

MEDICARE COST REPORT
TOUCHETTE REGIONAL HOSPITAL, INC.
Year ended December 31, 2011



Kerber, Eck & Braeckel LLP

CPAs and
Management Consultants

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fax 314.231.0079
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Board of Directors
Touchette Regional Hospital, Inc.

We have compiled the Centers for Medicare and Medicaid Services Complex Cost Report, Form CMS 2552-10 of Touchette Regional Hospital, Inc. for the year ended December 31, 2011 included in the accompanying prescribed form in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form prescribed by the Centers for Medicare and Medicaid Services information that is the representation of management. We have not audited or reviewed the cost report referred to above and, accordingly, do not express an opinion or any other form of assurance on it.

The Centers for Medicare and Medicaid Services Complex Cost Report, Form CMS 2552-10 is presented in accordance with the requirements of the Centers for Medicare and Medicaid Services, which differ from generally accepted accounting principles. Accordingly, the cost report is not designed for those who are not informed about such differences.

Kerber, Eck & Braeckel LLP

St. Louis, Missouri
May 29, 2012

Other Locations

Belleville, IL • Carbondale, IL • Springfield, IL • Jacksonville, IL • Cape Girardeau, MO • Milwaukee, WI

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

WORKSHEET 5
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 05/29/2012 TIME: 16:37
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - 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 TOUCHETTE REGIONAL HOSPITAL (14-0077) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2011 AND ENDING 12/31/2011, 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.

ECR Encryption: 05/29/2012 16:37
 jdc1kmeUOXzvgdYFI4R::H7OqGuiy0
 4maDZOWDAFJOwN9QxKrkYgvN4WmKw
 d8BZ0p6oKX05:syN

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

 TITLE

 DATE

PI Encryption: 05/29/2012 16:37
 HgLkbOx1H9TRI.b9GmSqH4R0E.QQ10
 uG2lEOK.TRQa58yGF8enOHeJzoxYkY
 y3Hd0GnAj10Beeyn

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		-133,856	147,678		1
2 SUBPROVIDER - IPF					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					10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-133,856	147,678		200

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

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

HOSPITAL AND 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 DATE: _____ TIME: _____
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.
 CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
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(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		-133,856	147,678			1
2 SUBPROVIDER - IPF						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						10
11 HEALTH CLINIC - FQHC						11
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PROVIDER CCN: 14-0077 TOUCHETTE REGIONAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/29/2012 16:27

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:
 1 STREET: 5900 BOND STREET
 2 CITY: CENTREVILLE STATE: IL

P.O.BOX:
 ZIP CODE: 62207 COUNTY: ST. CLAIR

1
 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)			3
						V	XVIII	XIX	
3	HOSPITAL	14-0077	41180	1	07/01/1966	N	P	N	3
4	SUBPROVIDER - IPF								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	14-7315	41180		01/01/1996	N	P	N	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: 01/01/2011			TO: 12/31/2011				20
21	TYPE OF CONTROL								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 MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
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:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:	38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

	V	XVIII	XIX	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	1	2	3
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	Y	N
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N
49	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

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

PROGRAM CODE
2

UNWEIGHTED
FTEs
NONPROVIDER
SITE
3

UNWEIGHTED
FTEs
IN
HOSPITAL
4

RATIO
(COL.1/
(COL.3+COL.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
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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 1	PROGRAM CODE 2	UNWEIGHTED FTES NONPROVIDER SITE 3	UNWEIGHTED FTES IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
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' FOR NO IN APPLICABLE COLUMN.			N N 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 105
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.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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.	1 N	2 115
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.	1,000,000	3,000,000 119
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

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

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.	1 Y	2 140
-----	--	--------	----------

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

141	NAME: SOUTHERN ILLINOIS HEALTHCARE	CONTRACTOR'S NAME: SOUTHERN ILLINOIS HEALTHCARE	CONTRACTOR'S NUMBER:	141
142	STREET: 800 STATE STREET	P.O. BOX:		142
143	CITY: EAST ST. LOUIS	STATE: IL	ZIP CODE: 62203	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 N	2 N
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

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
	0	1	2
			ZIP CODE
			3
			CBSA
			4
			FTE/CAMPUS
			5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	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		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1	
2		Y/N	DATE	V/I	
1		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
1		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
1		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
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	Y/N	DATE
1	2	3	4	3	4
16	04/03/2012	Y	04/03/2012	Y	04/03/2012
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y		Y	
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

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 |

Y/N
1

DATE
2

HOME OFFICE COSTS

- | | | |
|----|--|----|
| 36 | 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

LINE	DESCRIPTION	WKST A 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		1	2	3	4	5	6	
1	SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	28,771,945		28,771,945	1,161,311.00	24.78	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A		166,851		166,851	916.00	182.15	4
4.01	PHYSICIANS-PART A - DIRECT TEACHING							4.01
5	PHYSICIAN-PART B		1,964,944		1,964,944	12,876.00	152.61	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		1,263,626		1,263,626	45,238.00	27.93	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		1,311,022		1,311,022	24,965.00	52.51	11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A		22,000		22,000	168.00	130.95	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN-PART A							15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		7,049,569		7,049,569			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		306,880		306,880			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A		10,498		10,498			22
23	PHYSICIAN PART B		138,833		138,833			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		308,359		308,359	12,587.00	24.50	26
27	ADMINISTRATIVE & GENERAL		5,296,549		5,296,549	216,712.00	24.44	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		104,288		104,288	1,649.00	63.24	28
29	MAINTENANCE & REPAIRS		617,485		617,485	31,018.00	19.91	29
30	OPERATION OF PLANT		1,160,802		1,160,802	73,620.00	15.77	30
31	LAUNDRY & LINEN SERVICE		18,221		18,221	2,371.00	7.68	31
32	HOUSEKEEPING		635,882		635,882	64,088.00	9.92	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		645,002	-450,948	194,054	14,903.00	13.02	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA			450,948	450,948	34,624.00	13.02	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,886,261		1,886,261	61,671.00	30.59	38
39	CENTRAL SERVICES AND SUPPLY		117,231		117,231	8,851.00	13.24	39
40	PHARMACY		729,932		729,932	21,539.00	33.89	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		563,681		563,681	35,610.00	15.83	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)		26,911,289		26,911,289	1,150,084.0	23.40	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		1,263,626		1,263,626	45,238.00	27.93	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)		25,647,663		25,647,663	1,104,846.0	23.21	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)		1,333,022		1,333,022	25,133.00	53.04	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)		7,060,067		7,060,067		27.53%	5
6	TOTAL (SUM OF LINES 3 THRU 5)		34,040,752		34,040,752	1,129,979.0	30.13	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)		12,083,693		12,083,693	579,243.00	20.86	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	650,273	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		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		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	3,051,083	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN		10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	77,471	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	92,138	14
15 WORKERS' COMPENSATION INSURANCE	501,747	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	1,800,203	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	727,911	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	148,743	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	7,049,569	24

PART B - OTHER THAN CORE RELATED COST

25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25
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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER	
			LINE #				
	1	2	3		4	5	
1 COST OF SUPPLIES CHG TO PATIENTS	A	MEDICAL SUPPLIES CHRGD TO PA	71			181,666	1
2		EMPLOYEE BENEFITS	4			53	2
3							3
4							4
5							5
6							6
7							7
500 TOTAL RECLASSIFICATIONS						181,719	500
CODE LETTER - A							
1 COST OF DRUGS CHG TO PATIENTS	B	DRUGS CHARGED TO PATIENTS	73			2,598,575	1
500 TOTAL RECLASSIFICATIONS						2,598,575	500
CODE LETTER - B							
1 ESTABLISH CAFETERIA COSTS	C	CAFETERIA	11		450,948	329,715	1
500 TOTAL RECLASSIFICATIONS					450,948	329,715	500
CODE LETTER - C							
1 RECLASS ER PHYSICIAN BENEFITS	D	EMERGENCY	91			29,320	1
500 TOTAL RECLASSIFICATIONS						29,320	500
CODE LETTER - D							
1 RECLASS OTHER PHYSICIAN BENEFITS	E	CLINIC	90			36,353	1
500 TOTAL RECLASSIFICATIONS						36,353	500
CODE LETTER - E							
1 RECLASS INTEREST EXPENSE	F	CAP REL COSTS-MVBLE EQUIP	2			410,042	1
500 TOTAL RECLASSIFICATIONS						410,042	500
CODE LETTER - F							
1 RECLASS PHYSICIAN ADMIN COSTS	G	CLINIC	90			7,500	1
500 TOTAL RECLASSIFICATIONS						7,500	500
CODE LETTER - G							
1 TO RECLASS INSURANCE EXPENSE	H	CAP REL COSTS-BLDG & FIXT	1			94,973	1
2		CAP REL COSTS-MVBLE EQUIP	2			71,285	2
500 TOTAL RECLASSIFICATIONS						166,258	500
CODE LETTER - H							
GRAND TOTAL (INCREASES)					450,948	3,759,482	

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF. 10
			LINE #	SALARY	OTHER	
	1	6	7	8	9	
1 COST OF SUPPLIES CHG TO PATIENTS	A	CENTRAL SERVICES & SUPPLY	14		51,375	1
2		ADULTS & PEDIATRICS	30		73	2
3		ADULTS & PEDIATRICS	30		90	3
4		OPERATING ROOM	50		126,542	4
5		DELIVERY ROOM & LABOR ROOM	52		241	5
6		CLINIC	90		501	6
7		EMERGENCY	91		2,897	7
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					181,719	500
1 COST OF DRUGS CHG TO PATIENTS	B	PHARMACY	15		2,598,575	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					2,598,575	500
1 ESTABLISH CAFETERIA COSTS	C	DIETARY	10	450,948	329,715	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C				450,948	329,715	500
1 RECLASS ER PHYSICIAN BENEFITS	D	EMPLOYEE BENEFITS	4		29,320	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					29,320	500
1 RECLASS OTHER PHYSICIAN BENEFITS	E	EMPLOYEE BENEFITS	4		36,353	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					36,353	500
1 RECLASS INTEREST EXPENSE	F	INTEREST EXPENSE	113		410,042	11 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					410,042	500
1 RECLASS PHYSICIAN ADMIN COSTS	G	ADMINISTRATIVE & GENERAL	5		7,500	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					7,500	500
1 TO RECLASS INSURANCE EXPENSE	H	ADMINISTRATIVE & GENERAL	5		94,973	12 1
2		ADMINISTRATIVE & GENERAL	5		71,285	12 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - H GRAND TOTAL (DECREASES)				450,948	3,759,482	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	2,192,648					2,192,648		1
2 LAND IMPROVEMENTS	1,122,806	73,925		73,925	555,855	640,876		2
3 BUILDINGS AND FIXTURES	37,325,643	1,580,033		1,580,033	22,299,052	16,606,624		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	3,618,385	55,630		55,630	3,319,544	354,471		5
6 MOVABLE EQUIPMENT	23,056,130	455,102		455,102	8,653,666	14,857,566		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	67,315,612	2,164,690		2,164,690	34,828,117	34,652,185		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	67,315,612	2,164,690		2,164,690	34,828,117	34,652,185		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	912,844						912,844 1
2 CAP REL COSTS-MVBLE EQUIP	1,008,290						1,008,290 2
3 TOTAL (SUM OF LINES 1-2)	1,921,134						1,921,134 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	19,794,619		19,794,619	0.571237				1
2 CAP REL COSTS-MVBLE EQUIP	14,857,566		14,857,566	0.428763				2
3 TOTAL (SUM OF LINES 1-2)	34,652,185		34,652,185	1.000000				3

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(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	912,844			94,973		1,658,017	2,665,834 1
2 CAP REL COSTS-MVBLE EQUIP	1,008,290		410,042	71,285		174,223	1,663,840 2
3 TOTAL	1,921,134		410,042	166,258		1,832,240	4,329,674 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)	B	-30,798	ADMINISTRATIVE & GENERAL	5	3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)	B	-57,369	ADMINISTRATIVE & GENERAL	5	5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)	B	-2,889	ADMINISTRATIVE & GENERAL	5	6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-7,890,152			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-27,888			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-271,686	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-9,751	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				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			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				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
33 MISCELLANEOUS INCOME	B	-276	NURSING ADMINISTRATION	13	33
34 TOUCHETTE ELDERLY APTS.	B	-29,415	NURSING ADMINISTRATION	13	34
35 ARCHVIEW	B	-1,620	CLINIC	90	35
36 LOSS ON SALE OF ASSETS - KHRH BLDG	B	1,658,017	CAP REL COSTS-BLDG & FIXT	1	14 36
37 LOSS ON SALE OF ASSETS - EQUIPMENT	B	174,223	CAP REL COSTS-MVBLE EQUIP	2	14 37
38 TRANSPORTATION	B	-19,088	ADMINISTRATIVE & GENERAL	5	38
39 GAIN ON DISPOSAL OF ASSETS	B	-204	ADMINISTRATIVE & GENERAL	5	39
40 MISCELLANEOUS INCOME	B	-148,706	ADMINISTRATIVE & GENERAL	5	40
41 IHA ASSOCIATION DUES	A	-22,522	ADMINISTRATIVE & GENERAL	5	41
42 MALPRACTICE ADJUSTMENT	A	1,800,000	ADMINISTRATIVE & GENERAL	5	42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-4,880,124			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		27,888	-27,888	1
2		SIHF SERVICES				2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4)			27,888	-27,888	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.

SYMBOL (1)		NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6	7
6	B	SIHF			100.00	NOT FOR PROFIT
7						
8						
9						
10						

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	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	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS	1,137,041	1,118,041	19,000	153,400	144	10,620	531	1
2	53	ANESTHESIOLOGY	948,370	948,370		200,300				2
3	65	RESPIRATORY THERAPY	166,137	163,137	3,000	177,200	24	2,045	102	3
4	90	CLINIC	3,344,001	3,331,501	12,500	177,200	84	7,156	358	4
5	91	EMERGENCY	2,314,304	2,159,953	154,351	177,200	832	70,880	3,544	5
6	90.01	PARTIAL HOSPITALIZATION	71,000	71,000		154,100				6
200		TOTAL	7,980,853	7,792,002	188,851		1,084	90,701	4,535	200

PROVIDER CCN: 14-0077 TOUCHETTE REGIONAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/29/2012 16:27

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	
10		11		12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS	AGGREGATE					10,620	8,380	1,126,421	1
2	53	ANESTHESIOLOGY	ANESTHESIOLOGY							948,370	2
3	65	RESPIRATORY THERAPY	RESPIRATORY THE					2,045	955	164,092	3
4	90	CLINIC	CLINIC					7,156	5,344	3,336,845	4
5	91	EMERGENCY	EMERGENCY					70,880	83,471	2,243,424	5
6	90.01	PARTIAL HOSPITALIZATION	PARTIAL HOSPITA							71,000	6
200		TOTAL						90,701	98,150	7,890,152	200

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	
1 GENERAL SERVICE COST CENTERS						1
1 CAP REL COSTS-BLDG & FIXT	2,665,834	2,665,834				2
2 CAP REL COSTS-MVBLE EQUIP	1,663,840		1,663,840			2
4 EMPLOYEE BENEFITS	6,235,881	28,746	17,942	6,282,569		4
5 ADMINISTRATIVE & GENERAL	11,238,515	358,546	223,781	1,255,762	13,076,604	5
6 MAINTENANCE & REPAIRS	923,513	293,228	183,014	146,400	1,546,155	6
7 OPERATION OF PLANT	2,068,905	439,098	274,059	275,215	3,057,277	7
8 LAUNDRY & LINEN SERVICE	179,268	16,753	10,456	4,320	210,797	8
9 HOUSEKEEPING	899,043	58,451	36,481	150,761	1,144,736	9
10 DIETARY	335,938	88,555	55,270	46,008	525,771	10
11 CAFETERIA	508,977	36,667	22,885	106,915	675,444	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,065,514	19,979	12,469	447,214	2,545,176	13
14 CENTRAL SERVICES & SUPPLY	187,059	28,012	17,483	27,794	260,348	14
15 PHARMACY	895,808	20,202	12,609	173,060	1,101,679	15
16 MEDICAL RECORDS & LIBRARY	766,267	38,153	23,812	133,643	961,875	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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,412,845	411,136	256,604	1,056,189	7,136,774	30
43 NURSERY	820,092	23,013	14,363	170,624	1,028,092	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,423,461	191,993	119,830	204,021	1,939,305	50
52 DELIVERY ROOM & LABOR ROOM	984,060	126,084	78,694	189,028	1,377,866	52
53 ANESTHESIOLOGY	24,718	1,805	1,126		27,649	53
54 RADIOLOGY-DIAGNOSTIC	2,278,166	68,161	42,541	355,069	2,743,937	54
60 LABORATORY	2,680,998	50,673	31,627	184,150	2,947,448	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,038,930	25,137	15,689	177,794	1,257,550	65
66 PHYSICAL THERAPY	364,251	33,378	20,832		418,461	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	181,666				181,666	71
73 DRUGS CHARGED TO PATIENTS	2,598,575				2,598,575	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,354,080	27,405	17,104	156,395	1,554,984	90
90.01 PARTIAL HOSPITALIZATION	358,139	134,213	83,767	75,042	651,161	90.01
91 EMERGENCY	3,401,072	133,223	83,149	647,571	4,265,015	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS				286,464	1,745,380	101
101 HOME HEALTH AGENCY	1,458,916					101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	55,014,331	2,652,611	1,655,587	6,269,439	54,979,725	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	116,400	13,223	8,253	13,130	151,006	190
192 PHYSICIANS' PRIVATE OFFICES	3,976				3,976	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	55,134,707	2,665,834	1,663,840	6,282,569	55,134,707	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	13,076,604					5
6 MAINTENANCE & REPAIRS	480,727	2,026,882				6
7 OPERATION OF PLANT	950,562	448,295	4,456,134			7
8 LAUNDRY & LINEN SERVICE	65,541	17,103	48,281	341,722		8
9 HOUSEKEEPING	355,919	59,675	168,453		1,728,783	9
10 DIETARY	163,472	90,409	255,211		4,909	10
11 CAFETERIA	210,008	37,435	105,674		11,410	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	791,341	20,397	57,578		80,035	13
14 CENTRAL SERVICES & SUPPLY	80,947	28,598	80,729		16,320	14
15 PHARMACY	342,532	20,625	58,222		16,320	15
16 MEDICAL RECORDS & LIBRARY	299,064	38,952	109,955		16,347	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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,218,934	419,744	1,184,876	123,018	146,988	30
43 NURSERY	319,652	23,495	66,323			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	602,965	196,013	553,317	61,510	163,334	50
52 DELIVERY ROOM & LABOR ROOM	428,403	128,724	363,371	34,173	81,654	52
53 ANESTHESIOLOGY	8,597	1,842	5,201		65,334	53
54 RADIOLOGY-DIAGNOSTIC	853,139	69,588	196,436	44,424	65,334	54
60 LABORATORY	916,415	51,734	146,039	17,086	65,334	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	390,995	25,663	72,444	10,252	196,001	65
66 PHYSICAL THERAPY	130,107	34,076	96,193	17,086	65,334	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	56,483					71
73 DRUGS CHARGED TO PATIENTS	807,944					73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	483,473	27,979	78,980		204,148	90
90.01 PARTIAL HOSPITALIZATION	202,458	137,023	386,798		65,334	90.01
91 EMERGENCY	1,326,070	136,012	383,944	34,173	326,642	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	542,670				65,334	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	13,028,418	2,013,382	4,418,025	341,722	1,656,112	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,950	13,500	38,109		7,337	190
192 PHYSICIANS' PRIVATE OFFICES	1,236				65,334	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	13,076,604	2,026,882	4,456,134	341,722	1,728,783	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	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	1,039,772					10
11 CAFETERIA		1,039,971				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		97,615	3,592,142			13
14 CENTRAL SERVICES & SUPPLY		14,029		480,971		14
15 PHARMACY		34,102		1,510	1,574,990	15
16 MEDICAL RECORDS & LIBRARY		56,360		34		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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,039,772	289,998	1,662,934	86,668	8,687	30
43 NURSERY		34,794	199,557	11,645		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		50,300	288,463	157,811	3,181	50
52 DELIVERY ROOM & LABOR ROOM		44,439	254,855	17,859	590	52
53 ANESTHESIOLOGY				4,049	28	53
54 RADIOLOGY-DIAGNOSTIC		91,324		18,783	36,172	54
60 LABORATORY		60,283		6,938	299	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		46,162		34,894	18	65
66 PHYSICAL THERAPY				1,237	22	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				70,428		71
73 DRUGS CHARGED TO PATIENTS					1,514,429	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		58,791	406,402	5,043	4,661	90
90.01 PARTIAL HOSPITALIZATION		18,305		61		90.01
91 EMERGENCY		136,024	779,931	60,852	6,810	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY				3,159	93	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,039,772	1,032,526	3,592,142	480,971	1,574,990	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		7,445				190
192 PHYSICIANS' PRIVATE OFFICES						192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,039,772	1,039,971	3,592,142	480,971	1,574,990	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	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	1,482,587				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
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	1,371,011	15,689,404		15,689,404	30
43 NURSERY		1,683,558		1,683,558	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		4,016,199		4,016,199	50
52 DELIVERY ROOM & LABOR ROOM		2,731,934		2,731,934	52
53 ANESTHESIOLOGY		112,700		112,700	53
54 RADIOLOGY-DIAGNOSTIC		4,119,137		4,119,137	54
60 LABORATORY		4,211,576		4,211,576	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		2,033,979		2,033,979	65
66 PHYSICAL THERAPY		762,516		762,516	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		308,577		308,577	71
73 DRUGS CHARGED TO PATIENTS		4,920,948		4,920,948	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		2,824,461		2,824,461	90
90.01 PARTIAL HOSPITALIZATION		1,461,140		1,461,140	90.01
91 EMERGENCY	111,576	7,567,049		7,567,049	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
101 HOME HEALTH AGENCY		2,356,636		2,356,636	101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	1,482,587	54,799,814		54,799,814	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		264,347		264,347	190
192 PHYSICIANS' PRIVATE OFFICES		70,546		70,546	192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	1,482,587	55,134,707		55,134,707	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		28,746	17,942	46,688	46,688	4
5 ADMINISTRATIVE & GENERAL		358,546	223,781	582,327	9,329	5
6 MAINTENANCE & REPAIRS		293,228	183,014	476,242	1,088	6
7 OPERATION OF PLANT		439,098	274,059	713,157	2,045	7
8 LAUNDRY & LINEN SERVICE		16,753	10,456	27,209	32	8
9 HOUSEKEEPING		58,451	36,481	94,932	1,120	9
10 DIETARY		88,555	55,270	143,825	342	10
11 CAFETERIA		36,667	22,885	59,552	795	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		19,979	12,469	32,448	3,324	13
14 CENTRAL SERVICES & SUPPLY		28,012	17,483	45,495	207	14
15 PHARMACY		20,202	12,609	32,811	1,286	15
16 MEDICAL RECORDS & LIBRARY		38,153	23,812	61,965	993	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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		411,136	256,604	667,740	7,849	30
43 NURSERY		23,013	14,363	37,376	1,268	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		191,993	119,830	311,823	1,516	50
52 DELIVERY ROOM & LABOR ROOM		126,084	78,694	204,778	1,405	52
53 ANESTHESIOLOGY		1,805	1,126	2,931		53
54 RADIOLOGY-DIAGNOSTIC		68,161	42,541	110,702	2,639	54
60 LABORATORY		50,673	31,627	82,300	1,369	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		25,137	15,689	40,826	1,321	65
66 PHYSICAL THERAPY		33,378	20,832	54,210		66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		27,405	17,104	44,509	1,162	90
90.01 PARTIAL HOSPITALIZATION		134,213	83,767	217,980	558	90.01
91 EMERGENCY		133,223	83,149	216,372	4,813	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY					2,129	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		2,652,611	1,655,587	4,308,198	46,590	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		13,223	8,253	21,476	98	190
192 PHYSICIANS' PRIVATE OFFICES						192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		2,665,834	1,663,840	4,329,674	46,688	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	591,656					5
6 MAINTENANCE & REPAIRS	21,751	499,081				6
7 OPERATION OF PLANT	43,010	110,384	868,596			7
8 LAUNDRY & LINEN SERVICE	2,965	4,211	9,411	43,828		8
9 HOUSEKEEPING	16,104	14,694	32,835		159,685	9
10 DIETARY	7,397	22,261	49,746		453	10
11 CAFETERIA	9,502	9,218	20,598		1,054	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	35,806	5,022	11,223		7,393	13
14 CENTRAL SERVICES & SUPPLY	3,663	7,042	15,736		1,507	14
15 PHARMACY	15,498	5,079	11,349		1,507	15
16 MEDICAL RECORDS & LIBRARY	13,532	9,591	21,433		1,510	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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	100,381	103,354	230,957	15,778	13,577	30
43 NURSERY	14,463	5,785	12,928			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	27,282	48,264	107,853	7,889	15,087	50
52 DELIVERY ROOM & LABOR ROOM	19,384	31,696	70,829	4,383	7,542	52
53 ANESTHESIOLOGY	389	454	1,014		6,035	53
54 RADIOLOGY-DIAGNOSTIC	38,602	17,135	38,290	5,698	6,035	54
60 LABORATORY	41,465	12,739	28,466	2,191	6,035	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	17,691	6,319	14,121	1,315	18,104	65
66 PHYSICAL THERAPY	5,887	8,391	18,750	2,191	6,035	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	2,556					71
73 DRUGS CHARGED TO PATIENTS	36,557					73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	21,876	6,889	15,395		18,857	90
90.01 PARTIAL HOSPITALIZATION	9,161	33,739	75,395		6,035	90.01
91 EMERGENCY	60,000	33,490	74,839	4,383	30,171	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	24,554				6,035	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	589,476	495,757	861,168	43,828	152,972	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,124	3,324	7,428		678	190
192 PHYSICIANS' PRIVATE OFFICES	56				6,035	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	591,656	499,081	868,596	43,828	159,685	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	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	224,024					10
11 CAFETERIA		100,719				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			9,454			13
14 CENTRAL SERVICES & SUPPLY			1,359	75,009		14
15 PHARMACY			3,303	235	71,068	15
16 MEDICAL RECORDS & LIBRARY			5,458	5		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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	224,024	28,084	48,456	13,516	392	30
43 NURSERY		3,370	5,815	1,816		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		4,871	8,405	24,613	144	50
52 DELIVERY ROOM & LABOR ROOM		4,304	7,426	2,785	27	52
53 ANESTHESIOLOGY				631	1	53
54 RADIOLOGY-DIAGNOSTIC		8,845		2,929	1,632	54
60 LABORATORY		5,838		1,082	13	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		4,471		5,442	1	65
66 PHYSICAL THERAPY				193	1	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				10,983		71
73 DRUGS CHARGED TO PATIENTS					68,336	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		5,694	11,842	786	210	90
90.01 PARTIAL HOSPITALIZATION		1,773		10		90.01
91 EMERGENCY		13,174	22,726	9,490	307	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY				493	4	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	224,024	99,998	104,670	75,009	71,068	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		721				190
192 PHYSICIANS' PRIVATE OFFICES						192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	224,024	100,719	104,670	75,009	71,068	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	16		25		
1 GENERAL SERVICE COST CENTERS					1
2 CAP REL COSTS-BLDG & FIXT					2
4 CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6 ADMINISTRATIVE & GENERAL					6
7 MAINTENANCE & REPAIRS					7
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING					10
11 DIETARY					11
12 CAFETERIA					12
13 MAINTENANCE OF PERSONNEL					13
14 NURSING ADMINISTRATION					14
15 CENTRAL SERVICES & SUPPLY					15
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY	114,487				17
19 SOCIAL SERVICE					19
20 NONPHYSICIAN ANESTHETISTS					20
21 NURSING SCHOOL					21
22 I&R SRVCES-SALARY & FRINGES APPRVD					22
23 I&R SRVCES-OTHER PRGM COSTS APPRVD					23
30 PARAMED ED PRGM-(SPECIFY)					30
43 INPATIENT ROUTINE SERV COST CENTERS					43
ADULTS & PEDIATRICS	105,871	1,559,979		1,559,979	
NURSERY		82,821		82,821	
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		557,747		557,747	50
52 DELIVERY ROOM & LABOR ROOM		354,559		354,559	52
53 ANESTHESIOLOGY		11,455		11,455	53
54 RADIOLOGY-DIAGNOSTIC		232,507		232,507	54
60 LABORATORY		181,498		181,498	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		109,611		109,611	65
66 PHYSICAL THERAPY		95,658		95,658	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		13,539		13,539	71
73 DRUGS CHARGED TO PATIENTS		104,893		104,893	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		127,220		127,220	90
90.01 PARTIAL HOSPITALIZATION		344,651		344,651	90.01
91 EMERGENCY	8,616	478,381		478,381	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
101 HOME HEALTH AGENCY		33,215		33,215	101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	114,487	4,287,734		4,287,734	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		35,849		35,849	190
192 PHYSICIANS' PRIVATE OFFICES		6,091		6,091	192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	114,487	4,329,674		4,329,674	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	166,926					1
2 CAP REL COSTS-MVBLE EQUIP		166,926				2
4 EMPLOYEE BENEFITS	1,800	1,800	26,498,642			4
5 ADMINISTRATIVE & GENERAL	22,451	22,451	5,296,548	-13,076,604	42,058,103	5
6 MAINTENANCE & REPAIRS	18,361	18,361	617,485		1,546,155	6
7 OPERATION OF PLANT	27,495	27,495	1,160,802		3,057,277	7
8 LAUNDRY & LINEN SERVICE	1,049	1,049	18,221		210,797	8
9 HOUSEKEEPING	3,660	3,660	635,882		1,144,736	9
10 DIETARY	5,545	5,545	194,054		525,771	10
11 CAFETERIA	2,296	2,296	450,948		675,444	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,251	1,251	1,886,261		2,545,176	13
14 CENTRAL SERVICES & SUPPLY	1,754	1,754	117,231		260,348	14
15 PHARMACY	1,265	1,265	729,932		1,101,679	15
16 MEDICAL RECORDS & LIBRARY	2,389	2,389	563,681		961,875	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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	25,744	25,744	4,454,800		7,136,774	30
43 NURSERY	1,441	1,441	719,660		1,028,092	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,022	12,022	860,521		1,939,305	50
52 DELIVERY ROOM & LABOR ROOM	7,895	7,895	797,284		1,377,866	52
53 ANESTHESIOLOGY	113	113			27,649	53
54 RADIOLOGY-DIAGNOSTIC	4,268	4,268	1,497,612		2,743,937	54
60 LABORATORY	3,173	3,173	776,709		2,947,448	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,574	1,574	749,902		1,257,550	65
66 PHYSICAL THERAPY	2,090	2,090			418,461	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					181,666	71
73 DRUGS CHARGED TO PATIENTS					2,598,575	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,716	1,716	659,642		1,554,984	90
90.01 PARTIAL HOSPITALIZATION	8,404	8,404	316,513		651,161	90.01
91 EMERGENCY	8,342	8,342	2,731,328		4,265,015	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY			1,208,248		1,745,380	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	166,098	166,098	26,443,264	-13,076,604	41,903,121	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	828	828	55,378		151,006	190
192 PHYSICIANS' PRIVATE OFFICES					3,976	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,665,834	1,663,840	6,282,569		13,076,604	202
203 UNIT COST MULT-WS B PT I	15.970154	9.967531	0.237090		0.310918	203
204 COST TO BE ALLOC PER B PT II			46,688		591,656	204
205 UNIT COST MULT-WS B PT II			0.001762		0.014068	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING HOURS OF SERVICE	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	124,314					6
7 OPERATION OF PLANT	27,495	96,819				7
8 LAUNDRY & LINEN SERVICE	1,049	1,049	264,267			8
9 HOUSEKEEPING	3,660	3,660		64,088		9
10 DIETARY	5,545	5,545		182	51,420	10
11 CAFETERIA	2,296	2,296		423		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,251	1,251		2,967		13
14 CENTRAL SERVICES & SUPPLY	1,754	1,754		605		14
15 PHARMACY	1,265	1,265		605		15
16 MEDICAL RECORDS & LIBRARY	2,389	2,389		606		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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	25,744	25,744	95,136	5,449	51,420	30
43 NURSERY	1,441	1,441				43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,022	12,022	47,568	6,055		50
52 DELIVERY ROOM & LABOR ROOM	7,895	7,895	26,427	3,027		52
53 ANESTHESIOLOGY	113	113		2,422		53
54 RADIOLOGY-DIAGNOSTIC	4,268	4,268	34,355	2,422		54
60 LABORATORY	3,173	3,173	13,213	2,422		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,574	1,574	7,928	7,266		65
66 PHYSICAL THERAPY	2,090	2,090	13,213	2,422		66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,716	1,716		7,568		90
90.01 PARTIAL HOSPITALIZATION	8,404	8,404		2,422		90.01
91 EMERGENCY	8,342	8,342	26,427	12,109		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY				2,422		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	123,486	95,991	264,267	61,394	51,420	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	828	828		272		190
192 PHYSICIANS' PRIVATE OFFICES				2,422		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,026,882	4,456,134	341,722	1,728,783	1,039,772	202
203 UNIT COST MULT-WS B PT I	16.304535	46.025408	1.293094	26.975144	20.221159	203
204 COST TO BE ALLOC PER B PT II	499,081	868,596	43,828	159,685	224,024	204
205 UNIT COST MULT-WS B PT II	4.014681	8.971338	0.165847	2.491652	4.356748	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA MEALS SERVED 11	NURSING - ADMINIS- TRATION DIRECT NRSNG HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	67,609					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	6,346	395,797				13
14 CENTRAL SERVICES & SUPPLY	912		1,241,050			14
15 PHARMACY	2,217		3,896	2,702,491		15
16 MEDICAL RECORDS & LIBRARY	3,664		87		35,611	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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	18,853	183,229	223,629	14,905	32,931	30
43 NURSERY	2,262	21,988	30,048			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,270	31,784	407,205	5,459		50
52 DELIVERY ROOM & LABOR ROOM	2,889	28,081	46,081	1,013		52
53 ANESTHESIOLOGY			10,448	48		53
54 RADIOLOGY-DIAGNOSTIC	5,937		48,465	62,067		54
60 LABORATORY	3,919		17,901	513		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,001		90,036	31		65
66 PHYSICAL THERAPY			3,191	38		66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			181,725			71
73 DRUGS CHARGED TO PATIENTS				2,598,575		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,822	44,779	13,012	7,998		90
90.01 PARTIAL HOSPITALIZATION	1,190		158			90.01
91 EMERGENCY	8,843	85,936	157,017	11,685	2,680	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY			8,151	159		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	67,125	395,797	1,241,050	2,702,491	35,611	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	484					190
192 PHYSICIANS' PRIVATE OFFICES						192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,039,971	3,592,142	480,971	1,574,990	1,482,587	202
203 UNIT COST MULT-WS B PT I	15.382138	9.075718	0.387552	0.582792	41.632838	203
204 COST TO BE ALLOC PER B PT II	100,719	104,670	75,009	71,068	114,487	204
205 UNIT COST MULT-WS B PT II	1.489728	0.264454	0.060440	0.026297	3.214934	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		
	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 SRVCS-SALARY & FRINGES APPRVD	21
22	I&R SRVCS-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
	INPATIENT ROUTINE SERV COST CENTERS	
30	ADULTS & PEDIATRICS	30
43	NURSERY	43
	ANCILLARY SERVICE COST CENTERS	
50	OPERATING ROOM	50
52	DELIVERY ROOM & LABOR ROOM	52
53	ANESTHESIOLOGY	53
54	RADIOLOGY-DIAGNOSTIC	54
60	LABORATORY	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65	RESPIRATORY THERAPY	65
66	PHYSICAL THERAPY	66
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	71
73	DRUGS CHARGED TO PATIENTS	73
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	PARTIAL HOSPITALIZATION	90.01
91	EMERGENCY	91
92	OBSERVATION BEDS	92
	OTHER REIMBURSABLE COST CENTERS	
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 & CANTEEN	190
192	PHYSICIANS' PRIVATE OFFICES	192
200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART 1, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	15,689,404		15,689,404	8,380	15,697,784	30
43 NURSERY	1,683,558		1,683,558		1,683,558	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,016,199		4,016,199		4,016,199	50
52 DELIVERY ROOM & LABOR ROOM	2,731,934		2,731,934		2,731,934	52
53 ANESTHESIOLOGY	112,700		112,700		112,700	53
54 RADIOLOGY-DIAGNOSTIC	4,119,137		4,119,137		4,119,137	54
60 LABORATORY	4,211,576		4,211,576		4,211,576	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	2,033,979		2,033,979	955	2,034,934	65
66 PHYSICAL THERAPY	762,516		762,516		762,516	66
71 MEDICAL SUPPLIES CHRGD TO	308,577		308,577		308,577	71
73 DRUGS CHARGED TO PATIENTS	4,920,948		4,920,948		4,920,948	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,824,461		2,824,461	5,344	2,829,805	90
90.01 PARTIAL HOSPITALIZATION	1,461,140		1,461,140		1,461,140	90.01
91 EMERGENCY	7,567,049		7,567,049	83,471	7,650,520	91
92 OBSERVATION BEDS	525,512		525,512		525,512	92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	2,356,636		2,356,636		2,356,636	101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	55,325,326		55,325,326	98,150	55,423,476	200
201 LESS OBSERVATION BEDS	525,512		525,512		525,512	201
202 TOTAL (SEE INSTRUCTIONS)	54,799,814		54,799,814		54,897,964	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	10,938,512		10,938,512			30
43 NURSERY	677,860		677,860			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,635,741	2,533,093	4,168,834	0.963387	0.963387	0.963387 50
52 DELIVERY ROOM & LABOR ROOM	851,021	228,398	1,079,419	2.530930	2.530930	2.530930 52
53 ANESTHESIOLOGY	323,830	493,924	817,754	0.137817	0.137817	0.137817 53
54 RADIOLOGY-DIAGNOSTIC	1,894,763	9,578,776	11,473,539	0.359012	0.359012	0.359012 54
60 LABORATORY	5,055,534	9,126,276	14,181,810	0.296970	0.296970	0.296970 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	3,491,671	1,719,171	5,210,842	0.390336	0.390336	0.390519 65
66 PHYSICAL THERAPY	106,639	1,978,812	2,085,451	0.365636	0.365636	0.365636 66
71 MEDICAL SUPPLIES CHRGD TO	224,842	141,381	366,223	0.842593	0.842593	0.842593 71
73 DRUGS CHARGED TO PATIENTS	4,974,421	20,301,414	25,275,835	0.194690	0.194690	0.194690 73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		4,499,146	4,499,146	0.627777	0.627777	0.628965 90
90.01 PARTIAL HOSPITALIZATION		1,151,771	1,151,771	1.268603	1.268603	1.268603 90.01
91 EMERGENCY	1,915,968	13,358,743	15,274,711	0.495397	0.495397	0.500862 91
92 OBSERVATION BEDS	1,575	172,985	174,560	3.010495	3.010495	3.010495 92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY		1,617,016	1,617,016			101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	32,092,377	66,900,906	98,993,283			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	32,092,377	66,900,906	98,993,283			202

PROVIDER CCN: 14-0077 TOUCHETTE REGIONAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
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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	SWING-BED	REDUCED	TOTAL	PER	INPAT	INPAT PGM	
	COST (FROM WKST B, PT. II, COL. 26)	ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)	PATIENT DAYS	DIEM (COL.3 = COL.4)	PGM DAYS	CAP COST (COL.5 x COL.6)	
	1	2	3	4	5	6	7	
30 INPAT ROUTINE SERV COST CTRS								30
31 ADULTS & PEDIATRICS	1,559,979		1,559,979	11,620	134.25	3,001	402,884	31
32 INTENSIVE CARE UNIT								32
33 CORONARY CARE UNIT								33
34 BURN INTENSIVE CARE UNIT								34
35 SURGICAL INTENSIVE CARE UNIT								35
40 OTHER SPECIAL CARE (SPECIFY)								40
41 SUBPROVIDER - IPF								41
42 SUBPROVIDER - IRF								42
43 SUBPROVIDER I	82,821		82,821	778	106.45			43
44 NURSERY								44
45 SKILLED NURSING FACILITY								45
200 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	1,642,800		1,642,800	12,398		3,001	402,884	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0077) [] 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	557,747	4,168,834	0.133790	222,172	29,724	50
52 DELIVERY ROOM & LABOR ROOM	354,559	1,079,419	0.328472	4,316	1,418	52
53 ANESTHESIOLOGY	11,455	817,754	0.014008	40,728	571	53
54 RADIOLOGY-DIAGNOSTIC	232,507	11,473,539	0.020265	460,313	9,328	54
60 LABORATORY	181,498	14,181,810	0.012798	1,468,632	18,796	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	109,611	5,210,842	0.021035	1,006,157	21,165	65
66 PHYSICAL THERAPY	95,658	2,085,451	0.045869	43,465	1,994	66
71 MEDICAL SUPPLIES CHRGD TO PA	13,539	366,223	0.036969	209,024	7,727	71
73 DRUGS CHARGED TO PATIENTS	104,893	25,275,835	0.004150	1,358,534	5,638	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	127,220	4,499,146	0.028276			90
90.01 PARTIAL HOSPITALIZATION	344,651	1,151,771	0.299236			90.01
91 EMERGENCY	478,381	15,274,711	0.031318	392,897	12,305	91
92 OBSERVATION BEDS	52,223	174,560	0.299169	1,575	471	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	2,663,942	85,759,895	85,759,895	5,207,813	109,137	200

PROVIDER CCN: 14-0077 TOUCHETTE REGIONAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
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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	
30 INPAT ROUTINE SERV COST CTRS						30
31 ADULTS & PEDIATRICS						31
32 INTENSIVE CARE UNIT						32
33 CORONARY CARE UNIT						33
34 BURN INTENSIVE CARE UNIT						34
35 SURGICAL INTENSIVE CARE UNIT						35
40 OTHER SPECIAL CARE (SPECIFY)						40
41 SUBPROVIDER - IPF						41
42 SUBPROVIDER - IRF						42
43 SUBPROVIDER I						43
44 NURSERY						44
45 SKILLED NURSING FACILITY						45
200 NURSING FACILITY						200
200 TOTAL (SUM OF LINES 30-199)						200

PROVIDER CCN: 14-0077 TOUCHETTE REGIONAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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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	11,620		3,001		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	778				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	12,398		3,001		200

PROVIDER CCN: 14-0077 TOUCHETTE REGIONAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/29/2012 16:27

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK TITLE V HOSPITAL (14-0077) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX IRF NF

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
71 MEDICAL SUPPLIES CHRGED TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
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 PARTIAL HOSPITALIZATION						90.01
91 EMERGENCY						91
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 [XX] HOSPITAL (14-0077) [] SUB (OTHER) [] ICF/MR [XX] 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	4,168,834			222,172		335,458	50
52 DELIVERY ROOM & LABOR ROOM	1,079,419			4,316			52
53 ANESTHESIOLOGY	817,754			40,728		66,561	53
54 RADIOLOGY-DIAGNOSTIC	11,473,539			460,313		1,208,131	54
60 LABORATORY	14,181,810			1,468,632		107,634	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	5,210,842			1,006,157		409,846	65
66 PHYSICAL THERAPY	2,085,451			43,465			66
71 MEDICAL SUPPLIES CHRGD TO P	366,223			209,024		127,077	71
73 DRUGS CHARGED TO PATIENTS	25,275,835			1,358,534		3,884,599	73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	4,499,146					6,951	90
90.01 PARTIAL HOSPITALIZATION	1,151,771					504,497	90.01
91 EMERGENCY	15,274,711			392,897		858,195	91
92 OBSERVATION BEDS	174,560			1,575		47,910	92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	85,759,895			5,207,813		7,556,859	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0077) [] 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 1, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	COST SERVICES SUBJECT TO DED & COINS 6			
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.963387	335,458				323,176		50
52 DELIVERY ROOM & LABOR ROOM	2.530930							52
53 ANESTHESIOLOGY	0.137817	66,561				9,173		53
54 RADIOLOGY-DIAGNOSTIC	0.359012	1,208,131				433,734		54
60 LABORATORY	0.296970	107,634				31,964		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.390336	409,846				159,978		65
66 PHYSICAL THERAPY	0.365636							66
71 MEDICAL SUPPLIES CHRGED TO PATI	0.842593	127,077				107,074		71
73 DRUGS CHARGED TO PATIENTS	0.194690	3,884,599		7,762		756,293	1,511	73
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	0.627777	6,951				4,364		90
90.01 PARTIAL HOSPITALIZATION	1.268603	504,497				640,006		90.01
91 EMERGENCY	0.495397	858,195				425,147		91
92 OBSERVATION BEDS	3.010495	47,910				144,233		92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)		7,556,859		7,762		3,035,142	1,511	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		7,556,859		7,762		3,035,142	1,511	202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0077) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFERA
 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)	11,620	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	11,620	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	11,620	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)	3,001	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)	15,697,784	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	15,697,784	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	15,697,784	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0077) [] 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) 1,350.93 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 4,054,141 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) 4,054,141 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						1,882,931 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)						5,937,072 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 402,884 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 109,137 51
 52 TOTAL PROGRAM EXCLUDABLE COST 512,021 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 5,425,051 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 INSTRUC (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) 389 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,350.93 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 525,512 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	1,559,979	15,697,784	0.099376	525,512	52,223	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0077) [] 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
30 INPATIENT ROUTINE SERVICE COST CENTERS		2,784,330		30
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.963387	222,172	214,038	50
52 DELIVERY ROOM & LABOR ROOM	2.530930	4,316	10,923	52
53 ANESTHESIOLOGY	0.137817	40,728	5,613	53
54 RADIOLOGY-DIAGNOSTIC	0.359012	460,313	165,258	54
60 LABORATORY	0.296970	1,468,632	436,140	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.390519	1,006,157	392,923	65
66 PHYSICAL THERAPY	0.365636	43,465	15,892	66
71 MEDICAL SUPPLIES CHRGD TO PATI	0.842593	209,024	176,122	71
73 DRUGS CHARGED TO PATIENTS	0.194690	1,358,534	264,493	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.628965			90
90.01 PARTIAL HOSPITALIZATION	1.268603			90.01
91 EMERGENCY	0.500862	392,897	196,787	91
92 OBSERVATION BEDS	3.010495	1,575	4,742	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		5,207,813	1,882,931	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		5,207,813		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0077)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	3,143,932	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	66,144	2
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	120.13	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)		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)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		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		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		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)		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
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.2284	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.5227	31
32	SUM OF LINES 30 AND 31	0.7511	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.5118	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	1,609,064	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)	4,819,140	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)	4,819,140	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	297,391	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK HOSPITAL (14-0077)
APPLICABLE BOX: SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		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)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	5,116,531	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	5,116,531	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	435,692	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	26,012	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	363,811	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	254,668	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	4,909,495	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
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)	4,909,495	71
72	INTERIM PAYMENTS	5,043,351	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-133,856	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	111,295	75
90	TO BE COMPLETED BY CONTRACTOR		90
91	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		91
92	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		92
93	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		94
95	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		96
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

CHECK APPLICABLE BOX: HOSPITAL (14-0077) IPF - IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	1,511	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)	3,035,142	2
3	PPS PAYMENTS	1,922,833	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	1,511	11
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
12	ANCILLARY SERVICE CHARGES	7,762	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)	7,762	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)	7,762	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	6,251	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)	1,511	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)	1,922,833	24
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	455,638	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	1,468,706	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)	1,468,706	30
31	PRIMARY PAYER PAYMENTS	11,105	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	1,457,601	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)	263,177	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	184,224	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)	1,641,825	37
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)	1,641,825	40
41	INTERIM PAYMENTS	1,494,147	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	147,678	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
TO BE COMPLETED BY CONTRACTOR			
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

PROVIDER CCN: 14-0077 TOUCHETTE REGIONAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0077) [] 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		4,961,387		1,456,215	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 08/12/2011	81,964	08/12/2011	37,932	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	81,964		37,932	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		5,043,351		1,494,147	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50				5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99				5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01				6.01
	PROVIDER PROVIDER TO .02				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)	PROGRAM				7

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

PROVIDER CCN: 14-0077 TOUCHETTE REGIONAL HOSPITAL
PERIOD FROM 01/01/2011 TO 12/31/2011

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0077) - [] 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	3,116	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	3,001	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	11,231	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	98,993,283	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	8,502,792	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

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	3,750,632			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	6,851,416			4
5	OTHER RECEIVABLES	1,102,827			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,862,000			6
7	INVENTORY	1,953,136			7
8	PREPAID EXPENSES				8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	10,796,011			11
FIXED ASSETS					
12	LAND	2,192,647			12
13	LAND IMPROVEMENTS	640,876			13
14	ACCUMULATED DEPRECIATION	-538,781			14
15	BUILDINGS	20,286,191			15
16	ACCUMULATED DEPRECIATION	-11,148,501			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	15,212,038			23
24	ACCUMULATED DEPRECIATION	-12,522,498			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)	14,121,972			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	912,262			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	912,262			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	25,830,245			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,699,406			37
38	SALARIES, WAGES & FEES PAYABLE	2,224,126			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	1,142,774			40
41	DEFERRED INCOME	4,425,665			41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	865,455			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	10,357,426			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	2,354,572			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	2,201,192			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	4,555,764			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	14,913,190			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	10,917,055			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	10,917,055			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	25,830,245			60

PROVIDER CCN: 14-0077 TOUCHETTE REGIONAL HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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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		16,000,408							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		-5,029,555							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		10,970,853							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		10,970,853							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 CHANGE IN VALUE OF BENEFICIA	53,798								13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		53,798							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		10,917,055							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	11,617,947		11,617,947	2
3 SUBPROVIDER IPF				3
4 SUBPROVIDER IRF				4
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)	11,617,947		11,617,947	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	11,617,947		11,617,947	18
19 ANCILLARY SERVICES	20,474,430		20,474,430	19
20 OUTPATIENT SERVICES		66,900,906	66,900,906	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
24 AMBULANCE				24
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)	32,092,377	66,900,906	98,993,283	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		60,014,831	29
30 PROVISION FOR BAD DEBTS	6,608,994		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		6,608,994	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		66,623,825	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	98,993,283	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	36,468,993	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	62,524,290	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	66,623,825	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-4,099,535	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	13,456	6
7	INCOME FROM INVESTMENTS	37,535	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	2,889	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	271,686	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	23,817	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	9,751	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	76,413	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS	416,930	23
24	OTHER (MISCELLANEOUS)	430,092	24
24.01	OTHER (RELATED PARTY)	27,888	24.01
24.02	OTHER (LOSS ON DISPOSAL OF CAPITAL ASSETS)	-2,240,477	24.02
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	-930,020	25
26	TOTAL (LINE 5 PLUS LINE 25)	-5,029,555	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)	-5,029,555	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7315

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
1 GENERAL SERVICE COST CENTER						1
2 CAPITAL RELATED-BLDGS & FIXTURES						2
3 CAPITAL RELATED-MOVABLE EQUIPMENT						3
4 PLANT OPERATION & MAINTENANCE						4
5 TRANSPORTATION (SEE INSTRUCTIONS)						5
ADMINISTRATIVE AND GENERAL	312,056		24,936		193,305	530,297
HHA REIMBURSABLE SERVICES						
6 SKILLED NURSING CARE	615,727		21,817			637,544
7 PHYSICAL THERAPY	135,992		4,652			140,644
8 OCCUPATIONAL THERAPY	38,321		1,356			39,677
9 SPEECH PATHOLOGY	9,821		282			10,103
10 MEDICAL SOCIAL SERVICES	96,331		4,320			100,651
11 HOME HEALTH AIDE						
12 SUPPLIES (SEE INSTRUCTIONS)						
13 DRUGS						
14 DME						
HHA NONREIMBURSABLE SERVICES						
15 HOME DIALYSIS AIDE SERVICES						
16 RESPIRATORY THERAPY						
17 PRIVATE DUTY NURSING						
18 CLINIC						
19 HEALTH PROMOTION ACTIVITIES						
20 DAY CARE PROGRAM						
21 HOME DELIVERED MEALS PROGRAM						
22 HOMEMAKER SERVICE						
23 ALL OTHERS						
24 TOTAL (SUM OF LINES 1-23)	1,208,248		57,363		193,305	1,458,916

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7315

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET)	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE)	PLANT OPERATN & MAINT (SQUARE FEET)	TRANSPORT- ATION (MILEAGE)	RECONCIL- IATION	ADMIN & GENERAL (ACCUM COST)	
	1	2	3	4	5A	5	
1	GENERAL SERVICE COST CENTER						1
2	CAPITAL RELATED-BLDGS & FIXT						2
3	CAPITAL RELATED-MOVABLE EQUIP						3
4	PLANT OPERATION & MAINTENANCE						4
5	TRANSPORTATION (SEE INSTR.)						5
6	ADMINISTRATIVE AND GENERAL				-530,297	928,619	6
7	HHA REIMBURSABLE SERVICES						7
8	SKILLED NURSING CARE					637,544	8
9	PHYSICAL THERAPY					140,644	9
10	OCCUPATIONAL THERAPY					39,677	10
11	SPEECH PATHOLOGY					10,103	11
12	MEDICAL SOCIAL SERVICES					100,651	12
13	HOME HEALTH AIDE						13
14	SUPPLIES (SEE INSTRUCTIONS)						14
15	DRUGS						15
16	DME						16
17	HHA NONREIMBURSABLE SERVICES						17
18	HOME DIALYSIS AIDE SERVICES						18
19	RESPIRATORY THERAPY						19
20	PRIVATE DUTY NURSING						20
21	CLINIC						21
22	HEALTH PROMOTION ACTIVITIES						22
23	DAY CARE PROGRAM						23
24	HOME DELIVERED MEALS PROGRAM						24
25	HOMEMAKER SERVICE						25
26	ALL OTHERS						26
23.50	TELEMEDICINE						23.50
24	TOTAL (SUM OF LINES 1-23)				-530,297	928,619	24
25	COST TO BE ALLOC (PER W/S H)					530,297	25
26	UNIT COST MULTIPLIER					0.571060	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7315

WORKSHEET H-2
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL. 4A-23) 24	I&R COST % POST STEP- DOWN ADJS 25	SUBTOTAL (SUM OF COL. 4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	165,574		165,574			1
2 SKILLED NURSING CARE	1,504,415		1,504,415	113,686	1,618,101	2
3 PHYSICAL THERAPY	331,927		331,927	25,083	357,010	3
4 OCCUPATIONAL THERAPY	93,627		93,627	7,075	100,702	4
5 SPEECH PATHOLOGY	23,859		23,859	1,803	25,662	5
6 MEDICAL SOCIAL SERVICES	237,234		237,234	17,927	255,161	6
7 HOME HEALTH AIDE						7
8 SUPPLIES						8
9 DRUGS						9
10 EME						10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY						12
13 PRIVATE DUTY NURSING						13
14 CLINIC						14
15 HEALTH PROMOTION ACTIVITIES						15
16 DAY CARE PROGRAM						16
17 HOME DELIVERED MEALS PROGRAM						17
18 HOMEMAKER SERVICE						18
19 ALL OTHERS						19
20 TOTAL (SUM OF LINES 1-19)	2,356,636		2,356,636	165,574	2,356,636	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.				0.075568		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7315

WORKSHEET H-2
 PART II

HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS SERVED 11	MAINTENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINISTRATION DIRECT NRSNG HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	
1 ADMINISTRATIVE AND GENERAL		2,422					8,151	159	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)		2,422					8,151	159	20
21 TOTAL COST TO BE ALLOCATED		65,334					3,159	93	21
22 UNIT COST MULTIPLIER							0.387560		22
22 UNIT COST MULTIPLIER		26.975227						0.584906	22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7315

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	SHARED	TOTAL HHA	TOTAL	AVERAGE	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I) 1	ANCILLARY COSTS (FROM PART II) 2	COSTS (COLS. 1+2) 3	VISITS 4	COST PER VISIT (COL.3 ÷ COL.4) 5	
1	SKILLED NURSING CARE	2	1,618,101		1,618,101	8,112	199.47	1
2	PHYSICAL THERAPY	3	357,010		357,010	2,655	134.47	2
3	OCCUPATIONAL THERAPY	4	100,702		100,702	814	123.71	3
4	SPEECH PATHOLOGY	5	25,662		25,662	194	132.28	4
5	MEDICAL SOCIAL SERVICES	6	255,161		255,161	59	4,324.76	5
6	HOME HEALTH AIDE	7						6
7	TOTAL (SUM OF LINES 1-6)		2,356,636		2,356,636	11,834		7

PATIENT SERVICES

8	SKILLED NURSING CARE							8
9	PHYSICAL THERAPY							9
10	OCCUPATIONAL THERAPY							10
11	SPEECH PATHOLOGY							11
12	MEDICAL SOCIAL SERVICES							12
13	HOME HEALTH AIDE							13
14	TOTAL (SUM OF LINES 8-13)							14

SUPPLIES AND DRUGS COST COMPUTATIONS		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	RATIO	
OTHER PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I) 1	ANCILLARY COSTS (FROM PART II) 2	COSTS (COLS. 1+2) 3	CHARGES (FROM HHA RECORD) 4	(COL.3 ÷ COL.4) 5	
15	COST OF MEDICAL SUPPLIES	8				3,566		15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7315

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 B			PART B			
PATIENT SERVICES		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
		6	7	8	9	10	11	12
1	SKILLED NURSING CARE	642	573		128,060	114,296		242,356
2	PHYSICAL THERAPY	266	354		35,769	47,602		83,371
3	OCCUPATIONAL THERAPY	67	78		8,289	9,649		17,938
4	SPEECH PATHOLOGY	15	28		1,984	3,704		5,688
5	MEDICAL SOCIAL SERVICES	10	2		43,248	8,650		51,898
6	HOME HEALTH AIDE							
7	TOTAL (SUM OF LINES 1-6)	1,000	1,035		217,350	183,901		401,251

PATIENT SERVICES		CBSA NO.	PROGRAM VISITS		PART A	PART B		PART B
			NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR		NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
		1	2	3	4	5	6	7
8	SKILLED NURSING CARE	41180	642	573				8
9	PHYSICAL THERAPY	41180	266	354				9
10	OCCUPATIONAL THERAPY	41180	67	78				10
11	SPEECH PATHOLOGY	41180	15	28				11
12	MEDICAL SOCIAL SERVICES	41180	10	2				12
13	HOME HEALTH AIDE	41180						13
14	TOTAL (SUM OF LINES 8-13)		1,000	1,035				14

SUPPLIES AND DRUGS COST COMPUTATIONS		PROGRAM COVERED CHARGES			COST OF SERVICES			
OTHER PATIENT SERVICES		PART B			PART B			
		NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
		6	7	8	9	10	11	
15	COST OF MEDICAL SUPPLIES	708						15
16	COST OF DRUGS		2,858					16

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

LINE	FROM WKST C, PART I, COL.9,	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	
			2	3	4	
1	PHYSICAL THERAPY	0.365636			COL 2, LINE 2	1
2	OCCUPATIONAL THERAPY				COL 2, LINE 3	2
3	SPEECH PATHOLOGY				COL 2, LINE 4	3
4	MEDICAL SUPPLIES CHRGD TO PAT	0.842593			COL 2, LINE 15	4
5	DRUGS CHARGED TO PATIENTS	0.194690			COL 2, LINE 16	5

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7315

WORKSHEET H-4
 PARTS I & II

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

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

DESCRIPTION	----- PART B -----		
	PART A 1	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	
1 REASONABLE COST OF PART A & PART B SERVICES			1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)			2
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	PART B	
	SERVICES 1	SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	151,163	171,544	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	3,694	4,289	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	1,884	360	14
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)	156,741	176,193	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	156,741	176,193	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	156,741	176,193	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)	156,741	176,193	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	156,741	176,193	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	156,741	176,193	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. 15-11, SECTION 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7315

WORKSHEET H-5

DESCRIPTION	PART A		PART B		
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		156,741		176,193	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.					
					3.01
		NONE		NONE	3.02
	PROGRAM				3.03
	TO				3.04
	PROVIDER				3.05
					3.06
					3.07
					3.08
					3.09
					3.50
		NONE		NONE	3.51
	PROVIDER				3.52
	TO				3.53
	PROGRAM				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 H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		156,741		176,193	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
	PROGRAM				5.01
	TO				5.02
	PROVIDER				5.03
					5.04
					5.05
					5.06
					5.07
					5.08
					5.09
	PROVIDER				5.50
	TO				5.51
	PROGRAM				5.52
					5.53
					5.54
					5.55
					5.56
					5.57
					5.58
					5.59
					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 (SEE INSTR.)					
	PROGRAM				6.01
	TO				
	PROVIDER				
	PROVIDER				6.02
	TO				
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7
8 NAME OF CONTRACTOR:	_____		CONTRACTOR NUMBER:	_____	DATE:
				_____	_____

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-007) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT				
2	CAPITAL DRG OTHER THAN OUTLIER	253,450		1	
3	CAPITAL DRG OUTLIER PAYMENTS	2,299		2	
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	30.77		3	
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)			4	
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)			5	
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)			6	
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.2284		7	
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.5227		8	
10	SUM OF LINES 7 AND 8	0.7511		9	
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1643		10	
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	41,642		11	
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	297,391		12	

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)			1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)			2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)			3
4	CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)			4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)			5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)			1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)			2
3	NET PROGRAM INPATIENT CAPITAL COSTS 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 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS						30
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
71 MEDICAL SUPPLIES CHRGD TO PAT						71
73 DRUGS CHARGED TO PATIENTS						73
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 PARTIAL HOSPITALIZATION						90.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY						101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)						118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CA						190
192 PHYSICIANS' PRIVATE OFFICES						192
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	25.83						25.83 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	5.33	8.05					13.38 50
52 DELIVERY ROOM & LABOR ROOM	0.40						0.40 52
53 ANESTHESIOLOGY	4.98	8.14					13.12 53
54 RADIOLOGY-DIAGNOSTIC	4.01	10.53					14.54 54
60 LABORATORY	10.36	0.76					11.12 60
65 RESPIRATORY THERAPY	19.31	7.87					27.18 65
66 PHYSICAL THERAPY	2.08						2.08 66
71 MEDICAL SUPPLIES CHRGD TO PATI	57.08	34.70					91.78 71
73 DRUGS CHARGED TO PATIENTS	5.37	15.40					20.77 73
90 CLINIC		0.15					0.15 90
90.01 PARTIAL HOSPITALIZATION		43.80					43.80 90.01
91 EMERGENCY	2.57	5.62					8.19 91
92 OBSERVATION BEDS	0.90	27.45					28.35 92
200 TOTAL CHARGES	6.07	8.82					14.89 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	2,665,834	4.84	-2,665,834	-8.70		1
2	CAP REL COSTS-MVBLE EQUIP	1,663,840	3.02	-1,663,840	-5.43		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	6,235,881	11.31	-6,235,881	-20.36		4
5	ADMINISTRATIVE & GENERAL	11,238,515	20.38	-11,238,515	-36.69		5
6	MAINTENANCE & REPAIRS	923,513	1.68	-923,513	-3.01		6
7	OPERATION OF PLANT	2,068,905	3.75	-2,068,905	-6.75		7
8	LAUNDRY & LINEN SERVICE	179,268	0.33	-179,268	-0.59		8
9	HOUSEKEEPING	899,043	1.63	-899,043	-2.93		9
10	DIETARY	335,938	0.61	-335,938	-1.10		10
11	CAFETERIA	508,977	0.92	-508,977	-1.66		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	2,065,514	3.75	-2,065,514	-6.74		13
14	CENTRAL SERVICES & SUPPLY	187,059	0.34	-187,059	-0.61		14
15	PHARMACY	895,808	1.62	-895,808	-2.92		15
16	MEDICAL RECORDS & LIBRARY	766,267	1.39	-766,267	-2.50		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCS-SALARY & FRINGES APP						21
22	I&R SRVCS-OTHER PRGM COSTS APP						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,412,845	9.82	10,276,559	33.55	15,689,404	28.46
43	NURSERY	820,092	1.49	863,466	2.82	1,683,558	3.05
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,423,461	2.58	2,592,738	8.46	4,016,199	7.28
52	DELIVERY ROOM & LABOR ROOM	984,060	1.78	1,747,874	5.71	2,731,934	4.96
53	ANESTHESIOLOGY	24,718	0.04	87,982	0.29	112,700	0.20
54	RADIOLOGY-DIAGNOSTIC	2,278,166	4.13	1,840,971	6.01	4,119,137	7.47
60	LABORATORY	2,680,998	4.86	1,530,578	5.00	4,211,576	7.64
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,038,930	1.88	995,049	3.25	2,033,979	3.69
66	PHYSICAL THERAPY	364,251	0.66	398,265	1.30	762,516	1.38
71	MEDICAL SUPPLIES CHRGD TO PATI	181,666	0.33	126,911	0.41	308,577	0.56
73	DRUGS CHARGED TO PATIENTS	2,598,575	4.71	2,322,373	7.58	4,920,948	8.93
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
90	CLINIC	1,354,080	2.46	1,470,381	4.80	2,824,461	5.12
90.01	PARTIAL HOSPITALIZATION	358,139	0.65	1,103,001	3.60	1,461,140	2.65
91	EMERGENCY	3,401,072	6.17	4,165,977	13.60	7,567,049	13.72
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
101	HOME HEALTH AGENCY	1,458,916	2.65	897,720	2.93	2,356,636	4.27
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CAN	116,400	0.21	147,947	0.48	264,347	0.48
192	PHYSICIANS' PRIVATE OFFICES	3,976	0.01	66,570	0.22	70,546	0.13
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	55,134,707	100.00			55,134,707	100.00

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	1,559,979		1,559,979	11,620	134.25	3,001	402,884 30
200	TOTAL	1,559,979		1,559,979	11,620		3,001	402,884 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								402,884
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								109,137
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								512,021
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								631
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								3,001
PER DISCHARGE CAPITAL COSTS								811.44
PER DIEM CAPITAL COSTS								170.62

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)	5,425,051
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	7,992,143
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.679

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)	512,021
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.064

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	3,035,142
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	7,556,859
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.402