60 LABORATORY		100			60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED ED LAB DIRECT	PARAMED ED PRGM RADIOLOGY ASSIGNED TIME	PARAMED ED PRGM RAD ONC ASSIGNED TIME	PARAMED ED PRGM PARAMEDICS ASSIGNED TIME
	22	23.10	23.20	23.30	23.40
69 ELECTROCARDIOLOGY	70				69
69.10 PEDIATRIC CARDIOLOGY					69.10
70 ELECTROENCEPHALOGRAPHY					70
70.10 APNEA MONITORING					70.10
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					71
73 DRUGS CHARGED TO PATIENTS					73
75.10 NUTRITIONAL SUPPORT					75.10
75.20 HEMODIALYSIS	75				75.20
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 CHILDRENS CLINIC					90.01
91 EMERGENCY	140				100 91
91.05 AMBULATORY CARE					91.05
91.10 PSYCHIATRIC PARTIAL					91.10
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	1,565	100	100	100	100 118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
190.10 MCC WORD PROCESSING					190.10
192 PHYSICIANS' PRIVATE OFFICES					192
192.01 SPECIALISTS/PCP'S					192.01
192.02 MEDWORKS					192.02
192.03 SWEDISHAMERICAN ER					192.03
192.20 IDLE SPACE					192.20
193 NONPAID WORKERS					193
193.10 HOTEL					193.10
193.30 PHYSICIAN BILLING					193.30
193.40 MEALS ON WHEELS					193.40
193.50 WEE CARE					193.50
193.60 PHYSICIAN RELATED AREAS					193.60
193.70 WOMEN'S CENTER					193.70
193.80 MARKETING EXPENSES					193.80
193.90 COMPLIMENTARY MEDICINE					193.90

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	I&R PROGRAM COSTS ASSIGNED TIME 22	PARAMED ED LAB DIRECT 23.10	PARAMED ED PRGM RADIOLOGY ASSIGNED TIME 23.20	PARAMED ED PRGM RAD ONC ASSIGNED TIME 23.30	PARAMED ED PRGM PARAMEDICS ASSIGNED TIME 23.40	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	5,599,968	120,099	154,396	210,097	1,088,866	202
203 UNIT COST MULT-WS B PT I	3,578.254313	1,200.990000	1,543.960000	2,100.970000	10,888.660000	203
204 COST TO BE ALLOC PER B PT II	25,383	895	1,415	1,654	5,797	204
205 UNIT COST MULT-WS B PT II	16.219169	8.950000	14.150000	16.540000	57.970000	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	59,012,499		59,012,499		59,012,499	30
31 INTENSIVE CARE UNIT	13,189,820		13,189,820	49,068	13,238,888	31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF	4,325,093		4,325,093	24,153	4,349,246	40
43 NURSERY	5,600,953		5,600,953		5,600,953	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	39,989,606		39,989,606	37,229	40,026,835	50
50.20 GASTROENTEROLOGY	1,700,830		1,700,830		1,700,830	50.20
52 DELIVERY ROOM & LABOR ROOM	7,450,424		7,450,424		7,450,424	52
53 ANESTHESIOLOGY	551,831		551,831	12,217	564,048	53
54 RADIOLOGY-DIAGNOSTIC	36,374,711		36,374,711	190,690	36,565,401	54
54.10 RADIATION ONCOLOGY	21,577,077		21,577,077	9,448	21,586,525	54.10
54.20 CT	3,684,751		3,684,751		3,684,751	54.20
54.30 MRI	2,848,353		2,848,353		2,848,353	54.30
60 LABORATORY	16,450,154		16,450,154		16,450,154	60
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
65 RESPIRATORY THERAPY	4,606,816		4,606,816		4,606,816	65
66 PHYSICAL THERAPY	7,074,111		7,074,111		7,074,111	66
69 ELECTROCARDIOLOGY	1,908,161		1,908,161		1,908,161	69
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	1,921,579		1,921,579		1,921,579	70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO	5,706,250		5,706,250		5,706,250	71
73 DRUGS CHARGED TO PATIENTS	15,879,329		15,879,329		15,879,329	73
75.10 NUTRITIONAL SUPPORT	148,544		148,544		148,544	75.10
75.20 HEMODIALYSIS	1,004,175		1,004,175		1,004,175	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,049,368		3,049,368	5,169	3,054,537	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	19,514,093		19,514,093	54,327	19,568,420	91
91.05 AMBULATORY CARE	375,459		375,459		375,459	91.05
91.10 PSYCHIATRIC PARTIAL	1,856,477		1,856,477		1,856,477	91.10
92 OBSERVATION BEDS	1,492,111		1,492,111		1,492,111	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	10,433,577		10,433,577		10,433,577	101
200 SUBTOTAL (SEE INSTRUCTIONS)	287,726,152		287,726,152	382,301	288,108,453	200
201 LESS OBSERVATION BEDS	1,492,111		1,492,111		1,492,111	201
202 TOTAL (SEE INSTRUCTIONS)	286,234,041		286,234,041	382,301	286,616,342	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	88,116,403		88,116,403			30
31 INTENSIVE CARE UNIT	36,902,527		36,902,527			31
31.01 PEDIATRIC ICU						31.01
40 SUBPROVIDER - IPF	6,500,114		6,500,114			40
43 NURSERY	8,999,340		8,999,340			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	114,439,492	81,004,811	195,444,303	0.204609	0.204609	0.204799 50
50.20 GASTROENTEROLOGY	2,827,187	4,736,148	7,563,335	0.224878	0.224878	0.224878 50.20
52 DELIVERY ROOM & LABOR ROOM	16,333,083	1,696,470	18,029,553	0.413234	0.413234	0.413234 52
53 ANESTHESIOLOGY	5,620,777	4,576,430	10,197,207	0.054116	0.054116	0.055314 53
54 RADIOLOGY-DIAGNOSTIC	77,360,788	90,387,330	167,748,118	0.216841	0.216841	0.217978 54
54.10 RADIATION ONCOLOGY	1,467,599	73,773,160	75,240,759	0.286774	0.286774	0.286899 54.10
54.20 CT	14,085,501	35,647,900	49,733,401	0.074090	0.074090	0.074090 54.20
54.30 MRI	6,267,470	16,360,017	22,627,487	0.125880	0.125880	0.125880 54.30
60 LABORATORY	56,473,408	84,007,308	140,480,716	0.117099	0.117099	0.117099 60
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
65 RESPIRATORY THERAPY	19,241,708	4,272,974	23,514,682	0.195912	0.195912	0.195912 65
66 PHYSICAL THERAPY	9,937,682	14,904,935	24,842,617	0.284757	0.284757	0.284757 66
OUTPATIENT SERVICE COST CENTERS						
69 ELECTROCARDIOLOGY	12,901,698	14,062,755	26,964,453	0.070766	0.070766	0.070766 69
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	1,000,434	9,307,182	10,307,616	0.186423	0.186423	0.186423 70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO	32,894,724	10,660,365	43,555,089	0.131012	0.131012	0.131012 71
73 DRUGS CHARGED TO PATIENTS	91,781,438	22,380,455	114,161,893	0.139095	0.139095	0.139095 73
75.10 NUTRITIONAL SUPPORT	147,052	407,666	554,718	0.267783	0.267783	0.267783 75.10
75.20 HEMODIALYSIS	2,192,270	139,231	2,331,501	0.430699	0.430699	0.430699 75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPS						76.99
90 CLINIC	81,229	3,701,815	3,783,044	0.806062	0.806062	0.807428 90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	23,582,083	48,101,747	71,683,830	0.272224	0.272224	0.272982 91
91.05 AMBULATORY CARE	17,186	192,238	209,424	1.792817	1.792817	1.792817 91.05
91.10 PSYCHIATRIC PARTIAL	63,582	1,280,004	1,343,586	1.381733	1.381733	1.381733 91.10
92 OBSERVATION BEDS	157,940	2,726,421	2,884,361	0.517311	0.517311	0.517311 92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		12,985,682	12,985,682			101
200 SUBTOTAL (SEE INSTRUCTIONS)	629,392,715	537,313,044	1,166,705,759			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	629,392,715	537,313,044	1,166,705,759			202

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL	REDUCED	TOTAL	PER	INPAT	INPAT PGM
	COST	CAP-REL		DIEM		
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)	(COL.3 ÷ COL.4)	DAYS	(COL.5 x COL.6)
	1	2	3	5	6	7
INPAT ROUTINE SERV COST CTRS						
30 ADULTS & PEDIATRICS						30
31 INTENSIVE CARE UNIT						31
31.01 PEDIATRIC ICU						31.01
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [XX] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
50.20 GASTROENTEROLOGY					50.20
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
54.10 RADIATION ONCOLOGY					54.10
54.20 CT					54.20
54.30 MRI					54.30
60 LABORATORY					60
62.30 BLOOD CLOTTING FACTORS ADMIN					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
69.10 PEDIATRIC CARDIOLOGY					69.10
70 ELECTROENCEPHALOGRAPHY					70
70.10 APNEA MONITORING					70.10
71 MEDICAL SUPPLIES CHRGED TO PA					71
73 DRUGS CHARGED TO PATIENTS					73
75.10 NUTRITIONAL SUPPORT					75.10
75.20 HEMODIALYSIS					75.20
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 CHILDRENS CLINIC					90.01
91 EMERGENCY					91
91.05 AMBULATORY CARE					91.05
91.10 PSYCHIATRIC PARTIAL					91.10
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)					200

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
31.01 PEDIATRIC ICU					31.01
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
31.01 PEDIATRIC ICU				31.01
32 CORONARY CARE UNIT				32
33 BURN INTENSIVE CARE UNIT				33
34 SURGICAL INTENSIVE CARE UNIT				34
35 OTHER SPECIAL CARE (SPECIFY)				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF				41
42 SUBPROVIDER I				42
43 NURSERY				43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)				200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [XX] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P	
	PHYSICIAN			MEDICAL	COST	COST	
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF	
	COST			COST	COLS.1-4)	COLS.2-4)	
	1	2	3	4	5	6	
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
50.20 GASTROENTEROLOGY							50.20
52 DELIVERY ROOM & LABOR ROOM							52
53 ANESTHESIOLOGY							53
54 RADIOLOGY-DIAGNOSTIC			154,396		154,396	154,396	54
54.10 RADIATION ONCOLOGY			210,097		210,097	210,097	54.10
54.20 CT							54.20
54.30 MRI							54.30
60 LABORATORY			120,099		120,099	120,099	60
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
69 ELECTROCARDIOLOGY							69
69.10 PEDIATRIC CARDIOLOGY							69.10
70 ELECTROENCEPHALOGRAPHY							70
70.10 APNEA MONITORING							70.10
71 MEDICAL SUPPLIES CHRGED TO PA							71
73 DRUGS CHARGED TO PATIENTS							73
75.10 NUTRITIONAL SUPPORT							75.10
75.20 HEMODIALYSIS							75.20
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC							90
90.01 CHILDRENS CLINIC							90.01
91 EMERGENCY			1,088,866		1,088,866	1,088,866	91
91.05 AMBULATORY CARE							91.05
91.10 PSYCHIATRIC PARTIAL							91.10
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)			1,573,458		1,573,458	1,573,458	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [XX] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	195,444,303						50
50.20 GASTROENTEROLOGY	7,563,335						50.20
52 DELIVERY ROOM & LABOR ROOM	18,029,553						52
53 ANESTHESIOLOGY	10,197,207						53
54 RADIOLOGY-DIAGNOSTIC	167,748,118	0.000920	0.000920				54
54.10 RADIATION ONCOLOGY	75,240,759	0.002792	0.002792				54.10
54.20 CT	49,733,401						54.20
54.30 MRI	22,627,487						54.30
60 LABORATORY	140,480,716	0.000855	0.000855				60
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY	23,514,682						65
66 PHYSICAL THERAPY	24,842,617						66
69 ELECTROCARDIOLOGY	26,964,453						69
69.10 PEDIATRIC CARDIOLOGY							69.10
70 ELECTROENCEPHALOGRAPHY	10,307,616						70
70.10 APNEA MONITORING							70.10
71 MEDICAL SUPPLIES CHRGED TO P	43,555,089						71
73 DRUGS CHARGED TO PATIENTS	114,161,893						73
75.10 NUTRITIONAL SUPPORT	554,718						75.10
75.20 HEMODIALYSIS	2,331,501						75.20
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	3,783,044						90
90.01 CHILDRENS CLINIC							90.01
91 EMERGENCY	71,683,830	0.015190	0.015190				91
91.05 AMBULATORY CARE	209,424						91.05
91.10 PSYCHIATRIC PARTIAL	1,343,586						91.10
92 OBSERVATION BEDS	2,884,361						92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	1,013,201,693						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [XX] TITLE V - O/P [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		5	6	7
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	COST SERVICES SUBJECT TO DED & COINS 5			
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.204609							50
50.20 GASTROENTEROLOGY	0.224878							50.20
52 DELIVERY ROOM & LABOR ROOM	0.413234							52
53 ANESTHESIOLOGY	0.054116							53
54 RADIOLOGY-DIAGNOSTIC	0.216841		3,853				835	54
54.10 RADIATION ONCOLOGY	0.286774							54.10
54.20 CT	0.074090							54.20
54.30 MRI	0.125880							54.30
60 LABORATORY	0.117099		933				109	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO								62.30
65 RESPIRATORY THERAPY	0.195912							65
66 PHYSICAL THERAPY	0.284757		22,859				6,509	66
69 ELECTROCARDIOLOGY	0.070766							69
69.10 PEDIATRIC CARDIOLOGY								69.10
70 ELECTROENCEPHALOGRAPHY	0.186423							70
70.10 APNEA MONITORING								70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	0.131012		102				13	71
73 DRUGS CHARGED TO PATIENTS	0.139095		79				11	73
75.10 NUTRITIONAL SUPPORT	0.267783							75.10
75.20 HEMODIALYSIS	0.430699							75.20
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	0.806062		69				56	90
90.01 CHILDRENS CLINIC								90.01
91 EMERGENCY	0.272224		1,144				311	91
91.05 AMBULATORY CARE	1.792817							91.05
91.10 PSYCHIATRIC PARTIAL	1.381733							91.10
92 OBSERVATION BEDS	0.517311							92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			29,039				7,844	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			29,039				7,844	202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 ÷ COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	7,245,223		7,245,223	65,020	111.43	28,011	3,121,266 30
31 INTENSIVE CARE UNIT	1,226,755		1,226,755	8,114	151.19	3,717	561,973 31
31.01 PEDIATRIC ICU							31.01
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	804,930		804,930	4,166	193.21	1,394	269,335 40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY	252,517		252,517	6,770	37.30		43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	9,529,425		9,529,425	84,070		33,122	3,952,574 200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,196,350	195,444,303	0.011238	40,871,628	459,315	50
50.20 GASTROENTEROLOGY	267,201	7,563,335	0.035328	1,401,777	49,522	50.20
52 DELIVERY ROOM & LABOR ROOM	1,286,497	18,029,553	0.071355	61,375	4,379	52
53 ANESTHESIOLOGY	63,554	10,197,207	0.006232	1,965,169	12,247	53
54 RADIOLOGY-DIAGNOSTIC	3,017,373	167,748,118	0.017988	41,075,244	738,861	54
54.10 RADIATION ONCOLOGY	593,364	75,240,759	0.007886	1,357,733	10,707	54.10
54.20 CT	161,362	49,733,401	0.003245	6,477,272	21,019	54.20
54.30 MRI	156,183	22,627,487	0.006902	2,626,841	18,130	54.30
60 LABORATORY	757,969	140,480,716	0.005396	24,694,887	133,254	60
62.30 BLOOD CLOTTING FACTORS ADMIN						62.30
65 RESPIRATORY THERAPY	205,841	23,514,682	0.008754	10,817,937	94,700	65
66 PHYSICAL THERAPY	214,056	24,842,617	0.008616	6,018,447	51,855	66
69 ELECTROCARDIOLOGY	182,715	26,964,453	0.006776	3,350,936	22,706	69
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	200,437	10,307,616	0.019446	513,173	9,979	70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PA	93,317	43,555,089	0.002143	12,233,163	26,216	71
73 DRUGS CHARGED TO PATIENTS	192,882	114,161,893	0.001690	40,912,705	69,142	73
75.10 NUTRITIONAL SUPPORT	714	554,718	0.001287	23,751	31	75.10
75.20 HEMODIALYSIS	104,848	2,331,501	0.044970	1,591,881	71,587	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	23,755	3,783,044	0.006279	79,691	500	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	1,214,693	71,683,830	0.016945	9,904,223	167,827	91
91.05 AMBULATORY CARE	166,720	209,424	0.796088	3,079	2,451	91.05
91.10 PSYCHIATRIC PARTIAL	168,800	1,343,586	0.125634	42,952	5,396	91.10
92 OBSERVATION BEDS	183,192	2,884,361	0.063512	20,271	1,287	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	11,451,823	1,013,201,693	1,013,201,693	206,044,135	1,971,111	200

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
31.01 PEDIATRIC ICU					31.01
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	65,020		28,011	30
31 INTENSIVE CARE UNIT	8,114		3,717	31
31.01 PEDIATRIC ICU				31.01
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	4,166		1,394	40
41 SUBPROVIDER - IRF				41
42 SUBPROVIDER I				42
43 NURSERY	6,770			43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	84,070		33,122	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P	
	PHYSICIAN			MEDICAL	COST	COST	
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF	
	COST			COST	COLS.1-4)	COLS.2-4)	
	1	2	3	4	5	6	
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
50.20 GASTROENTEROLOGY							50.20
52 DELIVERY ROOM & LABOR ROOM							52
53 ANESTHESIOLOGY							53
54 RADIOLOGY-DIAGNOSTIC			154,396		154,396	154,396	54
54.10 RADIATION ONCOLOGY			210,097		210,097	210,097	54.10
54.20 CT							54.20
54.30 MRI							54.30
60 LABORATORY			120,099		120,099	120,099	60
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
69 ELECTROCARDIOLOGY							69
69.10 PEDIATRIC CARDIOLOGY							69.10
70 ELECTROENCEPHALOGRAPHY							70
70.10 APNEA MONITORING							70.10
71 MEDICAL SUPPLIES CHRGED TO PA							71
73 DRUGS CHARGED TO PATIENTS							73
75.10 NUTRITIONAL SUPPORT							75.10
75.20 HEMODIALYSIS							75.20
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC							90
90.01 CHILDRENS CLINIC							90.01
91 EMERGENCY			1,088,866		1,088,866	1,088,866	91
91.05 AMBULATORY CARE							91.05
91.10 PSYCHIATRIC PARTIAL							91.10
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)			1,573,458		1,573,458	1,573,458	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13		
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	195,444,303			40,871,628		13,947,895		50	
50.20 GASTROENTEROLOGY	7,563,335			1,401,777		1,376,096		50.20	
52 DELIVERY ROOM & LABOR ROOM	18,029,553			61,375		6,009		52	
53 ANESTHESIOLOGY	10,197,207			1,965,169		755,701		53	
54 RADIOLOGY-DIAGNOSTIC	167,748,118	0.000920	0.000920	41,075,244	37,789	23,341,569	21,474	54	
54.10 RADIATION ONCOLOGY	75,240,759	0.002792	0.002792	1,357,733	3,791	28,358,669	79,177	54.10	
54.20 CT	49,733,401			6,477,272		9,654,998		54.20	
54.30 MRI	22,627,487			2,626,841		5,495,175		54.30	
60 LABORATORY	140,480,716	0.000855	0.000855	24,694,887	21,114	2,400,857	2,053	60	
62.30 BLOOD CLOTTING FACTORS ADMIN								62.30	
65 RESPIRATORY THERAPY	23,514,682			10,817,937		1,584,427		65	
66 PHYSICAL THERAPY	24,842,617			6,018,447		44,552		66	
69 ELECTROCARDIOLOGY	26,964,453			3,350,936		5,241,913		69	
69.10 PEDIATRIC CARDIOLOGY								69.10	
70 ELECTROENCEPHALOGRAPHY	10,307,616			513,173		2,612,698		70	
70.10 APNEA MONITORING								70.10	
71 MEDICAL SUPPLIES CHRGED TO P	43,555,089			12,233,163		3,389,250		71	
73 DRUGS CHARGED TO PATIENTS	114,161,893			40,912,705		16,761,409		73	
75.10 NUTRITIONAL SUPPORT	554,718			23,751		28,670		75.10	
75.20 HEMODIALYSIS	2,331,501			1,591,881		63,530		75.20	
76.97 CARDIAC REHABILITATION								76.97	
76.98 HYPERBARIC OXYGEN THERAPY								76.98	
76.99 LITHOTRIPSY								76.99	
OUTPATIENT SERVICE COST CENTERS									
90 CLINIC	3,783,044			79,691		1,242,559		90	
90.01 CHILDRENS CLINIC								90.01	
91 EMERGENCY	71,683,830	0.015190	0.015190	9,904,223	150,445	7,150,532	108,617	91	
91.05 AMBULATORY CARE	209,424			3,079				91.05	
91.10 PSYCHIATRIC PARTIAL	1,343,586			42,952		234,908		91.10	
92 OBSERVATION BEDS	2,884,361			20,271		1,319,438		92	
OTHER REIMBURSABLE COST CENTERS									
200 TOTAL (SUM OF LINES 50-199)	1,013,201,693			206,044,135	213,139	125,010,855	211,321	200	

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES SUBJECT TO DED & COINS 5	COST SVCS NOT SUBJECT TO DED & COINS 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	0.204609	13,947,895			2,853,865	50
50.20 GASTROENTEROLOGY	0.224878	1,376,096			309,454	50.20
52 DELIVERY ROOM & LABOR ROOM	0.413234	6,009			2,483	52
53 ANESTHESIOLOGY	0.054116	755,701			40,896	53
54 RADIOLOGY-DIAGNOSTIC	0.216841	23,341,569			5,061,409	54
54.10 RADIATION ONCOLOGY	0.286774	28,358,669			8,132,529	54.10
54.20 CT	0.074090	9,654,998			715,339	54.20
54.30 MRI	0.125880	5,495,175			691,733	54.30
60 LABORATORY	0.117099	2,400,857			281,138	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO						62.30
65 RESPIRATORY THERAPY	0.195912	1,584,427			310,408	65
66 PHYSICAL THERAPY	0.284757	44,552			12,686	66
69 ELECTROCARDIOLOGY	0.070766	5,241,913			370,949	69
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	0.186423	2,612,698			487,067	70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	0.131012	3,389,250			444,032	71
73 DRUGS CHARGED TO PATIENTS	0.139095	16,761,409			2,331,428	73
75.10 NUTRITIONAL SUPPORT	0.267783	28,670			7,677	75.10
75.20 HEMODIALYSIS	0.430699	63,530			27,362	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	0.806062	1,242,559			1,001,580	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	0.272224	7,150,532			1,946,546	91
91.05 AMBULATORY CARE	1.792817					91.05
91.10 PSYCHIATRIC PARTIAL	1.381733	234,908			324,580	91.10
92 OBSERVATION BEDS	0.517311	1,319,438			682,560	92
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)		125,010,855			26,035,721	200
201 LESS PBP CLINIC LAB SERVICES						201
202 NET CHARGES (LINE 200 - LINE 201)		125,010,855			26,035,721	202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S228) [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,196,350	195,444,303	0.011238	7,470	84	50
50.20 GASTROENTEROLOGY	267,201	7,563,335	0.035328			50.20
52 DELIVERY ROOM & LABOR ROOM	1,286,497	18,029,553	0.071355			52
53 ANESTHESIOLOGY	63,554	10,197,207	0.006232	2,694	17	53
54 RADIOLOGY-DIAGNOSTIC	3,017,373	167,748,118	0.017988	35,304	635	54
54.10 RADIATION ONCOLOGY	593,364	75,240,759	0.007886			54.10
54.20 CT	161,362	49,733,401	0.003245	33,213	108	54.20
54.30 MRI	156,183	22,627,487	0.006902	12,792	88	54.30
60 LABORATORY	757,969	140,480,716	0.005396	417,961	2,255	60
62.30 BLOOD CLOTTING FACTORS ADMIN						62.30
65 RESPIRATORY THERAPY	205,841	23,514,682	0.008754	4,744	42	65
66 PHYSICAL THERAPY	214,056	24,842,617	0.008616	17,491	151	66
69 ELECTROCARDIOLOGY	182,715	26,964,453	0.006776	47,079	319	69
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	200,437	10,307,616	0.019446			70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PA	93,317	43,555,089	0.002143	30,955	66	71
73 DRUGS CHARGED TO PATIENTS	192,882	114,161,893	0.001690	473,614	800	73
75.10 NUTRITIONAL SUPPORT	714	554,718	0.001287	544	1	75.10
75.20 HEMODIALYSIS	104,848	2,331,501	0.044970			75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	23,755	3,783,044	0.006279	573	4	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	1,214,693	71,683,830	0.016945	141,560	2,399	91
91.05 AMBULATORY CARE	166,720	209,424	0.796088			91.05
91.10 PSYCHIATRIC PARTIAL	168,800	1,343,586	0.125634			91.10
92 OBSERVATION BEDS	183,192	2,884,361	0.063512			92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	11,451,823	1,013,201,693	1,013,201,693	1,225,994	6,969	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S228) [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P	
	PHYSICIAN			MEDICAL	COST	COST	
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF	
	COST			COST	COLS.1-4)	COLS.2-4)	
	1	2	3	4	5	6	
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
50.20 GASTROENTEROLOGY							50.20
52 DELIVERY ROOM & LABOR ROOM							52
53 ANESTHESIOLOGY							53
54 RADIOLOGY-DIAGNOSTIC			154,396		154,396	154,396	54
54.10 RADIATION ONCOLOGY			210,097		210,097	210,097	54.10
54.20 CT							54.20
54.30 MRI							54.30
60 LABORATORY			120,099		120,099	120,099	60
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
69 ELECTROCARDIOLOGY							69
69.10 PEDIATRIC CARDIOLOGY							69.10
70 ELECTROENCEPHALOGRAPHY							70
70.10 APNEA MONITORING							70.10
71 MEDICAL SUPPLIES CHRGED TO PA							71
73 DRUGS CHARGED TO PATIENTS							73
75.10 NUTRITIONAL SUPPORT							75.10
75.20 HEMODIALYSIS							75.20
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC							90
90.01 CHILDRENS CLINIC							90.01
91 EMERGENCY			1,088,866		1,088,866	1,088,866	91
91.05 AMBULATORY CARE							91.05
91.10 PSYCHIATRIC PARTIAL							91.10
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)			1,573,458		1,573,458	1,573,458	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S228) [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	195,444,303			7,470			50
50.20 GASTROENTEROLOGY	7,563,335						50.20
52 DELIVERY ROOM & LABOR ROOM	18,029,553						52
53 ANESTHESIOLOGY	10,197,207			2,694			53
54 RADIOLOGY-DIAGNOSTIC	167,748,118	0.000920	0.000920	35,304	32	14,929	14 54
54.10 RADIATION ONCOLOGY	75,240,759	0.002792	0.002792				54.10
54.20 CT	49,733,401			33,213		1,131	54.20
54.30 MRI	22,627,487			12,792			54.30
60 LABORATORY	140,480,716	0.000855	0.000855	417,961	357		60
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY	23,514,682			4,744			65
66 PHYSICAL THERAPY	24,842,617			17,491			66
69 ELECTROCARDIOLOGY	26,964,453			47,079		2,000	69
69.10 PEDIATRIC CARDIOLOGY							69.10
70 ELECTROENCEPHALOGRAPHY	10,307,616						70
70.10 APNEA MONITORING							70.10
71 MEDICAL SUPPLIES CHRGED TO P	43,555,089			30,955			71
73 DRUGS CHARGED TO PATIENTS	114,161,893			473,614		3,460	73
75.10 NUTRITIONAL SUPPORT	554,718			544			75.10
75.20 HEMODIALYSIS	2,331,501						75.20
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	3,783,044			573			90
90.01 CHILDRENS CLINIC							90.01
91 EMERGENCY	71,683,830	0.015190	0.015190	141,560	2,150		91
91.05 AMBULATORY CARE	209,424						91.05
91.10 PSYCHIATRIC PARTIAL	1,343,586						91.10
92 OBSERVATION BEDS	2,884,361						92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	1,013,201,693			1,225,994	2,539	21,520	14 200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [XX] IPF (14-S228) [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS	
		PPS REIMBURSED SERVICES 2	COST REIMB. COST REIMB. SVCES NOT SUBJECT TO DED & COINS 3	PPS SERVICES DED & COINS 5	COST COST SVCES NOT SUBJECT TO DED & COINS 6
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.204609				50
50.20 GASTROENTEROLOGY	0.224878				50.20
52 DELIVERY ROOM & LABOR ROOM	0.413234				52
53 ANESTHESIOLOGY	0.054116				53
54 RADIOLOGY-DIAGNOSTIC	0.216841	14,929		3,237	54
54.10 RADIATION ONCOLOGY	0.286774				54.10
54.20 CT	0.074090	1,131		84	54.20
54.30 MRI	0.125880				54.30
60 LABORATORY	0.117099				60
62.30 BLOOD CLOTTING FACTORS ADMIN CO					62.30
65 RESPIRATORY THERAPY	0.195912				65
66 PHYSICAL THERAPY	0.284757				66
69 ELECTROCARDIOLOGY	0.070766	2,000		142	69
69.10 PEDIATRIC CARDIOLOGY					69.10
70 ELECTROENCEPHALOGRAPHY	0.186423				70
70.10 APNEA MONITORING					70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	0.131012				71
73 DRUGS CHARGED TO PATIENTS	0.139095	3,460		481	73
75.10 NUTRITIONAL SUPPORT	0.267783				75.10
75.20 HEMODIALYSIS	0.430699				75.20
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	0.806062				90
90.01 CHILDRENS CLINIC					90.01
91 EMERGENCY	0.272224				91
91.05 AMBULATORY CARE	1.792817				91.05
91.10 PSYCHIATRIC PARTIAL	1.381733				91.10
92 OBSERVATION BEDS	0.517311				92
OTHER REIMBURSABLE COST CENTERS					
200 SUBTOTAL (SEE INSTRUCTIONS)		21,520		3,944	200
201 LESS PBP CLINIC LAB SERVICES					201
202 NET CHARGES (LINE 200 - LINE 201)		21,520		3,944	202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL	REDUCED	TOTAL	PER	INPAT	INPAT PGM	
	COST	CAP-REL		DIEM			CAP COST
	(FROM WKST SWING-BED	COST	(COL.1 MINUS	(COL.3 ÷	PGM	(COL.5 x	
	B, PT. II, ADJUSTMENT	(COL.2)	PATIENT	COL.4)	DAYS	COL.6)	
	COL. 26)		DAYS				
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS							30
31 INTENSIVE CARE UNIT							31
31.01 PEDIATRIC ICU							31.01
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
50.20 GASTROENTEROLOGY					50.20
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
54.10 RADIATION ONCOLOGY					54.10
54.20 CT					54.20
54.30 MRI					54.30
60 LABORATORY					60
62.30 BLOOD CLOTTING FACTORS ADMIN					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
69.10 PEDIATRIC CARDIOLOGY					69.10
70 ELECTROENCEPHALOGRAPHY					70
70.10 APNEA MONITORING					70.10
71 MEDICAL SUPPLIES CHRGED TO PA					71
73 DRUGS CHARGED TO PATIENTS					73
75.10 NUTRITIONAL SUPPORT					75.10
75.20 HEMODIALYSIS					75.20
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 CHILDRENS CLINIC					90.01
91 EMERGENCY					91
91.05 AMBULATORY CARE					91.05
91.10 PSYCHIATRIC PARTIAL					91.10
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)					200

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
31.01 PEDIATRIC ICU					31.01
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
31.01 PEDIATRIC ICU				31.01
32 CORONARY CARE UNIT				32
33 BURN INTENSIVE CARE UNIT				33
34 SURGICAL INTENSIVE CARE UNIT				34
35 OTHER SPECIAL CARE (SPECIFY)				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF				41
42 SUBPROVIDER I				42
43 NURSERY				43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)				200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL COST	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (SUM OF COLS.1-4)	TOTAL O/P COST (SUM OF COLS.2-4)	
	1	2	3	4	5	6	
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
50.20 GASTROENTEROLOGY							50.20
52 DELIVERY ROOM & LABOR ROOM							52
53 ANESTHESIOLOGY							53
54 RADIOLOGY-DIAGNOSTIC			154,396		154,396	154,396	54
54.10 RADIATION ONCOLOGY			210,097		210,097	210,097	54.10
54.20 CT							54.20
54.30 MRI							54.30
60 LABORATORY			120,099		120,099	120,099	60
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
69 ELECTROCARDIOLOGY							69
69.10 PEDIATRIC CARDIOLOGY							69.10
70 ELECTROENCEPHALOGRAPHY							70
70.10 APNEA MONITORING							70.10
71 MEDICAL SUPPLIES CHRGED TO PA							71
73 DRUGS CHARGED TO PATIENTS							73
75.10 NUTRITIONAL SUPPORT							75.10
75.20 HEMODIALYSIS							75.20
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC							90
90.01 CHILDRENS CLINIC							90.01
91 EMERGENCY			1,088,866		1,088,866	1,088,866	91
91.05 AMBULATORY CARE							91.05
91.10 PSYCHIATRIC PARTIAL							91.10
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)			1,573,458		1,573,458	1,573,458	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	195,444,303			8,027,170			50
50.20 GASTROENTEROLOGY	7,563,335			420,245			50.20
52 DELIVERY ROOM & LABOR ROOM	18,029,553			5,359,459			52
53 ANESTHESIOLOGY	10,197,207			1,015,183			53
54 RADIOLOGY-DIAGNOSTIC	167,748,118	0.000920	0.000920	4,358,214	4,010		54
54.10 RADIATION ONCOLOGY	75,240,759	0.002792	0.002792	109,866	307		54.10
54.20 CT	49,733,401			2,009,583			54.20
54.30 MRI	22,627,487			867,527			54.30
60 LABORATORY	140,480,716	0.000855	0.000855	13,053,666	11,161		60
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY	23,514,682			1,534,675			65
66 PHYSICAL THERAPY	24,842,617			1,105,528			66
69 ELECTROCARDIOLOGY	26,964,453			2,350,065			69
69.10 PEDIATRIC CARDIOLOGY							69.10
70 ELECTROENCEPHALOGRAPHY	10,307,616			147,047			70
70.10 APNEA MONITORING							70.10
71 MEDICAL SUPPLIES CHRGED TO P	43,555,089			17,364,112			71
73 DRUGS CHARGED TO PATIENTS	114,161,893			17,252,458			73
75.10 NUTRITIONAL SUPPORT	554,718						75.10
75.20 HEMODIALYSIS	2,331,501			202,870			75.20
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	3,783,044			965			90
90.01 CHILDRENS CLINIC							90.01
91 EMERGENCY	71,683,830	0.015190	0.015190	2,299,319	34,927		91
91.05 AMBULATORY CARE	209,424						91.05
91.10 PSYCHIATRIC PARTIAL	1,343,586						91.10
92 OBSERVATION BEDS	2,884,361			3,516			92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	1,013,201,693			77,481,468	50,405		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS	
		PPS REIMBURSED SERVICES 2	COST REIMB. COST REIMB. SUBJECT TO DED & COINS DED & COINS 3	COST COST SUBJECT TO DED & COINS DED & COINS 5	COST COST SUBJECT TO DED & COINS DED & COINS 6
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.204609				50
50.20 GASTROENTEROLOGY	0.224878				50.20
52 DELIVERY ROOM & LABOR ROOM	0.413234				52
53 ANESTHESIOLOGY	0.054116				53
54 RADIOLOGY-DIAGNOSTIC	0.216841				54
54.10 RADIATION ONCOLOGY	0.286774				54.10
54.20 CT	0.074090				54.20
54.30 MRI	0.125880				54.30
60 LABORATORY	0.117099				60
62.30 BLOOD CLOTTING FACTORS ADMIN CO					62.30
65 RESPIRATORY THERAPY	0.195912				65
66 PHYSICAL THERAPY	0.284757				66
69 ELECTROCARDIOLOGY	0.070766				69
69.10 PEDIATRIC CARDIOLOGY					69.10
70 ELECTROENCEPHALOGRAPHY	0.186423				70
70.10 APNEA MONITORING					70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	0.131012				71
73 DRUGS CHARGED TO PATIENTS	0.139095				73
75.10 NUTRITIONAL SUPPORT	0.267783				75.10
75.20 HEMODIALYSIS	0.430699				75.20
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	0.806062				90
90.01 CHILDRENS CLINIC					90.01
91 EMERGENCY	0.272224				91
91.05 AMBULATORY CARE	1.792817				91.05
91.10 PSYCHIATRIC PARTIAL	1.381733				91.10
92 OBSERVATION BEDS	0.517311				92
OTHER REIMBURSABLE COST CENTERS					
200 SUBTOTAL (SEE INSTRUCTIONS)					200
201 LESS PBP CLINIC LAB SERVICES					201
202 NET CHARGES (LINE 200 - LINE 201)					202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S228) [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
50.20 GASTROENTEROLOGY					50.20
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
54.10 RADIATION ONCOLOGY					54.10
54.20 CT					54.20
54.30 MRI					54.30
60 LABORATORY					60
62.30 BLOOD CLOTTING FACTORS ADMIN					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
69.10 PEDIATRIC CARDIOLOGY					69.10
70 ELECTROENCEPHALOGRAPHY					70
70.10 APNEA MONITORING					70.10
71 MEDICAL SUPPLIES CHRGED TO PA					71
73 DRUGS CHARGED TO PATIENTS					73
75.10 NUTRITIONAL SUPPORT					75.10
75.20 HEMODIALYSIS					75.20
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 CHILDRENS CLINIC					90.01
91 EMERGENCY					91
91.05 AMBULATORY CARE					91.05
91.10 PSYCHIATRIC PARTIAL					91.10
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S228) [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
50.20 GASTROENTEROLOGY						50.20
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC			154,396		154,396	54
54.10 RADIATION ONCOLOGY			210,097		210,097	54.10
54.20 CT						54.20
54.30 MRI						54.30
60 LABORATORY			120,099		120,099	60
62.30 BLOOD CLOTTING FACTORS ADMIN						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY						70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
75.10 NUTRITIONAL SUPPORT						75.10
75.20 HEMODIALYSIS						75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY			1,088,866		1,088,866	91
91.05 AMBULATORY CARE						91.05
91.10 PSYCHIATRIC PARTIAL						91.10
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)			1,573,458		1,573,458	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S228) [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	195,444,303			5,272			50
50.20 GASTROENTEROLOGY	7,563,335						50.20
52 DELIVERY ROOM & LABOR ROOM	18,029,553						52
53 ANESTHESIOLOGY	10,197,207			1,347			53
54 RADIOLOGY-DIAGNOSTIC	167,748,118	0.000920	0.000920	35,682	33		54
54.10 RADIATION ONCOLOGY	75,240,759	0.002792	0.002792				54.10
54.20 CT	49,733,401			13,149			54.20
54.30 MRI	22,627,487			8,280			54.30
60 LABORATORY	140,480,716	0.000855	0.000855	500,674	428		60
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY	23,514,682			3,270			65
66 PHYSICAL THERAPY	24,842,617			12,051			66
69 ELECTROCARDIOLOGY	26,964,453			69,014			69
69.10 PEDIATRIC CARDIOLOGY							69.10
70 ELECTROENCEPHALOGRAPHY	10,307,616						70
70.10 APNEA MONITORING							70.10
71 MEDICAL SUPPLIES CHRGED TO P	43,555,089			1,019			71
73 DRUGS CHARGED TO PATIENTS	114,161,893			332,352			73
75.10 NUTRITIONAL SUPPORT	554,718						75.10
75.20 HEMODIALYSIS	2,331,501						75.20
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	3,783,044						90
90.01 CHILDRENS CLINIC							90.01
91 EMERGENCY	71,683,830	0.015190	0.015190	165,383	2,512		91
91.05 AMBULATORY CARE	209,424						91.05
91.10 PSYCHIATRIC PARTIAL	1,343,586			20,630			91.10
92 OBSERVATION BEDS	2,884,361						92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	1,013,201,693			1,168,123	2,973		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [XX] IPF (14-S228) [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS	
		PPS REIMBURSED SERVICES 2	COST REIMB. COST REIMB. SUBJECT TO SUBJECT TO DED & COINS DED & COINS 3	COST COST SUBJECT TO SUBJECT TO DED & COINS DED & COINS 5	COST COST SUBJECT TO SUBJECT TO DED & COINS DED & COINS 6
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.204609				50
50.20 GASTROENTEROLOGY	0.224878				50.20
52 DELIVERY ROOM & LABOR ROOM	0.413234				52
53 ANESTHESIOLOGY	0.054116				53
54 RADIOLOGY-DIAGNOSTIC	0.216841				54
54.10 RADIATION ONCOLOGY	0.286774				54.10
54.20 CT	0.074090				54.20
54.30 MRI	0.125880				54.30
60 LABORATORY	0.117099				60
62.30 BLOOD CLOTTING FACTORS ADMIN CO					62.30
65 RESPIRATORY THERAPY	0.195912				65
66 PHYSICAL THERAPY	0.284757				66
69 ELECTROCARDIOLOGY	0.070766				69
69.10 PEDIATRIC CARDIOLOGY					69.10
70 ELECTROENCEPHALOGRAPHY	0.186423				70
70.10 APNEA MONITORING					70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	0.131012				71
73 DRUGS CHARGED TO PATIENTS	0.139095				73
75.10 NUTRITIONAL SUPPORT	0.267783				75.10
75.20 HEMODIALYSIS	0.430699				75.20
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	0.806062				90
90.01 CHILDRENS CLINIC					90.01
91 EMERGENCY	0.272224				91
91.05 AMBULATORY CARE	1.792817				91.05
91.10 PSYCHIATRIC PARTIAL	1.381733				91.10
92 OBSERVATION BEDS	0.517311				92
OTHER REIMBURSABLE COST CENTERS					
200 SUBTOTAL (SEE INSTRUCTIONS)					200
201 LESS PBP CLINIC LAB SERVICES					201
202 NET CHARGES (LINE 200 - LINE 201)					202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK	<input checked="" type="checkbox"/>	TITLE V-INPT	<input checked="" type="checkbox"/>	HOSPITAL (14-0228)	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	ICF/MR	<input type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>		<input type="checkbox"/>	TEFRA
BOXES	<input type="checkbox"/>	TITLE XIX-INPT	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF	<input type="checkbox"/>		<input checked="" type="checkbox"/>	OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS										
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	65,020	1							
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	65,020	2							
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3							
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	65,020	4							
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5							
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6							
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7							
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8							
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)		9							
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10							
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11							
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12							
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13							
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14							
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	6,770	15							
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16							
SWING-BED ADJUSTMENT										
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17							
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18							
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19							
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20							
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	59,012,499	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	59,012,499	27							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT										
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	116,811,765	28							
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29							
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	116,811,765	30							

31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.505193	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)	1,796.55	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	59,012,499	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[XX]	TITLE V-INPT	[XX]	HOSPITAL (14-0228)	[]	SUB (OTHER)	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF			[]	TEFRA
BOXES	[]	TITLE XIX-INPT	[]	IRF			[XX]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

38	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS						907.61	38
39	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)							39
40	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)							40
41	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)							41
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)							41
		TOTAL	TOTAL	AVERAGE		PROGRAM		PROGRAM
		INPATIENT	INPATIENT	PER DIEM				COST
		COST	DAYS	(COL. 1 ÷		DAYS		(COL. 3 x
		1	2	COL. 2)		4		COL. 4)
				3				5
42	NURSERY (TITLES V AND XIX ONLY)	5,600,953	6,770	827.32				42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
43	INTENSIVE CARE UNIT	13,189,820	8,114	1,625.56				43
43.01	PEDIATRIC ICU							43.01
44	CORONARY CARE UNIT							44
45	BURN INTENSIVE CARE UNIT							45
46	SURGICAL INTENSIVE CARE UNIT							46
47	OTHER SPECIAL CARE (SPECIFY)							47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)							48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)							49
	PASS-THROUGH COST ADJUSTMENTS							
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)							50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)							51
52	TOTAL PROGRAM EXCLUDABLE COST							52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)							53
	TARGET AMOUNT AND LIMIT COMPUTATION							
54	PROGRAM DISCHARGES							54
55	TARGET AMOUNT PER DISCHARGE							55
56	TARGET AMOUNT (LINE 54 x LINE 55)							56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT							57
58	BONUS PAYMENT (SEE INSTRUCTIONS)							58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E							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 INSTRU (TITLE XVIII ONLY)							64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)							65

66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)	1,644	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 27)	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	1	2		4	5	
90	CAPITAL-RELATED COST					90
91	NURSING SCHOOL COST					91
92	ALLIED HEALTH COST					92
93	ALL OTHER MEDICAL EDUCATION					93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	65,020	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	65,020	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	65,020	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	28,011	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	59,012,499	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	59,012,499	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	116,811,765	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	116,811,765	30

31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.505193	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)	1,796.55	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	59,012,499	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0228) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 907.61 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 25,423,064 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) 25,423,064 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	13,238,888	8,114	1,631.61	3,717	6,064,694	43
43.01 PEDIATRIC ICU						43.01
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					36,859,866	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					68,347,624	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 3,683,239 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 2,184,250 51
 52 TOTAL PROGRAM EXCLUDABLE COST 5,867,489 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 62,480,135 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 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 INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 65

66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)	1,644	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	907.61	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	1,492,111	89

		ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST					
90	CAPITAL-RELATED COST	7,245,223	59,012,499	0.122774	1,492,111	183,192
91	NURSING SCHOOL COST					91
92	ALLIED HEALTH COST					92
93	ALL OTHER MEDICAL EDUCATION					93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[]	HOSPITAL	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S228)	[]	SNF			[]	TEFRA
BOXES	[]	TITLE XIX-INPT	[]	IRF	[]	NF			[]	OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS										
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,166	1							
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,166	2							
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3							
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,166	4							
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5							
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6							
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7							
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8							
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,394	9							
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10							
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11							
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12							
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13							
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14							
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15							
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16							
SWING-BED ADJUSTMENT										
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17							
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18							
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19							
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20							
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,349,246	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	4,349,246	27							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT										
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	4,906,041	28							
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29							
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,906,041	30							

31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.886508	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)	1,177.64	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	4,349,246	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[]	HOSPITAL	[]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S228)			[]	TEFRA
BOXES	[]	TITLE XIX-INPT	[]	IRF			[]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

38	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							
	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)						1,043.99	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)						1,455,322	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)						1,455,322	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						180,814	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)						1,636,136	49
	PASS-THROUGH COST ADJUSTMENTS							
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)						269,335	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)						9,508	51
52	TOTAL PROGRAM EXCLUDABLE COST						278,843	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)						1,357,293	53
	TARGET AMOUNT AND LIMIT COMPUTATION							
54	PROGRAM DISCHARGES							54
55	TARGET AMOUNT PER DISCHARGE							55
56	TARGET AMOUNT (LINE 54 x LINE 55)							56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT							57
58	BONUS PAYMENT (SEE INSTRUCTIONS)							58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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 COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E							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 INSTRU (TITLE XVIII ONLY)							64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (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

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	65,020	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	65,020	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	65,020	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	15,314	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	6,770	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	4,517	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)	59,012,499	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	59,012,499	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	116,811,765	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	116,811,765	30

31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.505193	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)	1,796.55	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	59,012,499	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS						
	TOTAL	TOTAL	AVERAGE	PROGRAM	PROGRAM	
	INPATIENT	INPATIENT	PER DIEM	DAYS	COST	
	COST	DAYS	(COL. 1 ÷		(COL. 3 x	
	1	2	COL. 2)	4	COL. 4)	
			3	5		
38					907.61	38
39					13,899,140	39
40						40
41					13,899,140	41
42	5,600,953	6,770	827.32	4,517	3,737,004	42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	13,189,820	8,114	1,625.56	1,107	1,799,495	43
43.01						43.01
44						44
45						45
46						46
47						47
48					12,969,522	48
49					32,405,161	49
PASS-THROUGH COST ADJUSTMENTS						
50						50
51					50,405	51
52					50,405	52
53						53
TARGET AMOUNT AND LIMIT COMPUTATION						
54						54
55						55
56						56
57						57
58						58
59						59
60						60
61						61
62						62
63						63
PROGRAM INPATIENT ROUTINE SWING BED COST						
64						64
65						65

66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)	1,644	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 27)	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	1	2		4	5	
90	CAPITAL-RELATED COST					90
91	NURSING SCHOOL COST					91
92	ALLIED HEALTH COST					92
93	ALL OTHER MEDICAL EDUCATION					93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[]	HOSPITAL	[]	SUB (OTHER)	[]	ICF/MR	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[XX]	IPF (14-S228)	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[]	IRF	[]	NF			[XX]	OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS										
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,166	1							
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,166	2							
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3							
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,166	4							
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5							
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6							
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7							
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8							
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	505	9							
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10							
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11							
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12							
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13							
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14							
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15							
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16							
SWING-BED ADJUSTMENT										
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17							
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18							
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19							
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20							
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,325,093	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	4,325,093	27							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT										
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	4,906,041	28							
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29							
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,906,041	30							

31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.881585	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)	1,177.64	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	4,325,093	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S228) [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

38	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
39	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,038.19	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	524,286	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)	524,286	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	198,379	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	722,665	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)	2,973	51
52	TOTAL PROGRAM EXCLUDABLE COST	2,973	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)		53
TARGET AMOUNT AND LIMIT COMPUTATION			
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (LINE 54 x LINE 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT		57
58	BONUS PAYMENT (SEE INSTRUCTIONS)		58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E		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 INSTRU (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-0228) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	(COL.1 x COL.2) 3
INPATIENT ROUTINE SERVICE COST CENTERS			
30 ADULTS & PEDIATRICS			30
31 INTENSIVE CARE UNIT			31
31.01 PEDIATRIC ICU			31.01
40 SUBPROVIDER - IPF			40
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	0.204609		50
50.20 GASTROENTEROLOGY	0.224878		50.20
52 DELIVERY ROOM & LABOR ROOM	0.413234		52
53 ANESTHESIOLOGY	0.054116		53
54 RADIOLOGY-DIAGNOSTIC	0.216841		54
54.10 RADIATION ONCOLOGY	0.286774		54.10
54.20 CT	0.074090		54.20
54.30 MRI	0.125880		54.30
60 LABORATORY	0.117099		60
62.30 BLOOD CLOTTING FACTORS ADMIN CO			62.30
65 RESPIRATORY THERAPY	0.195912		65
66 PHYSICAL THERAPY	0.284757		66
69 ELECTROCARDIOLOGY	0.070766		69
69.10 PEDIATRIC CARDIOLOGY			69.10
70 ELECTROENCEPHALOGRAPHY	0.186423		70
70.10 APNEA MONITORING			70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	0.131012		71
73 DRUGS CHARGED TO PATIENTS	0.139095		73
75.10 NUTRITIONAL SUPPORT	0.267783		75.10
75.20 HEMODIALYSIS	0.430699		75.20
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
90 CLINIC	0.806062		90
90.01 CHILDRENS CLINIC			90.01
91 EMERGENCY	0.272224		91
91.05 AMBULATORY CARE	1.792817		91.05
91.10 PSYCHIATRIC PARTIAL	1.381733		91.10
92 OBSERVATION BEDS	0.517311		92
OTHER REIMBURSABLE COST CENTERS			
200 TOTAL (SUM OF LINES 50-94 AND 96-98)			200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			201
202 NET CHARGES (LINE 200 MINUS LINE 201)			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		39,141,140		30
31 INTENSIVE CARE UNIT		18,495,644		31
31.01 PEDIATRIC ICU				31.01
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.204799	40,871,628	8,370,469	50
50.20 GASTROENTEROLOGY	0.224878	1,401,777	315,229	50.20
52 DELIVERY ROOM & LABOR ROOM	0.413234	61,375	25,362	52
53 ANESTHESIOLOGY	0.055314	1,965,169	108,701	53
54 RADIOLOGY-DIAGNOSTIC	0.217978	41,075,244	8,953,500	54
54.10 RADIATION ONCOLOGY	0.286899	1,357,733	389,532	54.10
54.20 CT	0.074090	6,477,272	479,901	54.20
54.30 MRI	0.125880	2,626,841	330,667	54.30
60 LABORATORY	0.117099	24,694,887	2,891,747	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.195912	10,817,937	2,119,364	65
66 PHYSICAL THERAPY	0.284757	6,018,447	1,713,795	66
69 ELECTROCARDIOLOGY	0.070766	3,350,936	237,132	69
69.10 PEDIATRIC CARDIOLOGY				69.10
70 ELECTROENCEPHALOGRAPHY	0.186423	513,173	95,667	70
70.10 APNEA MONITORING				70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	0.131012	12,233,163	1,602,691	71
73 DRUGS CHARGED TO PATIENTS	0.139095	40,912,705	5,690,753	73
75.10 NUTRITIONAL SUPPORT	0.267783	23,751	6,360	75.10
75.20 HEMODIALYSIS	0.430699	1,591,881	685,622	75.20
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.807428	79,691	64,345	90
90.01 CHILDRENS CLINIC				90.01
91 EMERGENCY	0.272982	9,904,223	2,703,675	91
91.05 AMBULATORY CARE	1.792817	3,079	5,520	91.05
91.10 PSYCHIATRIC PARTIAL	1.381733	42,952	59,348	91.10
92 OBSERVATION BEDS	0.517311	20,271	10,486	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		206,044,135	36,859,866	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		206,044,135		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S228) [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
31.01 PEDIATRIC ICU				31.01
40 SUBPROVIDER - IPF		1,943,347		40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.204799	7,470	1,530	50
50.20 GASTROENTEROLOGY	0.224878			50.20
52 DELIVERY ROOM & LABOR ROOM	0.413234			52
53 ANESTHESIOLOGY	0.055314	2,694	149	53
54 RADIOLOGY-DIAGNOSTIC	0.217978	35,304	7,695	54
54.10 RADIATION ONCOLOGY	0.286899			54.10
54.20 CT	0.074090	33,213	2,461	54.20
54.30 MRI	0.125880	12,792	1,610	54.30
60 LABORATORY	0.117099	417,961	48,943	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.195912	4,744	929	65
66 PHYSICAL THERAPY	0.284757	17,491	4,981	66
69 ELECTROCARDIOLOGY	0.070766	47,079	3,332	69
69.10 PEDIATRIC CARDIOLOGY				69.10
70 ELECTROENCEPHALOGRAPHY	0.186423			70
70.10 APNEA MONITORING				70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	0.131012	30,955	4,055	71
73 DRUGS CHARGED TO PATIENTS	0.139095	473,614	65,877	73
75.10 NUTRITIONAL SUPPORT	0.267783	544	146	75.10
75.20 HEMODIALYSIS	0.430699			75.20
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.807428	573	463	90
90.01 CHILDRENS CLINIC				90.01
91 EMERGENCY	0.272982	141,560	38,643	91
91.05 AMBULATORY CARE	1.792817			91.05
91.10 PSYCHIATRIC PARTIAL	1.381733			91.10
92 OBSERVATION BEDS	0.517311			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,225,994	180,814	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,225,994		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0228) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		14,007,563		30
31 INTENSIVE CARE UNIT		4,896,976		31
31.01 PEDIATRIC ICU				31.01
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.204609	8,027,170	1,642,431	50
50.20 GASTROENTEROLOGY	0.224878	420,245	94,504	50.20
52 DELIVERY ROOM & LABOR ROOM	0.413234	5,359,459	2,214,711	52
53 ANESTHESIOLOGY	0.054116	1,015,183	54,938	53
54 RADIOLOGY-DIAGNOSTIC	0.216841	4,358,214	945,039	54
54.10 RADIATION ONCOLOGY	0.286774	109,866	31,507	54.10
54.20 CT	0.074090	2,009,583	148,890	54.20
54.30 MRI	0.125880	867,527	109,204	54.30
60 LABORATORY	0.117099	13,053,666	1,528,571	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.195912	1,534,675	300,661	65
66 PHYSICAL THERAPY	0.284757	1,105,528	314,807	66
69 ELECTROCARDIOLOGY	0.070766	2,350,065	166,305	69
69.10 PEDIATRIC CARDIOLOGY				69.10
70 ELECTROENCEPHALOGRAPHY	0.186423	147,047	27,413	70
70.10 APNEA MONITORING				70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	0.131012	17,364,112	2,274,907	71
73 DRUGS CHARGED TO PATIENTS	0.139095	17,252,458	2,399,731	73
75.10 NUTRITIONAL SUPPORT	0.267783			75.10
75.20 HEMODIALYSIS	0.430699	202,870	87,376	75.20
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.806062	965	778	90
90.01 CHILDRENS CLINIC				90.01
91 EMERGENCY	0.272224	2,299,319	625,930	91
91.05 AMBULATORY CARE	1.792817			91.05
91.10 PSYCHIATRIC PARTIAL	1.381733			91.10
92 OBSERVATION BEDS	0.517311	3,516	1,819	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		77,481,468	12,969,522	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		77,481,468		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S228) [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
31.01 PEDIATRIC ICU				31.01
40 SUBPROVIDER - IPF		1,984,866		40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.204609	5,272	1,079	50
50.20 GASTROENTEROLOGY	0.224878			50.20
52 DELIVERY ROOM & LABOR ROOM	0.413234			52
53 ANESTHESIOLOGY	0.054116	1,347	73	53
54 RADIOLOGY-DIAGNOSTIC	0.216841	35,682	7,737	54
54.10 RADIATION ONCOLOGY	0.286774			54.10
54.20 CT	0.074090	13,149	974	54.20
54.30 MRI	0.125880	8,280	1,042	54.30
60 LABORATORY	0.117099	500,674	58,628	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.195912	3,270	641	65
66 PHYSICAL THERAPY	0.284757	12,051	3,432	66
69 ELECTROCARDIOLOGY	0.070766	69,014	4,884	69
69.10 PEDIATRIC CARDIOLOGY				69.10
70 ELECTROENCEPHALOGRAPHY	0.186423			70
70.10 APNEA MONITORING				70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	0.131012	1,019	134	71
73 DRUGS CHARGED TO PATIENTS	0.139095	332,352	46,229	73
75.10 NUTRITIONAL SUPPORT	0.267783			75.10
75.20 HEMODIALYSIS	0.430699			75.20
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.806062			90
90.01 CHILDRENS CLINIC				90.01
91 EMERGENCY	0.272224	165,383	45,021	91
91.05 AMBULATORY CARE	1.792817			91.05
91.10 PSYCHIATRIC PARTIAL	1.381733	20,630	28,505	91.10
92 OBSERVATION BEDS	0.517311			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,168,123	198,379	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,168,123		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0228)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	44,877,597	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	2,349,596	2
3	MANAGED CARE SIMULATED PAYMENTS	7,456,640	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	296.28	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)	12.38	5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)	12.38	9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	19.04	10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)	12.38	12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	12.38	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	12.38	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	12.38	15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	12.38	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.041785	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.040988	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.040988	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	1,158,837	22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)	6.66	24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK HOSPITAL (14-0228)
APPLICABLE BOX: SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)	1,158,837	29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0608	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.2675	31
32	SUM OF LINES 30 AND 31	0.3283	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1630	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	7,315,048	34
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	55,701,078	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	55,701,078	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	4,397,930	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)	447,714	52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	87,589	53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)	213,139	58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	60,847,450	59
60	PRIMARY PAYER PAYMENTS	116,148	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	60,731,302	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	4,658,752	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	227,690	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	1,368,266	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	957,786	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	56,802,646	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK HOSPITAL (14-0228)
APPLICABLE BOX: SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	56,802,646	71
72	INTERIM PAYMENTS	56,455,596	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	347,050	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	741,217	75

TO BE COMPLETED BY CONTRACTOR

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

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL (14-0228) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	19,715,242	40
41	INTERIM PAYMENTS	19,675,284	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	39,958	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	45,120	44
TO BE COMPLETED BY CONTRACTOR			
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: [] HOSPITAL [XX] IPF (14-S228) [] IRF
 [] SUB (OTHER) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)	3,930	2
3	PPS PAYMENTS	3,049	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)	0.851	5
6	LINE 2 TIMES LINE 5	3,344	6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6	0.9118	7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200	14	9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)	3,063	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	647	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	2,416	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	2,416	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,416	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 (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	2,416	37

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0228) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		56,455,596		19,675,284	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
	.01	NONE		NONE	3.01
	.02				3.02
	.03				3.03
	.04				3.04
	.05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	.52				3.52
	.53				3.53
	.54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		56,455,596		19,675,284	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
	.01	NONE		NONE	5.01
	.02				5.02
	.03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	.50	NONE		NONE	5.50
	.51				5.51
	.52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56

		.57		5.57
		.58		5.58
		.59		5.59
		.99		5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT	PROGRAM			
(BALANCE DUE) BASED ON THE COST REPORT	TO	.01	39,958	6.01
	PROVIDER			
	PROVIDER			
	TO	.02	-56,455,596	6.02
	PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			19,715,242	7

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

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
 PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/30/2011 09:35

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [XX] IPF (14-S228) [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		922,817		2,401	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		922,817		2,401	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56
--	--	------	--	------	--

		.57			5.57
		.58			5.58
		.59			5.59
		.99			5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER PROVIDER TO PROGRAM	.01	2,539	15 6.01
			.02		6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			925,356	2,416 7

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

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0228) [] CAH
APPLICABLE BOX

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	19,153 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	31,728 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	4,802 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	71,490 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,166,705,759 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	41,812,399 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 + LINE 31)	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

CHECK [] HOSPITAL
 APPLICABLE BOX: [XX] IPF (14-S228)

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS)	1,028,796	1
2	NET IPF PPS OUTLIER PAYMENT	42,985	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)	0.01	4
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	11.413699	9
10	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (\text{LINE 8/LINE 9})) \text{ RAISED TO THE POWER OF } .5150^{-1}\}$		10
11	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	1,071,781	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	1,071,781	16
17	PRIMARY PAYER PAYMENTS	965	17
18	SUBTOTAL (LINE 16 LESS LINE 17)	1,070,816	18
19	DEDUCTIBLES	116,748	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	954,068	20
21	COINSURANCE	31,251	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	922,817	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)		23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	922,817	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	2,539	28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	925,356	31
32	INTERIM PAYMENTS	922,817	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS THE SUM OF LINES 32 AND 33)	2,539	34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (SEE INSTRUCTIONS)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [XX] TITLE V [XX] HOSPITAL (14-0228) [] SNF [] PPS
 APPLICABLE [] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [XX] OTHER
 [] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	1
2	MEDICAL AND OTHER SERVICES	7,844 2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	7,844 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	7,844 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	29,039 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)	29,039 12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	29,039 16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 7 (SEE INSTRUCTIONS))	21,195 17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 7 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LINE 7)	7,844 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 22-26)	27
28	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)	28
29	TITLE V OR XIX PPS, LESSER OF LINES 27 OR 28, NON-PPS ENTER AMOUNT FROM LINE 27	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19-21 MINUS 29)	7,844 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)	7,844 36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	7,844 38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL (14-0228) NF PPS
APPLICABLE TITLE XIX SUB (OTHER) ICF/MR TEFRA
BOXES: SNF OTHER

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

40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	7,844	40
41	INTERIM PAYMENTS	8,722	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	-878	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-0228) [] SNF [] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [XX] OTHER
 [] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	32,405,161 1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	32,405,161 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	32,405,161 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	77,481,468 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)	77,481,468 12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	77,481,468 16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 7 (SEE INSTRUCTIONS))	45,076,307 17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 7 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LINE 7)	32,405,161 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	50,405 26
27	SUBTOTAL (SUM OF LINES 22-26)	50,405 27
28	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)	28
29	TITLE V OR XIX PPS, LESSER OF LINES 27 OR 28, NON-PPS ENTER AMOUNT FROM LINE 27	50,405 29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19-21 MINUS 29)	32,354,756 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)	32,354,756 36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	32,354,756 38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL (14-0228) NF PPS
APPLICABLE TITLE XIX SUB (OTHER) ICF/MR TEFRA
BOXES: SNF OTHER

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

40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	32,354,756	40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	32,354,756	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [] HOSPITAL [] SNF [] PPS
 APPLICABLE [XX] TITLE XIX [XX] IPF (14-S228) [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [XX] OTHER
 [] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	722,665 1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	722,665 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	722,665 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	1,168,123 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)	1,168,123 12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	1,168,123 16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 7 (SEE INSTRUCTIONS))	445,458 17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 7 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LINE 7)	722,665 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	2,973 26
27	SUBTOTAL (SUM OF LINES 22-26)	2,973 27
28	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)	28
29	TITLE V OR XIX PPS, LESSER OF LINES 27 OR 28, NON-PPS ENTER AMOUNT FROM LINE 27	2,973 29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19-21 MINUS 29)	719,692 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)	719,692 36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	719,692 38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
APPLICABLE TITLE XIX SUB (OTHER) (14-S228) ICF/MR TEFRA
BOXES: SNF OTHER

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

40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	719,692	40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	719,692	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996		1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)		2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA		3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))		4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)		5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)		6
7	ENTER THE LESSER OF LINE 5 OR LINE 6		7
		PRIMARY CARE 1	OTHER 2
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR		TOTAL 3 8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6		9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		10
11	TOTAL WEIGHTED FTE COUNT		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)		13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT		17
18	PER RESIDENT AMOUNT		18
19	APPROVED AMOUNT FOR RESIDENT COSTS		19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)		20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)		22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)		23
24	MULTIPLY LINE 22 TIMES LINE 23		24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)		25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE
26	INPATIENT DAYS		26
27	TOTAL INPATIENT DAYS	75,656	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS		28
29	PROGRAM DIRECT GME AMOUNT		29
30	REDUCTION FOR NURSING/ALLIED HEALTH		30
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY		

	(NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)	
31	NET PROGRAM DIRECT GME AMOUNT	31
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)	32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)	34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)	35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)	36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME	
	PART A REASONABLE COST	
37	REASONABLE COST (SEE INSTRUCTIONS)	37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)	38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)	39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)	40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)	41
	PART B REASONABLE COST	
42	REASONABLE COST (SEE INSTRUCTIONS)	42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)	43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)	44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B	
48	TOTAL PROGRAM GME PAYMENT (LINE 31)	48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)	49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)	50

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996	15.05	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)		2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA		3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))		4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)	15.05	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)	19.04	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6	15.05	7
		PRIMARY CARE 1	OTHER 2
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	19.04	TOTAL 3
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	15.05	19.04 8
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		10
11	TOTAL WEIGHTED FTE COUNT	15.05	11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)	15.05	12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)	15.05	13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)	15.05	14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	15.05	17
18	PER RESIDENT AMOUNT	82,943.28	18
19	APPROVED AMOUNT FOR RESIDENT COSTS	1,248,296	1,248,296 19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)		20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		3.99 21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)		22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)		23
24	MULTIPLY LINE 22 TIMES LINE 23		24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)		1,248,296 25
COMPUTATION OF PROGRAM PATIENT LOAD			
		INPATIENT PART A	MANAGED CARE
26	INPATIENT DAYS	33,122	4,802 26
27	TOTAL INPATIENT DAYS	75,656	75,656 27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.437797	0.063472 28
29	PROGRAM DIRECT GME AMOUNT	546,500	79,232 29
30	REDUCTION FOR NURSING/ALLIED HEALTH		11,195 30
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY			

(NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
31	NET PROGRAM DIRECT GME AMOUNT	614,537 31
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)	32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)	34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)	35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)	36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME		
PART A REASONABLE COST		
37	REASONABLE COST (SEE INSTRUCTIONS)	69,983,760 37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)	38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)	39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)	117,113 40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)	69,866,647 41
PART B REASONABLE COST		
42	REASONABLE COST (SEE INSTRUCTIONS)	26,039,665 42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)	6,464 43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)	26,033,201 44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)	95,899,848 45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)	0.728538 46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)	0.271462 47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	TOTAL PROGRAM GME PAYMENT (LINE 31)	614,537 48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)	447,714 49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)	166,823 50

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996		1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)		2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA		3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))		4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)		5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)		6
7	ENTER THE LESSER OF LINE 5 OR LINE 6		7
		PRIMARY CARE 1	OTHER 2
			TOTAL 3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR		8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6		9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		10
11	TOTAL WEIGHTED FTE COUNT		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)		13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT		17
18	PER RESIDENT AMOUNT		18
19	APPROVED AMOUNT FOR RESIDENT COSTS		19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)		20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)		22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)		23
24	MULTIPLY LINE 22 TIMES LINE 23		24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)		25
COMPUTATION OF PROGRAM PATIENT LOAD			
		INPATIENT PART A	MANAGED CARE
26	INPATIENT DAYS	16,926	26
27	TOTAL INPATIENT DAYS	75,656	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.223723	28
29	PROGRAM DIRECT GME AMOUNT		29
30	REDUCTION FOR NURSING/ALLIED HEALTH		30
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY			

	(NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)	
31	NET PROGRAM DIRECT GME AMOUNT	31
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)	32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)	34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)	35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)	36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME	
	PART A REASONABLE COST	
37	REASONABLE COST (SEE INSTRUCTIONS)	37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)	38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)	39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)	40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)	41
	PART B REASONABLE COST	
42	REASONABLE COST (SEE INSTRUCTIONS)	42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)	43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)	44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B	
48	TOTAL PROGRAM GME PAYMENT (LINE 31)	48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)	49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)	50

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	28,903,000			1
2 TEMPORARY INVESTMENTS	4,236,000			2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	56,790,000			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7 INVENTORY	4,972,000			7
8 PREPAID EXPENSES	8,547,000			8
9 OTHER CURRENT ASSETS				9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	103,448,000			11
FIXED ASSETS				
12 LAND	1,604,229			12
13 LAND IMPROVEMENTS	6,122,785			13
14 ACCUMULATED DEPRECIATION	-4,432,789			14
15 BUILDINGS	174,369,480			15
16 ACCUMULATED DEPRECIATION	-82,511,594			16
17 LEASEHOLD IMPROVEMENTS	5,016,727			17
18 ACCUMULATED AMORTIZATION	-2,112,006			18
19 FIXED EQUIPMENT	6,072,277			19
20 ACCUMULATED DEPRECIATION	-4,304,715			20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	168,187,502			23
24 ACCUMULATED DEPRECIATION	-107,527,896			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)	160,484,000			30
OTHER ASSETS				
31 INVESTMENTS				31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	180,671,000	1,891,000	5,636,000	34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	180,671,000	1,891,000	5,636,000	35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	444,603,000	1,891,000	5,636,000	36

BALANCE SHEET

WORKSHEET G
 (CONTINUED)

LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	13,897,000			37
38 SALARIES, WAGES & FEES PAYABLE				38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)				40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	51,911,000			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	65,808,000			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	111,229,000			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	33,627,000			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	144,856,000			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	210,664,000			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	233,939,000			52
53 SPECIFIC PURPOSE FUND BALANCE		1,891,000		53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED			5,636,000	54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57 PLANT FUND BALANCE - INVESTED IN PLANT				57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)	233,939,000	1,891,000	5,636,000	59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	444,603,000	1,891,000	5,636,000	60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		210,767,000		2,255,000		5,081,000			1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		22,062,000							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		232,829,000		2,255,000		5,081,000			3
4 ADDITIONS (CREDIT ADJUSTMENTS)	1,110,000		1,064,000		94,000				4
5 CONTRIBUTIONS									5
6 OTHER					461,000				6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)	1,110,000		1,064,000		555,000				10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		233,939,000		3,319,000		5,636,000			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 OTHER			1,428,000						13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)			1,428,000						18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		233,939,000		1,891,000		5,636,000			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	99,973,978		99,973,978	1
2 SUBPROVIDER IPF	6,500,114		6,500,114	2
3 SUBPROVIDER IRF				3
5 SWING BED - SNF				5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	106,474,092		106,474,092	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT	36,928,653		36,928,653	11
11.01 PEDIATRIC ICU				11.01
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)	36,928,653		36,928,653	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	143,402,745		143,402,745	17
18 ANCILLARY SERVICES	458,372,859	452,418,497	910,791,356	18
19 OUTPATIENT SERVICES	23,680,517	53,339,367	77,019,884	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY		12,985,682	12,985,682	22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	625,456,121	518,743,546	1,144,199,667	28

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		398,212,712	29
30 BAD DEBT	36,446,891		30
31 FOUNDATION EXPENSE	1,772,210		31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		38,219,101	36
37 INCOME TAX PROVISION	-192,000		37
38 IHREF CONTR	-2,813		38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)	-194,813		42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		436,237,000	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	1,144,199,667	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	741,998,667	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	402,201,000	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	436,237,000	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-34,036,000	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	14,872,698	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		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	1,344,633	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)	317,328	19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	333,346	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (EMPLOYEE HEALTH)	830,136	24
24.01	OTHER (PHYSICIAN PAGING AND ANSWERING)	379,950	24.01
24.02	OTHER (MRI JOINT VENTURE INCOME)	2,045,942	24.02
24.04	OTHER (FOUNDATION REVENUE)	1,573,000	24.04
24.05	OTHER (CHILD CARE CENTER)	1,265,476	24.05
24.06	OTHER (MSO OTHER REVENUE)	1,667,168	24.06
24.07	OTHER (PUBLIC AID ASSESSMENT REVENUE)	23,335,000	24.07
24.08	OTHER (SURGICENTER JOINT VENTURE)	537,333	24.08
24.09	OTHER (GRANT REVENUE)	4,497,225	24.09
24.12	OTHER (SWEDISHAMERICAN ER)	378,601	24.12
24.13	OTHER (MISC.)	2,720,164	24.13
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	56,098,000	25
26	TOTAL (LINE 5 PLUS LINE 25)	22,062,000	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	22,062,000	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7448

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF COLS.1-5) 6	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXTURES							1
2 CAPITAL RELATED-MOVABLE EQUIPMENT							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTRUCTIONS)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	1,184,814	401,630	45,378		176,587	1,808,409	5
6 SKILLED NURSING CARE	1,550,014	525,426	59,364		231,017	2,365,821	6
7 PHYSICAL THERAPY	611,311	207,223	23,413		91,111	933,058	7
8 OCCUPATIONAL THERAPY	228,973	77,618	8,769		34,127	349,487	8
9 SPEECH PATHOLOGY	74,888	25,386	2,868		11,161	114,303	9
10 MEDICAL SOCIAL SERVICES	63,483	21,520	2,431		9,462	96,896	10
11 HOME HEALTH AIDE	32,424	10,991	1,242		4,833	49,490	11
12 SUPPLIES (SEE INSTRUCTIONS)							12
13 DRUGS							13
14 DME	222,678	74,251	1,679		1,300,580	1,599,188	14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING	315,279	29,584	8,533		6,816	360,212	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	451,608	147,317	803		896,078	1,495,806	23
24 TOTAL (SUM OF LINES 1-23)	4,735,472	1,520,946	154,480		2,761,772	9,172,670	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7448

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5		1,808,409	-76,481	1,731,928	5
6		2,365,821		2,365,821	6
7		933,058		933,058	7
8		349,487		349,487	8
9		114,303		114,303	9
10		96,896		96,896	10
11		49,490		49,490	11
12					12
13					13
14		1,599,188	-635,187	964,001	14
15					15
16					16
17		360,212		360,212	17
18					18
19					19
20					20
21					21
22					22
23		1,495,806	-74,685	1,421,121	23
24		9,172,670	-786,353	8,386,317	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7448

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	0	1	2	3	4	4A	5	6	
GENERAL SERVICE COST CENTER									
1 CAPITAL RELATED-BLDGS & FIXT									1
2 CAPITAL RELATED-MOVABLE EQUIP									2
3 PLANT OPERATION & MAINTENANCE									3
4 TRANSPORTATION (SEE INSTR.)									4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	1,731,928					1,731,928	1,731,928		5
6 SKILLED NURSING CARE	2,365,821					2,365,821	615,745	2,981,566	6
7 PHYSICAL THERAPY	933,058					933,058	242,846	1,175,904	7
8 OCCUPATIONAL THERAPY	349,487					349,487	90,961	440,448	8
9 SPEECH PATHOLOGY	114,303					114,303	29,750	144,053	9
10 MEDICAL SOCIAL SERVICES	96,896					96,896	25,219	122,115	10
11 HOME HEALTH AIDE	49,490					49,490	12,881	62,371	11
12 SUPPLIES (SEE INSTRUCTIONS)									12
13 DRUGS									13
14 DME HHA NONREIMBURSABLE SERVICES	964,001					964,001	250,900	1,214,901	14
15 HOME DIALYSIS AIDE SERVICES									15
16 RESPIRATORY THERAPY									16
17 PRIVATE DUTY NURSING	360,212					360,212	93,752	453,964	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	1,421,121					1,421,121	369,874	1,790,995	23
24 TOTAL (SUM OF LINES 1-23)	8,386,317					8,386,317		8,386,317	24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7448

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-1,731,928	6,654,389	5
6 SKILLED NURSING CARE						2,365,821	6
7 PHYSICAL THERAPY						933,058	7
8 OCCUPATIONAL THERAPY						349,487	8
9 SPEECH PATHOLOGY						114,303	9
10 MEDICAL SOCIAL SERVICES						96,896	10
11 HOME HEALTH AIDE						49,490	11
12 SUPPLIES (SEE INSTRUCTIONS)							12
13 DRUGS							13
14 DME						964,001	14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING						360,212	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						1,421,121	23
23.50 TELEMEDICINE							23.50
24 TOTAL (SUM OF LINES 1-23)					-1,731,928	6,654,389	24
25 COST TO BE ALLOC (PER W/S H)						1,731,928	25
26 UNIT COST MULTIPLIER						0.260269	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7448

WORKSHEET H-2
 PART I

HHA COST CENTER	PARAMED ED LAB	PARAMED ED PRGM RADIOLOGY	PARAMED ED PRGM RAD ONC	PARAMED ED PRGM PARAMEDICS	SUBTOTAL (SUM OF COL. 4A-23)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (SUM OF COL. 4A-23)	ALLOCATED HHA A&G (SEE PT. 2)	
	23.10	23.20	23.30	23.40	24	25	26	27	
1 ADMINISTRATIVE AND GENERAL					51,217		51,217		1
2 SKILLED NURSING CARE					3,691,785		3,691,785	18,213	2
3 PHYSICAL THERAPY					1,453,871		1,453,871	7,172	3
4 OCCUPATIONAL THERAPY					545,318		545,318	2,690	4
5 SPEECH PATHOLOGY					178,273		178,273	879	5
6 MEDICAL SOCIAL SERVICES					151,577		151,577	748	6
7 HOME HEALTH AIDE					78,949		78,949	389	7
8 SUPPLIES									8
9 DRUGS									9
10 DME					1,497,703		1,497,703	7,388	10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING					577,491		577,491	2,849	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					2,207,393		2,207,393	10,889	19
20 TOTAL (SUM OF LINES 1-19)					10,433,577		10,433,577	51,217	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.								0.004933	21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7448

WORKSHEET H-2
 PART I

HHA COST CENTER	TOTAL HHA COSTS	
	28	
1 ADMINISTRATIVE AND GENERAL		1
2 SKILLED NURSING CARE	3,709,998	2
3 PHYSICAL THERAPY	1,461,043	3
4 OCCUPATIONAL THERAPY	548,008	4
5 SPEECH PATHOLOGY	179,152	5
6 MEDICAL SOCIAL SERVICES	152,325	6
7 HOME HEALTH AIDE	79,338	7
8 SUPPLIES		8
9 DRUGS		9
10 DME	1,505,091	10
11 HOME DIALYSIS AIDE SERVICES		11
12 RESPIRATORY THERAPY		12
13 PRIVATE DUTY NURSING	580,340	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	2,218,282	19
20 TOTAL (SUM OF LINES 1-19)	10,433,577	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7448

WORKSHEET H-2
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS FTE'S	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAINT-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4	4A	5	6	7	
1 ADMINISTRATIVE AND GENERAL	150	150		2,181		37,444	150	150	1
2 SKILLED NURSING CARE				2,096		3,011,857			2
3 PHYSICAL THERAPY				706		1,186,107			3
4 OCCUPATIONAL THERAPY				307		444,885			4
5 SPEECH PATHOLOGY				96		145,440			5
6 MEDICAL SOCIAL SERVICES				107		123,661			6
7 HOME HEALTH AIDE				141		64,409			7
8 SUPPLIES									8
9 DRUGS									9
10 DME				482		1,221,867			10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING CLINIC				1,188		471,133			13
14 HEALTH PROMOTION ACTIVITIES									14
15 DAY CARE PROGRAM									15
16 HOME DELIVERED MEALS PROGRAM									16
17 HOMEMAKER SERVICE									17
18 ALL OTHERS				682		1,800,851			18
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)	150	150		7,986		8,507,654	150	150	20
21 TOTAL COST TO BE ALLOCATED	2,214	3,711		115,412		1,920,603	952	2,220	21
22 UNIT COST MULTIPLIER	14.760000						6.346667		22
22 UNIT COST MULTIPLIER		24.740000		14.451791		0.225750		14.800000	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7448

WORKSHEET H-2
 PART II

HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	MAIN- TENANCE & PERSONNEL NUMBER HOUSED	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES * SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.
	8	9	10	11	12	13	14	15
1 ADMINISTRATIVE AND GENERAL		150						1
2 SKILLED NURSING CARE								2
3 PHYSICAL THERAPY								3
4 OCCUPATIONAL THERAPY								4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE								7
8 SUPPLIES								8
9 DRUGS								9
10 DME								10
11 HOME DIALYSIS AIDE SERVICES								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIES								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGRAM								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTAL (SUM OF LINES 1-19)		150						20
21 TOTAL COST TO BE ALLOCATED		2,148						21
22 UNIT COST MULTIPLIER								22
22 UNIT COST MULTIPLIER		14.320000						22

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
STATISTICAL BASIS

HHA NO.: 14-7448

WORKSHEET H-2
PART II

HHA COST CENTER	PARAMED ED PRGM RADIOLOGY ASSIGNED TIME	PARAMED ED PRGM RAD ONC ASSIGNED TIME	PARAMED ED PRGM PARAMEDICS ASSIGNED TIME	
	23.20	23.30	23.40	
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 TOTAL (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 NO.: 14-7448

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		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I) 1	(FROM PART II) 2	COLS. 1+2) 3	4	(COL.3 ÷ COL.4) 5	
1	SKILLED NURSING CARE	2	3,709,998		3,709,998	15,754	235.50	1
2	PHYSICAL THERAPY	3	1,461,043		1,461,043	6,909	211.47	2
3	OCCUPATIONAL THERAPY	4	548,008		548,008	2,914	188.06	3
4	SPEECH PATHOLOGY	5	179,152		179,152	905	197.96	4
5	MEDICAL SOCIAL SERVICES	6	152,325		152,325	288	528.91	5
6	HOME HEALTH AIDE	7	79,338		79,338	1,540	51.52	6
7	TOTAL (SUM OF LINES 1-6)		6,129,864		6,129,864	28,310		7

PATIENT SERVICES

8	SKILLED NURSING CARE							8
8.01	SKILLED NURSING CARE							8.01
8.02	SKILLED NURSING CARE							8.02
8.03	SKILLED NURSING CARE							8.03
9	PHYSICAL THERAPY							9
9.01	PHYSICAL THERAPY							9.01
9.02	PHYSICAL THERAPY							9.02
9.03	PHYSICAL THERAPY							9.03
10	OCCUPATIONAL THERAPY							10
10.01	OCCUPATIONAL THERAPY							10.01
10.02	OCCUPATIONAL THERAPY							10.02
10.03	OCCUPATIONAL THERAPY							10.03
11	SPEECH PATHOLOGY							11
11.01	SPEECH PATHOLOGY							11.01
11.02	SPEECH PATHOLOGY							11.02
11.03	SPEECH PATHOLOGY							11.03
12	MEDICAL SOCIAL SERVICES							12
12.01	MEDICAL SOCIAL SERVICES							12.01
12.02	MEDICAL SOCIAL SERVICES							12.02
12.03	MEDICAL SOCIAL SERVICES							12.03
13	HOME HEALTH AIDE							13
13.01	HOME HEALTH AIDE							13.01
13.02	HOME HEALTH AIDE							13.02
13.03	HOME HEALTH AIDE							13.03
14	TOTAL (SUM OF LINES 8-13)							14

SUPPLIES AND DRUGS COST COMPUTATIONS

OTHER PATIENT SERVICES	FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO
	WKST H-2, PART I, COL 28,	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	(FROM HHA RECORD)	(COL.3 ÷ COL.4)

15	COST OF MEDICAL SUPPLIES	LINE	1	2	3	4	5	
		8						15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7448

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS. 9-10)
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
PATIENT SERVICES	6	7	8	9	10	11	12
1 SKILLED NURSING CARE	5,483	3,490		1,291,247	821,895		2,113,142
2 PHYSICAL THERAPY	2,665	1,358		563,568	287,176		850,744
3 OCCUPATIONAL THERAPY	1,137	604		213,824	113,588		327,412
4 SPEECH PATHOLOGY	321	179		63,545	35,435		98,980
5 MEDICAL SOCIAL SERVICES	105	71		55,536	37,553		93,089
6 HOME HEALTH AIDE	623	523		32,097	26,945		59,042
7 TOTAL (SUM OF LINES 1-6)	10,334	6,225		2,219,817	1,322,592		3,542,409

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS			
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	1	2	3	4	8
8.01 SKILLED NURSING CARE	16974	85			8.01
8.02 SKILLED NURSING CARE	40420	4,408	2,650		8.02
8.03 SKILLED NURSING CARE	99904		11		8.03
9 PHYSICAL THERAPY	99914	990	825		9
9.01 PHYSICAL THERAPY	16974	44			9.01
9.02 PHYSICAL THERAPY	40420	2,180	1,105		9.02
9.03 PHYSICAL THERAPY	99904		253		9.03
10 OCCUPATIONAL THERAPY	99914	441			10
10.01 OCCUPATIONAL THERAPY	16974	13			10.01
10.02 OCCUPATIONAL THERAPY	40420	1,023	526		10.02
10.03 OCCUPATIONAL THERAPY	99904				10.03
11 SPEECH PATHOLOGY	99914	101	78		11
11.01 SPEECH PATHOLOGY	16974	11			11.01
11.02 SPEECH PATHOLOGY	40420	297	133		11.02
11.03 SPEECH PATHOLOGY	99904				11.03
12 MEDICAL SOCIAL SERVICES	99914	13	46		12
12.01 MEDICAL SOCIAL SERVICES	16974		1		12.01
12.02 MEDICAL SOCIAL SERVICES	40420	94	65		12.02
12.03 MEDICAL SOCIAL SERVICES	99904				12.03
13 HOME HEALTH AIDE	99914	11	5		13
13.01 HOME HEALTH AIDE	16974	7			13.01
13.02 HOME HEALTH AIDE	40420	575	318		13.02
13.03 HOME HEALTH AIDE	99904				13.03
14 TOTAL (SUM OF LINES 8-13)	99914	41	205		14
		10,334	6,225		

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7448

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

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

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

	FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
	1	1	2	3	4	
1 PHYSICAL THERAPY	66	0.284757			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 CHRGED TO PAT	71	0.131012			COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	73	0.139095			COL 2, LINE 16	5

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7448

WORKSHEET H-3
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I) 1	(FROM PART II) 2	COLS. 1+2) 3	(COL.3 ÷ COL.4) 5	
					TOTAL VISITS 4		
1	SKILLED NURSING CARE	2	3,709,998		3,709,998	235.50	1
2	PHYSICAL THERAPY	3	1,461,043		1,461,043	211.47	2
3	OCCUPATIONAL THERAPY	4	548,008		548,008	188.06	3
4	SPEECH PATHOLOGY	5	179,152		179,152	197.96	4
5	MEDICAL SOCIAL SERVICES	6	152,325		152,325	528.91	5
6	HOME HEALTH AIDE	7	79,338		79,338	51.52	6
7	TOTAL (SUM OF LINES 1-6)		6,129,864		6,129,864		7

PATIENT SERVICES

8	SKILLED NURSING CARE						8
8.01	SKILLED NURSING CARE						8.01
8.02	SKILLED NURSING CARE						8.02
8.03	SKILLED NURSING CARE						8.03
9	PHYSICAL THERAPY						9
9.01	PHYSICAL THERAPY						9.01
9.02	PHYSICAL THERAPY						9.02
9.03	PHYSICAL THERAPY						9.03
10	OCCUPATIONAL THERAPY						10
10.01	OCCUPATIONAL THERAPY						10.01
10.02	OCCUPATIONAL THERAPY						10.02
10.03	OCCUPATIONAL THERAPY						10.03
11	SPEECH PATHOLOGY						11
11.01	SPEECH PATHOLOGY						11.01
11.02	SPEECH PATHOLOGY						11.02
11.03	SPEECH PATHOLOGY						11.03
12	MEDICAL SOCIAL SERVICES						12
12.01	MEDICAL SOCIAL SERVICES						12.01
12.02	MEDICAL SOCIAL SERVICES						12.02
12.03	MEDICAL SOCIAL SERVICES						12.03
13	HOME HEALTH AIDE						13
13.01	HOME HEALTH AIDE						13.01
13.02	HOME HEALTH AIDE						13.02
13.03	HOME HEALTH AIDE						13.03
14	TOTAL (SUM OF LINES 8-13)						14

SUPPLIES AND DRUGS COST COMPUTATIONS

OTHER PATIENT SERVICES	FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO
	WKST H-2, PART I, COL 28,	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	(FROM HHA RECORD)	(COL.3 ÷ COL.4)

15	COST OF MEDICAL SUPPLIES	LINE	1	2	3	4	5	
		8						15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7448

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
1 SKILLED NURSING CARE	6	7	8	9	10	11	12
2 PHYSICAL THERAPY							
3 OCCUPATIONAL THERAPY							
4 SPEECH PATHOLOGY							
5 MEDICAL SOCIAL SERVICES							
6 HOME HEALTH AIDE							
7 TOTAL (SUM OF LINES 1-6)							

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		TOTAL
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	1	2	3	4
8.01 SKILLED NURSING CARE	16974			8
8.02 SKILLED NURSING CARE	40420			8.01
8.03 SKILLED NURSING CARE	99904			8.02
9 PHYSICAL THERAPY	16974			8.03
9.01 PHYSICAL THERAPY	40420			9
9.02 PHYSICAL THERAPY	99904			9.01
9.03 PHYSICAL THERAPY	99914			9.02
10 OCCUPATIONAL THERAPY	16974			9.03
10.01 OCCUPATIONAL THERAPY	40420			10
10.02 OCCUPATIONAL THERAPY	99904			10.01
10.03 OCCUPATIONAL THERAPY	99914			10.02
11 SPEECH PATHOLOGY	16974			10.03
11.01 SPEECH PATHOLOGY	40420			11
11.02 SPEECH PATHOLOGY	99904			11.01
11.03 SPEECH PATHOLOGY	99914			11.02
12 MEDICAL SOCIAL SERVICES	16974			11.03
12.01 MEDICAL SOCIAL SERVICES	40420			12
12.02 MEDICAL SOCIAL SERVICES	99904			12.01
12.03 MEDICAL SOCIAL SERVICES	99914			12.02
13 HOME HEALTH AIDE	16974			12.03
13.01 HOME HEALTH AIDE	40420			13
13.02 HOME HEALTH AIDE	99904			13.01
13.03 HOME HEALTH AIDE	99914			13.02
14 TOTAL (SUM OF LINES 8-13)				13.03

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7448

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

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

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

	FROM	COST TO	TOTAL	HHA	TRANSFER	
	WKST C,	CHARGE	HHA	SHARED	TO PART I	
	PART I,	RATIO	CHARGES	ANCILLARY	AS	
	COL.9,	1	(FROM	COSTS	INDICATED	
	LINE	1	PROVIDER	(COL.1 x		
			RECORDS)	COL.2)		
			2	3	4	
1	PHYSICAL THERAPY	66	0.284757		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 CHRGED TO PAT	71	0.131012		COL 2, LINE 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.139095		COL 2, LINE 16	5

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 14-7448

WORKSHEET H-4
 PARTS I & II

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

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

DESCRIPTION	----- PART B -----		
	PART A 1	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	
REASONABLE COST OF PART A & PART B SERVICES			
1 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)			1
2 TOTAL CHARGES	1,798,059		2
CUSTOMARY CHARGES			
3 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)			3
4 AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)			4
5 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)			5
6 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	1,798,059		6
7 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)	1,798,059		7
8 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)			8
9 PRIMARY PAYER PAYMENTS			9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A	PART B	
	SERVICES 1	SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	1,833,429	1,193,802	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	8,175		12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	28,248	23,465	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	6,360	7,585	14

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 14-7448

WORKSHEET H-4
PARTS I & II

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A	PART B	
	SERVICES	SERVICES	
	1	2	
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	194		15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	1,876,406	1,224,852	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	1,876,406	1,224,852	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	1,876,406	1,224,852	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	1,876,406	1,224,852	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	1,876,406	1,224,852	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	1,876,406	1,224,852	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 14-7448

WORKSHEET H-4
 PARTS I & II

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

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS			11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES			13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES			14

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 14-7448

WORKSHEET H-4
PARTS I & II

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)			22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)			24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)			26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)			29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)			31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)			32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

		.59			5.59
		.99			5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT	PROGRAM				
(BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	TO PROVIDER	.01			6.01
	PROVIDER TO PROGRAM	.02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			1,876,406	1,224,852	7
8 NAME OF CONTRACTOR:			CONTRACTOR NUMBER:	DATE:	
	_____		_____	_____	

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	3,665,143	1
2	CAPITAL DRG OUTLIER PAYMENTS	415,019	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	195.86	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	12.38	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0180	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	65,973	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.0608	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.2675	8
9	SUM OF LINES 7 AND 8	0.3283	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0687	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	251,795	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	4,397,930	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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	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					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
23.10 PARAMED ED - LAB					23.10
23.20 PARAMED ED PRGM - RADIOLOGY					23.20
23.30 PARAMED ED - RADIATION ONCOLOG					23.30
23.40 PARAMED ED - PARAMEDICAL TECHS					23.40
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
31.01 PEDIATRIC ICU					31.01
40 SUBPROVIDER - IPF					40
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
50.20 GASTROENTEROLOGY					50.20
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
54.10 RADIATION ONCOLOGY					54.10
54.20 CT					54.20
54.30 MRI					54.30
60 LABORATORY					60
62.30 BLOOD CLOTTING FACTORS ADMIN C					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
69.10 PEDIATRIC CARDIOLOGY					69.10
70 ELECTROENCEPHALOGRAPHY					70
70.10 APNEA MONITORING					70.10
71 MEDICAL SUPPLIES CHRGED TO PAT					71
73 DRUGS CHARGED TO PATIENTS					73
75.10 NUTRITIONAL SUPPORT					75.10
75.20 HEMODIALYSIS					75.20
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 CHILDRENS CLINIC					90.01
91 EMERGENCY					91
91.05 AMBULATORY CARE					91.05
91.10 PSYCHIATRIC PARTIAL					91.10
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
190.10 MCC WORD PROCESSING					190.10
192 PHYSICIANS' PRIVATE OFFICES					192
192.01 SPECIALISTS/PCP'S					192.01
192.02 MEDWORKS					192.02
192.03 SWEDISHAMERICAN ER					192.03
192.20 IDLE SPACE					192.20
193 NONPAID WORKERS					193
193.10 HOTEL					193.10
193.30 PHYSICIAN BILLING					193.30
193.40 MEALS ON WHEELS					193.40
193.50 WEE CARE					193.50
193.60 PHYSICIAN RELATED AREAS					193.60
193.70 WOMEN'S CENTER					193.70
193.80 MARKETING EXPENSES					193.80
193.90 COMPLIMENTARY MEDICINE					193.90

PROVIDER CCN: 14-0228 SWEDISHAMERICAN HOSPITAL
PERIOD FROM 06/01/2010 TO 05/31/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/30/2011 09:35

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	TOTAL (SUM OF LINE 118 AND LINES 190-201)				202
203	TOTAL STATISTICAL BASIS				203
204	UNIT COST MULTIPLIER				204
204	UNIT COST MULTIPLIER				204

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

HOSPITAL

COST CENTERS	----- TITLE XVIII -----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	43.08		23.55				66.63 30
31 INTENSIVE CARE UNIT	45.81		13.64				59.45 31
43 NURSERY			66.72				66.72 43
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	20.91	7.14	4.11				32.16 50
50.20 GASTROENTEROLOGY	18.53	18.19	5.56				42.28 50.20
52 DELIVERY ROOM & LABOR ROOM	0.34	0.03	29.73				30.10 52
53 ANESTHESIOLOGY	19.27	7.41	9.96				36.64 53
54 RADIOLOGY-DIAGNOSTIC	24.49	13.91	2.60				41.00 54
54.10 RADIATION ONCOLOGY	1.80	37.69	0.15				39.64 54.10
54.20 CT	13.02	19.41	4.04				36.47 54.20
54.30 MRI	11.61	24.29	3.83				39.73 54.30
60 LABORATORY	17.58	1.71	9.29				28.58 60
65 RESPIRATORY THERAPY	46.01	6.74	6.53				59.28 65
66 PHYSICAL THERAPY	24.23	0.18	4.45				28.86 66
69 ELECTROCARDIOLOGY	12.43	19.44	8.72				40.59 69
70 ELECTROENCEPHALOGRAPHY	4.98	25.35	1.43				31.76 70
71 MEDICAL SUPPLIES CHRGED TO PATI	28.09	7.78	39.87				75.74 71
73 DRUGS CHARGED TO PATIENTS	35.84	14.68	15.11				65.63 73
75.10 NUTRITIONAL SUPPORT	4.28	5.17					9.45 75.10
75.20 HEMODIALYSIS	68.28	2.72	8.70				79.70 75.20
90 CLINIC	2.11	32.85	0.03				34.99 90
91 EMERGENCY	13.82	9.98	3.21				27.01 91
91.05 AMBULATORY CARE	1.47						1.47 91.05
91.10 PSYCHIATRIC PARTIAL	3.20	17.48					20.68 91.10
92 OBSERVATION BEDS	0.70	45.74	0.12				46.56 92
200 TOTAL CHARGES	20.34	12.34	7.65				40.33 200

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

SUBPROVIDER-IPF

COST CENTERS	----- TITLE XVIII -----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
40 SUBPROVIDER - IPF	33.46		12.12				45.58 40
UTILIZATION PERCENTAGES BASED ON CHARGES							
53 ANESTHESIOLOGY	0.03		0.01				0.04 53
54 RADIOLOGY-DIAGNOSTIC	0.02	0.01	0.02				0.05 54
54.20 CT	0.07		0.03				0.10 54.20
54.30 MRI	0.06		0.04				0.10 54.30
60 LABORATORY	0.30		0.36				0.66 60
65 RESPIRATORY THERAPY	0.02		0.01				0.03 65
66 PHYSICAL THERAPY	0.07		0.05				0.12 66
69 ELECTROCARDIOLOGY	0.17	0.01	0.26				0.44 69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.07						0.07 71
73 DRUGS CHARGED TO PATIENTS	0.41		0.29				0.70 73
75.10 NUTRITIONAL SUPPORT	0.10						0.10 75.10
90 CLINIC	0.02						0.02 90
91 EMERGENCY	0.20		0.23				0.43 91
91.10 PSYCHIATRIC PARTIAL			1.54				1.54 91.10
200 TOTAL CHARGES	0.12		0.12				0.24 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	8,455,705	2.23	-8,455,705	-7.41		1
2	CAP REL COSTS-MVBLE EQUIP	13,424,438	3.53	-13,424,438	-11.76		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	3,754,428	0.99	-3,754,428	-3.29		4
5	ADMINISTRATIVE & GENERAL	53,613,433	14.11	-53,613,433	-46.98		5
6	MAINTENANCE & REPAIRS	2,023,796	0.53	-2,023,796	-1.77		6
7	OPERATION OF PLANT	4,632,395	1.22	-4,632,395	-4.06		7
8	LAUNDRY & LINEN SERVICE	1,368,079	0.36	-1,368,079	-1.20		8
9	HOUSEKEEPING	4,131,889	1.09	-4,131,889	-3.62		9
10	DIETARY	5,063,743	1.33	-5,063,743	-4.44		10
11	CAFETERIA	-1,361,232	-0.36	1,361,232	1.19		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,766,422	0.46	-1,766,422	-1.55		13
14	CENTRAL SERVICES & SUPPLY	3,047,383	0.80	-3,047,383	-2.67		14
15	PHARMACY	5,805,433	1.53	-5,805,433	-5.09		15
16	MEDICAL RECORDS & LIBRARY	2,596,907	0.68	-2,596,907	-2.28		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APP						21
22	I&R SRVCES-OTHER PRGM COSTS APP	4,568,605	1.20	-4,568,605	-4.00		22
23	PARAMED ED PRGM-(SPECIFY)						23
23.10	PARAMED ED - LAB	94,493	0.02	-94,493	-0.08		23.10
23.20	PARAMED ED PRGM - RADIOLOGY	118,844	0.03	-118,844	-0.10		23.20
23.30	PARAMED ED - RADIATION ONCOLOGY	164,429	0.04	-164,429	-0.14		23.30
23.40	PARAMED ED - PARAMEDICAL TECHS	857,827	0.23	-857,827	-0.75		23.40
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	32,875,688	8.65	29,249,893	25.63	62,125,581	16.35
31	INTENSIVE CARE UNIT	8,108,379	2.13	5,296,136	4.64	13,404,515	3.53
31.01	PEDIATRIC ICU						31.01
40	SUBPROVIDER - IPF	2,072,772	0.55	2,467,016	2.16	4,539,788	1.19
43	NURSERY	3,981,160	1.05	1,906,053	1.67	5,887,213	1.55
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	26,772,854	7.05	13,753,490	12.05	40,526,344	10.67
50.20	GASTROENTEROLOGY	900,860	0.24	1,014,665	0.89	1,915,525	0.50
52	DELIVERY ROOM & LABOR ROOM	3,874,001	1.02	3,576,423	3.13	7,450,424	1.96
53	ANESTHESIOLOGY	331,921	0.09	219,910	0.19	551,831	0.15
54	RADIOLOGY-DIAGNOSTIC	23,612,309	6.22	12,762,402	11.18	36,374,711	9.57
54.10	RADIATION ONCOLOGY	13,538,493	3.56	8,038,584	7.04	21,577,077	5.68
54.20	CT	2,506,524	0.66	1,178,227	1.03	3,684,751	0.97
54.30	MRI	2,001,686	0.53	846,667	0.74	2,848,353	0.75
60	LABORATORY	11,719,709	3.08	4,730,445	4.14	16,450,154	4.33
62.30	BLOOD CLOTTING FACTORS ADMIN CO						62.30
65	RESPIRATORY THERAPY	3,264,770	0.86	1,342,046	1.18	4,606,816	1.21
66	PHYSICAL THERAPY	5,272,127	1.39	1,801,984	1.58	7,074,111	1.86
69	ELECTROCARDIOLOGY	1,163,111	0.31	995,528	0.87	2,158,639	0.57
69.10	PEDIATRIC CARDIOLOGY						69.10

COST CENTER		--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
70	ELECTROENCEPHALOGRAPHY	1,204,242	0.32	717,337	0.63	1,921,579	0.51	70
70.10	APNEA MONITORING							70.10
71	MEDICAL SUPPLIES CHRGED TO PATI	3,982,391	1.05	1,723,859	1.51	5,706,250	1.50	71
73	DRUGS CHARGED TO PATIENTS	9,492,226	2.50	6,387,103	5.60	15,879,329	4.18	73
75.10	NUTRITIONAL SUPPORT	119,810	0.03	28,734	0.03	148,544	0.04	75.10
75.20	HEMODIALYSIS	656,831	0.17	615,713	0.54	1,272,544	0.33	75.20
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
90	CLINIC	2,356,791	0.62	692,577	0.61	3,049,368	0.80	90
90.01	CHILDRENS CLINIC							90.01
91	EMERGENCY	12,019,674	3.16	7,995,375	7.01	20,015,049	5.27	91
91.05	AMBULATORY CARE	45,458	0.01	330,001	0.29	375,459	0.10	91.05
91.10	PSYCHIATRIC PARTIAL	1,197,304	0.32	659,173	0.58	1,856,477	0.49	91.10
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	8,386,317	2.21	2,047,260	1.79	10,433,577	2.75	101
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CAN	701,813	0.18	404,981	0.35	1,106,794	0.29	190
190.10	MCC WORD PROCESSING							190.10
192	PHYSICIANS' PRIVATE OFFICES			132,647	0.12	132,647	0.03	192
192.01	SPECIALISTS/PCP'S	76,200,983	20.06	1,246,297	1.09	77,447,280	20.39	192.01
192.02	MEDWORKS							192.02
192.03	SWEDISHAMERICAN ER	2,596,383	0.68			2,596,383	0.68	192.03
192.20	IDLE SPACE			643,403	0.56	643,403	0.17	192.20
193	NONPAID WORKERS	37,751	0.01	15,915	0.01	53,666	0.01	193
193.10	HOTEL							193.10
193.30	PHYSICIAN BILLING							193.30
193.40	MEALS ON WHEELS							193.40
193.50	WEE CARE							193.50
193.60	PHYSICIAN RELATED AREAS	1,321,040	0.35	337,716	0.30	1,658,756	0.44	193.60
193.70	WOMEN'S CENTER							193.70
193.80	MARKETING EXPENSES	2,652,486	0.70	649,957	0.57	3,302,443	0.87	193.80
193.90	COMPLIMENTARY MEDICINE	818,160	0.22	319,500	0.28	1,137,660	0.30	193.90
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	379,913,041	100.00			379,913,041	100.00	202

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,196,350	195,444,303	0.011238	40,871,628	459,315	50
50.20 GASTROENTEROLOGY	267,201	7,563,335	0.035328	1,401,777	49,522	50.20
52 DELIVERY ROOM & LABOR ROOM	1,286,497	18,029,553	0.071355	61,375	4,379	52
53 ANESTHESIOLOGY	63,554	10,197,207	0.006232	1,965,169	12,247	53
54 RADIOLOGY-DIAGNOSTIC	3,017,373	167,748,118	0.017988	41,075,244	738,861	54
54.10 RADIATION ONCOLOGY	593,364	75,240,759	0.007886	1,357,733	10,707	54.10
54.20 CT	161,362	49,733,401	0.003245	6,477,272	21,019	54.20
54.30 MRI	156,183	22,627,487	0.006902	2,626,841	18,130	54.30
60 LABORATORY	757,969	140,480,716	0.005396	24,694,887	133,254	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO						62.30
65 RESPIRATORY THERAPY	205,841	23,514,682	0.008754	10,817,937	94,700	65
66 PHYSICAL THERAPY	214,056	24,842,617	0.008616	6,018,447	51,855	66
69 ELECTROCARDIOLOGY	182,715	26,964,453	0.006776	3,350,936	22,706	69
69.10 PEDIATRIC CARDIOLOGY						69.10
70 ELECTROENCEPHALOGRAPHY	200,437	10,307,616	0.019446	513,173	9,979	70
70.10 APNEA MONITORING						70.10
71 MEDICAL SUPPLIES CHRGED TO PATI	93,317	43,555,089	0.002143	12,233,163	26,216	71
73 DRUGS CHARGED TO PATIENTS	192,882	114,161,893	0.001690	40,912,705	69,142	73
75.10 NUTRITIONAL SUPPORT	714	554,718	0.001287	23,751	31	75.10
75.20 HEMODIALYSIS	104,848	2,331,501	0.044970	1,591,881	71,587	75.20
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	23,755	3,783,044	0.006279	79,691	500	90
90.01 CHILDRENS CLINIC						90.01
91 EMERGENCY	1,214,693	71,683,830	0.016945	9,904,223	167,827	91
91.05 AMBULATORY CARE	166,720	209,424	0.796088	3,079	2,451	91.05
91.10 PSYCHIATRIC PARTIAL	168,800	1,343,586	0.125634	42,952	5,396	91.10
92 OBSERVATION BEDS	183,192	2,884,361	0.063512	20,271	1,287	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL	11,451,823	1,013,201,693		206,044,135	1,971,111	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	REDUCED CAPITAL RELATED COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7	
INPATIENT ROUTINE SERVICE COST CENTERS								
30 ADULTS & PEDIATRICS	7,245,223		7,245,223	65,020	111.43	28,011	3,121,266	30
31 INTENSIVE CARE UNIT	1,226,755		1,226,755	8,114	151.19	3,717	561,973	31
31.01 PEDIATRIC ICU								31.01
200 TOTAL	8,471,978		8,471,978	73,134		31,728	3,683,239	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS 3,683,239

MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS 1,971,111

TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS 5,654,350

MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13) 6,052

MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6) 31,728

PER DISCHARGE CAPITAL COSTS 934.29

PER DIEM CAPITAL COSTS 178.21

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	62,480,135
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	263,680,919
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.237

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 9 LINE 41 + WKST D PART IV COL 11 LINE 200))	1,633,597
2. TOTAL MEDICARE CHARGES (WKST D-3 LINE 40 COLUMN 2 PLUS WKST D-3 LINE 202 COLUMN 2) (SEE CR 5619)	3,169,341
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.515

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 30-35, COLUMN 7 + WKST D PART II, LINE 200, COLUMN 5)	5,654,350
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.021

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, COLUMNS 2, 2.01 & 2.02 x (WKST B, PART I, COLUMN 26 - COLUMNS 20 & 23 / WKST C, PART I, COLUMN 8) LESS LINES 61, 66-68, 74, 94, 95 & 96) (SEE CR 5999)	25,811,693
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	124,966,303
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.207