

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: 01-23-2012 TIME: 09:07  
 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 MEMORIAL HOSPITAL (14-1338) (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.

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

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		537,777	-295,446		713,558	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		108,935				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		646,712	-295,446		713,558	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: 1900 STATE STREET  
 2 CITY: CHESTER

STATE: IL

P.O.BOX:  
 ZIP CODE: 62233

COUNTY: RANDOLPH

1  
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			3
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	14-1338	99914	1	09/01/2004	N	O	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF	14-Z338	99914		09/01/2004	N	O	N	7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA								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 8 21

INPATIENT PPS INFORMATION

22 DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO. 1 2  
 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. 3 N 23

	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
25							25
26				2			26
27				2			27
35							35
36			BEGINNING:		ENDING:		36
37							37
38			BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

	V 1	XVIII 2	XIX 3	
45	N	N	N	45
46	N	N	N	46
47	N	N	N	47
48	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	56
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 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))	64
ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	
1	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	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/(COL.3+COL.4))
1	2	3	4	5
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			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?			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 Y 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
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 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- SICAL ATIONAL SPEECH RATORY	Y Y Y N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		1,000,000 3,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	N		140
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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		1	2	
156 SUBPROVIDER - IPF		N	N	155
157 SUBPROVIDER - IRF		N	N	156
158 SUBPROVIDER - (OTHER)		N	N	157
159 SNF		N	N	158
160 HHA		N	N	159
161 CMHC		N	N	160
				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 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.                | Y | 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. | Y | 32 |
| 33 | IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.                                       | Y | 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

- |    |  |     |      |
|----|--|-----|------|
| 36 | WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?   | Y/N | DATE |
|    |  | 1   | 2    |
| 37 | IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  | N   | 36   |
| 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 WAGE INDEX INFORMATION

WORKSHEET S-3  
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	7,535,502		358,305.00		1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A						4
4.01	PHYSICIANS-PART A - DIRECT TEACHING						4.01
5	PHYSICIAN-PART B						5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		16,328	18,819	2,925.00		10
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		635,063		20,011.00		11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A		841,981		5,983.00		13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS						14
15	HOME OFFICE: PHYSICIAN-PART A						15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						16
WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		2,165,752				17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		10,149				19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A						22
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		137,757		6,296.00		26
27	ADMINISTRATIVE & GENERAL		1,121,355	-5,676	52,624.00		27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		92,648		978.00		28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		365,581		16,772.00		30
31	LAUNDRY & LINEN SERVICE		50,469		3,771.00		31
32	HOUSEKEEPING		247,176		23,037.00		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		299,668	-173,409	8,276.00		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)		32,608		619.00		35
36	CAFETERIA			160,266	16,969.00		36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		344,843		11,939.00		38
39	CENTRAL SERVICES AND SUPPLY		49,424		3,934.00		39
40	PHARMACY		287,091		7,965.00		40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		323,572		19,933.00		41
42	SOCIAL SERVICE		85,731		4,038.00		42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	7,660,758		7,660,758	359,902.00	21.29	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	16,328	18,819	35,147	2,925.00	12.02	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	7,644,430	-18,819	7,625,611	356,977.00	21.36	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	1,477,044		1,477,044	25,994.00	56.82	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	2,165,752		2,165,752		28.40	5
6	TOTAL (SUM OF LINES 3 THRU 5)	11,287,226	-18,819	11,268,407	382,971.00	29.42	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,437,923	-18,819	3,419,104	177,151.00	19.30	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	629,364 3
4 PRIOR YEAR PENSION SERVICE COST	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	832,454 8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	1,914 12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	663 14
15 WORKERS' COMPENSATION INSURANCE	109,823 15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	538,257 17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	15,936 20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	47,490 23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,175,901 24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 14-1338 MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10  
01/23/2012 09:07

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3  
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT	
0		LABOR	COST	
		1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL	1,201,756	400,585	2
3	SUBPROVIDER - IPF	1,201,756	400,585	3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTG			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18



PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (COLS. 2 + 3)
	1	2	3	4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL			200

	CBSA AT BEGINNING OF COST REPORTING PERIOD	CBSA ON/AFTER OF THE COST REPORTING PERIOD (IF APPLICABLE)
	1	2
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).	201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

	EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?
	1	2	3
202	STAFFING		202
203	RECRUITMENT		203
204	RETENTION OF EMPLOYEES		204
205	TRAINING		205
206	OTHER (SPECIFY)		206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)		207

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)				0.570881	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				486,954	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				694,514	5
6	MEDICAID CHARGES				2,747,925	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				1,568,738	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				387,270	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)				387,270	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	358,866	68,601	427,467		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	204,870	39,163	244,033		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE					22
23	COST OF CHARITY CARE	204,870	39,163	244,033		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					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)			1,434,066		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			333,303		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,100,763		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			628,405		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			872,438		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			1,259,708		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		1,643,743	1,643,743	-1,146,115	1
2	00200				1,307,292	2
3	00300					3
4	00400	137,757	2,183,447	2,321,204		4
5.01	00501	42,264	55,634	97,898		5.01
5.02	00502	140,016	198,147	338,163		5.02
5.03	00503	56,691	20,771	77,462		5.03
5.04	00504	130,060	8,941	139,001		5.04
5.05	00505	148,360	96,956	245,316		5.05
5.06	00506	603,964	2,089,839	2,693,803	-55,585	5.06
6	00600					6
7	00700	365,581	481,441	847,022		7
8	00800	50,469	57,021	107,490		8
9	00900	247,176	42,572	289,748		9
10	01000	299,668	224,679	524,347	-303,424	10
11	01100				280,427	11
12	01200					12
13	01300	344,843	2,640	347,483		13
14	01400	49,424	600,561	649,985	-596,485	14
15	01500	287,091	614,408	901,499	-542,943	15
16	01600	323,572	64,611	388,183		16
17	01700	85,731	7,207	92,938		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,454,621	63,307	1,517,928		30
ANCILLARY SERVICE COST CENTERS						
50	05000	522,670	619,407	1,142,077	-66,000	50
54	05400	708,817	348,625	1,057,442	-900	54
60	06000	596,684	694,209	1,290,893	-13,807	60
62	06200	26,589	80,969	107,558	13,807	62
62.30	06250					62.30
65	06500	261,790	63,435	325,225	-11,287	65
66	06600	2,000	562,397	564,397		66
67	06700		40,978	40,978		67
68	06800		48,304	48,304		68
71	07100				389,029	71
71.01	07101				207,456	71.01
71.02	07102					71.02
72	07200				10,567	72
73	07300				499,203	73
76	03950		42,887	42,887	-42,887	76
76.01	03951	127,162	713,026	840,188		76.01
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	92,400	2,858	95,258		90
91	09100	413,774	1,247,023	1,660,797		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118		7,519,174	12,920,043	20,439,217	-71,652	118
NONREIMBURSABLE COST CENTERS						
190	19000				5,768	190
192	19200	16,328	2,633	18,961		192
193.01	19301				42,887	193.01
194	07950				22,997	194
200		7,535,502	12,922,676	20,458,178		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	497,628		497,628	1
2	00200	1,307,292		1,307,292	2
3	00300				3
4	00400	2,321,204		2,321,204	4
5.01	00501	97,898	-5,746	92,152	5.01
5.02	00502	338,163		338,163	5.02
5.03	00503	77,462		77,462	5.03
5.04	00504	139,001		139,001	5.04
5.05	00505	245,316		245,316	5.05
5.06	00506	2,638,218	-1,670,874	967,344	5.06
6	00600				6
7	00700	847,022	-4,434	842,588	7
8	00800	107,490		107,490	8
9	00900	289,748		289,748	9
10	01000	220,923		220,923	10
11	01100	280,427	-54,661	225,766	11
12	01200				12
13	01300	347,483		347,483	13
14	01400	53,500		53,500	14
15	01500	358,556		358,556	15
16	01600	388,183	-2,862	385,321	16
17	01700	92,938		92,938	17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,517,928	-4,064	1,513,864	30
ANCILLARY SERVICE COST CENTERS					
50	05000	1,076,077	-460,000	616,077	50
54	05400	1,056,542	-4,000	1,052,542	54
60	06000	1,277,086		1,277,086	60
62	06200	121,365		121,365	62
62.30	06250				62.30
65	06500	313,938	-7,357	306,581	65
66	06600	564,397	-408	563,989	66
67	06700	40,978		40,978	67
68	06800	48,304		48,304	68
71	07100	389,029	-17,504	371,525	71
71.01	07101	207,456		207,456	71.01
71.02	07102				71.02
72	07200	10,567	-9,573	994	72
73	07300	499,203	-21,919	477,284	73
76	03950				76
76.01	03951	840,188	-94,004	746,184	76.01
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	95,258		95,258	90
91	09100	1,660,797	-396,016	1,264,781	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118		20,367,565	-2,753,422	17,614,143	118
NONREIMBURSABLE COST CENTERS					
190	19000	5,768		5,768	190
192	19200	18,961		18,961	192
193.01	19301	42,887	-1,054	41,833	193.01
194	07950	22,997		22,997	194
200		20,458,178	-2,754,476	17,703,702	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER
		COST CENTER	LINE #		
	1	2	3	4	5
1 TO RECLASS DRUG COST	A	DRUGS CHARGED TO PATIENTS	73		367,119 1
500 TOTAL RECLASSIFICATIONS					367,119 500
CODE LETTER - A					
1 TO RECLASS DEPRECIATION	B	CAP REL COSTS-MVBLE EQUIP	2		1,195,902 1
500 TOTAL RECLASSIFICATIONS					1,195,902 500
CODE LETTER - B					
1 TO RECLASS MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHRGED TO PA	71		389,029 1
2 TO RECLASS MEDICAL SUPPLIES	C	IMPLANTABLE SUPPLIES	71.01		207,456 2
3 TO RECLASS PACEMAKER SUPPLIES	C	IMPL. DEV. CHARGED TO PATIENT	72		10,567 3
500 TOTAL RECLASSIFICATIONS					607,052 500
CODE LETTER - C					
1 TO RECLASS IV THERAPY	D	DRUGS CHARGED TO PATIENTS	73		64,343 1
2 TO RECLASS DRUGS	D	DRUGS CHARGED TO PATIENTS	73		67,741 2
500 TOTAL RECLASSIFICATIONS					132,084 500
CODE LETTER - D					
1 CARDIAC REHAB	E	CARDIAC REHAB	193.01		42,887 1
500 TOTAL RECLASSIFICATIONS					42,887 500
CODE LETTER - E					
1 CAFETERIA	F	CAFETERIA	11	160,266	120,161 1
2 NON REIMB MEALS	F	NON-ALLOWABLE COSTS	194	13,143	9,854 2
500 TOTAL RECLASSIFICATIONS				173,409	130,015 500
CODE LETTER - F					
1 BLOOD BANK	G	WHOLE BLOOD & PCKD RED BLOOD	62	2,141	11,666 1
500 TOTAL RECLASSIFICATIONS				2,141	11,666 500
CODE LETTER - G					
1 LEASE/RENTAL	H	CAP REL COSTS-MVBLE EQUIP	2		30 1
2		CAP REL COSTS-MVBLE EQUIP	2		43,740 2
3		CAP REL COSTS-MVBLE EQUIP	2		66,000 3
4		CAP REL COSTS-MVBLE EQUIP	2		900 4
5		CAP REL COSTS-MVBLE EQUIP	2		720 5
500 TOTAL RECLASSIFICATIONS					111,390 500
CODE LETTER - H					
1 AUXILLARY	I	GIFT, FLOWER, COFFEE SHOP & C	190	5,676	92 1
500 TOTAL RECLASSIFICATIONS				5,676	92 500
CODE LETTER - I					
1 PROPERTY INSURANCE	L	CAP REL COSTS-BLDG & FIXT	1		49,787 1
500 TOTAL RECLASSIFICATIONS					49,787 500
CODE LETTER - L					
GRAND TOTAL (INCREASES)				181,226	2,647,994

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	A	PHARMACY	15		367,119	1
500 TOTAL RECLASSIFICATIONS					367,119	500
CODE LETTER - A						
1 TO RECLASS DEPRECIATION	B	CAP REL COSTS-BLDG & FIXT	1		1,195,902	9 1
500 TOTAL RECLASSIFICATIONS					1,195,902	500
CODE LETTER - B						
1 TO RECLASS MEDICAL SUPPLIES	C	CENTRAL SERVICES & SUPPLY	14		389,029	1
2 TO RECLASS MEDICAL SUPPLIES	C	CENTRAL SERVICES & SUPPLY	14		207,456	2
3 TO RECLASS PACEMAKER SUPPLIES	C	RESPIRATORY THERAPY	65		10,567	3
500 TOTAL RECLASSIFICATIONS					607,052	500
CODE LETTER - C						
1 TO RECLASS IV THERAPY	D	PHARMACY	15		64,343	1
2 TO RECLASS DRUGS	D	PHARMACY	15		67,741	2
500 TOTAL RECLASSIFICATIONS					132,084	500
CODE LETTER - D						
1 CARDIAC REHAB	E	CARDIAC REHAB	76		42,887	1
500 TOTAL RECLASSIFICATIONS					42,887	500
CODE LETTER - E						
1 CAFETERIA	F	DIETARY	10	160,266	120,161	1
2 NON REIMB MEALS	F	DIETARY	10	13,143	9,854	2
500 TOTAL RECLASSIFICATIONS				173,409	130,015	500
CODE LETTER - F						
1 BLOOD BANK	G	LABORATORY	60	2,141	11,666	1
500 TOTAL RECLASSIFICATIONS				2,141	11,666	500
CODE LETTER - G						
1 LEASE/RENTAL	H	OTHER ADMINISTRATIVE & GENERA	5.06		30	9 1
2		PHARMACY	15		43,740	9 2
3		OPERATING ROOM	50		66,000	9 3
4		RADIOLOGY-DIAGNOSTIC	54		900	9 4
5		RESPIRATORY THERAPY	65		720	9 5
500 TOTAL RECLASSIFICATIONS					111,390	500
CODE LETTER - H						
1 AUXILLARY	I	OTHER ADMINISTRATIVE & GENERA	5.06	5,676	92	1
500 TOTAL RECLASSIFICATIONS				5,676	92	500
CODE LETTER - I						
1 PROPERTY INSURANCE	L	OTHER ADMINISTRATIVE & GENERA	5.06		49,787	9 1
500 TOTAL RECLASSIFICATIONS					49,787	500
CODE LETTER - L						
GRAND TOTAL (DECREASES)				181,226	2,647,994	

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	202,557					202,557	1
2 LAND IMPROVEMENTS	433,529	25,011		25,011		458,540	2
3 BUILDINGS AND FIXTURES	13,119,658	115,375		115,375		13,235,033	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT	930,611	12,655		12,655		943,266	5
6 MOVABLE EQUIPMENT	10,548,009	533,729		533,729		11,081,738	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	25,234,364	686,770		686,770		25,921,134	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	25,234,364	686,770		686,770		25,921,134	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	1,643,743						1,643,743 1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	1,643,743						1,643,743 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 (SEE INSTR.) 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	1,399,819		1,399,819	0.140243				1
2 CAP REL COSTS-MVBLE EQUIP	8,581,549		8,581,549	0.859757				2
3 TOTAL (SUM OF LINES 1-2)	9,981,368		9,981,368	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	497,628						497,628 1
2 CAP REL COSTS-MVBLE EQUIP	1,307,292						1,307,292 2
3 TOTAL	1,804,920						1,804,920 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 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-1,507	OTHER ADMINISTRATIVE & GENERAL	5.06	4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-5,370	COMMUNICATIONS	5.01	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-497,377			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-54,661	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-423	MEDICAL SUPPLIES CHRGD TO PATI	71	16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-2,120	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	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		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33					33
34					34
35 MISC INCOME	B	-1,246	OTHER ADMINISTRATIVE & GENERAL	5.06	35
35.50 REBATES	A	-21,919	DRUGS CHARGED TO PATIENTS	73	35.50
35.51 REBATES	A	-17,081	MEDICAL SUPPLIES CHRGD TO PATI	71	35.51
35.52 REBATES	A	-464	IMPL. DEV. CHARGED TO PATIENT	72	35.52
35.53 REBATES	A	-9,109	IMPL. DEV. CHARGED TO PATIENT	72	35.53
36 PATIENT PHONE SERVICE-COST	A	-376	COMMUNICATIONS	5.01	36
36.01 CRNA FEES	A	-460,000	OPERATING ROOM	50	36.01
36.02 DICTATION FEES	B	-742	MEDICAL RECORDS & LIBRARY	16	36.02
36.03 ADMINISTRATIVE & GENERAL - MISC	B	-5	OTHER ADMINISTRATIVE & GENERAL	5.06	36.03
36.06 PROVISION FOR BAD DEBTS	A	-1,434,066	OTHER ADMINISTRATIVE & GENERAL	5.06	36.06
37					37
38 NON ALLOWABLE SALARIES	A	-6,401	OTHER ADMINISTRATIVE & GENERAL	5.06	38
39 NON ALLOWABLE OTHER	A	-79,125	OTHER ADMINISTRATIVE & GENERAL	5.06	39
39.01 NON ALLOWABLE DEPR & LEASE	A	-7,321	OTHER ADMINISTRATIVE & GENERAL	5.06	39.01
39.02 NON ALLOWABLE MED SCHOOL CONTRACT	A	-13,750	OTHER ADMINISTRATIVE & GENERAL	5.06	39.02
40 CRNA AND MD BILLING EXPENSE	A	-71,930	OTHER ADMINISTRATIVE & GENERAL	5.06	40
41					41
42					42
43 MISC INC ANALYSIS 5010-0220	B	-4,434	OPERATION OF PLANT	7	43
44					44
45 ADVERTISING	A	-1,054	CARDIAC REHAB	193.01	45
45.01 ADVERTISING	A	-408	PHYSICAL THERAPY	66	45.01
45.02 MISC REV PET SCANNER	A	-4,000	RADIOLOGY-DIAGNOSTIC	54	45.02
45.03 NON-ALLOWABLE MALPRACTICE	A	-55,523	OTHER ADMINISTRATIVE & GENERAL	5.06	45.03
45.05 HOSPICE	A	-4,064	ADULTS & PEDIATRICS	30	45.05
46					46
47					47

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
				COST CENTER 3	LINE NO. 4	
48						48
49						49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-2,754,476			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 ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						
2						
3						
4						
5	TOTALS (SUM OF LINES 1-4)					
	TRANSFER COL. 6, LINE 5 TO					
	WKST A-8, COL. 2, LINE 12.					

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1		2	3	4	5	6	7	8	9
1	60	LABORATORY			20,800				
2	65	RESPIRATORY THERAPY		925					
3	91	EMERGENCY	1,217,197	396,016	821,181				
4	76.01	CHEMOTHERAPY		94,004					
5	65	RESPIRATORY THERAPY		6,432					
200		TOTAL	1,339,358	497,377	841,981				200

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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	LAB							1
2	65 RESPIRATORY THERAPY	EEG						925	2
3	91 EMERGENCY	ER						396,016	3
4	76.01 CHEMOTHERAPY	AGGREGATE						94,004	4
5	65 RESPIRATORY THERAPY	AGGREGATE						6,432	5
200	TOTAL							497,377	200

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
 PARTS I & II

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED	1,497.90	1,155.08	91.60			9
10	AHSEA	71.26	71.26	53.44			10
11	STANDARD TRAVEL ALLOWANCE	35.63	35.63	26.72			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS					106,740	14
15	THERAPISTS					82,311	15
16	ASSISTANTS					4,895	16
17	SUBTOTAL ALLOWANCE AMOUNT					193,946	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					193,946	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					193,946	23

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS III & IV

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE	
24 THERAPISTS	24
25 ASSISTANTS	25
26 SUBTOTAL	26
27 STANDARD TRAVEL EXPENSE	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
29 THERAPISTS	29
30 ASSISTANTS	30
31 SUBTOTAL	31
32 OPTIONAL TRAVEL EXPENSE	32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE	
36 THERAPISTS	36
37 ASSISTANTS	37
38 SUBTOTAL	38
39 STANDARD TRAVEL EXPENSE	39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
40 THERAPISTS	40
41 ASSISTANTS	41
42 SUBTOTAL	42
43 OPTIONAL TRAVEL EXPENSE	43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES	
44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
 PARTS V,VI & VII

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					193,946	57
58						58
59						59
60						60
61						61
62						62
63					193,946	63
64					40,958	64
65						65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
 PARTS I & II

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		3,913.00	9,573.95	3,282.68		9
10	AHSEA		75.19	56.39	19.33		10
11	STANDARD TRAVEL ALLOWANCE	37.60	37.60	28.20			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					294,218	15
16	ASSISTANTS					539,875	16
17	SUBTOTAL ALLOWANCE AMOUNT					834,093	17
18	AIDES					63,454	18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					897,547	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					897,547	23

PROVIDER CCN: 14-1338 MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10  
01/23/2012 09:07

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS III & IV

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE	
24 THERAPISTS	24
25 ASSISTANTS	25
26 SUBTOTAL	26
27 STANDARD TRAVEL EXPENSE	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
29 THERAPISTS	29
30 ASSISTANTS	30
31 SUBTOTAL	31
32 OPTIONAL TRAVEL EXPENSE	32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE	
36 THERAPISTS	36
37 ASSISTANTS	37
38 SUBTOTAL	38
39 STANDARD TRAVEL EXPENSE	39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
40 THERAPISTS	40
41 ASSISTANTS	41
42 SUBTOTAL	42
43 OPTIONAL TRAVEL EXPENSE	43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES	
44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

PROVIDER CCN: 14-1338 MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
 PARTS V,VI & VII

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					897,547	57
58						58
59						59
60						60
61						61
62						62
63					897,547	63
64					541,777	64
65						65

PROVIDER CCN: 14-1338 MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
 PARTS I & II

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		188.75				9
10	AHSEA		68.47				10
11	STANDARD TRAVEL ALLOWANCE	34.24	34.24				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					12,924	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					12,924	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					12,924	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					68.47	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					53,407	22
23	TOTAL SALARY EQUIVALENCY					53,407	23

PROVIDER CCN: 14-1338 MEMORIAL HOSPITAL  
PERIOD FROM 07/01/2010 TO 06/30/2011

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS III & IV

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	24
25	ASSISTANTS	25
26	SUBTOTAL	26
27	STANDARD TRAVEL EXPENSE	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS	29
30	ASSISTANTS	30
31	SUBTOTAL	31
32	OPTIONAL TRAVEL EXPENSE	32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE		
36	THERAPISTS	36
37	ASSISTANTS	37
38	SUBTOTAL	38
39	STANDARD TRAVEL EXPENSE	39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS	40
41	ASSISTANTS	41
42	SUBTOTAL	42
43	OPTIONAL TRAVEL EXPENSE	43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

PROVIDER CCN: 14-1338 MEMORIAL HOSPITAL  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS V,VI & VII

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					53,407	57
58						58
59						59
60						60
61						61
62						62
63					53,407	63
64					13,475	64
65						65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	NEW CAP- REL COSTS BLDG&FIXT 1	NEW CAP- REL COSTS MOV EQUIP 2	EMPLOYEE BENEFITS 4	COMMUNICA- TION 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	497,628	497,628				1
2 CAP REL COSTS-MVBLE EQUIP	1,307,292		1,307,292			2
4 EMPLOYEE BENEFITS	2,321,204	9,540	25,061	2,355,805		4
5.01 COMMUNICATIONS	92,152	634	1,666	13,387	107,839	5.01
5.02 DATA PROCESSING	338,163	3,572	9,385	44,349	2,838	5.02
5.03 PURCHASING	77,462	12,150	31,918	17,956	1,622	5.03
5.04 ADMITTING	139,001	1,732	4,551	41,195	1,216	5.04
5.05 CREDIT AND COLLECTIONS	245,316	11,385	29,910	46,992	4,054	5.05
5.06 OTHER ADMINISTRATIVE & GENERAL	967,344	38,680	101,613	191,300	18,244	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	842,588	72,373	190,124	115,794	3,649	7
8 LAUNDRY & LINEN SERVICE	107,490	4,037	10,605	15,986	405	8
9 HOUSEKEEPING	289,748	7,258	19,067	90,933	405	9
10 DIETARY	220,923	6,194	16,271	39,991	2,027	10
11 CAFETERIA	225,766	10,389	27,292	50,763	405	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	347,483	9,517	25,002	109,226	3,243	13
14 CENTRAL SERVICES & SUPPLY	53,500	6,794	17,848	15,655	1,622	14
15 PHARMACY	358,556	6,335	16,643	90,933	2,027	15
16 MEDICAL RECORDS & LIBRARY	385,321	20,925	54,971	102,488	9,324	16
17 SOCIAL SERVICE	92,938	1,353	3,555	27,154	811	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	1,513,864	55,676	146,263	460,736	7,703	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	616,077	41,397	108,753	165,550	7,703	50
54 RADIOLOGY-DIAGNOSTIC	1,052,542	33,703	88,540	224,511	9,324	54
60 LABORATORY	1,277,086	13,927	36,588	188,994	5,270	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	121,365	815	2,142	8,422	405	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	306,581	10,689	28,081	82,919	3,649	65
66 PHYSICAL THERAPY	563,989	54,798	143,957	633	7,703	66
67 OCCUPATIONAL THERAPY	40,978					67
68 SPEECH PATHOLOGY	48,304	1,999	5,250		811	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	371,525					71
71.01 IMPLANTABLE SUPPLIES	207,456					71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT	994					72
73 DRUGS CHARGED TO PATIENTS	477,284					73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	746,184	13,831	36,335	40,277	1,622	76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
90 OUTPATIENT SERVICE COST CENTERS						
CLINIC	95,258	8,668	22,771	29,267	4,460	90
91 EMERGENCY	1,264,781	26,541	69,725	131,059	4,865	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	17,614,143	484,912	1,273,887	2,346,470	105,407	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,768	5,067	13,311		811	190
192 PHYSICIANS' PRIVATE OFFICES	18,961	4,201	11,036	5,172		192
193.01 CARDIAC REHAB	41,833	3,448	9,058		405	193.01
194 NON-ALLOWABLE COSTS	22,997			4,163	1,216	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	17,703,702	497,628	1,307,292	2,355,805	107,839	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	DATA	PURCHASING	ADMITTING	CREDIT &	SUBTOTAL	
	PROCESSING			COLLECTION		
	5.02	5.03	5.04	5.05	4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 DATA PROCESSING	398,307					5.02
5.03 PURCHASING	579	141,687				5.03
5.04 ADMITTING	16,349	375	204,419			5.04
5.05 CREDIT AND COLLECTIONS	20,475	435		358,567		5.05
5.06 OTHER ADMINISTRATIVE & GENERAL	19,083	4,471			1,340,735	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	681	5,739			1,230,948	7
8 LAUNDRY & LINEN SERVICE	24	2,298			140,845	8
9 HOUSEKEEPING	394	1,885			409,690	9
10 DIETARY	2,686	2,042			290,134	10
11 CAFETERIA					314,615	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	5,601	53			500,125	13
14 CENTRAL SERVICES & SUPPLY	742	176			96,337	14
15 PHARMACY	14,608	923			490,025	15
16 MEDICAL RECORDS & LIBRARY	37,416	2,023			612,468	16
17 SOCIAL SERVICE	4,467	223			130,501	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	90,254	1,548	11,849	20,919	2,308,812	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	18,572	3,305	13,886	24,517	999,760	50
54 RADIOLOGY-DIAGNOSTIC	4,644	4,201	52,622	92,918	1,563,005	54
60 LABORATORY	72,966	28,199	38,123	67,307	1,728,460	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	2,330	3,618	993	1,753	141,843	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	10,689	938	10,144	17,909	471,599	65
66 PHYSICAL THERAPY	3,946	663	13,234	23,365	812,288	66
67 OCCUPATIONAL THERAPY	245		941	1,662	43,826	67
68 SPEECH PATHOLOGY	168		676	1,193	58,401	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		17,382	18,684	32,988	440,579	71
71.01 IMPLANTABLE SUPPLIES		9,269	2,932	2,834	222,491	71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT		472	138	232	1,836	72
73 DRUGS CHARGED TO PATIENTS		22,304	23,003	40,612	563,203	73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	8,740	27,653	7,042	12,433	894,117	76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	8,187	112	1,454	2,568	172,745	90
91 EMERGENCY	30,187	1,072	8,698	15,357	1,552,285	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	374,033	141,379	204,419	358,567	17,531,673	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					24,957	190
192 PHYSICIANS' PRIVATE OFFICES	1,537	52			40,959	192
193.01 CARDIAC REHAB	253	256			55,253	193.01
194 NON-ALLOWABLE COSTS	22,484				50,860	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	398,307	141,687	204,419	358,567	17,703,702	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 CREDIT AND COLLECTIONS						5.05
5.06 OTHER ADMINISTRATIVE & GENERAL	1,340,735					5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	100,860	1,331,808				7
8 LAUNDRY & LINEN SERVICE	11,540	15,468	167,853			8
9 HOUSEKEEPING	33,569	27,812		471,071		9
10 DIETARY	23,773	23,733		8,677	346,317	10
11 CAFETERIA	25,779	39,809		14,554		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	40,979	36,468		13,332		13
14 CENTRAL SERVICES & SUPPLY	7,894	26,033		9,517		14
15 PHARMACY	40,151	24,276		8,875		15
16 MEDICAL RECORDS & LIBRARY	50,184	80,182		29,314		16
17 SOCIAL SERVICE	10,693	5,185		1,896		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	189,181	213,341	167,853	77,993	346,317	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	81,917	158,628		57,993		50
54 RADIOLOGY-DIAGNOSTIC	128,068	129,146		47,214		54
60 LABORATORY	141,625	53,368		19,511		60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	11,622	3,124		1,142		62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	38,641	40,959		14,974		65
66 PHYSICAL THERAPY	66,556	209,978		76,766		66
67 OCCUPATIONAL THERAPY	3,591					67
68 SPEECH PATHOLOGY	4,785	7,658		2,800		68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	36,100					71
71.01 IMPLANTABLE SUPPLIES	18,230					71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT	150					72
73 DRUGS CHARGED TO PATIENTS	46,147					73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	73,261	52,999		19,376		76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	14,154	33,214		12,143		90
91 EMERGENCY	127,190	101,702		37,181		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,326,640	1,283,083	167,853	453,258	346,317	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,045	19,416		7,098		190
192 PHYSICIANS' PRIVATE OFFICES	3,356	16,097		5,885		192
193.01 CARDIAC REHAB	4,527	13,212		4,830		193.01
194 NON-ALLOWABLE COSTS	4,167					194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,340,735	1,331,808	167,853	471,071	346,317	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINI- STRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 CREDIT AND COLLECTIONS						5.05
5.06 OTHER ADMINISTRATIVE & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	394,757					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	25,556	616,460				13
14 CENTRAL SERVICES & SUPPLY	3,663		143,444			14
15 PHARMACY	21,276		114	584,717		15
16 MEDICAL RECORDS & LIBRARY	23,980		9		796,137	16
17 SOCIAL SERVICE	6,354					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	107,802	343,486	2,900		46,140	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	38,735	123,421	5,179		54,075	50
54 RADIOLOGY-DIAGNOSTIC	52,530		564		204,948	54
60 LABORATORY	44,220		354		148,453	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	1,971				3,867	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	19,401		584		39,500	65
66 PHYSICAL THERAPY	148		27		51,534	66
67 OCCUPATIONAL THERAPY					3,666	67
68 SPEECH PATHOLOGY					2,631	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			69,817		72,759	71
71.01 IMPLANTABLE SUPPLIES			37,231		11,417	71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT			1,896		538	72
73 DRUGS CHARGED TO PATIENTS			23,704	365,985	89,575	73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	9,424	30,027	195	218,732	27,423	76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	6,848	21,819	64		5,663	90
91 EMERGENCY	30,665	97,707	806		33,948	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	392,573	616,460	143,444	584,717	796,137	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES	1,210					192
193.01 CARDIAC REHAB						193.01
194 NON-ALLOWABLE COSTS	974					194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	394,757	616,460	143,444	584,717	796,137	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 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 COMMUNICATIONS					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING					5.03
5.04 ADMITTING					5.04
5.05 CREDIT AND COLLECTIONS					5.05
5.06 OTHER ADMINISTRATIVE & GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	154,629				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	154,629	3,958,454		3,958,454	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		1,519,708		1,519,708	50
54 RADIOLOGY-DIAGNOSTIC		2,125,475		2,125,475	54
60 LABORATORY		2,135,991		2,135,991	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS		163,569		163,569	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY		625,658		625,658	65
66 PHYSICAL THERAPY		1,217,297		1,217,297	66
67 OCCUPATIONAL THERAPY		51,083		51,083	67
68 SPEECH PATHOLOGY		76,275		76,275	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		619,255		619,255	71
71.01 IMPLANTABLE SUPPLIES		289,369		289,369	71.01
71.02 PACEMAKERS					71.02
72 IMPL. DEV. CHARGED TO PATIENT		4,420		4,420	72
73 DRUGS CHARGED TO PATIENTS		1,088,614		1,088,614	73
76 CARDIAC REHAB					76
76.01 CHEMOTHERAPY		1,325,554		1,325,554	76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
90 OUTPATIENT SERVICE COST CENTERS					
CLINIC		266,650		266,650	90
91 EMERGENCY		1,981,484		1,981,484	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	154,629	17,448,856		17,448,856	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		53,516		53,516	190
192 PHYSICIANS' PRIVATE OFFICES		67,507		67,507	192
193.01 CARDIAC REHAB		77,822		77,822	193.01
194 NON-ALLOWABLE COSTS		56,001		56,001	194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	154,629	17,703,702		17,703,702	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	NEW CAP-	NEW CAP-	SUBTOTAL	EMPLOYEE
	CAP-REL	REL COSTS	REL COSTS		BENEFITS
	0	1	2	2A	4
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS		9,540	25,061	34,601	4
5.01 COMMUNICATIONS		634	1,666	2,300	197
5.02 DATA PROCESSING		3,572	9,385	12,957	651
5.03 PURCHASING		12,150	31,918	44,068	264
5.04 ADMITTING		1,732	4,551	6,283	605
5.05 CREDIT AND COLLECTIONS		11,385	29,910	41,295	690
5.06 OTHER ADMINISTRATIVE & GENERAL		38,680	101,613	140,293	2,810
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT		72,373	190,124	262,497	1,701
8 LAUNDRY & LINEN SERVICE		4,037	10,605	14,642	235
9 HOUSEKEEPING		7,258	19,067	26,325	1,336
10 DIETARY		6,194	16,271	22,465	587
11 CAFETERIA		10,389	27,292	37,681	746
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION		9,517	25,002	34,519	1,604
14 CENTRAL SERVICES & SUPPLY		6,794	17,848	24,642	230
15 PHARMACY		6,335	16,643	22,978	1,336
16 MEDICAL RECORDS & LIBRARY		20,925	54,971	75,896	1,505
17 SOCIAL SERVICE		1,353	3,555	4,908	399
19 NONPHYSICIAN ANESTHETISTS					17
20 NURSING SCHOOL					19
21 I&R SRVCES-SALARY & FRINGES APPRVD					20
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					21
23 PARAMED ED PRGM-(SPECIFY)					22
INPATIENT ROUTINE SERV COST CENTERS					23
30 ADULTS & PEDIATRICS		55,676	146,263	201,939	6,766
ANCILLARY SERVICE COST CENTERS					30
50 OPERATING ROOM		41,397	108,753	150,150	2,431
54 RADIOLOGY-DIAGNOSTIC		33,703	88,540	122,243	3,297
60 LABORATORY		13,927	36,588	50,515	2,776
62 WHOLE BLOOD & PCKD RED BLOOD CELLS		815	2,142	2,957	124
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62
65 RESPIRATORY THERAPY		10,689	28,081	38,770	1,218
66 PHYSICAL THERAPY		54,798	143,957	198,755	9
67 OCCUPATIONAL THERAPY					66
68 SPEECH PATHOLOGY		1,999	5,250	7,249	67
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					68
71.01 IMPLANTABLE SUPPLIES					71
71.02 PACEMAKERS					71.01
72 IMPL. DEV. CHARGED TO PATIENT					71.02
73 DRUGS CHARGED TO PATIENTS					72
76 CARDIAC REHAB					73
76.01 CHEMOTHERAPY		13,831	36,335	50,166	592
76.97 CARDIAC REHABILITATION					76
76.98 HYPERBARIC OXYGEN THERAPY					76.01
76.99 LITHOTRIPSY					76.97
OUTPATIENT SERVICE COST CENTERS					76.98
90 CLINIC		8,668	22,771	31,439	430
91 EMERGENCY		26,541	69,725	96,266	1,925
92 OBSERVATION BEDS					90
OTHER REIMBURSABLE COST CENTERS					91
SPECIAL PURPOSE COST CENTERS					92
118 SUBTOTALS (SUM OF LINES 1-117)		484,912	1,273,887	1,758,799	34,464
NONREIMBURSABLE COST CENTERS					118
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,067	13,311	18,378	190
192 PHYSICIANS' PRIVATE OFFICES		4,201	11,036	15,237	76
193.01 CARDIAC REHAB		3,448	9,058	12,506	192
194 NON-ALLOWABLE COSTS					193.01
200 CROSS FOOT ADJUSTMENTS					61
201 NEGATIVE COST CENTER					194
202 TOTAL (SUM OF LINES 118-201)		497,628	1,307,292	1,804,920	34,601

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	COMMUNICA-	DATA	PURCHASING	ADMITTING	CREDIT &	
	TION	PROCESSING			COLLECTION	
	5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS	2,497					5.01
5.02 DATA PROCESSING	66	13,674				5.02
5.03 PURCHASING	38	20	44,390			5.03
5.04 ADMITTING	28	561	117	7,594		5.04
5.05 CREDIT AND COLLECTIONS	94	703	136		42,918	5.05
5.06 OTHER ADMINISTRATIVE & GENERAL	424	655	1,401			5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	84	23	1,798			7
8 LAUNDRY & LINEN SERVICE	9	1	720			8
9 HOUSEKEEPING	9	14	590			9
10 DIETARY	47	92	640			10
11 CAFETERIA	9					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	75	192	17			13
14 CENTRAL SERVICES & SUPPLY	38	25	55			14
15 PHARMACY	47	501	289			15
16 MEDICAL RECORDS & LIBRARY	216	1,285	634			16
17 SOCIAL SERVICE	19	153	70			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	178	3,100	485	441	2,504	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	178	638	1,035	516	2,935	50
54 RADIOLOGY-DIAGNOSTIC	216	159	1,316	1,950	11,118	54
60 LABORATORY	122	2,505	8,835	1,418	8,057	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	9	80	1,133	37	210	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	84	367	294	377	2,144	65
66 PHYSICAL THERAPY	178	135	208	492	2,797	66
67 OCCUPATIONAL THERAPY		8		35	199	67
68 SPEECH PATHOLOGY	19	6		25	143	68
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			5,446	695	3,949	71
71.01 IMPLANTABLE SUPPLIES			2,904	109	339	71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT			148	5	28	72
73 DRUGS CHARGED TO PATIENTS			6,988	855	4,862	73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	38	300	8,664	262	1,488	76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	103	281	35	54	307	90
91 EMERGENCY	113	1,036	336	323	1,838	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	2,441	12,840	44,294	7,594	42,918	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19					190
192 PHYSICIANS' PRIVATE OFFICES		53	16			192
193.01 CARDIAC REHAB	9	9	80			193.01
194 NON-ALLOWABLE COSTS	28	772				194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,497	13,674	44,390	7,594	42,918	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 CREDIT AND COLLECTIONS						5.05
5.06 OTHER ADMINISTRATIVE & GENERAL	145,583					5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	10,952	277,055				7
8 LAUNDRY & LINEN SERVICE	1,253	3,218	20,078			8
9 HOUSEKEEPING	3,645	5,786		37,705		9
10 DIETARY	2,581	4,937		694	32,043	10
11 CAFETERIA	2,799	8,281		1,165		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	4,450	7,586		1,067		13
14 CENTRAL SERVICES & SUPPLY	857	5,416		762		14
15 PHARMACY	4,360	5,050		710		15
16 MEDICAL RECORDS & LIBRARY	5,449	16,680		2,346		16
17 SOCIAL SERVICE	1,161	1,079		152		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	20,541	44,382	20,078	6,243	32,043	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,895	32,999		4,642		50
54 RADIOLOGY-DIAGNOSTIC	13,906	26,866		3,779		54
60 LABORATORY	15,378	11,102		1,562		60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	1,262	650		91		62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	4,196	8,521		1,199		65
66 PHYSICAL THERAPY	7,227	43,682		6,144		66
67 OCCUPATIONAL THERAPY	390					67
68 SPEECH PATHOLOGY	520	1,593		224		68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,920					71
71.01 IMPLANTABLE SUPPLIES	1,980					71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT	16					72
73 DRUGS CHARGED TO PATIENTS	5,011					73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	7,955	11,025		1,551		76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
90 OUTPATIENT SERVICE COST CENTERS CLINIC	1,537	6,909		972		90
91 EMERGENCY	13,811	21,157		2,976		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	144,052	266,919	20,078	36,279	32,043	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	222	4,039		568		190
192 PHYSICIANS' PRIVATE OFFICES	364	3,349		471		192
193.01 CARDIAC REHAB	492	2,748		387		193.01
194 NON-ALLOWABLE COSTS	453					194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	145,583	277,055	20,078	37,705	32,043	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINI- STRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 CREDIT AND COLLECTIONS						5.05
5.06 OTHER ADMINISTRATIVE & GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	50,681					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,281	52,791				13
14 CENTRAL SERVICES & SUPPLY	470		32,495			14
15 PHARMACY	2,732		26	38,029		15
16 MEDICAL RECORDS & LIBRARY	3,079		2		107,092	16
17 SOCIAL SERVICE	816					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	13,840	29,415	657		6,207	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,973	10,569	1,173		7,275	50
54 RADIOLOGY-DIAGNOSTIC	6,744		128		27,559	54
60 LABORATORY	5,677		80		19,972	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	253				520	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	2,491		132		5,314	65
66 PHYSICAL THERAPY	19		6		6,933	66
67 OCCUPATIONAL THERAPY					493	67
68 SPEECH PATHOLOGY					354	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			15,816		9,788	71
71.01 IMPLANTABLE SUPPLIES			8,434		1,536	71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT			430		72	72
73 DRUGS CHARGED TO PATIENTS			5,370	23,803	12,051	73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	1,210	2,571	44	14,226	3,689	76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	879	1,869	14		762	90
91 EMERGENCY	3,937	8,367	183		4,567	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	50,401	52,791	32,495	38,029	107,092	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES	155					192
193.01 CARDIAC REHAB						193.01
194 NON-ALLOWABLE COSTS	125					194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	50,681	52,791	32,495	38,029	107,092	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 COMMUNICATIONS					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING					5.03
5.04 ADMITTING					5.04
5.05 CREDIT AND COLLECTIONS					5.05
5.06 OTHER ADMINISTRATIVE & GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	8,757				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	8,757	397,576		397,576	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		228,409		228,409	50
54 RADIOLOGY-DIAGNOSTIC		219,281		219,281	54
60 LABORATORY		127,999		127,999	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS		7,326		7,326	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY		65,107		65,107	65
66 PHYSICAL THERAPY		266,585		266,585	66
67 OCCUPATIONAL THERAPY		1,125		1,125	67
68 SPEECH PATHOLOGY		10,133		10,133	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		39,614		39,614	71
71.01 IMPLANTABLE SUPPLIES		15,302		15,302	71.01
71.02 PACEMAKERS					71.02
72 IMPL. DEV. CHARGED TO PATIENT		699		699	72
73 DRUGS CHARGED TO PATIENTS		58,940		58,940	73
76 CARDIAC REHAB					76
76.01 CHEMOTHERAPY		103,781		103,781	76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		45,591		45,591	90
91 EMERGENCY		156,835		156,835	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	8,757	1,744,303		1,744,303	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		23,226		23,226	190
192 PHYSICIANS' PRIVATE OFFICES		19,721		19,721	192
193.01 CARDIAC REHAB		16,231		16,231	193.01
194 NON-ALLOWABLE COSTS		1,439		1,439	194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	8,757	1,804,920		1,804,920	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP- REL COSTS BLDG&FIXT SQ FEET	NEW CAP- REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS  GROSS SALARIES	COMMUNICA- TION  # NON PT. TELEPHONES	DATA PROCESSING  TIME SPENT	
	1	2	4	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	87,896					1
2 CAP REL COSTS-MVBLE EQUIP		87,896				2
4 EMPLOYEE BENEFITS	1,685	1,685	7,437,659			4
5.01 COMMUNICATIONS	112	112	42,264	266		5.01
5.02 DATA PROCESSING	631	631	140,016	7	1,642,331	5.02
5.03 PURCHASING	2,146	2,146	56,691	4	2,389	5.03
5.04 ADMITTING	306	306	130,060	3	67,412	5.04
5.05 CREDIT AND COLLECTIONS	2,011	2,011	148,360	10	84,424	5.05
5.06 OTHER ADMINISTRATIVE & GENERAL	6,832	6,832	603,964	45	78,684	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	12,783	12,783	365,581	9	2,807	7
8 LAUNDRY & LINEN SERVICE	713	713	50,469	1	99	8
9 HOUSEKEEPING	1,282	1,282	287,091	1	1,623	9
10 DIETARY	1,094	1,094	126,258	5	11,074	10
11 CAFETERIA	1,835	1,835	160,266	1		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,681	1,681	344,843	8	23,096	13
14 CENTRAL SERVICES & SUPPLY	1,200	1,200	49,424	4	3,059	14
15 PHARMACY	1,119	1,119	287,091	5	60,233	15
16 MEDICAL RECORDS & LIBRARY	3,696	3,696	323,572	23	154,278	16
17 SOCIAL SERVICE	239	239	85,731	2	18,419	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	9,834	9,834	1,454,621	19	372,145	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,312	7,312	522,670	19	76,578	50
54 RADIOLOGY-DIAGNOSTIC	5,953	5,953	708,817	23	19,149	54
60 LABORATORY	2,460	2,460	596,684	13	300,860	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	144	144	26,589	1	9,607	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	1,888	1,888	261,790	9	44,072	65
66 PHYSICAL THERAPY	9,679	9,679	2,000	19	16,269	66
67 OCCUPATIONAL THERAPY					1,010	67
68 SPEECH PATHOLOGY	353	353		2	691	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
71.01 IMPLANTABLE SUPPLIES						71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	2,443	2,443	127,162	4	36,037	76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,531	1,531	92,400	11	33,756	90
91 EMERGENCY	4,688	4,688	413,774	12	124,469	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	85,650	85,650	7,408,188	260	1,542,240	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	895	895		2		190
192 PHYSICIANS' PRIVATE OFFICES	742	742	16,328		6,339	192
193.01 CARDIAC REHAB	609	609		1	1,044	193.01
194 NON-ALLOWABLE COSTS			13,143	3	92,708	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	497,628	1,307,292	2,355,805	107,839	398,307	202
203 UNIT COST MULT-WS B PT I	5.661555	14.873168	0.316740	405.409774	0.242525	203
204 COST TO BE ALLOC PER B PT II			34,601	2,497	13,674	204
205 UNIT COST MULT-WS B PT II			0.004652	9.387218	0.008326	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING	ADMITTING	CREDIT & COLLECTION	RECON-CILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	
	SUPPLY COS	GROSS CHARGES	GROSS CHARGES			
	5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 COMMUNICATIONS						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING	3,171,150					5.03
5.04 ADMITTING	8,385	31,287,239				5.04
5.05 CREDIT AND COLLECTIONS	9,725		31,083,197			5.05
5.06 OTHER ADMINISTRATIVE & GENERAL	100,064			-1,340,735	16,362,967	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	128,455				1,230,948	7
8 LAUNDRY & LINEN SERVICE	51,441				140,845	8
9 HOUSEKEEPING	42,180				409,690	9
10 DIETARY	45,695				290,134	10
11 CAFETERIA					314,615	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,196				500,125	13
14 CENTRAL SERVICES & SUPPLY	3,935				96,337	14
15 PHARMACY	20,662				490,025	15
16 MEDICAL RECORDS & LIBRARY	45,286				612,468	16
17 SOCIAL SERVICE	5,000				130,501	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	34,649	1,813,392	1,813,392		2,308,812	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	73,965	2,125,250	2,125,250		999,760	50
54 RADIOLOGY-DIAGNOSTIC	94,016	8,055,324	8,055,324		1,563,005	54
60 LABORATORY	631,138	5,834,510	5,834,510		1,728,460	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	80,969	151,988	151,988		141,843	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	20,990	1,552,423	1,552,423		471,599	65
66 PHYSICAL THERAPY	14,834	2,025,399	2,025,399		812,288	66
67 OCCUPATIONAL THERAPY		144,084	144,084		43,826	67
68 SPEECH PATHOLOGY		103,422	103,422		58,401	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	389,029	2,859,563	2,859,563		440,579	71
71.01 IMPLANTABLE SUPPLIES	207,456	448,692	245,687		222,491	71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT	10,567	21,129	20,092		1,836	72
73 DRUGS CHARGED TO PATIENTS	499,203	3,520,481	3,520,481		563,203	73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	618,912	1,077,762	1,077,762		894,117	76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,506	222,578	222,578		172,745	90
91 EMERGENCY	23,997	1,331,242	1,331,242		1,552,285	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	3,164,255	31,287,239	31,083,197	-1,340,735	16,190,938	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					24,957	190
192 PHYSICIANS' PRIVATE OFFICES	1,169				40,959	192
193.01 CARDIAC REHAB	5,726				55,253	193.01
194 NON-ALLOWABLE COSTS					50,860	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	141,687	204,419	358,567		1,340,735	202
203 UNIT COST MULT-WS B PT I	0.044680	0.006534	0.011536		0.081937	203
204 COST TO BE ALLOC PER B PT II	44,390	7,594	42,918		145,583	204
205 UNIT COST MULT-WS B PT II	0.013998	0.000243	0.001381		0.008897	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA
	OF PLANT SQ FEET	AND LINEN SERVICE PATIENT DAYS	SQUARE FEET	PATIENT DAYS	SALARIES
	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 COMMUNICATIONS					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING					5.03
5.04 ADMITTING					5.04
5.05 CREDIT AND COLLECTIONS					5.05
5.06 OTHER ADMINISTRATIVE & GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT	61,390				7
8 LAUNDRY & LINEN SERVICE	713	2,192			8
9 HOUSEKEEPING	1,282		59,395		9
10 DIETARY	1,094		1,094	2,192	10
11 CAFETERIA	1,835		1,835		11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	1,681		1,681		344,843
14 CENTRAL SERVICES & SUPPLY	1,200		1,200		49,424
15 PHARMACY	1,119		1,119		287,091
16 MEDICAL RECORDS & LIBRARY	3,696		3,696		323,572
17 SOCIAL SERVICE	239		239		85,731
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	9,834	2,192	9,834	2,192	1,454,621
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	7,312		7,312		522,670
54 RADIOLOGY-DIAGNOSTIC	5,953		5,953		708,817
60 LABORATORY	2,460		2,460		596,684
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	144		144		26,589
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY	1,888		1,888		261,790
66 PHYSICAL THERAPY	9,679		9,679		2,000
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY	353		353		68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					71
71.01 IMPLANTABLE SUPPLIES					71.01
71.02 PACEMAKERS					71.02
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76 CARDIAC REHAB					76
76.01 CHEMOTHERAPY	2,443		2,443		127,162
76.97 CARDIAC REHABILITATION					76.01
76.98 HYPERBARIC OXYGEN THERAPY					76.97
76.99 LITHOTRIPSY					76.98
OUTPATIENT SERVICE COST CENTERS					76.99
90 CLINIC	1,531		1,531		92,400
91 EMERGENCY	4,688		4,688		413,774
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	59,144	2,192	57,149	2,192	5,297,168
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	895		895		190
192 PHYSICIANS' PRIVATE OFFICES	742		742		16,328
193.01 CARDIAC REHAB	609		609		193.01
194 NON-ALLOWABLE COSTS					13,143
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	1,331,808	167,853	471,071	346,317	394,757
203 UNIT COST MULT-WS B PT I	21.694217	76.575274	7.931156	157.991332	0.074110
204 COST TO BE ALLOC PER B PT II	277,055	20,078	37,705	32,043	50,681
205 UNIT COST MULT-WS B PT II	4.513031	9.159672	0.634818	14.618157	0.009515

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINI- STRATION SALARIES	CENTRAL SERVICES & SUPPLY COSTED REQUIS	PHARMACY COSTED REQUIS	MEDICAL RECORDS + LIBRARY GROSS CHARGES	SOCIAL SERVICE TIME SPENT	
	13	14	15	16	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 COMMUNICATIONS						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING						5.03
5.04 ADMITTING						5.04
5.05 CREDIT AND COLLECTIONS						5.05
5.06 OTHER ADMINISTRATIVE & GENERAL						5.06
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	2,610,627					13
14 CENTRAL SERVICES & SUPPLY		799,288				14
15 PHARMACY		638	2,878,995			15
16 MEDICAL RECORDS & LIBRARY		50		31,290,240		16
17 SOCIAL SERVICE					2,192	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	1,454,621	16,157		1,813,391	2,192	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	522,670	28,858		2,125,250		50
54 RADIOLOGY-DIAGNOSTIC		3,140		8,055,324		54
60 LABORATORY		1,971		5,834,510		60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS				151,989		62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		3,253		1,552,423		65
66 PHYSICAL THERAPY		150		2,025,399		66
67 OCCUPATIONAL THERAPY				144,084		67
68 SPEECH PATHOLOGY				103,422		68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		389,029		2,859,563		71
71.01 IMPLANTABLE SUPPLIES		207,456		448,692		71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT		10,567		21,129		72
73 DRUGS CHARGED TO PATIENTS		132,084	1,802,017	3,520,481		73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	127,162	1,087	1,076,978	1,077,762		76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	92,400	356		222,578		90
91 EMERGENCY	413,774	4,492		1,334,243		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	2,610,627	799,288	2,878,995	31,290,240	2,192	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
193.01 CARDIAC REHAB						193.01
194 NON-ALLOWABLE COSTS						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	616,460	143,444	584,717	796,137	154,629	202
203 UNIT COST MULT-WS B PT I	0.236135	0.179465	0.203098	0.025444	70.542427	203
204 COST TO BE ALLOC PER B PT II	52,791	32,495	38,029	107,092	8,757	204
205 UNIT COST MULT-WS B PT II	0.020222	0.040655	0.013209	0.003423	3.994982	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 COMMUNICATIONS	5.01
5.02 DATA PROCESSING	5.02
5.03 PURCHASING	5.03
5.04 ADMITTING	5.04
5.05 CREDIT AND COLLECTIONS	5.05
5.06 OTHER ADMINISTRATIVE & GENERAL	5.06
6 MAINTENANCE & REPAIRS	6
7 OPERATION OF PLANT	7
8 LAUNDRY & LINEN SERVICE	8
9 HOUSEKEEPING	9
10 DIETARY	10
11 CAFETERIA	11
12 MAINTENANCE OF PERSONNEL	12
13 NURSING ADMINISTRATION	13
14 CENTRAL SERVICES & SUPPLY	14
15 PHARMACY	15
16 MEDICAL RECORDS & LIBRARY	16
17 SOCIAL SERVICE	17
19 NONPHYSICIAN ANESTHETISTS	19
20 NURSING SCHOOL	20
21 I&R SRVCES-SALARY & FRINGES APPRVD	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23 PARAMED ED PRGM-(SPECIFY)	23
INPATIENT ROUTINE SERV COST CENTERS	
30 ADULTS & PEDIATRICS	30
ANCILLARY SERVICE COST CENTERS	
50 OPERATING ROOM	50
54 RADIOLOGY-DIAGNOSTIC	54
60 LABORATORY	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS	62.30
65 RESPIRATORY THERAPY	65
66 PHYSICAL THERAPY	66
67 OCCUPATIONAL THERAPY	67
68 SPEECH PATHOLOGY	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	71
71.01 IMPLANTABLE SUPPLIES	71.01
71.02 PACEMAKERS	71.02
72 IMPL. DEV. CHARGED TO PATIENT	72
73 DRUGS CHARGED TO PATIENTS	73
76 CARDIAC REHAB	76
76.01 CHEMOTHERAPY	76.01
76.97 CARDIAC REHABILITATION	76.97
76.98 HYPERBARIC OXYGEN THERAPY	76.98
76.99 LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS	
90 CLINIC	90
91 EMERGENCY	91
92 OBSERVATION BEDS	92
OTHER REIMBURSABLE COST CENTERS	
SPECIAL PURPOSE COST CENTERS	
118 SUBTOTALS (SUM OF LINES 1-117)	118
NONREIMBURSABLE COST CENTERS	
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	190
192 PHYSICIANS' PRIVATE OFFICES	192
193.01 CARDIAC REHAB	193.01
194 NON-ALLOWABLE COSTS	194
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	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT			
	1	2	3	4	5
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	3,958,454		3,958,454		30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1,519,708		1,519,708		50
54 RADIOLOGY-DIAGNOSTIC	2,125,475		2,125,475		54
60 LABORATORY	2,135,991		2,135,991		60
62 WHOLE BLOOD & PCKD RED BLOO	163,569		163,569		62
62.30 BLOOD CLOTTING FACTORS ADMI					62.30
65 RESPIRATORY THERAPY	625,658		625,658		65
66 PHYSICAL THERAPY	1,217,297		1,217,297		66
67 OCCUPATIONAL THERAPY	51,083		51,083		67
68 SPEECH PATHOLOGY	76,275		76,275		68
71 MEDICAL SUPPLIES CHRGED TO	619,255		619,255		71
71.01 IMPLANTABLE SUPPLIES	289,369		289,369		71.01
71.02 PACEMAKERS					71.02
72 IMPL. DEV. CHARGED TO PATIE	4,420		4,420		72
73 DRUGS CHARGED TO PATIENTS	1,088,614		1,088,614		73
76 CARDIAC REHAB					76
76.01 CHEMOTHERAPY	1,325,554		1,325,554		76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	266,650		266,650		90
91 EMERGENCY	1,981,484		1,981,484		91
92 OBSERVATION BEDS	414,150		414,150		92
OTHER REIMBURSABLE COST CENTERS					
200 SUBTOTAL (SEE INSTRUCTIONS)	17,863,006		17,863,006		200
201 LESS OBSERVATION BEDS	414,150		414,150		201
202 TOTAL (SEE INSTRUCTIONS)	17,448,856		17,448,856		202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,491,721		1,491,721			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	261,113	1,864,137	2,125,250	0.715073		50
54 RADIOLOGY-DIAGNOSTIC	429,815	7,625,509	8,055,324	0.263860		54
60 LABORATORY	847,260	4,987,250	5,834,510	0.366096		60
62 WHOLE BLOOD & PCKD RED BLOO	82,001	69,988	151,989	1.076190		62
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
65 RESPIRATORY THERAPY	352,387	1,200,036	1,552,423	0.403020		65
66 PHYSICAL THERAPY	205,466	1,819,933	2,025,399	0.601016		66
67 OCCUPATIONAL THERAPY	37,250	106,834	144,084	0.354536		67
68 SPEECH PATHOLOGY	21,794	81,628	103,422	0.737512		68
71 MEDICAL SUPPLIES CHRGED TO	698,152	2,161,411	2,859,563	0.216556		71
71.01 IMPLANTABLE SUPPLIES	224,594	224,098	448,692	0.644917		71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIE		21,129	21,129	0.209191		72
73 DRUGS CHARGED TO PATIENTS	1,017,817	2,502,664	3,520,481	0.309223		73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY	5,984	1,071,778	1,077,762	1.229913		76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		222,578	222,578	1.198007		90
91 EMERGENCY	3,001	1,331,242	1,334,243	1.485100		91
92 OBSERVATION BEDS	1	321,670	321,671	1.287496		92
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)	5,678,356	25,611,885	31,290,241			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		25,611,885	31,290,241			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1338) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	COST SERVICES SUBJECT TO DED & COINS 5	COST SVCES NOT SUBJECT TO DED & COINS 6	COST 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.715073		856,012		612,111		50
54 RADIOLOGY-DIAGNOSTIC	0.263860		3,049,022		804,515		54
60 LABORATORY	0.366096		2,143,890		784,870		60
62 WHOLE BLOOD & PCKD RED BLOOD CE	1.076190		52,328		56,315		62
62.30 BLOOD CLOTTING FACTORS ADMIN CO							62.30
65 RESPIRATORY THERAPY	0.403020		576,064		232,165		65
66 PHYSICAL THERAPY	0.601016		740,660		445,149		66
67 OCCUPATIONAL THERAPY	0.354536		36,570		12,965		67
68 SPEECH PATHOLOGY	0.737512		34,127		25,169		68
71 MEDICAL SUPPLIES CHRGED TO PATI	0.216556		1,087,059		235,409		71
71.01 IMPLANTABLE SUPPLIES	0.644917		108,785		70,157		71.01
71.02 PACEMAKERS							71.02
72 IMPL. DEV. CHARGED TO PATIENT	0.209191		7,567		1,583		72
73 DRUGS CHARGED TO PATIENTS	0.309223		1,105,487	6,036	341,842	1,866	73
76 CARDIAC REHAB							76
76.01 CHEMOTHERAPY	1.229913		751,819		924,672		76.01
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	1.198007		131,575		157,628		90
91 EMERGENCY	1.485100		458,640		681,126		91
92 OBSERVATION BEDS	1.287496		158,588		204,181		92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)			11,298,193	6,036	5,589,857	1,866	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)			11,298,193	6,036	5,589,857	1,866	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-Z338)  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT SUBJECT TO	COST SERVICES	COST SVCS NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.715073						50
54 RADIOLOGY-DIAGNOSTIC	0.263860						54
60 LABORATORY	0.366096						60
62 WHOLE BLOOD & PCKD RED BLOOD CE	1.076190						62
62.30 BLOOD CLOTTING FACTORS ADMIN CO							62.30
65 RESPIRATORY THERAPY	0.403020						65
66 PHYSICAL THERAPY	0.601016						66
67 OCCUPATIONAL THERAPY	0.354536						67
68 SPEECH PATHOLOGY	0.737512						68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.216556						71
71.01 IMPLANTABLE SUPPLIES	0.644917						71.01
71.02 PACEMAKERS							71.02
72 IMPL. DEV. CHARGED TO PATIENT	0.209191						72
73 DRUGS CHARGED TO PATIENTS	0.309223						73
76 CARDIAC REHAB							76
76.01 CHEMOTHERAPY	1.229913						76.01
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	1.198007						90
91 EMERGENCY	1.485100						91
92 OBSERVATION BEDS	1.287496						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

PROVIDER CCN: 14-1338 MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2010 TO 06/30/2011

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 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 01/23/2012 09:07

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM (COL.3 ÷ COL.4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS							30
31 INTENSIVE CARE UNIT							31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY							43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)							200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-1338) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL
	COST	CHARGES	COST TO		
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL.3 x
	B, PT. II,	C, PT. I,	(COL.1 ÷	CHARGES	COL.4)
	COL. 26)	COL. 8)	COL.2)		
	1	2	3	4	5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62 WHOLE BLOOD & PCKD RED BLOOD					62
62.30 BLOOD CLOTTING FACTORS ADMIN					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGD TO PA					71
71.01 IMPLANTABLE SUPPLIES					71.01
71.02 PACEMAKERS					71.02
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76 CARDIAC REHAB					76
76.01 CHEMOTHERAPY					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)					200

PROVIDER CCN: 14-1338 MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2010 TO 06/30/2011

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

VERSION: 2011.10  
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

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

PROVIDER CCN: 14-1338 MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2010 TO 06/30/2011

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 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

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

PROVIDER CCN: 14-1338 MEMORIAL HOSPITAL  
 PERIOD FROM 07/01/2010 TO 06/30/2011

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 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-1338) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] NF [XX] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	HEALTH 3	COST (SUM OF COLS.1-4) 5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62 WHOLE BLOOD & PCKD RED BLOOD						62
62.30 BLOOD CLOTTING FACTORS ADMIN						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGED TO PA						71
71.01 IMPLANTABLE SUPPLIES						71.01
71.02 PACEMAKERS						71.02
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB						76
76.01 CHEMOTHERAPY						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1338)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

  

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
54 RADIOLOGY-DIAGNOSTIC							54
60 LABORATORY							60
62 WHOLE BLOOD & PCKD RED BLOOD							62
62.30 BLOOD CLOTTING FACTORS ADMIN							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
71 MEDICAL SUPPLIES CHRGD TO P							71
71.01 IMPLANTABLE SUPPLIES							71.01
71.02 PACEMAKERS							71.02
72 IMPL. DEV. CHARGED TO PATIEN							72
73 DRUGS CHARGED TO PATIENTS							73
76 CARDIAC REHAB							76
76.01 CHEMOTHERAPY							76.01
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC							90
91 EMERGENCY							91
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)							200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1338) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [ ] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB.	COST REIMB.	COST	COST	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.715073		178,570			127,691	50
54 RADIOLOGY-DIAGNOSTIC	0.263860		620,118			163,624	54
60 LABORATORY	0.366096		559,792			204,938	60
62 WHOLE BLOOD & PCKD RED BLOOD CE	1.076190		5,691			6,125	62
62.30 BLOOD CLOTTING FACTORS ADMIN CO							62.30
65 RESPIRATORY THERAPY	0.403020		98,901			39,859	65
66 PHYSICAL THERAPY	0.601016		64,146			38,553	66
67 OCCUPATIONAL THERAPY	0.354536		816			289	67
68 SPEECH PATHOLOGY	0.737512		8,690			6,409	68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.216556		288,748			62,530	71
71.01 IMPLANTABLE SUPPLIES	0.644917						71.01
71.02 PACEMAKERS							71.02
72 IMPL. DEV. CHARGED TO PATIENT	0.209191						72
73 DRUGS CHARGED TO PATIENTS	0.309223		116,326			35,971	73
76 CARDIAC REHAB							76
76.01 CHEMOTHERAPY	1.229913		10,315			12,687	76.01
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	1.198007		8,875			10,632	90
91 EMERGENCY	1.485100		211,728			314,437	91
92 OBSERVATION BEDS	1.287496		18,038			23,224	92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)			2,190,754			1,046,969	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)			2,190,754			1,046,969	202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1338) [ ] 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)	2,443 1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,052 2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3 3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,052 4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	172 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)	172 6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	23 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)	24 8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,110 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)	172 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)	172 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 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 13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	14 14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	15 15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	16 16
SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	17 17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	18 18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	107.32 19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	107.32 20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,958,454 21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	22 22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	23 23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	2,468 24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	2,576 25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	572,644 26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,385,810 27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,319,978 28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	29 29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,319,978 30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.459415 31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	32 32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,130.59 33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	34 34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	35 35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	36 36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,385,810 37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1338) [ ] 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) 1,650.00 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,831,500 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,831,500 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					913,209 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,744,709 49

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

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

PROGRAM INPATIENT ROUTINE SWING BED COST  
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 283,800 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUC (TITLE XVIII ONLY) 283,800 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 567,600 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 251 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,650.00 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 414,150 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST	397,576	3,385,810	0.117424	414,150	48,631 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1338) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	2,443	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,052	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,052	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	172	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)	172	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	23	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)	24	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	65	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	107.32	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	107.32	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,958,454	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)	2,468	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	2,576	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	572,644	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,385,810	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,319,978	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,319,978	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.459415	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,130.59	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)	3,385,810	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1338) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,650.00 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 107,250 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) 107,250 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					47,031 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					154,281 49

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

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 251 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-1338) [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		821,494			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.715073	156,812	112,132		50
54 RADIOLOGY-DIAGNOSTIC	0.263860	255,153	67,325		54
60 LABORATORY	0.366096	468,665	171,576		60
62 WHOLE BLOOD & PCKD RED BLOOD CE	1.076190	60,522	65,133		62
62.30 BLOOD CLOTTING FACTORS ADMIN CO					62.30
65 RESPIRATORY THERAPY	0.403020	220,828	88,998		65
66 PHYSICAL THERAPY	0.601016	60,106	36,125		66
67 OCCUPATIONAL THERAPY	0.354536	13,069	4,633		67
68 SPEECH PATHOLOGY	0.737512	13,345	9,842		68
71 MEDICAL SUPPLIES CHRGED TO PATI	0.216556	525,978	113,904		71
71.01 IMPLANTABLE SUPPLIES	0.644917	161,279	104,012		71.01
71.02 PACEMAKERS					71.02
72 IMPL. DEV. CHARGED TO PATIENT	0.209191				72
73 DRUGS CHARGED TO PATIENTS	0.309223	442,198	136,738		73
76 CARDIAC REHAB					76
76.01 CHEMOTHERAPY	1.229913				76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	1.198007				90
91 EMERGENCY	1.485100	1,879	2,791		91
92 OBSERVATION BEDS	1.287496				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,379,834	913,209		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,379,834			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B SNF(14-Z338) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.715073	261	187		50
54 RADIOLOGY-DIAGNOSTIC	0.263860	9,360	2,470		54
60 LABORATORY	0.366096	72,133	26,408		60
62 WHOLE BLOOD & PCKD RED BLOOD CE	1.076190	2,176	2,342		62
62.30 BLOOD CLOTTING FACTORS ADMIN CO					62.30
65 RESPIRATORY THERAPY	0.403020	35,138	14,161		65
66 PHYSICAL THERAPY	0.601016	94,248	56,645		66
67 OCCUPATIONAL THERAPY	0.354536	17,850	6,328		67
68 SPEECH PATHOLOGY	0.737512	3,574	2,636		68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.216556	69,435	15,037		71
71.01 IMPLANTABLE SUPPLIES	0.644917				71.01
71.02 PACEMAKERS					71.02
72 IMPL. DEV. CHARGED TO PATIENT	0.209191				72
73 DRUGS CHARGED TO PATIENTS	0.309223	101,403	31,356		73
76 CARDIAC REHAB					76
76.01 CHEMOTHERAPY	1.229913				76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	1.198007				90
91 EMERGENCY	1.485100				91
92 OBSERVATION BEDS	1.287496				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		405,578	157,570		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		405,578			202

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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK  TITLE V  HOSPITAL (14-1338)  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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		42,605			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.715073	10,746	7,684		50
54 RADIOLOGY-DIAGNOSTIC	0.263860	17,000	4,486		54
60 LABORATORY	0.366096	38,199	13,985		60
62 WHOLE BLOOD & PCKD RED BLOOD CE	1.076190				62
62.30 BLOOD CLOTTING FACTORS ADMIN CO					62.30
65 RESPIRATORY THERAPY	0.403020	8,274	3,335		65
66 PHYSICAL THERAPY	0.601016	1,788	1,075		66
67 OCCUPATIONAL THERAPY	0.354536				67
68 SPEECH PATHOLOGY	0.737512				68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.216556	38,756	8,393		71
71.01 IMPLANTABLE SUPPLIES	0.644917				71.01
71.02 PACEMAKERS					71.02
72 IMPL. DEV. CHARGED TO PATIENT	0.209191				72
73 DRUGS CHARGED TO PATIENTS	0.309223	25,749	7,962		73
76 CARDIAC REHAB					76
76.01 CHEMOTHERAPY	1.229913				76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	1.198007				90
91 EMERGENCY	1.485100	75	111		91
92 OBSERVATION BEDS	1.287496				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		140,587	47,031		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		140,587			202



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [XX] HOSPITAL (14-1338) [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOX: [ ] IRF [ ] SWING BED SNF

INPATIENT  
 PART A

PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,791,459		4,238,904
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.		90,702		186,708
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 02/04/2011	107,875		NONE
	.02			3.01
	.03			3.02
	.04			3.03
	.05			3.04
	.06			3.05
	.07			3.06
	.08			3.07
	.09			3.08
	.10			3.09
	.11	NONE		3.50
	.12		02/04/2011	61,899
	.13			3.51
	.14			3.52
	.15			3.53
	.16			3.54
	.17			3.55
	.18			3.56
	.19			3.57
	.20			3.58
	.21			3.59
	.22			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		107,875		-61,899
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		1,990,036		4,363,713

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 .10	NONE		NONE	5.50
	TO .11				5.51
	PROGRAM .12				5.52
	.13				5.53
	.14				5.54
	.15				5.55
	.16				5.56
	.17				5.57
	.18				5.58
	.19				5.59
	.20				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	537,777			6.01
	TO .02				
	PROVIDER .03				
	PROVIDER .04				
	TO .05				
	PROGRAM .06			-295,446	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		2,527,813		4,068,267	7

8 NAME OF CONTRACTOR: \_\_\_\_\_ CONTRACTOR NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK APPLICABLE BOX:	[ ] HOSPITAL [ ] IPF [ ] IRF	[ ] SUB (OTHER) [ ] SNF [XX] SWING BED SNF (14-Z338)	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1				543,735		1
2				NONE		2
3		.01 02/04/2011		69,806		3.01
		.02				3.02
		.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.50		NONE		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		69,806		3.99
4				613,541		4
TO BE COMPLETED BY CONTRACTOR						
5		.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
6		.01		108,935		6.01
		.02				6.02
7				722,476		7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:	DATE:	

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL (14-1338) [ ] 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	541 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,110 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,801 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	31,290,241 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	427,467 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7 7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8 8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	30 30
31	OTHER ADJUSTMENTS (SPECIFY)	31 31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32 32

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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [ ] TITLE V [XX] SWING BED - SNF (14-Z338)  
APPLICABLE [XX] TITLE XVIII [ ] SWING BED - NF  
BOXES [ ] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	573,276	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)	159,146	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	344	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)	732,422	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	732,422	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	732,422	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	9,946	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)	722,476	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)	722,476	19
20 INTERIM PAYMENTS	613,541	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	108,935	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART V

CHECK [XX] HOSPITAL (14-1338)  
APPLICABLE BOX: [ ] SUB (OTHER)

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

1	INPATIENT SERVICES	2,744,709	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	2,744,709	4
5	PRIMARY PAYER PAYMENTS	3,947	5
6	TOTAL COST (LINE 5 LESS LINE 6) (FOR CAH, SEE INSTRUCTIONS)	2,768,170	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 1.000000)		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)	2,768,170	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	285,207	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	2,482,963	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	2,482,963	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	44,850	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	44,850	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	38,204	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26 (LINE 26 HOSPITAL AND SUBPROVIDER ONLY))	2,527,813	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	2,527,813	30
31	INTERIM PAYMENTS	1,990,036	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	537,777	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

CHECK [ ] TITLE V [XX] HOSPITAL (14-1338) [ ] SNF [ ] PPS  
 APPLICABLE [XX] TITLE XIX [ ] IPF [ ] NF [ ] TEFRA  
 BOXES: [ ] IRF [ ] ICF/MR [XX] OTHER  
 [ ] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	154,281 1
2	MEDICAL AND OTHER SERVICES	1,046,969 2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3 3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	1,201,250 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5 5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6 6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	1,201,250 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	42,605 8
9	ANCILLARY SERVICE CHARGES	2,331,341 9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10 10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11 11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12 12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13 13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14 14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	15 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	16 16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 7 (SEE INSTRUCTIONS))	17 17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 7 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18 18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19 19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20 20
21	COST OF COVERED SERVICES (LINE 7)	1,201,250 21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22 22
23	OUTLIER PAYMENTS	23 23
24	PROGRAM CAPITAL PAYMENTS	24 24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25 25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26 26
27	SUBTOTAL (SUM OF LINES 22-26 PLUS LINE 3 MINUS LINES 5 AND 6)	27 27
28	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)	28 28
29	TITLE V OR XIX PPS, ENTER AMOUNT FROM LINE 27, NON-PPS ENTER AMOUNT FROM LINE 21	1,201,250 29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30 30
31	SUBTOTAL (SUM OF LINES 19-20 PLUS 29 MINUS 30)	1,201,250 31
32	DEDUCTIBLES	32 32
33	COINSURANCE	33 33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34 34
35	UTILIZATION REVIEW	35 35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	1,201,250 36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37 37
38	SUBTOTAL (LINE 36 ± LINE 37)	1,201,250 38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39 39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	1,201,250 40
41	INTERIM PAYMENTS	487,692 41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	713,558 42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43 43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	3,647,382			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	6,323,766			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,799,803			6
7	INVENTORY	187,971			7
8	PREPAID EXPENSES				8
9	OTHER CURRENT ASSETS	665,092			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	7,024,408			11
FIXED ASSETS					
12	LAND	202,557			12
13	LAND IMPROVEMENTS	458,540			13
14	ACCUMULATED DEPRECIATION	-406,623			14
15	BUILDINGS	13,235,033			15
16	ACCUMULATED DEPRECIATION	-5,749,218			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	943,266			19
20	ACCUMULATED DEPRECIATION	-871,251			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	11,081,738			23
24	ACCUMULATED DEPRECIATION	-7,355,370			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)	11,538,672			30
OTHER ASSETS					
31	INVESTMENTS	16,427,425			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	16,427,425			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	34,990,505			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	768,193			37
38	SALARIES, WAGES & FEES PAYABLE				38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	892,689			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,660,882			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	1,660,882			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	33,329,623			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)	33,329,623			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	34,990,505			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		31,152,544							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		2,177,079							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		33,329,623							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 RESTRICTED FUND BALANCE CHAN									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		33,329,623							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 CORRECTION									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		33,329,623							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	1,491,721		1,491,721	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY				8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	1,491,721		1,491,721	
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
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	1,491,721		1,491,721	17
18 ANCILLARY SERVICES	4,186,635	25,611,885	29,798,520	18
19 OUTPATIENT SERVICES				19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 LABORATORY GROSSUP		-116,353	-116,353	27
27.01 PROFESSIONAL FEES	113,427	1,867,012	1,980,439	27.01
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	5,791,783	27,362,544	33,154,327	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		20,458,178	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)	34	34	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)		20,458,212	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	33,154,327	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	11,365,113	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	21,789,214	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	20,458,212	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	1,331,002	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	75,910	6
7	INCOME FROM INVESTMENTS	502,399	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	1,507	10
11	REBATES AND REFUNDS OF EXPENSES	48,573	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	54,661	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	423	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	742	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (REPLACEMENT TAX)	23,378	24
24.03	OTHER (INTEREST INCOME OTHER)	4,424	24.03
24.04	OTHER (CARELINK REVENUE)		24.04
24.05	OTHER (DR OFFICE BLDG)	73,523	24.05
24.06	OTHER (DIALYSIS BLDG REVENUE)	57,744	24.06
24.07	OTHER (NON ALLOWABLE INCOME)	775	24.07
24.08	OTHER (MEALS ON WHEELS)		24.08
24.09	OTHER (MAINTENANCE EMPLOYEES)		24.09
24.10	OTHER (US CONSUMER REVENUES)	2,819	24.10
24.13	OTHER (MISC)	58,095	24.13
24.14	OTHER (TRANSITIONAL CARE REVENUE)		24.14
24.15	OTHER (MRI TECH)		24.15
24.16	OTHER (HEALTHY HEART)	9,245	24.16
24.17	OTHER (GAIN ON ASSETS)		24.17
24.18	OTHER (MISC)	67,021	24.18
24.19	OTHER (GRANTS)		24.19
24.20	OTHER (OTHER)		24.20
24.21	OTHER (NON OPERATING AR INTEREST)		24.21
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	981,239	25
26	TOTAL (LINE 5 PLUS LINE 25)	2,312,241	26
27	OTHER EXPENSES (CARELINK EXPENSE)		27
27.01	OTHER EXPENSES (DR OFFICE BLDG DEPRECIATION)	31,224	27.01
27.02	OTHER EXPENSES (MAINTENANCE SALARIES)		27.02
27.03	OTHER EXPENSES (DEPRECIATION)	4,306	27.03
27.04	OTHER EXPENSES (LOSS ON ASSETS)		27.04
27.05	OTHER EXPENSES (DIALYSIS DEPRECIATION)	12,969	27.05
27.06	OTHER EXPENSES (LOSS ON ASSETS)	68,873	27.06
27.07	OTHER EXPENSES (DIALYSIS OTHER)	341	27.07
27.08	OTHER EXPENSES (BUILDING EXP)		27.08
27.09	OTHER EXPENSES (OTHER)	17,448	27.09
27.10	OTHER EXPENSES (MISC)	1	27.10
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	135,162	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	2,177,079	29

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 COMMUNICATIONS					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING					5.03
5.04 ADMITTING					5.04
5.05 CREDIT AND COLLECTIONS					5.05
5.06 OTHER ADMINISTRATIVE & GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
30 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62 WHOLE BLOOD & PCKD RED BLOOD C					62
62.30 BLOOD CLOTTING FACTORS ADMIN C					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGED TO PAT					71
71.01 IMPLANTABLE SUPPLIES					71.01
71.02 PACEMAKERS					71.02
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76 CARDIAC REHAB					76
76.01 CHEMOTHERAPY					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
90 OUTPATIENT SERVICE COST CENTERS CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
193.01 CARDIAC REHAB					193.01
194 NON-ALLOWABLE COSTS					194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204