

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: 05-30-2012 TIME: 15:45
 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 MORRIS HOSPITAL (14-0101) (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.

(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		170,808	214,484			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		170,808	214,484			200

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 150 WEST HIGH STREET
 2 CITY: MORRIS

STATE: IL

P.O.BOX:
 ZIP CODE: 60450

COUNTY: GRUNDY

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 6	XVIII 7	XIX 8		
3	HOSPITAL	MORRIS HOSPITAL	14-0101	16974	1	07/01/1966	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF	MORRIS HOSPITAL	14-U101	16974		10/07/1994	N		N	8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									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
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.	N	N
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	3	N

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

45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	V 1	XVIII 2	XIX 3
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N
48	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
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
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))
			3	4	5
ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
	PROGRAM NAME	PROGRAM CODE			
	1	2			
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))
			3	4	5

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	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))		
1	2	3	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)?			N 105		
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106		
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107		
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108		
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- SICAL	OCUP- ATIONAL	RESPI- RATORY	N N N 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.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 1,099,571 PAID LOSSES: AND/OR SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	Y		118.02
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.	Y		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.	N		140
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.				
141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
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.	Y		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	HOSPITAL	N 155
156	SUBPROVIDER - IPF	N 156
157	SUBPROVIDER - IRF	N 157
158	SUBPROVIDER - (OTHER)	N 158
159	SNF	N 159
160	HHA	N 160
161	CMHC	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	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.			169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE	
PROVIDER ORGANIZATION AND OPERATION				
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N	2	1
		Y/N	DATE	V/I
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
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3
FINANCIAL DATA AND REPORTS				
		Y/N	TYPE	DATE
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	N	2	3
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	1	Y/N
			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
				Y/N
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			N
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			14
BED COMPLEMENT				
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15
PART A				
		Y/N	DATE	
PS&R REPORT DATA				
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)	N	2	3
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)	Y	04/10/2012	4
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		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

		Y/N	DATE	
		1	2	
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	
SALARIES								
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	45,838,215		45,838,215	1,585,230.40	28.92	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A		518,570		518,570	4,212.00	123.12	4
4.01	PHYSICIANS-PART A - DIRECT TEACHING							4.01
5	PHYSICIAN-PART B		3,548,031		3,548,031	35,181.00	100.85	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)		141,272	57,297	198,569	12,043.00	16.49	10
OTHER WAGES & RELATED COSTS								
11	CONTRACT LABOR (SEE INSTRUCTIONS)		452,106		452,106	6,804.00	66.45	11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A							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)		11,005,812		11,005,812			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		52,496		52,496			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A		137,094		137,094			22
23	PHYSICIAN PART B		937,993		937,993			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	EMPLOYEE BENEFITS		316,051		316,051	11,107.20	28.45	26
27	ADMINISTRATIVE & GENERAL		6,679,784	405,122	7,084,906	252,491.20	28.06	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS					27,352.00		29
30	OPERATION OF PLANT		723,546		723,546			30
31	LAUNDRY & LINEN SERVICE		24,359		24,359	2,163.20	11.26	31
32	HOUSEKEEPING		1,135,484		1,135,484	80,412.80	14.12	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		1,093,774	-669,219	424,555	69,388.80	6.12	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA			541,488	541,488			36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		538,798		538,798	16,224.00	33.21	38
39	CENTRAL SERVICES AND SUPPLY		610,075	-334,688	275,387	34,736.00	7.93	39
40	PHARMACY		1,259,207		1,259,207	31,491.20	39.99	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,374,566	-102,941	1,271,625	72,363.20	17.57	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)		42,290,184		42,290,184	1,550,049.4	27.28	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		141,272	57,297	198,569	12,043.00	16.49	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)		42,148,912	-57,297	42,091,615	1,538,006.4	27.37	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)		452,106		452,106	6,804.00	66.45	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)		11,142,906		11,142,906		26.47%	5
6	TOTAL (SUM OF LINES 3 THRU 5)		53,743,924	-57,297	53,686,627	1,544,810.4	34.75	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)		13,755,644	-160,238	13,595,406	597,729.60	22.75	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	780,991	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)	7,114,256	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	246,798	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	74,886	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	285,713	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	256,228	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE		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	3,242,718	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	53,270	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	60,387	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	12,115,247	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
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VERSION: 2011.10
05/30/2012 15:45

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL		2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTG		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)			0.318798	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)					
2	NET REVENUE FROM MEDICAID			3,888,810	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?			N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				5
6	MEDICAID CHARGES			35,294,365	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)			11,251,773	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)			7,362,963	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)					
9	NET REVENUE FROM STAND-ALONE SCHIP			77,973	9
10	STAND-ALONE SCHIP CHARGES			525,183	10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)			167,427	11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)			89,454	12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)					
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)			71,988	13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)			613,840	14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)			195,691	15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)			123,703	16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)					
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE				17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)			7,576,120	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	9,272,219	488,012	9,760,231	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	2,955,965	155,577	3,111,542	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	2,955,965	155,577	3,111,542	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM			N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)				25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			7,427,219	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			385,292	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			7,041,927	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			2,244,952	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			5,356,494	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			12,932,614	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100				2,657,638	1
2	00200				5,305,135	2
3	00300					3
4	00400	316,051	12,307,764	12,623,815	-9,590	4
5	00500	6,679,784	22,803,213	29,482,997	-3,283,018	5
6	00600					6
7	00700	723,546	2,106,009	2,829,555	-27,173	7
8	00800	24,359	395,346	419,705	-381	8
9	00900	1,135,484	574,902	1,710,386	-15,046	9
10	01000	1,093,774	622,558	1,716,332	-1,173,045	10
11	01100				907,170	11
12	01200					12
13	01300		16,388	555,186	-543	13
14	01400	538,798	5,121,990	5,732,065	-1,443,937	14
15	01500	610,075	4,796,954	6,056,161	-31,811	15
16	01600	1,259,207	400,250	1,774,816	-295,812	16
17	01700	1,374,566				17
19	01900					19
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	7,839,480	801,937	8,641,417	-929,059	30
31	03100	2,863,466	363,429	3,226,895	-1,086,930	31
43	04300				673,762	43
ANCILLARY SERVICE COST CENTERS						
50	05000	2,918,367	4,491,912	7,410,279	-3,459,394	50
51	05100	387,224	16,096	403,320	-12,089	51
52	05200				972,366	52
53	05300		32,677	32,677	-21,395	53
54	05400	1,772,734	1,236,673	3,009,407	-726,307	54
54.01	05401	289,320	432,225	721,545	-480	54.01
54.02	05402	502,067	119,284	621,351	-51,489	54.02
55	05500	447,061	942,086	1,389,147	-26,063	55
57	05700	615,469	671,600	1,287,069	-4,426	57
58	05800	248,832	266,150	514,982	-172,659	58
59.97	05901	122,948	39,960	162,908	-27,539	59.97
60	06000	3,460,027	4,785,828	8,245,855	-239,087	60
65	06500	1,446,701	253,137	1,699,838	-1,476,382	65
66	06600	666,593	110,204	776,797	-5,259	66
67	06700	178,583	201,101	379,684	-4,197	67
68	06800	39,213	90	39,303		68
71	07100				195,827	71
72	07200				4,464,470	72
73	07300					73
76	03950					76
OUTPATIENT SERVICE COST CENTERS						
90	09000	5,555,648	2,388,586	7,944,234	-687,850	90
91	09100	2,587,566	888,157	3,475,723	-41,705	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118		45,696,943	67,186,506	112,883,449	-76,298	118
NONREIMBURSABLE COST CENTERS						
190.01	19001				95,991	190.01
193.01	19301	141,272	143,408	284,680	-19,693	193.01
200		45,838,215	67,329,914	113,168,129		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	2,657,638	45	2,657,683	1
2	00200	CAP REL COSTS-MVBLE EQUIP	5,305,135		5,305,135	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	12,614,225	-6,942,752	5,671,473	4
5	00500	ADMINISTRATIVE & GENERAL	26,199,979	-4,329,712	21,870,267	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	2,802,382		2,802,382	7
8	00800	LAUNDRY & LINEN SERVICE	419,324		419,324	8
9	00900	HOUSEKEEPING	1,695,340		1,695,340	9
10	01000	DIETARY	543,287		543,287	10
11	01100	CAFETERIA	907,170	-345,010	562,160	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	554,643		554,643	13
14	01400	CENTRAL SERVICES & SUPPLY	4,288,128		4,288,128	14
15	01500	PHARMACY	6,024,350		6,024,350	15
16	01600	MEDICAL RECORDS & LIBRARY	1,479,004		1,479,004	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	7,712,358		7,712,358	30
31	03100	INTENSIVE CARE UNIT	2,139,965	-239,125	1,900,840	31
43	04300	NURSERY	673,762		673,762	43
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	3,950,885		3,950,885	50
51	05100	RECOVERY ROOM	391,231		391,231	51
52	05200	DELIVERY ROOM & LABOR ROOM	972,366		972,366	52
53	05300	ANESTHESIOLOGY	11,282		11,282	53
54	05400	RADIOLOGY-DIAGNOSTIC	2,283,100		2,283,100	54
54.01	05401	NUCLEAR MEDICINE	721,065		721,065	54.01
54.02	05402	ULTRA SOUND	569,862		569,862	54.02
55	05500	RADIOLOGY-THERAPEUTIC	1,363,084		1,363,084	55
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	1,282,643		1,282,643	57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	342,323		342,323	58
59.97	05901	CARDIAC REHAB	135,369		135,369	59.97
60	06000	LABORATORY	8,006,768	-257,849	7,748,919	60
65	06500	RESPIRATORY THERAPY	223,456		223,456	65
66	06600	PHYSICAL THERAPY	771,538		771,538	66
67	06700	OCCUPATIONAL THERAPY	375,487		375,487	67
68	06800	SPEECH PATHOLOGY	39,303		39,303	68
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	195,827		195,827	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	4,464,470		4,464,470	72
73	07300	DRUGS CHARGED TO PATIENTS				73
76	03950	OTHER ANCILLARY				76
OUTPATIENT SERVICE COST CENTERS						
90	09000	CLINIC	7,256,384	-3,064,004	4,192,380	90
91	09100	EMERGENCY	3,434,018		3,434,018	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117)	112,807,151	-15,178,407	97,628,744	118
NONREIMBURSABLE COST CENTERS						
190.01	19001	MEALS ON WHEELS	95,991	-28,527	67,464	190.01
193.01	19301	PATIENT TRANSPORTATION	264,987		264,987	193.01
200		TOTAL (SUM OF LINES 118-199)	113,168,129	-15,206,934	97,961,195	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER	
			LINE #				
1		2	3		4	5	
1 LDR & NURSERY	A	DELIVERY ROOM & LABOR ROOM	52		838,491	133,875	1
2		NURSERY	43		580,999	92,763	2
3 CAFETERIA RECLASS	A	CAFETERIA	11		541,488	365,682	3
4		ADMINISTRATIVE & GENERAL	5		70,434	47,566	4
5		MEALS ON WHEELS	190.01		57,297	38,694	5
6 DEPRECIATION	A	CAP REL COSTS-BLDG & FIXT	1			2,657,638	6
7		CAP REL COSTS-MVBLE EQUIP	2			5,305,135	7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36							36
37							37
38 PURCHASING	A	ADMINISTRATIVE & GENERAL	5		334,688	1,069,188	38
39 RECLASS ICU INTERMEDIATE TO A&P	A	ADULTS & PEDIATRICS	30		759,070	167,894	39
40 CENTRAL PROCESSING SUPPLIES RECLASS	A	MEDICAL SUPPLIES CHRGD TO PA	71		102,941	92,886	40
500 TOTAL RECLASSIFICATIONS					3,285,408	9,971,321	500
CODE LETTER - A							
1 IMPLANTABLE DEVICE COST	B	IMPL. DEV. CHARGED TO PATIENT	72			4,464,470	1
2							2
500 TOTAL RECLASSIFICATIONS						4,464,470	500
CODE LETTER - B							
GRAND TOTAL (INCREASES)					3,285,408	14,435,791	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		OTHER	WKST A-7 REF.
			LINE #	SALARY		
1	1	6	7	8	9	10
1 LDR & NURSERY	A	ADULTS & PEDIATRICS	30	838,491	133,875	1
2		ADULTS & PEDIATRICS	30	580,999	92,763	2
3 CAFETERIA RECLASS	A	DIETARY	10	541,488	365,682	3
4		DIETARY	10	70,434	47,566	4
5		DIETARY	10	57,297	38,694	5
6 DEPRECIATION	A	EMPLOYEE BENEFITS	4		9,590	9 6
7		ADMINISTRATIVE & GENERAL	5		2,129,434	9 7
8		ADMINISTRATIVE & GENERAL	5		2,675,460	9 8
9		OPERATION OF PLANT	7		27,173	9 9
10		LAUNDRY & LINEN SERVICE	8		381	9 10
11		HOUSEKEEPING	9		15,046	9 11
12		DIETARY	10		51,884	9 12
13		NURSING ADMINISTRATION	13		543	9 13
14		CENTRAL SERVICES & SUPPLY	14		40,061	9 14
15		PHARMACY	15		31,811	9 15
16		MEDICAL RECORDS & LIBRARY	16		99,985	9 16
17		ADULTS & PEDIATRICS	30		209,895	9 17
18		INTENSIVE CARE UNIT	31		159,966	9 18
19		OPERATING ROOM	50		372,896	9 19
20		RECOVERY ROOM	51		12,089	9 20
21		ANESTHESIOLOGY	53		21,395	9 21
22		RADIOLOGY-DIAGNOSTIC	54		726,307	9 22
23		NUCLEAR MEDICINE	54.01		480	9 23
24		ULTRA SOUND	54.02		51,489	9 24
25		RADIOLOGY-THERAPEUTIC	55		2,776	9 25
26		RADIOLOGY-THERAPEUTIC	55		23,287	9 26
27		COMPUTED TOMOGRAPHY (CT) SCAN	57		4,426	9 27
28		MAGNETIC RESONANCE IMAGING (M	58		172,659	9 28
29		CARDIAC REHAB	59.97		27,539	9 29
30		LABORATORY	60		239,087	9 30
31		RESPIRATORY THERAPY	65		98,410	9 31
32		PHYSICAL THERAPY	66		5,259	9 32
33		OCCUPATIONAL THERAPY	67		4,197	9 33
34		CLINIC	90		525,428	9 34
35		CLINIC	90		162,422	9 35
36		EMERGENCY	91		41,705	9 36
37		PATIENT TRANSPORTATION	193.01		19,693	9 37
38 PURCHASING	A	CENTRAL SERVICES & SUPPLY	14	334,688	1,069,188	9 38
39 RECLASS ICU INTERMEDIATE TO A&P	A	INTENSIVE CARE UNIT	31	759,070	167,894	39
40 CENTRAL PROCESSING SUPPLIES RECLASS	A	MEDICAL RECORDS & LIBRARY	16	102,941	92,886	40
500 TOTAL RECLASSIFICATIONS CODE LETTER - A				3,285,408	9,971,321	500
1 IMPLANTABLE DEVICE COST	B	OPERATING ROOM	50		3,086,498	1
2		RESPIRATORY THERAPY	65		1,377,972	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					4,464,470	500
GRAND TOTAL (DECREASES)				3,285,408	14,435,791	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	----- ACQUISITIONS -----			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND	BALANCE	DEPRECIATED
	1	2	3	4	RETIREMENTS	6	ASSETS
					5		7
1 LAND	6,494,014		56,083	56,083		6,550,097	1
2 LAND IMPROVEMENTS	5,225,836	97,147		97,147		5,322,983	2
3 BUILDINGS AND FIXTURES	62,463,686	155,516	255,942	411,458	187,117	62,688,027	3
4 BUILDING IMPROVEMENTS	1,584,424	1,310		1,310		1,585,734	4
5 FIXED EQUIPMENT	20,390,768	229,095	11,156	240,251	73,500	20,557,519	5
6 MOVABLE EQUIPMENT	50,107,174	4,625,826	92,372	4,718,198	2,187,154	52,638,218	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	146,265,902	5,108,894	415,553	5,524,447	2,447,771	149,342,578	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	146,265,902	5,108,894	415,553	5,524,447	2,447,771	149,342,578	10

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

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

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

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

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (SEE INSTR.)	TAXES (SEE INSTR.)	OTHER	TOTAL(2)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	12	13	14	15
1 CAP REL COSTS-BLDG & FIXT	2,657,638		45				2,657,683
2 CAP REL COSTS-MVBLE EQUIP	5,305,135						5,305,135
3 TOTAL	7,962,773		45				7,962,818

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
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)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,560,978			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-84,501	ADMINISTRATIVE & GENERAL	5	11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-345,010	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	-5,104	ADMINISTRATIVE & GENERAL	5	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES	B	-7,152	ADMINISTRATIVE & GENERAL	5	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 BAD DEBT EXPENSE	A	-7,427,219	ADMINISTRATIVE & GENERAL	5	33
34 EMPLOYEE SELF INSURANCE	A	-6,942,752	EMPLOYEE BENEFITS	4	34
35 LIFELINE	A	-55,971	ADMINISTRATIVE & GENERAL	5	35
36 FUND DEPR FEES	A	-74,643	ADMINISTRATIVE & GENERAL	5	36
37 CHANGE IN CASH FLOW DERIVATIVE	A	3,621,370	ADMINISTRATIVE & GENERAL	5	10 37
38 LOSS OF ASSET DISPOSAL	A	45	CAP REL COSTS-BLDG & FIXT	1	10 38
39 MEALS ON WHEELS	A	-28,527	MEALS ON WHEELS	190.01	39
40 ASSOC DUES - LOBBYING COST	A	-26,243	ADMINISTRATIVE & GENERAL	5	40
41 PHYSICIAN RECRUITMENT	A	-270,249	ADMINISTRATIVE & GENERAL	5	41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-15,206,934			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						
2						
3						
4						
5	TOTALS (SUM OF LINES 1-4)					
	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	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6					
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 CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 05/30/2012 15:45

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	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		
LINE NO.	1	2	3	4	5	6	7	8	9		
1	60	LABORATORY	AGGREGATE - LAB	524,349	244,903	279,446	260,000	2,132	266,500	13,325	1
2	90	CLINIC	AGGREGATE - CL	3,064,004	3,064,004						2
3	31	INTENSIVE CARE UNIT	AGGREGATE - HOS	478,249	239,124	239,124	260,000	2,080	260,000	13,000	3
200		TOTAL		4,066,602	3,548,031	518,570		4,212	526,500	26,325	200

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 05/30/2012 15:45

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 60	LABORATORY	AGGREGATE - LAB				266,500	12,946	257,849	1
2 90	CLINIC	AGGREGATE - CL						3,064,004	2
3 31	INTENSIVE CARE UNIT	AGGREGATE - HOS				260,000		239,125	3
200	TOTAL					526,500	12,946	3,560,978	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	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	2,657,683	2,657,683				1
2 CAP REL COSTS-MVBLE EQUIP	5,305,135		5,305,135			2
4 EMPLOYEE BENEFITS	5,671,473	8,718	17,403	5,697,594		4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	21,870,267	611,640	1,220,927	886,754	24,589,588	5
6 OPERATION OF PLANT	2,802,382	261,150	521,294	90,560	3,675,386	7
8 LAUNDRY & LINEN SERVICE	419,324	25,400	50,702	3,049	498,475	8
9 HOUSEKEEPING	1,695,340	19,641	39,206	142,118	1,896,305	9
10 DIETARY	543,287	79,144	157,984	53,138	833,553	10
11 CAFETERIA	562,160	40,515	80,874	67,773	751,322	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	554,643	22,121	44,158	67,436	688,358	13
14 CENTRAL SERVICES & SUPPLY	4,288,128	96,740	193,107	34,468	4,612,443	14
15 PHARMACY	6,024,350	15,753	31,446	157,604	6,229,153	15
16 MEDICAL RECORDS & LIBRARY	1,479,004	62,288	124,337	159,158	1,824,787	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,712,358	483,656	965,449	898,534	10,059,997	30
31 INTENSIVE CARE UNIT	1,900,840	43,851	87,534	263,388	2,295,613	31
43 NURSERY	673,762	8,268	16,505	72,718	771,253	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,950,885	83,931	167,539	365,266	4,567,621	50
51 RECOVERY ROOM	391,231	88,167	175,994	48,465	703,857	51
52 DELIVERY ROOM & LABOR ROOM	972,366	6,209	12,393	104,946	1,095,914	52
53 ANESTHESIOLOGY	11,282	7,543	15,057		33,882	53
54 RADIOLOGY-DIAGNOSTIC	2,283,100	151,630	302,677	221,877	2,959,284	54
54.01 NUCLEAR MEDICINE	721,065	6,267	12,509	36,212	776,053	54.01
54.02 ULTRA SOUND	569,862	11,373	22,701	62,839	666,775	54.02
55 RADIOLOGY-THERAPEUTIC	1,363,084			55,955	1,419,039	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	1,282,643	17,784	35,500	77,033	1,412,960	57
58 MAGNETIC RESONANCE IMAGING (MRI)	342,323	101,019	201,649	31,144	676,135	58
59.97 CARDIAC REHAB	135,369			15,388	150,757	59.97
60 LABORATORY	7,748,919	78,767	157,231	433,060	8,417,977	60
65 RESPIRATORY THERAPY	223,456	78,100	155,899	181,071	638,526	65
66 PHYSICAL THERAPY	771,538	57,864	115,505	83,431	1,028,338	66
67 OCCUPATIONAL THERAPY	375,487	15,507	30,954	22,352	444,300	67
68 SPEECH PATHOLOGY	39,303	3,409	6,805	4,908	54,425	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	195,827			12,884	208,711	71
72 IMPL. DEV. CHARGED TO PATIENT	4,464,470				4,464,470	72
73 DRUGS CHARGED TO PATIENTS						73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	4,192,380	9,414	18,792	695,350	4,915,936	90
91 EMERGENCY	3,434,018	160,015	319,413	323,862	4,237,308	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	97,628,744	2,655,884	5,301,544	5,672,741	97,598,501	118
NONREIMBURSABLE COST CENTERS						
190.01 MEALS ON WHEELS	67,464			7,171	74,635	190.01
193.01 PATIENT TRANSPORTATION	264,987	1,799	3,591	17,682	288,059	193.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	97,961,195	2,657,683	5,305,135	5,697,594	97,961,195	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 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	24,589,588					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,231,762	4,907,148				7
8 LAUNDRY & LINEN SERVICE	167,058	70,174	735,707			8
9 HOUSEKEEPING	635,524	54,263		2,586,092		9
10 DIETARY	279,355	218,657		118,231	1,449,796	10
11 CAFETERIA	251,797	111,933		60,524		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	230,695	61,116		33,047		13
14 CENTRAL SERVICES & SUPPLY	1,545,805	267,269		144,517		14
15 PHARMACY	2,087,626	43,523		23,534		15
16 MEDICAL RECORDS & LIBRARY	611,555	172,088		93,051		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,371,460	1,336,222	587,236	722,521	1,157,216	30
31 INTENSIVE CARE UNIT	769,347	121,151	120,503	65,508	237,466	31
43 NURSERY	258,476	22,844	27,968	12,352	55,114	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,530,783	231,882		125,382		50
51 RECOVERY ROOM	235,889	243,584		131,710		51
52 DELIVERY ROOM & LABOR ROOM	367,282	17,153		9,275		52
53 ANESTHESIOLOGY	11,355	20,840		11,268		53
54 RADIOLOGY-DIAGNOSTIC	991,769	418,918		226,516		54
54.01 NUCLEAR MEDICINE	260,085	17,313		9,361		54.01
54.02 ULTRA SOUND	223,462	31,420		16,989		54.02
55 RADIOLOGY-THERAPEUTIC	475,574					55
57 COMPUTED TOMOGRAPHY (CT) SCAN	473,537	49,134		26,567		57
58 MAGNETIC RESONANCE IMAGING (MRI)	226,599	279,092		150,910		58
59.97 CARDIAC REHAB	50,524					59.97
60 LABORATORY	2,821,184	217,615		117,668		60
65 RESPIRATORY THERAPY	213,994	215,771		116,671		65
66 PHYSICAL THERAPY	344,635	159,865		86,441		66
67 OCCUPATIONAL THERAPY	148,902	42,842		23,165		67
68 SPEECH PATHOLOGY	18,240	9,418		5,092		68
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	69,947					71
72 IMPL. DEV. CHARGED TO PATIENT	1,496,214					72
73 DRUGS CHARGED TO PATIENTS						73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,647,517	26,010		14,064		90
91 EMERGENCY	1,420,083	442,082		239,041		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	24,468,035	4,902,179	735,707	2,583,405	1,449,796	118
NONREIMBURSABLE COST CENTERS						
190.01 MEALS ON WHEELS	25,013					190.01
193.01 PATIENT TRANSPORTATION	96,540	4,969		2,687		193.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	24,589,588	4,907,148	735,707	2,586,092	1,449,796	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 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	1,175,576					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	18,368	1,031,584				13
14 CENTRAL SERVICES & SUPPLY	39,033	63,310	6,672,377			14
15 PHARMACY	34,441	55,862		8,474,139		15
16 MEDICAL RECORDS & LIBRARY	80,362				2,781,843	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	259,453	420,828			113,444	30
31 INTENSIVE CARE UNIT	73,474	119,172			65,704	31
43 NURSERY	18,368	29,793			8,710	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	61,993	156,413			295,056	50
51 RECOVERY ROOM	11,480				46,310	51
52 DELIVERY ROOM & LABOR ROOM	29,849				12,510	52
53 ANESTHESIOLOGY					30,141	53
54 RADIOLOGY-DIAGNOSTIC	84,954				128,915	54
54.01 NUCLEAR MEDICINE	6,888				39,584	54.01
54.02 ULTRA SOUND	13,776				64,316	54.02
55 RADIOLOGY-THERAPEUTIC					45,043	55
57 COMPUTED TOMOGRAPHY (CT) SCAN					333,443	57
58 MAGNETIC RESONANCE IMAGING (MRI)					75,402	58
59.97 CARDIAC REHAB					2,982	59.97
60 LABORATORY	121,690	167,586			486,412	60
65 RESPIRATORY THERAPY	50,513				274,512	65
66 PHYSICAL THERAPY	29,849				26,591	66
67 OCCUPATIONAL THERAPY					8,028	67
68 SPEECH PATHOLOGY					1,462	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			6,672,377		115,582	71
72 IMPL. DEV. CHARGED TO PATIENT					61,631	72
73 DRUGS CHARGED TO PATIENTS				8,474,139	160,050	73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	144,651				100,791	90
91 EMERGENCY	82,658				285,224	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,161,800	1,012,964	6,672,377	8,474,139	2,781,843	118
NONREIMBURSABLE COST CENTERS						
190.01 MEALS ON WHEELS	6,888	11,172				190.01
193.01 PATIENT TRANSPORTATION	6,888	7,448				193.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,175,576	1,031,584	6,672,377	8,474,139	2,781,843	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	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
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	18,028,377		18,028,377	30
31 INTENSIVE CARE UNIT	3,867,938		3,867,938	31
43 NURSERY	1,204,878		1,204,878	43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	6,969,130		6,969,130	50
51 RECOVERY ROOM	1,372,830		1,372,830	51
52 DELIVERY ROOM & LABOR ROOM	1,531,983		1,531,983	52
53 ANESTHESIOLOGY	107,486		107,486	53
54 RADIOLOGY-DIAGNOSTIC	4,810,356		4,810,356	54
54.01 NUCLEAR MEDICINE	1,109,284		1,109,284	54.01
54.02 ULTRA SOUND	1,016,738		1,016,738	54.02
55 RADIOLOGY-THERAPEUTIC	1,939,656		1,939,656	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	2,295,641		2,295,641	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,408,138		1,408,138	58
59.97 CARDIAC REHAB	204,263		204,263	59.97
60 LABORATORY	12,350,132		12,350,132	60
65 RESPIRATORY THERAPY	1,509,987		1,509,987	65
66 PHYSICAL THERAPY	1,675,719		1,675,719	66
67 OCCUPATIONAL THERAPY	667,237		667,237	67
68 SPEECH PATHOLOGY	88,637		88,637	68
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	7,066,617		7,066,617	71
72 IMPL. DEV. CHARGED TO PATIENT	6,022,315		6,022,315	72
73 DRUGS CHARGED TO PATIENTS	8,634,189		8,634,189	73
76 OTHER ANCILLARY				76
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	6,848,969		6,848,969	90
91 EMERGENCY	6,706,396		6,706,396	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	97,436,896		97,436,896	118
NONREIMBURSABLE COST CENTERS				
190.01 MEALS ON WHEELS	117,708		117,708	190.01
193.01 PATIENT TRANSPORTATION	406,591		406,591	193.01
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	97,961,195		97,961,195	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS & FIXTURES	MOVABLE EQUIPMENT			
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4		8,718	17,403	26,121	26,121	4
5		611,640	1,220,927	1,832,567	4,067	5
6						6
7		261,150	521,294	782,444	415	7
8		25,400	50,702	76,102	14	8
9		19,641	39,206	58,847	652	9
10		79,144	157,984	237,128	244	10
11		40,515	80,874	121,389	311	11
12						12
13		22,121	44,158	66,279	309	13
14		96,740	193,107	289,847	158	14
15		15,753	31,446	47,199	723	15
16		62,288	124,337	186,625	730	16
17						17
19						19
INPATIENT ROUTINE SERV COST CENTERS						
30		483,656	965,449	1,449,105	4,111	30
31		43,851	87,534	131,385	1,208	31
43		8,268	16,505	24,773	333	43
ANCILLARY SERVICE COST CENTERS						
50		83,931	167,539	251,470	1,675	50
51		88,167	175,994	264,161	222	51
52		6,209	12,393	18,602	481	52
53		7,543	15,057	22,600		53
54		151,630	302,677	454,307	1,018	54
54.01		6,267	12,509	18,776	166	54.01
54.02		11,373	22,701	34,074	288	54.02
55					257	55
57		17,784	35,500	53,284	353	57
58		101,019	201,649	302,668	143	58
59.97					71	59.97
60		78,767	157,231	235,998	1,986	60
65		78,100	155,899	233,999	830	65
66		57,864	115,505	173,369	383	66
67		15,507	30,954	46,461	103	67
68		3,409	6,805	10,214	23	68
71					59	71
72						72
73						73
76						76
OUTPATIENT SERVICE COST CENTERS						
90		9,414	18,792	28,206	3,189	90
91		160,015	319,413	479,428	1,485	91
92						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118		2,655,884	5,301,544	7,957,428	26,007	118
NONREIMBURSABLE COST CENTERS						
190.01					33	190.01
193.01		1,799	3,591	5,390	81	193.01
200						200
201						201
202		2,657,683	5,305,135	7,962,818	26,121	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 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	1,836,634					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	92,002	874,861				7
8 LAUNDRY & LINEN SERVICE	12,478	12,511	101,105			8
9 HOUSEKEEPING	47,468	9,674		116,641		9
10 DIETARY	20,865	38,983		5,333	302,553	10
11 CAFETERIA	18,807	19,956		2,730		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	17,231	10,896		1,491		13
14 CENTRAL SERVICES & SUPPLY	115,459	47,650		6,518		14
15 PHARMACY	155,928	7,759		1,061		15
16 MEDICAL RECORDS & LIBRARY	45,678	30,680		4,197		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	251,818	238,225	80,701	32,587	241,495	30
31 INTENSIVE CARE UNIT	57,464	21,599	16,560	2,955	49,556	31
43 NURSERY	19,306	4,073	3,844	557	11,502	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	114,337	41,341		5,655		50
51 RECOVERY ROOM	17,619	43,427		5,941		51
52 DELIVERY ROOM & LABOR ROOM	27,433	3,058		418		52
53 ANESTHESIOLOGY	848	3,715		508		53
54 RADIOLOGY-DIAGNOSTIC	74,077	74,686		10,217		54
54.01 NUCLEAR MEDICINE	19,426	3,087		422		54.01
54.02 ULTRA SOUND	16,691	5,602		766		54.02
55 RADIOLOGY-THERAPEUTIC	35,521					55
57 COMPUTED TOMOGRAPHY (CT) SCAN	35,369	8,760		1,198		57
58 MAGNETIC RESONANCE IMAGING (MRI)	16,925	49,757		6,807		58
59.97 CARDIAC REHAB	3,774					59.97
60 LABORATORY	210,719	38,797		5,307		60
65 RESPIRATORY THERAPY	15,984	38,468		5,262		65
66 PHYSICAL THERAPY	25,741	28,501		3,899		66
67 OCCUPATIONAL THERAPY	11,122	7,638		1,045		67
68 SPEECH PATHOLOGY	1,362	1,679		230		68
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	5,224					71
72 IMPL. DEV. CHARGED TO PATIENT	111,755					72
73 DRUGS CHARGED TO PATIENTS						73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	123,056	4,637		634		90
91 EMERGENCY	106,068	78,816		10,782		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,827,555	873,975	101,105	116,520	302,553	118
NONREIMBURSABLE COST CENTERS						
190.01 MEALS ON WHEELS	1,868					190.01
193.01 PATIENT TRANSPORTATION	7,211	886		121		193.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,836,634	874,861	101,105	116,641	302,553	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 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	163,193					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,550	98,756				13
14 CENTRAL SERVICES & SUPPLY	5,419	6,061	471,112			14
15 PHARMACY	4,781	5,348		222,799		15
16 MEDICAL RECORDS & LIBRARY	11,156				279,066	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	36,016	40,286			11,379	30
31 INTENSIVE CARE UNIT	10,200	11,409			6,591	31
43 NURSERY	2,550	2,852			874	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,606	14,974			29,596	50
51 RECOVERY ROOM	1,594				4,645	51
52 DELIVERY ROOM & LABOR ROOM	4,144				1,255	52
53 ANESTHESIOLOGY					3,023	53
54 RADIOLOGY-DIAGNOSTIC	11,793				12,931	54
54.01 NUCLEAR MEDICINE	956				3,971	54.01
54.02 ULTRA SOUND	1,912				6,451	54.02
55 RADIOLOGY-THERAPEUTIC					4,518	55
57 COMPUTED TOMOGRAPHY (CT) SCAN					33,447	57
58 MAGNETIC RESONANCE IMAGING (MRI)					7,563	58
59.97 CARDIAC REHAB					299	59.97
60 LABORATORY	16,893	16,043			48,818	60
65 RESPIRATORY THERAPY	7,012				27,536	65
66 PHYSICAL THERAPY	4,144				2,667	66
67 OCCUPATIONAL THERAPY					805	67
68 SPEECH PATHOLOGY					147	68
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			471,112		11,594	71
72 IMPL. DEV. CHARGED TO PATIENT					6,182	72
73 DRUGS CHARGED TO PATIENTS				222,799	16,054	73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	20,080				10,110	90
91 EMERGENCY	11,475				28,610	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	161,281	96,973	471,112	222,799	279,066	118
NONREIMBURSABLE COST CENTERS						
190.01 MEALS ON WHEELS	956	1,070				190.01
193.01 PATIENT TRANSPORTATION	956	713				193.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	163,193	98,756	471,112	222,799	279,066	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	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
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	2,385,723		2,385,723	30
31 INTENSIVE CARE UNIT	308,927		308,927	31
43 NURSERY	70,664		70,664	43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	467,654		467,654	50
51 RECOVERY ROOM	337,609		337,609	51
52 DELIVERY ROOM & LABOR ROOM	55,391		55,391	52
53 ANESTHESIOLOGY	30,694		30,694	53
54 RADIOLOGY-DIAGNOSTIC	639,029		639,029	54
54.01 NUCLEAR MEDICINE	46,804		46,804	54.01
54.02 ULTRA SOUND	65,784		65,784	54.02
55 RADIOLOGY-THERAPEUTIC	40,296		40,296	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	132,411		132,411	57
58 MAGNETIC RESONANCE IMAGING (MRI)	383,863		383,863	58
59.97 CARDIAC REHAB	4,144		4,144	59.97
60 LABORATORY	574,561		574,561	60
65 RESPIRATORY THERAPY	329,091		329,091	65
66 PHYSICAL THERAPY	238,704		238,704	66
67 OCCUPATIONAL THERAPY	67,174		67,174	67
68 SPEECH PATHOLOGY	13,655		13,655	68
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	487,989		487,989	71
72 IMPL. DEV. CHARGED TO PATIENT	117,937		117,937	72
73 DRUGS CHARGED TO PATIENTS	238,853		238,853	73
76 OTHER ANCILLARY				76
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	189,912		189,912	90
91 EMERGENCY	716,664		716,664	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	7,943,533		7,943,533	118
NONREIMBURSABLE COST CENTERS				
190.01 MEALS ON WHEELS	3,927		3,927	190.01
193.01 PATIENT TRANSPORTATION	15,358		15,358	193.01
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	7,962,818		7,962,818	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	183,214					1
2 CAP REL COSTS-MVBLE EQUIP		183,214				2
4 EMPLOYEE BENEFITS	601	601	45,522,164			4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	42,165	42,165	7,084,906	-24,589,588	73,371,607	5
6 OPERATION OF PLANT	18,003	18,003	723,546		3,675,386	6
8 LAUNDRY & LINEN SERVICE	1,751	1,751	24,359		498,475	8
9 HOUSEKEEPING	1,354	1,354	1,135,484		1,896,305	9
10 DIETARY	5,456	5,456	424,555		833,553	10
11 CAFETERIA	2,793	2,793	541,488		751,322	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,525	1,525	538,798		688,358	13
14 CENTRAL SERVICES & SUPPLY	6,669	6,669	275,387		4,612,443	14
15 PHARMACY	1,086	1,086	1,259,207		6,229,153	15
16 MEDICAL RECORDS & LIBRARY	4,294	4,294	1,271,625		1,824,787	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	33,342	33,342	7,179,060		10,059,997	30
31 INTENSIVE CARE UNIT	3,023	3,023	2,104,396		2,295,613	31
43 NURSERY	570	570	580,999		771,253	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,786	5,786	2,918,367		4,567,621	50
51 RECOVERY ROOM	6,078	6,078	387,224		703,857	51
52 DELIVERY ROOM & LABOR ROOM	428	428	838,491		1,095,914	52
53 ANESTHESIOLOGY	520	520			33,882	53
54 RADIOLOGY-DIAGNOSTIC	10,453	10,453	1,772,734		2,959,284	54
54.01 NUCLEAR MEDICINE	432	432	289,320		776,053	54.01
54.02 ULTRA SOUND	784	784	502,067		666,775	54.02
55 RADIOLOGY-THERAPEUTIC			447,061		1,419,039	55
57 COMPUTED TOMOGRAPHY (CT) SCAN	1,226	1,226	615,469		1,412,960	57
58 MAGNETIC RESONANCE IMAGING (MRI)	6,964	6,964	248,832		676,135	58
59.97 CARDIAC REHAB			122,948		150,757	59.97
60 LABORATORY	5,430	5,430	3,460,027		8,417,977	60
65 RESPIRATORY THERAPY	5,384	5,384	1,446,701		638,526	65
66 PHYSICAL THERAPY	3,989	3,989	666,593		1,028,338	66
67 OCCUPATIONAL THERAPY	1,069	1,069	178,583		444,300	67
68 SPEECH PATHOLOGY	235	235	39,213		54,425	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			102,941		208,711	71
72 IMPL. DEV. CHARGED TO PATIENT					4,464,470	72
73 DRUGS CHARGED TO PATIENTS						73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	649	649	5,555,648		4,915,936	90
91 EMERGENCY	11,031	11,031	2,587,566		4,237,308	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	183,090	183,090	45,323,595	-24,589,588	73,008,913	118
NONREIMBURSABLE COST CENTERS						
190.01 MEALS ON WHEELS			57,297		74,635	190.01
193.01 PATIENT TRANSPORTATION	124	124	141,272		288,059	193.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,657,683	5,305,135	5,697,594		24,589,588	202
203 UNIT COST MULT-WS B PT I	14.505895	28.955948	0.125161		0.335138	203
204 COST TO BE ALLOC PER B PT II			26,121		1,836,634	204
205 UNIT COST MULT-WS B PT II			0.000574		0.025032	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET 7	PATIENT DAYS 8	SQUARE FEET 9	PATIENT DAYS 10	FTE'S 11	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5						5
6						6
7	122,445					7
8	1,751	15,599				8
9	1,354		119,340			9
10	5,456		5,456	15,599		10
11	2,793		2,793		512	11
12						12
13	1,525		1,525		8	13
14	6,669		6,669		17	14
15	1,086		1,086		15	15
16	4,294		4,294		35	16
17						17
19						19
INPATIENT ROUTINE SERV COST CENTERS						
30	33,342	12,451	33,342	12,451	113	30
31	3,023	2,555	3,023	2,555	32	31
43	570	593	570	593	8	43
ANCILLARY SERVICE COST CENTERS						
50	5,786		5,786		27	50
51	6,078		6,078		5	51
52	428		428		13	52
53	520		520			53
54	10,453		10,453		37	54
54.01	432		432		3	54.01
54.02	784		784		6	54.02
55						55
57	1,226		1,226			57
58	6,964		6,964			58
59.97						59.97
60	5,430		5,430		53	60
65	5,384		5,384		22	65
66	3,989		3,989		13	66
67	1,069		1,069			67
68	235		235			68
71						71
72						72
73						73
76						76
OUTPATIENT SERVICE COST CENTERS						
90	649		649		63	90
91	11,031		11,031		36	91
92						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118	122,321	15,599	119,216	15,599	506	118
NONREIMBURSABLE COST CENTERS						
190.01					3	190.01
193.01	124		124		3	193.01
200						200
201						201
202	4,907,148	735,707	2,586,092	1,449,796	1,175,576	202
203	40,076,344	47,163,728	21,669,951	92,941,599	2,296,046,875	203
204	874,861	101,105	116,641	302,553	163,193	204
205	7,144,930	6,481,505	0,977,384	19,395,666	318,736,328	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 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					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	277				13
14 CENTRAL SERVICES & SUPPLY	17	100			14
15 PHARMACY	15		100		15
16 MEDICAL RECORDS & LIBRARY				316,721,601	16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	113			12,916,355	30
31 INTENSIVE CARE UNIT	32			7,480,771	31
43 NURSERY	8			991,640	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	42			33,593,967	50
51 RECOVERY ROOM				5,272,719	51
52 DELIVERY ROOM & LABOR ROOM				1,424,324	52
53 ANESTHESIOLOGY				3,431,744	53
54 RADIOLOGY-DIAGNOSTIC				14,677,740	54
54.01 NUCLEAR MEDICINE				4,506,902	54.01
54.02 ULTRA SOUND				7,322,788	54.02
55 RADIOLOGY-THERAPEUTIC				5,128,453	55
57 COMPUTED TOMOGRAPHY (CT) SCAN				37,964,560	57
58 MAGNETIC RESONANCE IMAGING (MRI)				8,585,035	58
59.97 CARDIAC REHAB				339,576	59.97
60 LABORATORY	45			55,372,278	60
65 RESPIRATORY THERAPY				31,254,930	65
66 PHYSICAL THERAPY				3,027,509	66
67 OCCUPATIONAL THERAPY				913,989	67
68 SPEECH PATHOLOGY				166,461	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		100		13,159,760	71
72 IMPL. DEV. CHARGED TO PATIENT				7,017,086	72
73 DRUGS CHARGED TO PATIENTS			100	18,222,727	73
76 OTHER ANCILLARY					76
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC				11,475,721	90
91 EMERGENCY				32,474,566	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	272	100	100	316,721,601	118
NONREIMBURSABLE COST CENTERS					
190.01 MEALS ON WHEELS	3				190.01
193.01 PATIENT TRANSPORTATION	2				193.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	1,031,584	6,672,377	8,474,139	2,781,843	202
203 UNIT COST MULT-WS B PT I	3,724.129964	66,723.770000	84,741.390000	0.008783	203
204 COST TO BE ALLOC PER B PT II	98,756	471,112	222,799	279,066	204
205 UNIT COST MULT-WS B PT II	356.519856	4,711.120000	2,227.990000	0.000881	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT				
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	18,028,377		18,028,377		18,028,377	30
31 INTENSIVE CARE UNIT	3,867,938		3,867,938		3,867,938	31
43 NURSERY	1,204,878		1,204,878		1,204,878	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,969,130		6,969,130		6,969,130	50
51 RECOVERY ROOM	1,372,830		1,372,830		1,372,830	51
52 DELIVERY ROOM & LABOR ROOM	1,531,983		1,531,983		1,531,983	52
53 ANESTHESIOLOGY	107,486		107,486		107,486	53
54 RADIOLOGY-DIAGNOSTIC	4,810,356		4,810,356		4,810,356	54
54.01 NUCLEAR MEDICINE	1,109,284		1,109,284		1,109,284	54.01
54.02 ULTRA SOUND	1,016,738		1,016,738		1,016,738	54.02
55 RADIOLOGY-THERAPEUTIC	1,939,656		1,939,656		1,939,656	55
57 COMPUTED TOMOGRAPHY (CT) SC	2,295,641		2,295,641		2,295,641	57
58 MAGNETIC RESONANCE IMAGING	1,408,138		1,408,138		1,408,138	58
59.97 CARDIAC REHAB	204,263		204,263		204,263	59.97
60 LABORATORY	12,350,132		12,350,132	12,946	12,363,078	60
65 RESPIRATORY THERAPY	1,509,987		1,509,987		1,509,987	65
66 PHYSICAL THERAPY	1,675,719		1,675,719		1,675,719	66
67 OCCUPATIONAL THERAPY	667,237		667,237		667,237	67
68 SPEECH PATHOLOGY	88,637		88,637		88,637	68
71 MEDICAL SUPPLIES CHRGD TO	7,066,617		7,066,617		7,066,617	71
72 IMPL. DEV. CHARGED TO PATIE	6,022,315		6,022,315		6,022,315	72
73 DRUGS CHARGED TO PATIENTS	8,634,189		8,634,189		8,634,189	73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	6,848,969		6,848,969		6,848,969	90
91 EMERGENCY	6,706,396		6,706,396		6,706,396	91
92 OBSERVATION BEDS	3,533,256		3,533,256		3,533,256	92
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)	100,970,152		100,970,152	12,946	100,983,098	200
201 LESS OBSERVATION BEDS	3,533,256		3,533,256		3,533,256	201
202 TOTAL (SEE INSTRUCTIONS)	97,436,896		97,436,896		97,449,842	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	10,476,872		10,476,872			30
31 INTENSIVE CARE UNIT	7,480,771		7,480,771			31
43 NURSERY	991,640		991,640			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,850,653	26,743,314	33,593,967	0.207452	0.207452	0.207452 50
51 RECOVERY ROOM	1,406,939	3,865,780	5,272,719	0.260365	0.260365	0.260365 51
52 DELIVERY ROOM & LABOR ROOM	1,424,324		1,424,324	1.075586	1.075586	1.075586 52
53 ANESTHESIOLOGY	1,096,698	2,335,046	3,431,744	0.031321	0.031321	0.031321 53
54 RADIOLOGY-DIAGNOSTIC	2,910,345	11,767,395	14,677,740	0.327731	0.327731	0.327731 54
54.01 NUCLEAR MEDICINE	819,746	3,687,156	4,506,902	0.246130	0.246130	0.246130 54.01
54.02 ULTRA SOUND	1,378,164	5,944,624	7,322,788	0.138846	0.138846	0.138846 54.02
55 RADIOLOGY-THERAPEUTIC	5,995	5,122,458	5,128,453	0.378215	0.378215	0.378215 55
57 COMPUTED TOMOGRAPHY (CT) SC	7,178,690	30,785,870	37,964,560	0.060468	0.060468	0.060468 57
58 MAGNETIC RESONANCE IMAGING	1,356,323	7,228,712	8,585,035	0.164022	0.164022	0.164022 58
59.97 CARDIAC REHAB	2,242	337,334	339,576	0.601524	0.601524	0.601524 59.97
60 LABORATORY	15,569,553	39,802,725	55,372,278	0.223038	0.223038	0.223272 60
65 RESPIRATORY THERAPY	12,059,021	19,195,909	31,254,930	0.048312	0.048312	0.048312 65
66 PHYSICAL THERAPY	1,313,896	1,713,613	3,027,509	0.553498	0.553498	0.553498 66
67 OCCUPATIONAL THERAPY	303,161	610,828	913,989	0.730027	0.730027	0.730027 67
68 SPEECH PATHOLOGY	103,478	62,983	166,461	0.532479	0.532479	0.532479 68
71 MEDICAL SUPPLIES CHRGD TO	5,636,573	7,523,187	13,159,760	0.536987	0.536987	0.536987 71
72 IMPL. DEV. CHARGED TO PATIE	4,210,252	2,806,834	7,017,086	0.858236	0.858236	0.858236 72
73 DRUGS CHARGED TO PATIENTS	10,351,377	7,871,350	18,222,727	0.473814	0.473814	0.473814 73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	6,838	11,468,883	11,475,721	0.596823	0.596823	0.596823 90
91 EMERGENCY	6,347,948	26,126,618	32,474,566	0.206512	0.206512	0.206512 91
92 OBSERVATION BEDS	1,433,355	1,006,128	2,439,483	1.448363	1.448363	1.448363 92
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)	100,714,854	216,006,747	316,721,601			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	100,714,854	216,006,747	316,721,601			202

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 05/30/2012 15:45

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
30 INPAT ROUTINE SERV COST CTRS								
31 ADULTS & PEDIATRICS	2,385,723		2,385,723	15,486	154.06	7,754	1,194,581	30
32 INTENSIVE CARE UNIT	308,927		308,927	2,555	120.91	1,397	168,911	31
33 CORONARY CARE UNIT								32
34 BURN INTENSIVE CARE UNIT								33
35 SURGICAL INTENSIVE CARE UNIT								34
40 OTHER SPECIAL CARE (SPECIFY)								35
41 SUBPROVIDER - IPF								40
42 SUBPROVIDER - IRF								41
43 SUBPROVIDER I								42
44 NURSERY	70,664		70,664	593	119.16			43
45 SKILLED NURSING FACILITY								44
200 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	2,765,314		2,765,314	18,634		9,151	1,363,492	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0101) [] 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	467,654	33,593,967	0.013921	5,019,178	69,872	50
51 RECOVERY ROOM	337,609	5,272,719	0.064029	855,691	54,789	51
52 DELIVERY ROOM & LABOR ROOM	55,391	1,424,324	0.038889	1,103	43	52
53 ANESTHESIOLOGY	30,694	3,431,744	0.008944	538,576	4,817	53
54 RADIOLOGY-DIAGNOSTIC	639,029	14,677,740	0.043537	2,013,738	87,672	54
54.01 NUCLEAR MEDICINE	46,804	4,506,902	0.010385	530,734	5,512	54.01
54.02 ULTRA SOUND	65,784	7,322,788	0.008983	320,856	2,882	54.02
55 RADIOLOGY-THERAPEUTIC	40,296	5,128,453	0.007857			55
57 COMPUTED TOMOGRAPHY (CT) SCAN	132,411	37,964,560	0.003488	5,093,095	17,765	57
58 MAGNETIC RESONANCE IMAGING (M	383,863	8,585,035	0.044713	826,507	36,956	58
59.97 CARDIAC REHAB	4,144	339,576	0.012203	1,122	14	59.97
60 LABORATORY	574,561	55,372,278	0.010376	11,087,896	115,048	60
65 RESPIRATORY THERAPY	329,091	31,254,930	0.010529	8,374,984	88,180	65
66 PHYSICAL THERAPY	238,704	3,027,509	0.078845	1,007,474	79,434	66
67 OCCUPATIONAL THERAPY	67,174	913,989	0.073495	242,205	17,801	67
68 SPEECH PATHOLOGY	13,655	166,461	0.082031	92,730	7,607	68
71 MEDICAL SUPPLIES CHRGD TO PA	487,989	13,159,760	0.037082	4,064,044	150,703	71
72 IMPL. DEV. CHARGED TO PATIENT	117,937	7,017,086	0.016807	2,324,780	39,073	72
73 DRUGS CHARGED TO PATIENTS	238,853	18,222,727	0.013107	7,079,806	92,795	73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	189,912	11,475,721	0.016549			90
91 EMERGENCY	716,664	32,474,566	0.022068	3,204,767	70,723	91
92 OBSERVATION BEDS	467,563	2,439,483	0.191665	327,211	62,715	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	5,645,782	297,772,318	297,772,318	53,006,497	1,004,401	200

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX 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	
30 INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	15,486		7,754		30
31 INTENSIVE CARE UNIT	2,555		1,397		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	593				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	18,634		9,151		200

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0101) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] 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
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 NUCLEAR MEDICINE						54.01
54.02 ULTRA SOUND						54.02
55 RADIOLOGY-THERAPEUTIC						55
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59.97 CARDIAC REHAB						59.97
60 LABORATORY						60
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
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 (14-0101) [] 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	33,593,967			5,019,178		9,494,117		50	
51 RECOVERY ROOM	5,272,719			855,691		1,594,412		51	
52 DELIVERY ROOM & LABOR ROOM	1,424,324			1,103				52	
53 ANESTHESIOLOGY	3,431,744			538,576		555,346		53	
54 RADIOLOGY-DIAGNOSTIC	14,677,740			2,013,738		3,836,486		54	
54.01 NUCLEAR MEDICINE	4,506,902			530,734		1,798,474		54.01	
54.02 ULTRA SOUND	7,322,788			320,856		713,131		54.02	
55 RADIOLOGY-THERAPEUTIC	5,128,453							55	
57 COMPUTED TOMOGRAPHY (CT) SCA	37,964,560			5,093,095		8,629,843		57	
58 MAGNETIC RESONANCE IMAGING (8,585,035			826,507		2,073,355		58	
59.97 CARDIAC REHAB	339,576			1,122		165,958		59.97	
60 LABORATORY	55,372,278			11,087,896		1,915,477		60	
65 RESPIRATORY THERAPY	31,254,930			8,374,984		5,041,668		65	
66 PHYSICAL THERAPY	3,027,509			1,007,474		7,885		66	
67 OCCUPATIONAL THERAPY	913,989			242,205				67	
68 SPEECH PATHOLOGY	166,461			92,730				68	
71 MEDICAL SUPPLIES CHRGD TO P	13,159,760			4,064,044		3,586,877		71	
72 IMPL. DEV. CHARGED TO PATIEN	7,017,086			2,324,780		1,779,002		72	
73 DRUGS CHARGED TO PATIENTS	18,222,727			7,079,806		3,968,208		73	
76 OTHER ANCILLARY								76	
OUTPATIENT SERVICE COST CENTERS									
90 CLINIC	11,475,721					783,671		90	
91 EMERGENCY	32,474,566			3,204,767		4,485,992		91	
92 OBSERVATION BEDS	2,439,483			327,211		882,685		92	
OTHER REIMBURSABLE COST CENTERS									
200 TOTAL (SUM OF LINES 50-199)	297,772,318			53,006,497		51,312,587		200	

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0101) [] 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	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO	PPS REIMBURSED	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	COST SERVICES SUBJECT TO DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS	
	FROM WKST C, PT I, COL. 9 1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.207452	9,494,117			1,969,574		50
51 RECOVERY ROOM	0.260365	1,594,412			415,129		51
52 DELIVERY ROOM & LABOR ROOM	1.075586						52
53 ANESTHESIOLOGY	0.031321	555,346			17,394		53
54 RADIOLOGY-DIAGNOSTIC	0.327731	3,836,486			1,257,335		54
54.01 NUCLEAR MEDICINE	0.246130	1,798,474			442,658		54.01
54.02 ULTRA SOUND	0.138846	713,131			99,015		54.02
55 RADIOLOGY-THERAPEUTIC	0.378215						55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.060468	8,629,843			521,829		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.164022	2,073,355			340,076		58
59.97 CARDIAC REHAB	0.601524	165,958			99,828		59.97
60 LABORATORY	0.223038	1,915,477			427,224		60
65 RESPIRATORY THERAPY	0.048312	5,041,668			243,573		65
66 PHYSICAL THERAPY	0.553498	7,885			4,364		66
67 OCCUPATIONAL THERAPY	0.730027						67
68 SPEECH PATHOLOGY	0.532479						68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.536987	3,586,877			1,926,106		71
72 IMPL. DEV. CHARGED TO PATIENT	0.858236	1,779,002			1,526,804		72
73 DRUGS CHARGED TO PATIENTS	0.473814	3,968,208			1,880,193		73
76 OTHER ANCILLARY							76
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.596823	783,671			467,713		90
91 EMERGENCY	0.206512	4,485,992			926,411		91
92 OBSERVATION BEDS	1.448363	882,685			1,278,448		92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)		51,312,587			13,843,674		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		51,312,587			13,843,674		202

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
30 INPAT ROUTINE SERV COST CTRS								
31 ADULTS & PEDIATRICS	2,385,723		2,385,723	15,486	154.06	516	79,495	30
32 INTENSIVE CARE UNIT	308,927		308,927	2,555	120.91	135	16,323	31
33 CORONARY CARE UNIT								32
34 BURN INTENSIVE CARE UNIT								33
35 SURGICAL INTENSIVE CARE UNIT								34
40 OTHER SPECIAL CARE (SPECIFY)								35
41 SUBPROVIDER - IPF								40
42 SUBPROVIDER - IRF								41
43 SUBPROVIDER I								42
44 NURSERY	70,664		70,664	593	119.16	593	70,662	43
45 SKILLED NURSING FACILITY								44
200 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	2,765,314		2,765,314	18,634		1,244	166,480	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0101) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	467,654	33,593,967	0.013921		50
51 RECOVERY ROOM	337,609	5,272,719	0.064029		51
52 DELIVERY ROOM & LABOR ROOM	55,391	1,424,324	0.038889		52
53 ANESTHESIOLOGY	30,694	3,431,744	0.008944		53
54 RADIOLOGY-DIAGNOSTIC	639,029	14,677,740	0.043537		54
54.01 NUCLEAR MEDICINE	46,804	4,506,902	0.010385		54.01
54.02 ULTRA SOUND	65,784	7,322,788	0.008983		54.02
55 RADIOLOGY-THERAPEUTIC	40,296	5,128,453	0.007857		55
57 COMPUTED TOMOGRAPHY (CT) SCAN	132,411	37,964,560	0.003488		57
58 MAGNETIC RESONANCE IMAGING (M	383,863	8,585,035	0.044713		58
59.97 CARDIAC REHAB	4,144	339,576	0.012203		59.97
60 LABORATORY	574,561	55,372,278	0.010376		60
65 RESPIRATORY THERAPY	329,091	31,254,930	0.010529		65
66 PHYSICAL THERAPY	238,704	3,027,509	0.078845		66
67 OCCUPATIONAL THERAPY	67,174	913,989	0.073495		67
68 SPEECH PATHOLOGY	13,655	166,461	0.082031		68
71 MEDICAL SUPPLIES CHRGD TO PA	487,989	13,159,760	0.037082		71
72 IMPL. DEV. CHARGED TO PATIENT	117,937	7,017,086	0.016807		72
73 DRUGS CHARGED TO PATIENTS	238,853	18,222,727	0.013107		73
76 OTHER ANCILLARY					76
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	189,912	11,475,721	0.016549		90
91 EMERGENCY	716,664	32,474,566	0.022068		91
92 OBSERVATION BEDS	467,563	2,439,483	0.191665		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	5,645,782	297,772,318	297,772,318		200

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
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KPMG LLP COMPU-MAX 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 [] TITLE XVIII-PT A
BOXES [XX] TITLE XIX

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

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX 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 [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	15,486		516		30
31 INTENSIVE CARE UNIT	2,555		135		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	593		593		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	18,634		1,244		200

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0101) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 NUCLEAR MEDICINE						54.01
54.02 ULTRA SOUND						54.02
55 RADIOLOGY-THERAPEUTIC						55
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
59.97 CARDIAC REHAB						59.97
60 LABORATORY						60
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 OTHER ANCILLARY						76
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
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 (14-0101) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)	
	7	8	9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	33,593,967							50
51 RECOVERY ROOM	5,272,719							51
52 DELIVERY ROOM & LABOR ROOM	1,424,324							52
53 ANESTHESIOLOGY	3,431,744							53
54 RADIOLOGY-DIAGNOSTIC	14,677,740							54
54.01 NUCLEAR MEDICINE	4,506,902							54.01
54.02 ULTRA SOUND	7,322,788							54.02
55 RADIOLOGY-THERAPEUTIC	5,128,453							55
57 COMPUTED TOMOGRAPHY (CT) SCA	37,964,560							57
58 MAGNETIC RESONANCE IMAGING (8,585,035							58
59.97 CARDIAC REHAB	339,576							59.97
60 LABORATORY	55,372,278							60
65 RESPIRATORY THERAPY	31,254,930							65
66 PHYSICAL THERAPY	3,027,509							66
67 OCCUPATIONAL THERAPY	913,989							67
68 SPEECH PATHOLOGY	166,461							68
71 MEDICAL SUPPLIES CHRGD TO P	13,159,760							71
72 IMPL. DEV. CHARGED TO PATIEN	7,017,086							72
73 DRUGS CHARGED TO PATIENTS	18,222,727							73
76 OTHER ANCILLARY								76
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	11,475,721							90
91 EMERGENCY	32,474,566							91
92 OBSERVATION BEDS	2,439,483							92
OTHER REIMBURSABLE COST CENTERS								
200 TOTAL (SUM OF LINES 50-199)	297,772,318							200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0101) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	COST REIMB.	COST REIMB.	COST	COST		
	CHARGE RATIO	PPS	SVCES NOT	SVCES NOT	SVCES NOT	SVCES NOT	SVCES NOT
FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO	
PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.207452						50
51 RECOVERY ROOM	0.260365						51
52 DELIVERY ROOM & LABOR ROOM	1.075586						52
53 ANESTHESIOLOGY	0.031321						53
54 RADIOLOGY-DIAGNOSTIC	0.327731						54
54.01 NUCLEAR MEDICINE	0.246130						54.01
54.02 ULTRA SOUND	0.138846						54.02
55 RADIOLOGY-THERAPEUTIC	0.378215						55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.060468						57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.164022						58
59.97 CARDIAC REHAB	0.601524						59.97
60 LABORATORY	0.223038						60
65 RESPIRATORY THERAPY	0.048312						65
66 PHYSICAL THERAPY	0.553498						66
67 OCCUPATIONAL THERAPY	0.730027						67
68 SPEECH PATHOLOGY	0.532479						68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.536987						71
72 IMPL. DEV. CHARGED TO PATIENT	0.858236						72
73 DRUGS CHARGED TO PATIENTS	0.473814						73
76 OTHER ANCILLARY							76
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.596823						90
91 EMERGENCY	0.206512						91
92 OBSERVATION BEDS	1.448363						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0101) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	15,486	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	15,486	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	15,486	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)	7,754	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)	18,028,377	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	18,028,377	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	19,123,993	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,162,850	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	17,961,143	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.942710	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,159.83	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)	18,028,377	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0101) [] 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) 1,164.17 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 9,026,974 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) 9,026,974 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	3,867,938	2,555	1,513.87	1,397	2,114,876	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)					14,893,299	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					26,035,149	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 1,363,492 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 1,004,401 51
 52 TOTAL PROGRAM EXCLUDABLE COST 2,367,893 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 23,667,256 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 3,035 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,164.17 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 3,533,256 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) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	2,385,723	18,028,377	0.132332	3,533,256	467,563	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (14-0101) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX-INPT IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	15,486	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	15,486	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	15,486	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)	516	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)	593	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	593	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)	18,028,377	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	18,028,377	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	19,123,993	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,162,850	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	17,961,143	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.942710	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,159.83	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)	18,028,377	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0101) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] 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) 1,164.17 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 600,712 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) 600,712 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	1,204,878	593	2,031.83	593	1,204,875 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	3,867,938	2,555	1,513.87	135	204,372 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)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,009,959 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 166,480 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51
 52 TOTAL PROGRAM EXCLUDABLE COST 166,480 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 1,843,479 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 3,035 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COST	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
	1	2	3	4	5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST					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 (14-0101) [] 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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		7,905,012			30
31 INTENSIVE CARE UNIT		945,910			31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.207452	5,019,178	1,041,239		50
51 RECOVERY ROOM	0.260365	855,691	222,792		51
52 DELIVERY ROOM & LABOR ROOM	1.075586	1,103	1,186		52
53 ANESTHESIOLOGY	0.031321	538,576	16,869		53
54 RADIOLOGY-DIAGNOSTIC	0.327731	2,013,738	659,964		54
54.01 NUCLEAR MEDICINE	0.246130	530,734	130,630		54.01
54.02 ULTRA SOUND	0.138846	320,856	44,550		54.02
55 RADIOLOGY-THERAPEUTIC	0.378215				55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.060468	5,093,095	307,969		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.164022	826,507	135,565		58
59.97 CARDIAC REHAB	0.601524	1,122	675		59.97
60 LABORATORY	0.223272	11,087,896	2,475,617		60
65 RESPIRATORY THERAPY	0.048312	8,374,984	404,612		65
66 PHYSICAL THERAPY	0.553498	1,007,474	557,635		66
67 OCCUPATIONAL THERAPY	0.730027	242,205	176,816		67
68 SPEECH PATHOLOGY	0.532479	92,730	49,377		68
71 MEDICAL SUPPLIES CHRGED TO PATI	0.536987	4,064,044	2,182,339		71
72 IMPL. DEV. CHARGED TO PATIENT	0.858236	2,324,780	1,995,210		72
73 DRUGS CHARGED TO PATIENTS	0.473814	7,079,806	3,354,511		73
76 OTHER ANCILLARY OUTPATIENT SERVICE COST CENTERS					76
90 CLINIC	0.596823				90
91 EMERGENCY	0.206512	3,204,767	661,823		91
92 OBSERVATION BEDS	1.448363	327,211	473,920		92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		53,006,497	14,893,299		200
201 LESS BPP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		53,006,497			202

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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VERSION: 2011.10
 05/30/2012 15:45

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0101) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.207452				50
51 RECOVERY ROOM	0.260365				51
52 DELIVERY ROOM & LABOR ROOM	1.075586				52
53 ANESTHESIOLOGY	0.031321				53
54 RADIOLOGY-DIAGNOSTIC	0.327731				54
54.01 NUCLEAR MEDICINE	0.246130				54.01
54.02 ULTRA SOUND	0.138846				54.02
55 RADIOLOGY-THERAPEUTIC	0.378215				55
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.060468				57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.164022				58
59.97 CARDIAC REHAB	0.601524				59.97
60 LABORATORY	0.223272				60
65 RESPIRATORY THERAPY	0.048312				65
66 PHYSICAL THERAPY	0.553498				66
67 OCCUPATIONAL THERAPY	0.730027				67
68 SPEECH PATHOLOGY	0.532479				68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.536987				71
72 IMPL. DEV. CHARGED TO PATIENT	0.858236				72
73 DRUGS CHARGED TO PATIENTS	0.473814				73
76 OTHER ANCILLARY					76
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	0.596823				90
91 EMERGENCY	0.206512				91
92 OBSERVATION BEDS	1.448363				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)					200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)					202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0101)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	13,899,822	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	687,918	2
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	77.68	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)		30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)		31
32	SUM OF LINES 30 AND 31		32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)		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)	14,587,740	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)	14,587,740	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	1,201,734	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0101)
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)	15,789,474	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	15,789,474	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	1,637,428	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	31,696	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	244,012	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	170,808	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	165,143	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	14,291,158	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)	14,291,158	71
72	INTERIM PAYMENTS	14,120,350	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	170,808	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	165,398	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0101) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		14,120,350		8,425,013	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		NONE	3.01
	.02				3.02
	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
	.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		14,120,350		8,425,013	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
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01				6.01
	TO .02				6.02
	PROVIDER .01				6.01
	PROVIDER .02				6.02
	TO .01				6.01
	PROGRAM .02				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0101) [] 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	4,764 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	9,151 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	15,006 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	316,721,601 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	9,760,231 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7 7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8 8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	30 30
31	OTHER ADJUSTMENTS (SPECIFY)	31 31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32 32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-0101) [] SNF [XX] PPS
APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
BOXES: [] IRF [] ICF/MR [] OTHER
[] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	1
2	MEDICAL AND OTHER SERVICES	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

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	10,919,300			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	16,392,417			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY				7
8	PREPAID EXPENSES	9,269,538			8
9	OTHER CURRENT ASSETS	1,622,985			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	38,204,240			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	71,388,575			15
16	ACCUMULATED DEPRECIATION				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				23
24	ACCUMULATED DEPRECIATION				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)	71,388,575			30
OTHER ASSETS					
31	INVESTMENTS	738,576			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	52,784,109			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	53,522,685			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	163,115,500			36
LIABILITIES AND FUND BALANCES		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	14,433,359			37
38	SALARIES, WAGES & FEES PAYABLE				38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	1,663,487			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	174,238			43
44	OTHER CURRENT LIABILITIES	9,055,831			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	25,326,915			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	42,689,275			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	4,577,710			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	47,266,985			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	72,593,900			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	90,521,600			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)	90,521,600			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	163,115,500			60

PROVIDER CCN: 14-0101 MORRIS HOSPITAL
 PERIOD FROM 01/01/2011 TO 12/31/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 05/30/2012 15:45

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		91,914,631							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		544,278							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		92,458,909							3
4 ADDITIONS (CREDIT ADJUSTMENTS)	3,618								4
5 NET ASSETS RELEASED									5
6 OTHER NON HOSPITAL CONTRIBUTIONS									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		3,618							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		92,462,527							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 INVESTMENT RETURN	-20,116								13
14 RELEASED RESTRICTIONS	90,414								14
15 CONTRIBUTIONS	-65,216								15
16 LESS: FOUNDATION									16
17 LESS: AUXILIARY									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		5,082							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		92,457,445							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	15,054,223		15,054,223	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				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)	15,054,223		15,054,223	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
12 INTENSIVE CARE UNIT	7,697,423		7,697,423	11
13 CORONARY CARE UNIT				12
14 BURN INTENSIVE CARE UNIT				13
15 SURGICAL INTENSIVE CARE UNIT				14
16 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	7,697,423		7,697,423	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	22,751,646		22,751,646	17
18 ANCILLARY SERVICES	84,304,799	217,292,902	301,597,701	18
19 OUTPATIENT SERVICES				19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	107,056,445	217,292,902	324,349,347	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		113,168,129	29
30 ADD (SPECIFY)			30
31 FOUNDATION EXPENSE	265,562		31
32 AUXILIARY EXPENSE	332,768		32
33 ROUNDING			33
34			34
35	-9		35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		598,321	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)		113,766,450	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	324,349,347	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	209,299,801	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	115,049,546	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	113,766,450	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	1,283,096	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	446,370	6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER)	100	24
24.01	OTHER (NON OPERATING INVESTMENT INCOME)	482,469	24.01
24.02	OTHER (NON OPERATING LOSS ON DISPOSAL)	-45	24.02
24.03	OTHER (CHANGE IN CAH FLOW HEDGING DER.)	-3,621,370	24.03
24.04	OTHER (NET ASSETS RELEASED FROM RESTRICT)	70,412	24.04
24.05	OTHER (NET ASSETS TRANSFERS)		24.05
24.06	OTHER (OTHER)	1,863,244	24.06
24.07		20,002	24.07
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	-738,818	25
26	TOTAL (LINE 5 PLUS LINE 25)	544,278	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)	544,278	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-010)) [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	1,201,734		1
3	CAPITAL DRG OUTLIER PAYMENTS			2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	41.11		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)			7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)			8
10	SUM OF LINES 7 AND 8			9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)			10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)			11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	1,201,734		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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-01) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT	
1	CAPITAL DRG OTHER THAN OUTLIER	1
2	CAPITAL DRG OUTLIER PAYMENTS	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	8
9	SUM OF LINES 7 AND 8	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	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	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
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
51 RECOVERY ROOM					51
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
54.01 NUCLEAR MEDICINE					54.01
54.02 ULTRA SOUND					54.02
55 RADIOLOGY-THERAPEUTIC					55
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (MR)					58
59.97 CARDIAC REHAB					59.97
60 LABORATORY					60
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGED TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76 OTHER ANCILLARY					76
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190.01 MEALS ON WHEELS					190.01
193.01 PATIENT TRANSPORTATION					193.01
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