

HILLSBORO AREA HOSPITAL

HILLSBORO, ILLINOIS

TITLE XVIII-MEDICARE COST ANALYSIS

YEAR ENDED JUNE 30, 2011

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: 01/25/2012 TIME: 08:30  
 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 HILLSBORO AREA HOSPITAL (14-1332) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2010 AND ENDING 06/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 01/25/2012 08:30  
 6U6Q.HV1ZTvuFYlEciyG.8vMS1bGE0  
 58uTg0Gz0w88PQxQb0aQjvUjskwAxf  
 PptrR00c6TR0fV.cd

(SIGNED) \_\_\_\_\_  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

PI Encryption: 01/25/2012 08:30  
 MSehMiWE3:JcoJviFDitUCT0ft4:F0  
 oTR7R0NUopwuPbtTzXBkdM72H02zkZU  
 KK590Hhs8x0akPas  
 PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1	HOSPITAL	81,546	-65,712		38,687	1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF	101,575				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	183,121	-65,712		38,687	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: 1200 EAST TREMONT P.O.BOX: 1  
 2 CITY: HILLSBORO STATE: IL ZIP CODE: 62049 COUNTY: MONTGOMERY 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N)			3
						V	XVIII	XIX	
3	HOSPITAL	14-1332	00014	1	09/06/1975	N	O	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF	14-2332	00014		04/01/2004	N	O	N	7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTG								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: 07/01/2010			TO: 06/30/2011				20
21	TYPE OF CONTROL		2						21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID		OUT-OF-STATE MEDICAID		MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
		PAID DAYS	ELIGIBLE DAYS	PAID DAYS	ELIGIBLE DAYS			
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	1	2	3	4	5	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 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.				2			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.				2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	2	3	45
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? 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))
	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)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
	PROGRAM NAME 1	PROGRAM CODE 2	3	4	5
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
					66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTES NONPROVIDER SITE 3	UNWEIGHTED FTES IN HOSPITAL 4	RATIO (COL.1/ COL.3+COL.4) 5
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>				
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
<b>INPATIENT REHABILITATION FACILITY PPS</b>				
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
<b>LONG TERM CARE HOSPITAL PPS</b>				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
<b>TEFRA PROVIDERS</b>				
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
<b>TITLE V AND XIX INPATIENT SERVICES</b>				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/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
<b>RURAL PROVIDERS</b>				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			Y 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.			N N 107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

		1	2	
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		4,000,000 6,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y		140
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IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

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

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

		PART A	PART B	
155	HOSPITAL	N	N	155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	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

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1	
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y		3	
		Y/N	TYPE	DATE	
		1	2	3	
FINANCIAL DATA AND REPORTS					
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
		Y/N	Y/N		
		1	2		
APPROVED EDUCATIONAL ACTIVITIES					
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		
			Y	12	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		N	13	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		N	14	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N	15	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N	15	
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
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)	Y	09/02/2011	Y	09/02/2011
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I

LINE NO.	COMPONENT	WKST A	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS						TOTAL ALL PATIENTS	
			NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX		
1			2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	25	9,125	27,480.00		923	45	1,145	1
2	HMO									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						1,711		1,711	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									15
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		25	9,125	27,480.00		2,634	45	2,871	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)		25	9,125	27,480.00		2,634	45	2,871	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		25							27
28	OBSERVATION BED DAYS								183	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I  
 (CONTINUED)

LINE	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---			----- DISCHARGES -----			TOTAL ALL PATIENTS 15	
			TOTAL INTERNS & RESIDENTS 9	EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14		
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					332	20	419	1
2	HMO									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)			126.26			332	20	419	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)			126.26						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

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)				0.518431	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				609,624	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				692,407	5
6	MEDICAID CHARGES				3,675,582	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				1,905,536	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				603,505	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					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)				603,505	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	445,034	90,765	535,799		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	230,719	47,055	277,774		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE					22
23	COST OF CHARITY CARE	230,719	47,055	277,774		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)				1,647,409	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				279,579	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				1,367,830	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				709,125	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				986,899	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				1,590,404	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		909,997	909,997	-219,669	1
2	00200		508,497	508,497	19,216	2
3	00300					3
4	00400	65,005	2,100,173	2,165,178		4
5.01	00592	142,196	2,437,965	2,580,161		5.01
5.02	00591	147,398	412,938	560,336	-40,033	5.02
5.03	00571	109,833	6,835	116,668		5.03
5.04	00580	206,152	147,657	353,809		5.04
6	00600					6
7	00700	185,936	387,055	572,991		7
8	00800	44,370	39,236	83,606		8
9	00900	129,990	14,318	144,308		9
10	01000	121,192	117,151	238,343		10
11	01100					11
12	01200					12
13	01300					13
13.01	01301	117,655	4,015	121,670		13.01
13.02	01302	229,225	14,010	243,235		13.02
14	01400					14
14.01	01401					14.01
14.02	01402	39,427	2,357	41,784		14.02
15	01500		681,309	681,309	-289,562	15
16	01600	221,495	78,655	300,150		16
17	01700		568	568		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	803,649	132,338	935,987	-143	30
ANCILLARY SERVICE COST CENTERS						
50	05000	471,630	345,619	817,249	38,564	50
53	05300		170,595	170,595	-92,565	53
54	05400	419,812	478,526	898,338		54
54.01	03040		156,992	156,992		54.01
56	05600		430,638	430,638		56
60	06000	453,748	535,809	989,557		60
62.30	06250					62.30
65	06500	100,698	25,509	126,207	-8,092	65
65.50	03950	46,529	51,754	98,283		65.50
66	06600	696,758	86,785	783,543		66
67	06700	90,833	2,119	92,952		67
69	06900		41,163	41,163		69
71	07100		66,288	66,288	64,379	71
73	07300				287,591	73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	643,019	1,363,789	2,006,808	-172	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
118		5,486,550	11,750,660	17,237,210	-240,486	118
NONREIMBURSABLE COST CENTERS						
192.02	19201	567,000	330,888	897,888	240,486	192.02
192.03	19202	1,892	81	1,973		192.03
200		6,055,442	12,081,629	18,137,071		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	690,328	-27,049	663,279	1
2	00200	CAP REL COSTS-MVBLE EQUIP	527,713		527,713	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	2,165,178	-1,339	2,163,839	4
5.01	00592	ADMINISTRATION & ACCOUNTING	2,580,161	-1,682,114	898,047	5.01
5.02	00591	GENERAL	520,303	-174,542	345,761	5.02
5.03	00571	ADMITTING	116,668		116,668	5.03
5.04	00580	PATIENT ACCOUNTING	353,809		353,809	5.04
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	572,991		572,991	7
8	00800	LAUNDRY & LINEN SERVICE	83,606	-372	83,234	8
9	00900	HOUSEKEEPING	144,308		144,308	9
10	01000	DIETARY	238,343	-43,811	194,532	10
11	01100	CAFETERIA				11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION				13
13.01	01301	UR/QUALITY IMPROVEMENT	121,670		121,670	13.01
13.02	01302	NURSING ADMINISTRATION	243,235		243,235	13.02
14	01400	CENTRAL SERVICES & SUPPLY				14
14.01	01401	PURCHASING				14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	41,784		41,784	14.02
15	01500	PHARMACY	391,747		391,747	15
16	01600	MEDICAL RECORDS & LIBRARY	300,150	-3,859	296,291	16
17	01700	SOCIAL SERVICE	568		568	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	935,844		935,844	30
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	855,813		855,813	50
53	05300	ANESTHESIOLOGY	78,030	-56,984	21,046	53
54	05400	RADIOLOGY-DIAGNOSTIC	898,338	-413	897,925	54
54.01	03040	ULTRA SOUND	156,992		156,992	54.01
56	05600	RADIOISOTOPE	430,638		430,638	56
60	06000	LABORATORY	989,557	-69,371	920,186	60
62.30	06250	BLOOD CLOTTING FACTORS ADMIN COSTS				62.30
65	06500	RESPIRATORY THERAPY	118,115	-170	117,945	65
65.50	03950	SLEEP LAB	98,283		98,283	65.50
66	06600	PHYSICAL THERAPY	783,543	-7,893	775,650	66
67	06700	OCCUPATIONAL THERAPY	92,952		92,952	67
69	06900	ELECTROCARDIOLOGY	41,163	-20,780	20,383	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	130,667	-369	130,298	71
73	07300	DRUGS CHARGED TO PATIENTS	287,591		287,591	73
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	EMERGENCY	2,006,636	-550,560	1,456,076	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117)	16,996,724	-2,639,626	14,357,098	118
NONREIMBURSABLE COST CENTERS						
192.02	19201	ASSISTED LIVING	1,138,374	-953	1,137,421	192.02
192.03	19202	CARDIAC REHAB	1,973		1,973	192.03
200		TOTAL (SUM OF LINES 118-199)	18,137,071	-2,640,579	15,496,492	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		
			LINE #	SALARY	
	1	2	3	4	5
1 TO RECLASS DRUG COST FROM PHARMACY	A	DRUGS CHARGED TO PATIENTS	73		287,591 1
500 TOTAL RECLASSIFICATIONS					287,591 500
CODE LETTER - A					
1 TO RECLASS MED SUPPLY FROM PHARMACY	B	MEDICAL SUPPLIES CHRGED TO PA	71		1,061 1
500 TOTAL RECLASSIFICATIONS					1,061 500
CODE LETTER - B					
1 TO RECLASS MED SUPPLY FROM OR	C	MEDICAL SUPPLIES CHRGED TO PA	71		53,302 1
500 TOTAL RECLASSIFICATIONS					53,302 500
CODE LETTER - C					
1 TO RECLASS OXGEN FROM RT TO MED SUP	D	MEDICAL SUPPLIES CHRGED TO PA	71		8,092 1
500 TOTAL RECLASSIFICATIONS					8,092 500
CODE LETTER - D					
1 TO RECLASS INSURANCE	E	CAP REL COSTS-BLDG & FIXT	1		20,817 1
2		CAP REL COSTS-MVBLE EQUIP	2		19,216 2
500 TOTAL RECLASSIFICATIONS					40,033 500
CODE LETTER - E					
1 TO RECLASS DEPRECIATION	F	ASSISTED LIVING	192.02		138,475 1
500 TOTAL RECLASSIFICATIONS					138,475 500
CODE LETTER - F					
1 TO RECLASS ONCALL EXPENSE	G	OPERATING ROOM	50		92,413 1
500 TOTAL RECLASSIFICATIONS					92,413 500
CODE LETTER - G					
1 TO RECLASS IV THERAPY TO MED SUP	H	MEDICAL SUPPLIES CHRGED TO PA	71		1,924 1
2					2
3					3
4					4
5					5
500 TOTAL RECLASSIFICATIONS					1,924 500
CODE LETTER - H					
1 TO RECLASS ALF INTEREST EXPENSE	I	ASSISTED LIVING	192.02		102,011 1
500 TOTAL RECLASSIFICATIONS					102,011 500
CODE LETTER - I					
GRAND TOTAL (INCREASES)					724,902

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 TO RECLASS DRUG COST FROM PHARMACY	A	PHARMACY	15		287,591	1
500 TOTAL RECLASSIFICATIONS					287,591	500
CODE LETTER - A						
1 TO RECLASS MED SUPPLY FROM PHARMACY	B	PHARMACY	15		1,061	1
500 TOTAL RECLASSIFICATIONS					1,061	500
CODE LETTER - B						
1 TO RECLASS MED SUPPLY FROM OR	C	OPERATING ROOM	50		53,302	1
500 TOTAL RECLASSIFICATIONS					53,302	500
CODE LETTER - C						
1 TO RECLASS OXGEN FROM RT TO MED SUP	D	RESPIRATORY THERAPY	65		8,092	1
500 TOTAL RECLASSIFICATIONS					8,092	500
CODE LETTER - D						
1 TO RECLASS INSURANCE	E	GENERAL	5.02		40,033	12 1
2						12 2
500 TOTAL RECLASSIFICATIONS					40,033	500
CODE LETTER - E						
1 TO RECLASS DEPRECIATION	F	CAP REL COSTS-BLDG & FIXT	1		138,475	9 1
500 TOTAL RECLASSIFICATIONS					138,475	500
CODE LETTER - F						
1 TO RECLASS ONCALL EXPENSE	G	ANESTHESIOLOGY	53		92,413	1
500 TOTAL RECLASSIFICATIONS					92,413	500
CODE LETTER - G						
1 TO RECLASS IV THERAPY TO MED SUP	H	PHARMACY	15		910	1
2		ADULTS & PEDIATRICS	30		143	2
3		OPERATING ROOM	50		547	3
4		ANESTHESIOLOGY	53		152	4
5		EMERGENCY	91		172	5
500 TOTAL RECLASSIFICATIONS					1,924	500
CODE LETTER - H						
1 TO RECLASS ALF INTEREST EXPENSE	I	CAP REL COSTS-BLDG & FIXT	1		102,011	9 1
500 TOTAL RECLASSIFICATIONS					102,011	500
CODE LETTER - I						
GRAND TOTAL (DECREASES)					724,902	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	237,676					237,676		1
2 LAND IMPROVEMENTS	647,976	916,312		916,312		1,564,288		2
3 BUILDINGS AND FIXTURES	16,125,185	7,353,516		7,353,516	8,141,220	15,337,481		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	164,332					164,332		5
6 MOVABLE EQUIPMENT	6,199,021	892,845		892,845	16,669	7,075,197		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	23,374,190	9,162,673		9,162,673	8,157,889	24,378,974		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	23,374,190	9,162,673		9,162,673	8,157,889	24,378,974		10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL (1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	909,997						909,997 1
2 CAP REL COSTS-MVBLE EQUIP	508,497						508,497 2
3 TOTAL (SUM OF LINES 1-2)	1,418,494						1,418,494 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	17,066,101		17,066,101	0.706926				1
2 CAP REL COSTS-MVBLE EQUIP	7,075,197		7,075,197	0.293074				2
3 TOTAL (SUM OF LINES 1-2)	24,141,298		24,141,298	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL (2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	660,817		-18,355	20,817			663,279 1
2 CAP REL COSTS-MVBLE EQUIP	508,497			19,216			527,713 2
3 TOTAL	1,169,314		-18,355	40,033			1,190,992 3

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	
			COST CENTER	LINE NO.	REF	
	1	2	3	4	5	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-18,355	CAP REL COSTS-BLDG & FIXT	1	11	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-7,095	ADMINISTRATION & ACCOUNTING	5.01		4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)	B	-7,782	ADMINISTRATION & ACCOUNTING	5.01		5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-152	GENERAL	5.02		7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9 PARKING LOT (CHAPTER 21)						9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-640,711				10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-413	RADIOLOGY-DIAGNOSTIC	54		11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1					12
13 LAUNDRY AND LINEN SERVICE						13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-36,629	DIETARY	10		14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-369	MEDICAL SUPPLIES CHRGD TO PATI	71		16
17 SALE OF DRUGS TO OTHER THAN PATIENTS						17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-3,859	MEDICAL RECORDS & LIBRARY	16		18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						19
20 VENDING MACHINES	B	-14	ADMINISTRATION & ACCOUNTING	5.01		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 NUTRITIONAL SERVICES	A	-7,182	DIETARY	10		33
34 CRNA	A	-56,984	ANESTHESIOLOGY	53		34
35 LOBBYING PORTION OF DUES	A	-7,200	ADMINISTRATION & ACCOUNTING	5.01		35
36 MARKETING COSTS	A	-41,646	GENERAL	5.02		36
37 RECYCLED ALF WASHER	B	-25	ASSISTED LIVING	192.02		37
38 CASH OVER/SHORT	B	2	GENERAL	5.02		38
39 OTHER NON-OPERATING REVENUE	B	-213	ADMINISTRATION & ACCOUNTING	5.01		39
40 OTHER OPERATING REVENUE	B	-75	ADMINISTRATION & ACCOUNTING	5.01		40
41 EMPLOYEE MEALS - ALF	B	-928	ASSISTED LIVING	192.02		41
42 HOSPITAL YARD SALE	B	-417	ADMINISTRATION & ACCOUNTING	5.01		42
43 ALCOHOLIC BEVERAGES	A	-682	EMPLOYEE BENEFITS	4		43
44 DIAMOND CLUB FEES	B	-9,576	GENERAL	5.02		44
45 DAYCARE REVENUE	B	-4,130	ADMINISTRATION & ACCOUNTING	5.01		45
45.01 AMBULANCE RECEIPTS	B	-3,055	ADMINISTRATION & ACCOUNTING	5.01		45.01
45.02 RT MONEY	B	-170	RESPIRATORY THERAPY	65		45.02
45.05 MEDICAID TAX ASSESSMENT	A	-123,168	GENERAL	5.02		45.05
45.06 RETIREMENT OBLIGATION	A	-1,692	CAP REL COSTS-BLDG & FIXT	1	9	45.06
45.07 ACCRETION EXPENSE	A	-7,002	CAP REL COSTS-BLDG & FIXT	1	9	45.07
45.08 PROVISION FOR BAD DEBTS	A	-1,647,409	ADMINISTRATION & ACCOUNTING	5.01		45.08
45.10 O/P PT STAFF - OTHER REV	B	-7,893	PHYSICAL THERAPY	66		45.10
45.11 COURT INTEREST	B	-2	GENERAL	5.02		45.11
45.12 GARNISHMENT FEES	B	-7	EMPLOYEE BENEFITS	4		45.12
45.13 LINEN CHARGES TO SYSTEM	B	-372	LAUNDRY & LINEN SERVICE	8		45.13
45.48 DONATIONS	A	-3,785	ADMINISTRATION & ACCOUNTING	5.01		45.48
45.49 PHYSICIAN RECRUITMENT	A	-898	ADMINISTRATION & ACCOUNTING	5.01		45.49
45.50 LAND RENTAL TO HILLSBORO HEALTH SV	A	-41	ADMINISTRATION & ACCOUNTING	5.01		45.50
45.51 DONATIONS	A	-650	EMPLOYEE BENEFITS	4		45.51
46						46
47						47

PROVIDER CCN: 14-1332 HILLSBORO AREA HOSPITAL  
PERIOD FROM 07/01/2010 TO 06/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM VERSION: 2011.10  
IN LIEU OF FORM CMS-2552-10 (08/2011) 01/25/2012 08:19

ADJUSTMENTS TO EXPENSES

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED			WORKSHEET A-8	
				COST CENTER 3	LINE NO. 4	REF 5	WKST A-7	
48								48
49								49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-2,640,579					50

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 ADJUSTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	66	PHYSICAL THERAPY	20,098	20,098		1
2	4	EMPLOYEE BENEFITS	124,987	124,987		2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4)		145,085	145,085		5
	TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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

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

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

SYMBOL (1)	NAME (2)	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				TYPE OF BUSINESS (6)
		PERCENT OF OWNERSHIP (3)	NAME (4)	PERCENT OF OWNERSHIP (5)		
6	G HILLSBORO HEALTH SERVICES		HILLSBORO HEALTH SERVICES		HEALTH RELATED SERVICES	6
7	G HILLSBORO HEALTH SERVICES		HILLSBORO HEALTH SERVICES		HEALTH RELATED SERVICES	7
8						8
9						9
10						10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	LAB	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.				3	4	5	6	7	8	9
1	60	LABORATORY	LAB	113,537	69,371	44,166				1
2	69	ELECTROCARDIOLOGY	EKG	20,780	20,780					2
3	91	EMERGENCY	ER	1,257,551	550,560	706,991				3
200		TOTAL		1,391,868	640,711	751,157				200

PROVIDER CCN: 14-1332 HILLSBORO AREA HOSPITAL  
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10  
 01/25/2012 08:19

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT		
LINE NO.	11		12	13	14	15	16	17	18		
1	60	LABORATORY								69,371	1
2	69	ELECTROCARDIOLOGY								20,780	2
3	91	EMERGENCY								550,560	3
200		TOTAL								640,711	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION		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	663,279	663,279				1
2	CAP REL COSTS-MVBLE EQUIP	527,713		527,713			2
4	EMPLOYEE BENEFITS	2,163,839	2,472	5,431	2,171,742		4
5.01	ADMINISTRATION & ACCOUNTING	898,047	97,188	6,596	51,551	1,053,382	5.01
5.02	GENERAL	345,761	97,188	70,179	53,437	566,565	5.02
5.03	ADMITTING	116,668	7,151	935	39,818	164,572	5.03
5.04	PATIENT ACCOUNTING	353,809	10,736	4,635	74,737	443,917	5.04
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	572,991	45,005	9,007	67,408	694,411	7
8	LAUNDRY & LINEN SERVICE	83,234	19,836	2,359	16,086	121,515	8
9	HOUSEKEEPING	144,308	2,731	445	47,126	194,610	9
10	DIETARY	194,532	29,414	4,157	43,936	272,039	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
13.01	UR/QUALITY IMPROVEMENT	121,670	996	88	42,654	165,408	13.01
13.02	NURSING ADMINISTRATION	243,235	10,748	720	83,102	337,805	13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY	41,784	8,427	948	14,294	65,453	14.02
15	PHARMACY	391,747	5,326	13,472		410,545	15
16	MEDICAL RECORDS & LIBRARY	296,291	18,275	6,246	80,300	401,112	16
17	SOCIAL SERVICE	568				568	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	935,844	99,279	30,102	291,350	1,356,575	30
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	855,813	60,002	81,501	170,982	1,168,298	50
53	ANESTHESIOLOGY	21,046	559	15,117		36,722	53
54	RADIOLOGY-DIAGNOSTIC	897,925	49,478	122,994	152,197	1,222,594	54
54.01	ULTRA SOUND	156,992	2,058	318		159,368	54.01
56	RADIOISOTOPE	430,638	1,927			432,565	56
60	LABORATORY	920,186	18,418	70,970	164,500	1,174,074	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY	117,945	8,520	7,291	36,507	170,263	65
65.50	SLEEP LAB	98,283	2,803	514	16,868	118,468	65.50
66	PHYSICAL THERAPY	775,650	12,282	22,864	252,599	1,063,395	66
67	OCCUPATIONAL THERAPY	92,952		332	32,930	126,214	67
69	ELECTROCARDIOLOGY	20,383		3,366		23,749	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	130,298				130,298	71
73	DRUGS CHARGED TO PATIENTS	287,591				287,591	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	1,456,076	52,460	29,151	233,117	1,770,804	91
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (SUM OF LINES 1-117)	14,357,098	663,279	509,738	1,965,499	14,132,880	118
NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING	1,137,421		17,773	205,557	1,360,751	192.02
192.03	CARDIAC REHAB	1,973		202	686	2,861	192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	15,496,492	663,279	527,713	2,171,742	15,496,492	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINISTRATION & ACCOUNTING 5.01	SUBTOTAL (COLS.0-4)	GENERAL 5.02	ADMITTING 5.03	PATIENT ACCOUNTING 5.04	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATION & ACCOUNTING	1,053,382					5.01
5.02 GENERAL	41,321	607,886	607,886			5.02
5.03 ADMITTING	12,003	176,575	7,993	184,568		5.03
5.04 PATIENT ACCOUNTING	32,376	476,293	21,561		497,854	5.04
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	50,645	745,056	33,727			7
8 LAUNDRY & LINEN SERVICE	8,862	130,377	5,902			8
9 HOUSEKEEPING	14,193	208,803	9,452			9
10 DIETARY	19,841	291,880	13,213			10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
13.01 UR/QUALITY IMPROVEMENT	12,064	177,472	8,034			13.01
13.02 NURSING ADMINISTRATION	24,637	362,442	16,407			13.02
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING						14.01
14.02 CENTRAL SERVICES & SUPPLY	4,774	70,227	3,179			14.02
15 PHARMACY	29,942	440,487	19,940			15
16 MEDICAL RECORDS & LIBRARY	29,254	430,366	19,482			16
17 SOCIAL SERVICE	41	609	28			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	98,939	1,455,514	65,888	14,860	40,082	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	85,207	1,253,505	56,744	21,748	58,661	50
53 ANESTHESIOLOGY	2,678	39,400	1,784	2,998	8,087	53
54 RADIOLOGY-DIAGNOSTIC	89,167	1,311,761	59,381	41,199	111,143	54
54.01 ULTRA SOUND	11,623	170,991	7,740	6,120	16,508	54.01
56 RADIOISOTOPE	31,548	464,113	21,009	10,521	28,378	56
60 LABORATORY	85,629	1,259,703	57,024	26,351	71,077	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	12,418	182,681	8,270	3,364	9,074	65
65.50 SLEEP LAB	8,640	127,108	5,754	1,968	5,309	65.50
66 PHYSICAL THERAPY	77,557	1,140,952	51,649	19,328	52,133	66
67 OCCUPATIONAL THERAPY	9,205	135,419	6,130	1,911	5,154	67
69 ELECTROCARDIOLOGY	1,732	25,481	1,153	2,105	5,678	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	9,503	139,801	6,329	3,043	8,209	71
73 DRUGS CHARGED TO PATIENTS	20,975	308,566	13,968	8,125	21,914	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	129,155	1,899,959	86,006	20,927	56,447	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORE						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	953,929	14,033,427	607,747	184,568	497,854	118
NONREIMBURSABLE COST CENTERS						
192.02 ASSISTED LIVING	99,244	1,459,995				192.02
192.03 CARDIAC REHAB	209	3,070	139			192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,053,382	15,496,492	607,886	184,568	497,854	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATION & ACCOUNTING						5.01
5.02 GENERAL						5.02
5.03 ADMITTING						5.03
5.04 PATIENT ACCOUNTING						5.04
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	778,783					7
8 LAUNDRY & LINEN SERVICE	38,281	174,560				8
9 HOUSEKEEPING	5,271	10,079	233,605			9
10 DIETARY	56,766	3,131		364,990		10
11 CAFETERIA			11,276	232,887	244,163	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
13.01 UR/QUALITY IMPROVEMENT	1,923		3,524		8,281	13.01
13.02 NURSING ADMINISTRATION	20,743		3,599		7,059	13.02
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING						14.01
14.02 CENTRAL SERVICES & SUPPLY	16,262		9,716		5,697	14.02
15 PHARMACY	10,279		3,599			15
16 MEDICAL RECORDS & LIBRARY	35,268		3,599		18,036	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRCS	191,604	99,056	76,642	118,784	53,441	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	115,795	16,249	48,025	13,319	22,649	50
53 ANESTHESIOLOGY	1,078		3,650			53
54 RADIOLOGY-DIAGNOSTIC	95,485	7,989	5,940		23,510	54
54.01 ULTRA SOUND	3,971		3,650			54.01
56 RADIOISOTOPE	3,720		3,524			56
60 LABORATORY	35,544		3,650		26,262	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	16,442		3,650		5,502	65
65.50 SLEEP LAB	5,409	1,145	3,599		2,612	65.50
66 PHYSICAL THERAPY	23,702	21,895	15,606		32,236	66
67 OCCUPATIONAL THERAPY			3,776		4,335	67
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	101,240	15,016	26,580		34,543	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	778,783	174,560	233,605	364,990	244,163	118
NONREIMBURSABLE COST CENTERS						
192.02 ASSISTED LIVING						192.02
192.03 CARDIAC REHAB						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	778,783	174,560	233,605	364,990	244,163	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	UR/QUALITY IMPROVEMENT	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	13.01	13.02	14.02	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATION & ACCOUNTING						5.01
5.02 GENERAL						5.02
5.03 ADMITTING						5.03
5.04 PATIENT ACCOUNTING						5.04
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
13.01 UR/QUALITY IMPROVEMENT	199,234					13.01
13.02 NURSING ADMINISTRATION		410,250				13.02
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING						14.01
14.02 CENTRAL SERVICES & SUPPLY			105,081			14.02
15 PHARMACY				924	475,229	15
16 MEDICAL RECORDS & LIBRARY				580		16
17 SOCIAL SERVICE					507,331	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	199,234	178,735	7,710	4,351	107,895	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		104,837	34,668	2,291	54,820	50
53 ANESTHESIOLOGY			903	7,400		53
54 RADIOLOGY-DIAGNOSTIC			4,083	20,073	136,052	54
54.01 ULTRA SOUND			84			54.01
56 RADIOISOTOPE			1,038	34,448		56
60 LABORATORY			36,875		46,597	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY			1,503	3,261	5,233	65
65.50 SLEEP LAB			23		3,239	65.50
66 PHYSICAL THERAPY			2,264	20	73,508	66
67 OCCUPATIONAL THERAPY			67		2,243	67
69 ELECTROCARDIOLOGY			58			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			8,079			71
73 DRUGS CHARGED TO PATIENTS				401,925		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		126,678	6,222	1,460	77,744	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	199,234	410,250	105,081	475,229	507,331	118
NONREIMBURSABLE COST CENTERS						
192.02 ASSISTED LIVING						192.02
192.03 CARDIAC REHAB						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	199,234	410,250	105,081	475,229	507,331	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1					1
2					2
4					4
5.01					5.01
5.02					5.02
5.03					5.03
5.04					5.04
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
13.01					13.01
13.02					13.02
14					14
14.01					14.01
14.02					14.02
15					15
16					16
17	637				17
19					19
20					20
21					21
22					22
23					23
30	637	2,614,433		2,614,433	30
ANCILLARY SERVICE COST CENTERS					
50		1,803,311		1,803,311	50
53		65,300		65,300	53
54		1,816,616		1,816,616	54
54.01		209,064		209,064	54.01
56		566,751		566,751	56
60		1,563,083		1,563,083	60
62.30					62.30
65		238,980		238,980	65
65.50		156,166		156,166	65.50
66		1,433,293		1,433,293	66
67		159,035		159,035	67
69		34,475		34,475	69
71		165,461		165,461	71
73		754,498		754,498	73
76.97					76.97
76.98					76.98
76.99					76.99
OUTPATIENT SERVICE COST CENTERS					
91		2,452,822		2,452,822	91
92					92
OTHER REIMBURSABLE COST CENTERS					
99.10					99.10
99.20					99.20
99.30					99.30
99.40					99.40
118	637	14,033,288		14,033,288	118
NONREIMBURSABLE COST CENTERS					
192.02		1,459,995		1,459,995	192.02
192.03		3,209		3,209	192.03
200					200
201					201
202	637	15,496,492		15,496,492	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		2,472	5,431	7,903	7,903	4
5.01 ADMINISTRATION & ACCOUNTING		97,188	6,596	103,784	188	5.01
5.02 GENERAL		97,188	70,179	167,367	194	5.02
5.03 ADMITTING		7,151	935	8,086	145	5.03
5.04 PATIENT ACCOUNTING		10,736	4,635	15,371	272	5.04
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		45,005	9,007	54,012	245	7
8 LAUNDRY & LINEN SERVICE		19,836	2,359	22,195	59	8
9 HOUSEKEEPING		2,731	445	3,176	171	9
10 DIETARY		29,414	4,157	33,571	160	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
13.01 UR/QUALITY IMPROVEMENT		996	88	1,084	155	13.01
13.02 NURSING ADMINISTRATION		10,748	720	11,468	302	13.02
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING						14.01
14.02 CENTRAL SERVICES & SUPPLY		8,427	948	9,375	52	14.02
15 PHARMACY		5,326	13,472	18,798		15
16 MEDICAL RECORDS & LIBRARY		18,275	6,246	24,521	292	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		99,279	30,102	129,381	1,063	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		60,002	81,501	141,503	622	50
53 ANESTHESIOLOGY		559	15,117	15,676		53
54 RADIOLOGY-DIAGNOSTIC		49,478	122,994	172,472	554	54
54.01 ULTRA SOUND		2,058	318	2,376		54.01
56 RADIOISOTOPE		1,927		1,927		56
60 LABORATORY		18,418	70,970	89,388	598	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		8,520	7,291	15,811	133	65
65.50 SLEEP LAB		2,803	514	3,317	61	65.50
66 PHYSICAL THERAPY		12,282	22,864	35,146	919	66
67 OCCUPATIONAL THERAPY			332	332	120	67
69 ELECTROCARDIOLOGY			3,366	3,366		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		52,460	29,151	81,611	848	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)		663,279	509,738	1,173,017	7,153	118
NONREIMBURSABLE COST CENTERS						
192.02 ASSISTED LIVING			17,773	17,773	748	192.02
192.03 CARDIAC REHAB			202	202	2	192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		663,279	527,713	1,190,992	7,903	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	ADMINISTRATION & ACCOUNTING 5.01	GENERAL 5.02	ADMITTING 5.03	PATIENT ACCOUNTING 5.04	OPERATION OF PLANT 7	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATION & ACCOUNTING	103,972					5.01
5.02 GENERAL	4,079	171,640				5.02
5.03 ADMITTING	1,185	2,257	11,673			5.03
5.04 PATIENT ACCOUNTING	3,196	6,088		24,927		5.04
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	4,999	9,523			68,779	7
8 LAUNDRY & LINEN SERVICE	875	1,666			3,381	8
9 HOUSEKEEPING	1,401	2,669			466	9
10 DIETARY	1,958	3,731			5,013	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
13.01 UR/QUALITY IMPROVEMENT	1,191	2,268			170	13.01
13.02 NURSING ADMINISTRATION	2,432	4,633			1,832	13.02
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING						14.01
14.02 CENTRAL SERVICES & SUPPLY	471	898			1,436	14.02
15 PHARMACY	2,956	5,630			908	15
16 MEDICAL RECORDS & LIBRARY	2,888	5,501			3,115	16
17 SOCIAL SERVICE	4	8				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	9,766	18,604	939	2,006	16,920	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,411	16,022	1,374	2,936	10,227	50
53 ANESTHESIOLOGY	264	504	189	405	95	53
54 RADIOLOGY-DIAGNOSTIC	8,801	16,767	2,615	5,573	8,433	54
54.01 ULTRA SOUND	1,147	2,186	387	826	351	54.01
56 RADIOISOTOPE	3,114	5,932	665	1,420	329	56
60 LABORATORY	8,452	16,102	1,665	3,557	3,139	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	1,226	2,335	213	454	1,452	65
65.50 SLEEP LAB	853	1,625	124	266	478	65.50
66 PHYSICAL THERAPY	7,655	14,584	1,221	2,609	2,093	66
67 OCCUPATIONAL THERAPY	909	1,731	121	258		67
69 ELECTROCARDIOLOGY	171	326	133	284		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	938	1,787	192	411		71
73 DRUGS CHARGED TO PATIENTS	2,070	3,944	513	1,097		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	12,743	24,280	1,322	2,825	8,941	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
118 SUBTOTALS (SUM OF LINES 1-117)	94,155	171,601	11,673	24,927	68,779	118
NONREIMBURSABLE COST CENTERS						
192.02 ASSISTED LIVING	9,796					192.02
192.03 CARDIAC REHAB	21	39				192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	103,972	171,640	11,673	24,927	68,779	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	CAFETERIA 11	UR/QUALITY IMPROVEMENT 13.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATION & ACCOUNTING						5.01
5.02 GENERAL						5.02
5.03 ADMITTING						5.03
5.04 PATIENT ACCOUNTING						5.04
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	28,176					8
9 HOUSEKEEPING	1,627	9,510				9
10 DIETARY	505					10
11 CAFETERIA		459	44,938			11
12 MAINTENANCE OF PERSONNEL			28,673	29,132		12
13 NURSING ADMINISTRATION						13
13.01 UR/QUALITY IMPROVEMENT		143		988	5,999	13.01
13.02 NURSING ADMINISTRATION		147		842		13.02
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING						14.01
14.02 CENTRAL SERVICES & SUPPLY		396		680		14.02
15 PHARMACY		147				15
16 MEDICAL RECORDS & LIBRARY		147		2,152		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	15,988	3,117	14,625	6,377	5,999	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,623	1,955	1,640	2,702		50
53 ANESTHESIOLOGY		149				53
54 RADIOLOGY-DIAGNOSTIC	1,290	242		2,805		54
54.01 ULTRA SOUND		149				54.01
56 RADIOISOTOPE		143				56
60 LABORATORY		149		3,133		60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		149		657		65
65.50 SLEEP LAB	185	147		312		65.50
66 PHYSICAL THERAPY	3,534	635		3,846		66
67 OCCUPATIONAL THERAPY		154		517		67
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	2,424	1,082		4,121		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	28,176	9,510	44,938	29,132	5,999	118
NONREIMBURSABLE COST CENTERS						
192.02 ASSISTED LIVING						192.02
192.03 CARDIAC REHAB						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	28,176	9,510	44,938	29,132	5,999	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	NURSING ADMINISTRATION 13.02	CENTRAL SERVICES & SUPPLY 14.02	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATION & ACCOUNTING						5.01
5.02 GENERAL						5.02
5.03 ADMITTING						5.03
5.04 PATIENT ACCOUNTING						5.04
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
13.01 UR/QUALITY IMPROVEMENT						13.01
13.02 NURSING ADMINISTRATION	21,656					13.02
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING						14.01
14.02 CENTRAL SERVICES & SUPPLY		13,308				14.02
15 PHARMACY		117	28,556			15
16 MEDICAL RECORDS & LIBRARY		73		38,689		16
17 SOCIAL SERVICE					12	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	9,435	976	261	8,228	12	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	5,534	4,391	138	4,181		50
53 ANESTHESIOLOGY		114	445			53
54 RADIOLOGY-DIAGNOSTIC		517	1,206	10,375		54
54.01 ULTRA SOUND		11				54.01
56 RADIOISOTOPE		131	2,070			56
60 LABORATORY		4,671		3,553		60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		190	196	399		65
65.50 SLEEP LAB		3		247		65.50
66 PHYSICAL THERAPY		287	1	5,606		66
67 OCCUPATIONAL THERAPY		9		171		67
69 ELECTROCARDIOLOGY		7				69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		1,023				71
73 DRUGS CHARGED TO PATIENTS			24,151			73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	6,687	788	88	5,929		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	21,656	13,308	28,556	38,689	12	118
NONREIMBURSABLE COST CENTERS						
192.02 ASSISTED LIVING						192.02
192.03 CARDIAC REHAB						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	21,656	13,308	28,556	38,689	12	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
5.01 ADMINISTRATION & ACCOUNTING				5.01
5.02 GENERAL				5.02
5.03 ADMITTING				5.03
5.04 PATIENT ACCOUNTING				5.04
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
13.01 UR/QUALITY IMPROVEMENT				13.01
13.02 NURSING ADMINISTRATION				13.02
14 CENTRAL SERVICES & SUPPLY				14
14.01 PURCHASING				14.01
14.02 CENTRAL SERVICES & SUPPLY				14.02
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	243,697		243,697	30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	204,259		204,259	50
53 ANESTHESIOLOGY	17,841		17,841	53
54 RADIOLOGY-DIAGNOSTIC	231,650		231,650	54
54.01 ULTRA SOUND	7,433		7,433	54.01
56 RADIOISOTOPE	15,731		15,731	56
60 LABORATORY	134,407		134,407	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS				62.30
65 RESPIRATORY THERAPY	23,215		23,215	65
65.50 SLEEP LAB	7,618		7,618	65.50
66 PHYSICAL THERAPY	78,136		78,136	66
67 OCCUPATIONAL THERAPY	4,322		4,322	67
69 ELECTROCARDIOLOGY	4,287		4,287	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	4,351		4,351	71
73 DRUGS CHARGED TO PATIENTS	31,775		31,775	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	153,689		153,689	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	1,162,411		1,162,411	118
NONREIMBURSABLE COST CENTERS				
192.02 ASSISTED LIVING	28,317		28,317	192.02
192.03 CARDIAC REHAB	264		264	192.03
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	1,190,992		1,190,992	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP	CAP	EMPLOYEE	RECON-	ADMINISTRA
	BLDGS & FIXTURES SQUARE FEE T	MOVABLE EQUIPMENT DOLLAR VAL UE	BENEFITS		CILLIATION
	1	2	4	5A.01	5.01
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT	7,123,400				1
2 CAP REL COSTS-MVBLE EQUIP		508,498			2
4 EMPLOYEE BENEFITS	26,545	5,233	5,990,437		4
5.01 ADMINISTRATION & ACCOUNTING	1,043,759	6,356	142,196	-1,053,382	14,443,110 5.01
5.02 GENERAL	1,043,759	67,624	147,398		566,565 5.02
5.03 ADMITTING	76,800	901	109,833		164,572 5.03
5.04 PATIENT ACCOUNTING	115,300	4,466	206,152		443,917 5.04
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT	483,333	8,679	185,936		694,411 7
8 LAUNDRY & LINEN SERVICE	213,033	2,273	44,370		121,515 8
9 HOUSEKEEPING	29,333	429	129,990		194,610 9
10 DIETARY	315,900	4,006	121,192		272,039 10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
13.01 UR/QUALITY IMPROVEMENT	10,700	85	117,655		165,408 13.01
13.02 NURSING ADMINISTRATION	115,435	694	229,225		337,805 13.02
14 CENTRAL SERVICES & SUPPLY					14
14.01 PURCHASING					14.01
14.02 CENTRAL SERVICES & SUPPLY	90,500	913	39,427		65,453 14.02
15 PHARMACY	57,200	12,981			410,545 15
16 MEDICAL RECORDS & LIBRARY	196,265	6,019	221,495		401,112 16
17 SOCIAL SERVICE					568 17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	1,066,267	29,006	803,649		1,356,575 30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	644,400	78,533	471,630		1,168,298 50
53 ANESTHESIOLOGY	6,000	14,567			36,722 53
54 RADIOLOGY-DIAGNOSTIC	531,371	118,515	419,812		1,222,594 54
54.01 ULTRA SOUND	22,100	306			159,368 54.01
56 RADIOISOTOPE	20,700				432,565 56
60 LABORATORY	197,800	68,386	453,748		1,174,074 60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY	91,500	7,026	100,698		170,263 65
65.50 SLEEP LAB	30,100	495	46,529		118,468 65.50
66 PHYSICAL THERAPY	131,900	22,031	696,758		1,063,395 66
67 OCCUPATIONAL THERAPY		320	90,833		126,214 67
69 ELECTROCARDIOLOGY		3,243			23,749 69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					130,298 71
73 DRUGS CHARGED TO PATIENTS					287,591 73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	563,400	28,090	643,019		1,770,804 91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	7,123,400	491,177	5,421,545	-1,053,382	13,079,498 118
NONREIMBURSABLE COST CENTERS					
192.02 ASSISTED LIVING		17,126	567,000		1,360,751 192.02
192.03 CARDIAC REHAB		195	1,892		2,861 192.03
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	663,279	527,713	2,171,742		1,053,382 202
203 UNIT COST MULT-WS B PT I	0.093113	1.037788	0.362535		0.072933 203
204 COST TO BE ALLOC PER B PT II			7,903		103,972 204
205 UNIT COST MULT-WS B PT II			0.001319		0.007199 205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	RECON- CILLIATION	GENERAL	ADMITTING	PATIENT AC COUNTING	OPERATION OF PLANT	
		ACCUM COST 5.02	GROSS CHAR GES 5.03	GROSS CHAR GES 5.04	SQUARE FEE T 7	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATION & ACCOUNTING						5.01
5.02 GENERAL	-607,886	13,428,611				5.02
5.03 ADMITTING		176,575	26,992,818			5.03
5.04 PATIENT ACCOUNTING		476,293		26,992,818		5.04
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		745,056			4,333,904	7
8 LAUNDRY & LINEN SERVICE		130,377			213,033	8
9 HOUSEKEEPING		208,803			29,333	9
10 DIETARY		291,880			315,900	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
13.01 UR/QUALITY IMPROVEMENT		177,472			10,700	13.01
13.02 NURSING ADMINISTRATION		362,442			115,435	13.02
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING						14.01
14.02 CENTRAL SERVICES & SUPPLY		70,227			90,500	14.02
15 PHARMACY		440,487			57,200	15
16 MEDICAL RECORDS & LIBRARY		430,366			196,265	16
17 SOCIAL SERVICE		609				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS		1,455,514	2,173,164	2,173,164	1,066,267	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		1,253,505	3,180,466	3,180,466	644,400	50
53 ANESTHESIOLOGY		39,400	438,473	438,473	6,000	53
54 RADIOLOGY-DIAGNOSTIC		1,311,761	6,026,103	6,026,103	531,371	54
54.01 ULTRA SOUND		170,991	895,032	895,032	22,100	54.01
56 RADIOISOTOPE		464,113	1,538,600	1,538,600	20,700	56
60 LABORATORY		1,259,703	3,853,664	3,853,664	197,800	60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		182,681	491,999	491,999	91,500	65
65.50 SLEEP LAB		127,108	287,823	287,823	30,100	65.50
66 PHYSICAL THERAPY		1,140,952	2,826,558	2,826,558	131,900	66
67 OCCUPATIONAL THERAPY		135,419	279,459	279,459		67
69 ELECTROCARDIOLOGY		25,481	307,827	307,827		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		139,801	445,071	445,071		71
73 DRUGS CHARGED TO PATIENTS		308,566	1,188,144	1,188,144		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		1,899,959	3,060,435	3,060,435	563,400	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	-607,886	13,425,541	26,992,818	26,992,818	4,333,904	118
NONREIMBURSABLE COST CENTERS						
192.02 ASSISTED LIVING	-1,459,995					192.02
192.03 CARDIAC REHAB		3,070				192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I		607,886	184,568	497,854	778,783	202
203 UNIT COST MULT-WS B PT I		0.045268	0.006838	0.018444	0.179695	203
204 COST TO BE ALLOC PER B PT II		171,640	11,673	24,927	68,779	204
205 UNIT COST MULT-WS B PT II		0.012782	0.000432	0.000923	0.015870	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA FTE'S SERVED 11	UR/QUALITY IMPROVEMENT DIRECT NRS 13.01 13.02 13.03 13.04	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATION & ACCOUNTING						5.01
5.02 GENERAL						5.02
5.03 ADMITTING						5.03
5.04 PATIENT ACCOUNTING						5.04
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	159,346					8
9 HOUSEKEEPING	9,201	9,281				9
10 DIETARY	2,858		28,143			10
11 CAFETERIA		448	17,957	8,786		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
13.01 UR/QUALITY IMPROVEMENT		140		298	2,879	13.01
13.02 NURSING ADMINISTRATION		143		254		13.02
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING						14.01
14.02 CENTRAL SERVICES & SUPPLY		386		205		14.02
15 PHARMACY		143				15
16 MEDICAL RECORDS & LIBRARY		143		649		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCS-SALARY & FRINGES APPRVD						21
22 I&R SRVCS-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	90,422	3,045	9,159	1,923	2,879	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	14,833	1,908	1,027	815		50
53 ANESTHESIOLOGY		145				53
54 RADIOLOGY-DIAGNOSTIC	7,293	236		846		54
54.01 ULTRA SOUND		145				54.01
56 RADIOISOTOPE		140				56
60 LABORATORY		145		945		60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		145		198		65
65.50 SLEEP LAB	1,045	143		94		65.50
66 PHYSICAL THERAPY	19,987	620		1,160		66
67 OCCUPATIONAL THERAPY		150		156		67
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
91 OUTPATIENT SERVICE COST CENTERS						
EMERGENCY	13,707	1,056		1,243		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
118 SUBTOTALS (SUM OF LINES 1-117)	159,346	9,281	28,143	8,786	2,879	118
NONREIMBURSABLE COST CENTERS						
192.02 ASSISTED LIVING						192.02
192.03 CARDIAC REHAB						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	174,560	233,605	364,990	244,163	199,234	202
203 UNIT COST MULT-WS B PT I	1.095478	25.170240	12.969122	27.790007	69.202501	203
204 COST TO BE ALLOC PER B PT II	28,176	9,510	44,938	29,132	5,999	204
205 UNIT COST MULT-WS B PT II	0.176823	1.024674	1.596774	3.315730	2.083710	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINISTRATION DIRECT NRS ING HRS 13.02	CENTRAL SERVICES & SUPPLY COSTED REQ UIS. 14.02	PHARMACY COSTED REQ UIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATION & ACCOUNTING						5.01
5.02 GENERAL						5.02
5.03 ADMITTING						5.03
5.04 PATIENT ACCOUNTING						5.04
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
13.01 UR/QUALITY IMPROVEMENT						13.01
13.02 NURSING ADMINISTRATION	43,652					13.02
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING						14.01
14.02 CENTRAL SERVICES & SUPPLY		824,789				14.02
15 PHARMACY		7,256	340,042			15
16 MEDICAL RECORDS & LIBRARY		4,550		2,036		16
17 SOCIAL SERVICE					100	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	19,018	60,516	3,113	433	100	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	11,155	272,116	1,639	220		50
53 ANESTHESIOLOGY		7,087	5,295			53
54 RADIOLOGY-DIAGNOSTIC		32,048	14,363	546		54
54.01 ULTRA SOUND		659				54.01
56 RADIOISOTOPE		8,147	24,649			56
60 LABORATORY		289,428		187		60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		11,795	2,333	21		65
65.50 SLEEP LAB		180		13		65.50
66 PHYSICAL THERAPY		17,773	14	295		66
67 OCCUPATIONAL THERAPY		527		9		67
69 ELECTROCARDIOLOGY		455				69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		63,414				71
73 DRUGS CHARGED TO PATIENTS			287,591			73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
91 OUTPATIENT SERVICE COST CENTERS						
EMERGENCY	13,479	48,838	1,045	312		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
118 SUBTOTALS (SUM OF LINES 1-117)	43,652	824,789	340,042	2,036	100	118
NONREIMBURSABLE COST CENTERS						
192.02 ASSISTED LIVING						192.02
192.03 CARDIAC REHAB						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	410,250	105,081	475,229	507,331	637	202
203 UNIT COST MULT-WS B PT I	9.398195	0.127403	1.397560	249.180255	6.370000	203
204 COST TO BE ALLOC PER B PT II	21,656	13,308	28,556	38,689	12	204
205 UNIT COST MULT-WS B PT II	0.496106	0.016135	0.083978	19.002456	0.120000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

	GENERAL SERVICE COST CENTERS	
1	CAP REL COSTS-BLDG & FIXT	1
2	CAP REL COSTS-MVBLE EQUIP	2
4	EMPLOYEE BENEFITS	4
5.01	ADMINISTRATION & ACCOUNTING	5.01
5.02	GENERAL	5.02
5.03	ADMITTING	5.03
5.04	PATIENT ACCOUNTING	5.04
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
13.01	UR/QUALITY IMPROVEMENT	13.01
13.02	NURSING ADMINISTRATION	13.02
14	CENTRAL SERVICES & SUPPLY	14
14.01	PURCHASING	14.01
14.02	CENTRAL SERVICES & SUPPLY	14.02
15	PHARMACY	15
16	MEDICAL RECORDS & LIBRARY	16
17	SOCIAL SERVICE	17
19	NONPHYSICIAN ANESTHETISTS	19
20	NURSING SCHOOL	20
21	I&R SRVCES-SALARY & FRINGES APPRVD	21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
30	INPATIENT ROUTINE SERV COST CENTERS	30
	ADULTS & PEDIATRICS	
	ANCILLARY SERVICE COST CENTERS	
50	OPERATING ROOM	50
53	ANESTHESIOLOGY	53
54	RADIOLOGY-DIAGNOSTIC	54
54.01	ULTRA SOUND	54.01
56	RADIOISOTOPE	56
60	LABORATORY	60
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS	62.30
65	RESPIRATORY THERAPY	65
65.50	SLEEP LAB	65.50
66	PHYSICAL THERAPY	66
67	OCCUPATIONAL THERAPY	67
69	ELECTROCARDIOLOGY	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	71
73	DRUGS CHARGED TO PATIENTS	73
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
	OUTPATIENT SERVICE COST CENTERS	
91	EMERGENCY	91
92	OBSERVATION BEDS	92
	OTHER REIMBURSABLE COST CENTERS	
99.10	CORF	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	99.40
	SPECIAL PURPOSE COST CENTERS	
118	SUBTOTALS (SUM OF LINES 1-117)	118
	NONREIMBURSABLE COST CENTERS	
192.02	ASSISTED LIVING	192.02
192.03	CARDIAC REHAB	192.03
200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
30 INPATIENT ROUTINE SERV COST CENTERS					
ADULTS & PEDIATRICS	2,614,433		2,614,433		30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1,803,311		1,803,311		50
53 ANESTHESIOLOGY	65,300		65,300		53
54 RADIOLOGY-DIAGNOSTIC	1,816,616		1,816,616		54
54.01 ULTRA SOUND	209,064		209,064		54.01
56 RADIOISOTOPE	566,751		566,751		56
60 LABORATORY	1,563,083		1,563,083		60
62.30 BLOOD CLOTTING FACTORS ADMI					62.30
65 RESPIRATORY THERAPY	238,980		238,980		65
65.50 SLEEP LAB	156,166		156,166		65.50
66 PHYSICAL THERAPY	1,433,293		1,433,293		66
67 OCCUPATIONAL THERAPY	159,035		159,035		67
69 ELECTROCARDIOLOGY	34,475		34,475		69
71 MEDICAL SUPPLIES CHRGED TO	165,461		165,461		71
73 DRUGS CHARGED TO PATIENTS	754,498		754,498		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	2,452,822		2,452,822		91
92 OBSERVATION BEDS	157,327		157,327		92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THE					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	14,190,615		14,190,615		200
201 LESS OBSERVATION BEDS	157,327		157,327		201
202 TOTAL (SEE INSTRUCTIONS)	14,033,288		14,033,288		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			
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	2,173,164		2,173,164			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	46,143	2,890,099	2,936,242	0.614156		50
53 ANESTHESIOLOGY	7,953	430,520	438,473	0.148926		53
54 RADIOLOGY-DIAGNOSTIC	231,177	5,794,926	6,026,103	0.301458		54
54.01 ULTRA SOUND	110,579	784,453	895,032	0.233583		54.01
56 RADIOISOTOPE	45,414	1,493,186	1,538,600	0.368355		56
60 LABORATORY	514,177	3,339,487	3,853,664	0.405610		60
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
65 RESPIRATORY THERAPY	276,877	83,969	360,846	0.662277		65
65.50 SLEEP LAB	3,095	284,728	287,823	0.542577		65.50
66 PHYSICAL THERAPY	259,334	2,567,224	2,826,558	0.507081		66
67 OCCUPATIONAL THERAPY	131,260	148,199	279,459	0.569082		67
69 ELECTROCARDIOLOGY	36,986	270,841	307,827	0.111995		69
71 MEDICAL SUPPLIES CHRGED TO	297,513	522,935	820,448	0.201672		71
73 DRUGS CHARGED TO PATIENTS	489,505	698,639	1,188,144	0.635022		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,000	3,059,435	3,060,435	0.801462		91
92 OBSERVATION BEDS	64,750	314,656	379,406	0.414667		92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	4,688,927	22,683,297	27,372,224			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		22,683,297	27,372,224			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1332) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES		PROGRAM COSTS			
		PPS REIMBURSED SERVICES	COST REIMB. SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	COST SERVICES SUBJECT TO DED & COINS		
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.614156		1,604,639			985,499	50
53 ANESTHESIOLOGY	0.148926		217,023			32,320	53
54 RADIOLOGY-DIAGNOSTIC	0.301458		2,244,139			676,514	54
54.01 ULTRA SOUND	0.233583		346,071			80,836	54.01
56 RADIOISOTOPE	0.368355		606,519			223,414	56
60 LABORATORY	0.405610		1,650,516			669,466	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO							62.30
65 RESPIRATORY THERAPY	0.662277		47,136			31,217	65
65.50 SLEEP LAB	0.542577		119,008			64,571	65.50
66 PHYSICAL THERAPY	0.507081		981,436			497,668	66
67 OCCUPATIONAL THERAPY	0.569082		46,968			26,729	67
69 ELECTROCARDIOLOGY	0.111995		119,396			13,372	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.201672		334,408			67,441	71
73 DRUGS CHARGED TO PATIENTS	0.635022		474,920			301,585	73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	0.801462		1,084,711			869,355	91
92 OBSERVATION BEDS	0.414667		99,956			41,448	92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)			9,976,846			4,581,435	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)			9,976,846			4,581,435	202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B-SNF (14-Z332)  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES				PROGRAM COSTS		
		REIMBURSED SERVICES	PPS SUBJECT TO DED & COINS	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.614156						50	
53 ANESTHESIOLOGY	0.148926						53	
54 RADIOLOGY-DIAGNOSTIC	0.301458						54	
54.01 ULTRA SOUND	0.233583						54.01	
56 RADIOISOTOPE	0.368355						56	
60 LABORATORY	0.405610						60	
62.30 BLOOD CLOTTING FACTORS ADMIN CO.							62.30	
65 RESPIRATORY THERAPY	0.662277						65	
65.50 SLEEP LAB	0.542577						65.50	
66 PHYSICAL THERAPY	0.507081						66	
67 OCCUPATIONAL THERAPY	0.569082						67	
69 ELECTROCARDIOLOGY	0.111995						69	
71 MEDICAL SUPPLIES CHRGD TO PATI	0.201672						71	
73 DRUGS CHARGED TO PATIENTS	0.635022						73	
76.97 CARDIAC REHABILITATION							76.97	
76.98 HYPERBARIC OXYGEN THERAPY							76.98	
76.99 LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.801462						91	
92 OBSERVATION BEDS	0.414667						92	
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)							200	
201 LESS PBP CLINIC LAB SERVICES							201	
202 NET CHARGES (LINE 200 - LINE 201)							202	

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1332) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,054	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,328	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,328	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,711	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	15	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)	923	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)	1,711	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	117.00	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.00	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,614,433	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)	1,755	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)	1,472,736	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,141,697	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	934,335	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	934,335	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.221935	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)	703.57	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)	1,141,697	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1332) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [XX] 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) 859.72 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 793,522 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) 793,522 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	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)	1	2	3	4	5 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					468,015 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,261,537 49

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

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59  
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60  
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE 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 1,470,981 64  
 (TITLE XVIII ONLY)  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU 65  
 (TITLE XVIII ONLY)  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 1,470,981 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 67  
 (LINE 12 x LINE 19)  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 68  
 (LINE 13 x LINE 20)  
 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) 183 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 859.71 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 157,327 89

	COST	ROUTINE COST (FROM LINE 27)	COL. 1 + COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	1	2	3	4	5
90 CAPITAL-RELATED COST	243,697	1,141,697	0.213452	157,327	33,582 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  HOSPITAL (14-1332)  SUB (OTHER)  S/B SNF  PPS  
 APPLICABLE  TITLE XVIII-PT A  IPF  SNF  S/B NF  TEFRA  
 BOXES  TITLE XIX  IRF  NF  ICF/MR  OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	(COL.1 x COL.2)
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		818,126		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.614156	26,311	16,159	50
53 ANESTHESIOLOGY	0.148926	5,049	752	53
54 RADIOLOGY-DIAGNOSTIC	0.301458	132,111	39,826	54
54.01 ULTRA SOUND	0.233583	81,162	18,958	54.01
56 RADIOISOTOPE	0.368355	28,084	10,345	56
60 LABORATORY	0.405610	286,827	116,340	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.662277	116,127	76,908	65
65.50 SLEEP LAB	0.542577			65.50
66 PHYSICAL THERAPY	0.507081	41,708	21,149	66
67 OCCUPATIONAL THERAPY	0.569082	12,246	6,969	67
69 ELECTROCARDIOLOGY	0.111995	26,186	2,933	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.201672	162,636	32,799	71
73 DRUGS CHARGED TO PATIENTS	0.635022	196,213	124,600	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.801462	345	277	91
92 OBSERVATION BEDS	0.414667			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,115,005	468,015	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,115,005		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  S/B SNF(14-Z332)  PPS  
 APPLICABLE  TITLE XVIII-PT A  IPF  SNF  S/B NF  TEFRA  
 BOXES  TITLE XIX  IRF  NF  ICF/MR  OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.614156	3,975	2,441	50
53 ANESTHESIOLOGY	0.148926	57	8	53
54 RADIOLOGY-DIAGNOSTIC	0.301458	52,706	15,889	54
54.01 ULTRA SOUND	0.233583	11,313	2,643	54.01
56 RADIOISOTOPE	0.368355	5,936	2,187	56
60 LABORATORY	0.405610	149,676	60,710	60
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.662277	68,396	45,297	65
65.50 SLEEP LAB	0.542577	3,095	1,679	65.50
66 PHYSICAL THERAPY	0.507081	212,371	107,689	66
67 OCCUPATIONAL THERAPY	0.569082	117,710	66,987	67
69 ELECTROCARDIOLOGY	0.111995	1,932	216	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.201672	113,424	22,874	71
73 DRUGS CHARGED TO PATIENTS	0.635022	233,867	148,511	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.801462	512	410	91
92 OBSERVATION BEDS	0.414667			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		974,970	477,541	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		974,970		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

CHECK APPLICABLE BOX:           [XX] HOSPITAL (14-1332)           [ ] IPF                           [ ] IRF  
                                   [ ] SUB (OTHER)                   [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,581,435	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	4,581,435	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13 (e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	4,627,249	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 \$2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,711,920	26
27	SUBTOTAL ((LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23) (SEE INSTRUCTIONS)	2,915,329	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	2,915,329	30
31	PRIMARY PAYER PAYMENTS	1,281	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,914,048	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	259,936	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	259,936	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	259,936	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	3,173,984	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	3,173,984	40
41	INTERIM PAYMENTS	3,239,696	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-65,712	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	40,877	44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK APPLICABLE BOX:	[XX] HOSPITAL (14-1332) [ ] IPF [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF	INPATIENT		PART B		
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			864,398		2,853,891	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	01/14/2011	48,818	01/14/2011	44,004	3.01
		.02	05/20/2011	54,585	05/20/2011	341,801	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)			103,403		385,805	
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			967,801		3,239,696	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		NONE		NONE	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		NONE		NONE	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		81,546			6.01
		PROVIDER .02					6.02
		TO .02				-65,712	6.02
		PROGRAM					
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			1,049,347		3,173,984	7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:		DATE:	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK	[ ] HOSPITAL	[ ] SUB (OTHER)	INPATIENT							
APPLICABLE	[ ] IPF	[ ] SNF	PART A	PART B						
BOX:	[ ] IRF	[XX] SWING BED SNF (14-Z332)								
DESCRIPTION			MM/DD/YYYY	1	AMOUNT	2	MM/DD/YYYY	3	AMOUNT	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,655,927					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	05/20/2011		182,458				NONE	3.01
		.02								3.02
		.03								3.03
		.04								3.04
		.05								3.05
		.06								3.06
		.07								3.07
		.08								3.08
		.09								3.09
		.50	01/14/2011		26,244				NONE	3.50
		.51								3.51
		.52								3.52
		.53								3.53
		.54								3.54
		.55								3.55
		.56								3.56
		.57								3.57
		.58								3.58
		.59								3.59
		.99								3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				156,214					
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				1,812,141					4
TO BE COMPLETED BY CONTRACTOR										
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.									
		.01							NONE	5.01
		.02								5.02
		.03								5.03
		.04								5.04
		.05								5.05
		.06								5.06
		.07								5.07
		.08								5.08
		.09								5.09
		.50							NONE	5.50
		.51								5.51
		.52								5.52
		.53								5.53
		.54								5.54
		.55								5.55
		.56								5.56
		.57								5.57
		.58								5.58
		.59								5.59
		.99								5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)									
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT									
		.01			101,575					6.01
		.02								6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				1,913,716					7
8	NAME OF CONTRACTOR:				CONTRACTOR NUMBER:				DATE:	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL (14-1332) [ ] 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 14 419 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12 923 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12 1,145 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200 27,372,224 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20 535,799 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168 7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS) 8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH	
30	INITIAL/INTERIM HIT PAYMENT(S) 30
31	OTHER ADJUSTMENTS (SPECIFY) 31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31) 32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [ ] TITLE V [XX] SWING BED - SNF (14-Z332)  
 APPLICABLE [XX] TITLE XVIII [ ] SWING BED - NF  
 BOXES [ ] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A 1	PART B 2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	1,485,691	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	482,316	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	1,711	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	1,968,007	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	1,968,007	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	1,968,007	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	54,291	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	1,913,716	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	1,913,716	19
20 INTERIM PAYMENTS	1,812,141	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	101,575	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	17,397	23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART V

CHECK [XX] HOSPITAL (14-1332)  
 APPLICABLE BOX: [ ] SUB (OTHER)

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)

1	INPATIENT SERVICES	1,261,537	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,261,537	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 5 LESS LINE 6) (FOR CAH, SEE INSTRUCTIONS)	1,274,152	6
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.0000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6, 17 AND 18)	1,274,152	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	244,448	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	1,029,704	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,029,704	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	19,643	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	19,643	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	19,643	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26 (LINE 26 HOSPITAL AND SUBPROVIDER ONLY))	1,049,347	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,049,347	30
31	INTERIM PAYMENTS	967,801	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	81,546	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	11,261	34

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	584,396			1
2	TEMPORARY INVESTMENTS	133,591			2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	2,838,384			4
5	OTHER RECEIVABLES	68,464			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-748,000			6
7	INVENTORY	352,581			7
8	PREPAID EXPENSES	324,533			8
9	OTHER CURRENT ASSETS	148,794			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	3,702,743			11
FIXED ASSETS					
12	LAND	237,676			12
13	LAND IMPROVEMENTS	1,564,287			13
14	ACCUMULATED DEPRECIATION	-539,039			14
15	BUILDINGS	15,337,482			15
16	ACCUMULATED DEPRECIATION	-5,427,106			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	164,333			19
20	ACCUMULATED DEPRECIATION	-160,952			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	7,075,196			23
24	ACCUMULATED DEPRECIATION	-4,854,069			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)	13,397,808			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	10,541,250			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	10,541,250			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	27,641,801			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	991,898			37
38	SALARIES, WAGES & FEES PAYABLE	637,639			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	189,018			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	64,631			43
44	OTHER CURRENT LIABILITIES				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,883,186			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	6,956,759			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	6,956,759			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	8,839,945			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	18,801,856			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)	18,801,856			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	27,641,801			60

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		17,280,122							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		1,230,915							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		18,511,037							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 UNREALIZED CHANGE IN INVESTM	258,247								5
6 CONTRIBUTIONS OF EQUIPMENT	73,748								6
7 TRANSFERS FROM FOUNDATION	73,748								7
8 RETURN ON INVESTMENTS	8,415								8
9 CHANGE IN INTEREST OF FOUNDA									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		414,158							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		18,925,195							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 RELEASED CONTRIBUTIONS	95,454								13
14 CHANGE IN INTEREST OF FOUNDA	27,885								14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		123,339							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		18,801,856							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	2,686,641		2,686,641	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)	2,686,641		2,686,641	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,686,641		2,686,641	18
19 ANCILLARY SERVICES	3,689,141		3,689,141	19
20 OUTPATIENT SERVICES		23,714,059	23,714,059	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	6,375,782	23,714,059	30,089,841	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		18,137,071	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		18,137,071	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	30,089,841	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	11,018,039	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	19,071,802	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	18,137,071	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	934,731	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	205,332	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	7,095	10
11	REBATES AND REFUNDS OF EXPENSES	7,782	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	37,557	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	3,859	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	4,130	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISC. INCOME/ADJUSTMENTS)	30,424	24
24.01	OTHER (ROUNDING)	5	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	296,184	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,230,915	26
27	OTHER EXPENSES (0)		27
27.01	OTHER EXPENSES (0)		27.01
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	1,230,915	29