

RICHLAND MEMORIAL HOSPITAL

OLNEY, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED SEPTEMBER 30, 2012

National Government Services, Inc.
3200 Pleasant Run, Suite B
Springfield, IL 62711

Re: Provider: Richland Memorial Hospital

Provider Numbers: 14-0147, 14-S147, 14-U147, 14-5580, 14-7187, 14-1542

Period ended: 09/30/2012

Protested amounts claimed on submitted cost report.

Dear Sir or Madam:

The cost report for Richland Memorial Hospital, for the year ended September 30, 2010, claims additional amounts due the provider for an expense paid by the provider, but currently not classified as a reimbursable cost by National Government Services. The expense in question is the Illinois State Medicaid Provider Tax Assessment, in the amount of \$1,252,657, which we have included as an adjustment to line 6 (A&G) on worksheet A-8. We feel as though the expense should be, and is, allowed as a reimbursable cost under Medicare Guidelines and should remain on line 6 (A&G) for inclusion in the B-1 allocation process.

The calculation of the additional amounts due the provider was calculated by removing the adjustment on worksheet A-8. The expense was then allowed to be allocated by the B-1 accumulated cost statistic to the various Hospital departments. The protested amount claimed for the period ended September 30, 2010, is as follows:

Worksheet E-3, part I, line 21 \$ 0

Sincerely,

National Government Services, Inc.
3200 Pleasant Run, Suite B
Springfield, IL 62711

Re: Provider: Richland Memorial Hospital
Provider Numbers: 14-0147, 14-S147, 14-U147, 14-5580, 14-7187, 14-1542
Period ended: 09/30/2012
Protested amounts claimed on submitted cost report.

Dear Sir or Madam:

The Provider contends that its base-year hospital-specific rate, applied to calculate the payments to the Provider during this cost reporting period, is artificially low because of the application of a cumulative budget neutrality factor that encompasses all budget neutrality adjustments made prior to the base year. As reflected in the attached calculation, the Provider estimates that the reimbursement impact of this issue for this cost reporting period is \$81,000.

The Provider currently has an appeal of the determination of its base-year hospital specific rate pending before the Provider Reimbursement Review Board. As explained in that appeal, the Provider contends that applying a cumulative budget neutrality adjustment to the base year hospital-specific rate is fatally flawed for at least the following reasons:

- It is contrary to the statutory mandate to use "100 percent of the hospital's target amount." See, e.g., Soc. Sec. Act § 1886(d) (5) (D) (i).
- It is duplicative and removes twice the effect of recalibrating DRGs: once when the hospital-specific rate is divided by the hospital's case mix index and again when the budget neutrality factor is directly applied to the hospital-specific rate.

Richland Memorial Hospital
Hospital Specific Rate Recalculation
September 30, 2012

The hospital specific calculation without the cumulative
budget neutrality factor would be:

HSP difference for September 30, 2010	109.74
2011 Update Factor	1.0235
2012 Update Factor	1.0190
2011 Budget Neutrality	0.996731
2012 Budget Neutrality	0.997903
2012 Document & Coding	0.9528
2012 Rural Floor Add-on	<u>1.009</u>
2012 difference	109.44
DRG weight	<u>988.22</u>
	108,153
MDH payment factor	<u>0.75</u>
	<u>81,115</u>
Rounded	<u><u>81,000</u></u>

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: 02/15/2013 TIME: 14:30
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - AMENDED

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY RICHLAND MEMORIAL HOSPITAL (14-0147) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2011 AND ENDING 09/30/2012, 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, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 02/15/2013 14:30
 qHw3I3pjGaHDSY2xcsKHf17b3uUfD0
 nxUQS0tvEd28iJsiVwaMmSlZlJyN7H
 lvsglDnKlj0kILyg

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

 TITLE

PI Encryption: 02/15/2013 14:30
 lFtas:Kgppq8qDyll1y2VQFQ0Guc9M0
 bSx2o0:B5Zq7T:01YeovxFjeT3s1AN
 n5WF0TOIs60Tdb0x

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 5
1	HOSPITAL	-18,612	-46,574	44,856	1
2	SUBPROVIDER - IPF	5,606			2
3	SUBPROVIDER - IRF				3
4	SUBPROVIDER (OTHER)				4
5	SWING BED - SNF	18,316			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	5,310	-46,574	44,856	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: 800 EAST LOCUST
 2 CITY: OLNEY

STATE: IL

P.O.BOX:
 ZIP CODE: 62450-2958 COUNTY: RICHLAND

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)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	14-0147	99914	1	07/01/1966	N	P	P	3
4	SUBPROVIDER - IFF	14-S147	99914	4	07/01/1966	N	P	P	4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF	14-U147	99914		11/13/2003	N	P	N	7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF	14-5580	99914		11/05/1987	N	P	N	9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA	14-7187	99914		05/01/1980	N	P	N	12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE	14-1542	99914		04/23/1991				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: 10/01/2011			TO: 09/30/2012				20
21	TYPE OF CONTROL								21

INPATIENT PPS INFORMATION

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

	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.					25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2		26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			2		27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.					35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:	ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			1		37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING: 10/01/2011	ENDING: 09/30/2012	38

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER \$413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	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, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, 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 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, 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
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y 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.			N 71
INPATIENT REHABILITATION FACILITY PPS.				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			N 76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	PHY- SICAL	OCCUP- ATIONAL	RESPI- RATORY
		N	N	N
				109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	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.	2		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 407,294 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	Y	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.	1 N	2	140
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.				
141	NAME:	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, LINE 74 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)		TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX V	TITLE XIX 4
155	HOSPITAL	N	N	N	155
156	SUBPROVIDER - IPF	N	N	N	156
157	SUBPROVIDER - IRF	N	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	N	158
159	SNF	N	N	N	159
160	HHA	N	N	N	160
161	CMHC		N		161

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

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

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

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

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. Y 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. 1.00 169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1	2	1	
		N			
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	Y/N	DATE	V/I	
		1 <td>2 <td>3</td> </td>	2 <td>3</td>	3	
		N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1	2	3	
		Y	A	4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1	2	6	
		N		7	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1	2	3	4
		Y	11/11/2012	Y	11/11/2012
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- 41 FIRST NAME: DAVID LAST NAME: SCHNAKE TITLE: PARTNER 41
- 42 EMPLOYER: KERBER, ECK & BRAECKEL, LLP 42
- 43 PHONE NUMBER: 618-529-1040 E-MAIL ADDRESS: DAVIDS@KEBCPA.COM 43

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

LINE NO.	COMPONENT	WKST A	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS			TOTAL				
			NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	ALL PATIENTS	
1			2	3	4	5	6	7	8	9
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	39	14,274		3,026	723		4,910	1
2	HMO					23	205			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF					348			348	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								37	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		39	14,274		3,374	723		5,295	7
8	INTENSIVE CARE UNIT	31	8	2,928		756	181		1,228	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43					402		643	13
14	TOTAL (SEE INSTRUCTIONS)		47	17,202		4,130	1,306		7,166	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	16	5,856		634	766		2,245	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44	34	12,444		3,097			10,331	19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101				10,246			12,143	22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116	1	366						24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		98							27
28	OBSERVATION BED DAYS						136		619	28
29	AMBULANCE TRIPS					1,075				29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

LINE	COMPONENT	WKST A NO.	--- FULL TIME EQUIVALENTS ---			----- DISCHARGES -----			TOTAL ALL PATIENTS	
			TOTAL INTERNS & RESIDENTS	ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX		
1		1	9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					954	408	1,886	1
2	HMO									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)			346.24			954	408	1,886	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40		15.99			113	202	535	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44		27.93						19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101		14.30						22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116		4.73						24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)			409.19						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCB NON-COVERED DAYS									33

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	18,788,905	18,788,905	851,110.00	22.08	1	
2	NON-PHYSICIAN ANESTHETIST PART A						2	
3	NON-PHYSICIAN ANESTHETIST PART B		790,284	790,284	8,320.00	94.99	3	
4	PHYSICIAN-PART A ADMINISTRATIVE						4	
4.01	PHYSICIAN-PART A - 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 AN APPROVED PGM)						7.01	
8	HOME OFFICE PERSONNEL						8	
9	SNF	44	991,852	991,852	58,807.00	16.87	9	
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		3,771,954	3,771,954	140,623.00	26.82	10	
OTHER WAGES & RELATED COSTS								
11	CONTRACT LABOR (SEE INSTRUCTIONS)		283,528	283,528	4,058.00	69.87	11	
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12	
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE						13	
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS						14	
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						15	
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						16	
WAGE-RELATED COSTS								
17	WAGE-RELATED COSTS (CORE)		5,009,600	5,009,600			17	
18	WAGE-RELATED COSTS (OTHER)						18	
19	EXCLUDED AREAS		1,127,062	1,127,062			19	
20	NON-PHYSICIAN ANESTHETIST PART A						20	
21	NON-PHYSICIAN ANESTHETIST PART B		142,816	142,816			21	
22	PHYSICIAN PART A - ADMINISTRATIVE						22	
22.01	PHYSICIAN PART A - TEACHING						22.01	
23	PHYSICIAN PART B						23	
24	WAGE-RELATED COSTS (RHC/FOHC)						24	
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25	
OVERHEAD COSTS - DIRECT SALARIES								
26	EMPLOYEE BENEFITS		231,333	231,333	8,442.00	27.40	26	
27	ADMINISTRATIVE & GENERAL		1,735,179	1,735,179	91,482.00	18.97	27	
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		30,000	30,000	400.00	75.00	28	
29	MAINTENANCE & REPAIRS		498,274	498,274	25,234.00	19.75	29	
30	OPERATION OF PLANT						30	
31	LAUNDRY & LINEN SERVICE		226,289	226,289	18,536.00	12.21	31	
32	HOUSEKEEPING		381,139	381,139	35,916.00	10.61	32	
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33	
34	DIETARY		554,430	-363,072	191,358	18,662.00	10.25	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35	
36	CAFETERIA			363,072	363,072	34,657.00	10.48	36
37	MAINTENANCE OF PERSONNEL						37	
38	NURSING ADMINISTRATION		1,047,342	1,047,342	37,062.00	28.26	38	
39	CENTRAL SERVICES AND SUPPLY		77,922	77,922	6,186.00	12.60	39	
40	PHARMACY		456,799	456,799	14,309.00	31.92	40	
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		532,638	532,638	31,376.00	16.98	41	
42	SOCIAL SERVICE						42	
43	OTHER GENERAL SERVICE						43	

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	18,028,621	18,028,621	843,190.00	21.38	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	4,763,806	4,763,806	199,430.00	23.89	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	13,264,815	13,264,815	643,760.00	20.61	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	283,528	283,528	4,058.00	69.87	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	5,009,600	5,009,600		37.77*	5
6	TOTAL (SUM OF LINES 3 THRU 5)	18,557,943	18,557,943	647,818.00	28.65	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	5,771,345	5,771,345	322,262.00	17.91	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
RETIREMENT COST			
1	401K EMPLOYER CONTRIBUTIONS	590,780	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)			
5	401K/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST			
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	3,180,006	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)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	210,601	15
16	RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES			
17	FICA-EMPLOYERS PORTION ONLY	1,240,935	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	45,851	20
OTHER			
21	EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	107,988	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	5,376,161	24
PART B - OTHER THAN CORE RELATED COST			
25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)	162,732	25

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	1,355,192	1
2	HOSPITAL	1,097,379	2
3	SUBPROVIDER - IPF	196,190	3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF	30,000	8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE	31,623	13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7187

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		5,616		57	5,673	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		320.00	43.00	66.00	422.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS
 IN YOUR NORMAL WORK WEEK: 40.00

----- NUMBER OF EMPLOYEES -----
 (FULL TIME EQUIVALENT)
 STAFF CONTRACT TOTAL
 1 2 3

3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)						3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			2.00		2.00	4
5 OTHER ADMINISTRATIVE PERSONNEL			1.40		1.40	5
6 DIRECT NURSING SERVICE			6.80		6.80	6
7 NURSING SUPERVISOR						7
8 PHYSICAL THERAPY SERVICE						8
9 PHYSICAL THERAPY SUPERVISOR						9
10 OCCUPATIONAL THERAPY SERVICE						10
11 OCCUPATIONAL THERAPY SUPERVISOR						11
12 SPEECH PATHOLOGY SERVICE						12
13 SPEECH PATHOLOGY SUPERVISOR						13
14 MEDICAL SOCIAL SERVICE						14
15 MEDICAL SOCIAL SERVICE SUPERVISOR						15
16 HOME HEALTH AIDE			3.40		3.40	16
17 HOME HEALTH AIDE SUPERVISOR						17
18 OTHER (SPECIFY)						18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2				
21 SKILLED NURSING VISITS	4,266	1,138	132	76	5,612	21
22 SKILLED NURSING VISIT CHARGES	893,075	238,897	27,676	15,967	1,175,615	22
23 PHYSICAL THERAPY VISITS	2,205	63	17	27	2,312	23
24 PHYSICAL THERAPY VISIT CHARGES	463,579	13,284	3,587	5,697	486,147	24
25 OCCUPATIONAL THERAPY VISITS	377	42	2	12	433	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	79,011	8,835	421	2,524	90,791	26
27 SPEECH PATHOLOGY VISITS	36				36	27
28 SPEECH PATHOLOGY VISIT CHARGES	7,442				7,442	28
29 MEDICAL SOCIAL SERVICE VISITS	68	5	2	1	76	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	19,829	1,447	584	292	22,152	30
31 HOME HEALTH AIDE VISITS	1,540	186	1	50	1,777	31
32 HOME HEALTH AIDE VISIT CHARGES	187,432	22,768	122	6,124	216,446	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	8,492	1,434	154	166	10,246	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	1,650,368	285,231	32,390	30,604	1,998,593	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	452		61	12	525	36
37 TOTAL NUMBER OF OUTLIER EPISODES		27			27	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	87,305	14,117	6,348	829	108,599	38

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES. IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	11/12/2003	2

	GROUP	SNF	SWING BED	TOTAL
	1	DAYS	SNF DAYS	(COLS. 2 + 3)
		2	3	4
3	RUX			3
4	RUL			4
5	RVX	12		12
6	RVL	78		78
7	RHX	22		22
8	RHL	157	10	167
9	RMX	24	19	43
10	RML	135	14	149
11	RLX			11
12	RUC	14		14
13	RUB	7		7
14	RUA	43		43
15	RVC	125	13	138
16	RVB	163		163
17	RVA	621		621
18	RHC	249		249
19	RHB	237		237
20	RHA	557	39	596
21	RMC	112	32	144
22	RMB	97	35	132
23	RMA	224	60	284
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1	27	38	65
29	HE2	19		19
30	HE1		6	6
31	HD2			31
32	HD1	2	2	4
33	HC2			33
34	HC1			34
35	HB2			35
36	HB1	79	21	100
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1			40
41	LC2			41
42	LC1	14		14
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1		4	4
47	CD2			47
48	CD1	14	6	20
49	CC2			49
50	CC1	9	4	13
51	CB2			51
52	CB1	15	20	35
53	CA2			53
54	CA1	6	22	28
55	SE3			55
56	SE2			56
57	SE1			57
58	SSC			58
59	SSB			59
60	SSA			60
61	IB2			61
62	IB1			62
63	IA1			63
64	IA2			64
65	BB2			65
66	BB1			66
67	BA2			67
68	BA1			68

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1		13		13 72
73	PC2				73
74	PC1		4		4 74
75	PB2				75
76	PB1		18		18 76
77	PA2				77
78	PA1			3	3 78
199	AAA				199
200	TOTAL		3,097	348	3,445 200

		CBSA AT	CBSA ON/AFTER	
		BEGINNING	OCT 1 OF THE	
		OF COST	COST REPORTING	
		REPORTING	PERIOD (IF	
		PERIOD	APPLICABLE)	
		1	2	

SNF SERVICES

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). 00014 00014 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	
		1	2	WITH	
				DIRECT	
				PATIENT	
				CARE AND	
				RELATED	
				EXPENSES?	
202	STAFFING	1,318,845	62.95%	Y	202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING	3,014	0.14%	Y	205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	2,095,040			207

HOSPICE IDENTIFICATION DATA

HOSPICE NO.: 14-1542

WORKSHEET S-9
 PARTS I & II

PART I - ENROLLMENT DAYS

		----- UNDUPLICATED DAYS -----					
		TITLE XVIII	TITLE XIX	TITLE XVIII SKILLED NURSING FACILITY	TITLE XIX NURSING FACILITY	ALL OTHER	TOTAL (SUM OF COLS. 1, 2 & 5) 6
		1	2	3	4	5	6
1	CONTINUOUS HOME CARE						
2	ROUTINE HOME CARE	3,853	432			578	4,863
3	INPATIENT RESPITE CARE	1	9				10
4	GENERAL INPATIENT CARE						
5	TOTAL HOSPICE DAYS	3,854	441			578	4,873

PART II - CENSUS DATA

		TITLE XVIII	TITLE XIX	TITLE XVIII SKILLED NURSING FACILITY	TITLE XIX NURSING FACILITY	ALL OTHER	TOTAL (SUM OF COLS. 1, 2 & 5) 6
		1	2	3	4	5	6
6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	79	6			10	95
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE						
8	AVERAGE LENGTH OF STAY (LINE 5/LINE 6)	48.78	73.50			57.80	51.29
9	UNDUPLICATED CENSUS COUNT						

NOTE: PARTS I & II, COLUMNS 1 AND 2 ALSO INCLUDE THE DAYS REPORTED IN COLUMN 3 AND 4.

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 202, COL. 3 DIVIDED BY LINE 202, COL. 8) 0.289694 1

MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)

2 NET REVENUE FROM MEDICAID 2,497,473 2
 3 DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID? Y 3
 4 IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID? Y 4
 5 IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID 5
 6 MEDICAID CHARGES 23,249,983 6
 7 MEDICAID COST (LINE 1 TIMES LINE 6) 6,735,381 7
 8 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) 4,237,908 8
 IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.

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
 IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.

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
 IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.

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) 4,237,908 19

	UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3
20 TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	3,067,269	5,596,177	8,663,446 20
21 COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	888,569	1,621,179	2,509,748 21
22 PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	124,102	114,755	238,857 22
23 COST OF CHARITY CARE	764,467	1,506,424	2,270,891 23
24 DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM			N 24
25 IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)			25
26 TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			3,749,408 26
27 MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			312,052 27
28 NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			3,437,356 28
29 COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			995,781 29
30 COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			3,266,672 30
31 TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			7,504,580 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		539,859	539,859	370,945	1
2	00200		1,263,020	1,263,020	29,377	2
3	00300					3
4	00400	231,333	6,173,984	6,405,317		4
5	00500	1,735,179	6,363,619	8,098,798	-63,889	5
6	00600	498,274	309,639	807,913		6
7	00700		472,575	472,575		7
8	00800	226,289	79,212	305,501		8
9	00900	381,139	123,409	504,548		9
10	01000	554,430	762,737	1,317,167	-862,555	10
11	01100				862,555	11
12	01200					12
13	01300	1,047,342	83,081	1,130,423		13
14	01400	77,922	293,140	371,062		14
15	01500	456,799	1,595,085	2,051,884		15
16	01600	532,638	283,507	816,145		16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,914,627	157,671	2,072,298		30
31	03100	694,144	72,747	766,891		31
40	04000	683,430	222,292	905,722		40
43	04300	198,464	13,680	212,144		43
44	04400	991,852	125,985	1,117,837		44
ANCILLARY SERVICE COST CENTERS						
50	05000	646,768	227,372	874,140		50
53	05300	790,284	21,264	811,548		53
54	05400	637,708	193,082	830,790		54
56	05600	547	216,049	216,596		56
57	05700	112,088	141,959	254,047		57
58	05800		190,985	190,985		58
60	06000	948,721	1,274,541	2,223,262		60
62.30	06250					62.30
64	06400		28,050	28,050		64
65	06500	367,360	11,900	379,260		65
66	06600	1,175,273	128,330	1,303,603		66
68	06800	172,924	8,019	180,943		68
69	06900		166,473	166,473		69
71	07100		1,303,681	1,303,681	-167,162	71
72	07200				167,162	72
73	07300					73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	624,846	595,924	1,220,770		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	492,549	132,491	625,040		95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	666,440	167,948	834,388		101
SPECIAL PURPOSE COST CENTERS						
113	11300		336,433	336,433	-336,433	113
116	11600	203,122	226,297	429,419		116
118		17,062,492	24,306,040	41,368,532		118
NONREIMBURSABLE COST CENTERS						
192	19200	1,707,296	525,790	2,233,086		192
194	07950					194
194.01	07952	19,117	668	19,785		194.01
194.02	07953					194.02
200		18,788,905	24,832,498	43,621,403		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	910,804	-41,358	869,446	1
2	00200	1,292,397	-1,791	1,290,606	2
3	00300				3
4	00400	6,405,317	-274,388	6,130,929	4
5	00500	8,034,909	-4,643,859	3,391,050	5
6	00600	807,913		807,913	6
7	00700	472,575		472,575	7
8	00800	305,501	-214,113	91,388	8
9	00900	504,548		504,548	9
10	01000	454,612		454,612	10
11	01100	862,555	-256,214	606,341	11
12	01200				12
13	01300	1,130,423		1,130,423	13
14	01400	371,062	-8,367	362,695	14
15	01500	2,051,884	-35	2,051,849	15
16	01600	816,145	-1,855	814,290	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	2,072,298	-170	2,072,128	30
31	03100	766,891		766,891	31
40	04000	905,722	-153,513	752,209	40
43	04300	212,144		212,144	43
44	04400	1,117,837		1,117,837	44
ANCILLARY SERVICE COST CENTERS					
50	05000	874,140		874,140	50
53	05300	811,548	-790,284	21,264	53
54	05400	830,790		830,790	54
56	05600	216,596		216,596	56
57	05700	254,047		254,047	57
58	05800	190,985		190,985	58
60	06000	2,223,262	-20,534	2,202,728	60
62.30	06250				62.30
64	06400	28,050		28,050	64
65	06500	379,260		379,260	65
66	06600	1,303,603		1,303,603	66
68	06800	180,943		180,943	68
69	06900	166,473		166,473	69
71	07100	1,136,519		1,136,519	71
72	07200	167,162		167,162	72
73	07300				73
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
91	09100	1,220,770	-544,178	676,592	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
95	09500	625,040		625,040	95
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
101	10100	834,388		834,388	101
SPECIAL PURPOSE COST CENTERS					
113	11300				113
116	11600	429,419		429,419	116
118		41,368,532	-6,950,659	34,417,873	118
NONREIMBURSABLE COST CENTERS					
192	19200	2,233,086		2,233,086	192
194	07950				194
194.01	07952	19,785		19,785	194.01
194.02	07953				194.02
200		43,621,403	-6,950,659	36,670,744	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 RECLASS CAFETERIA	A	CAFETERIA	11		363,072	499,483 1
500 TOTAL RECLASSIFICATIONS					363,072	499,483 500
CODE LETTER - A						
1 INTEREST EXPENSE	B	CAP REL COSTS-BLDG & FIXT	1			319,886 1
2		CAP REL COSTS-MVBLE EQUIP	2			16,547 2
500 TOTAL RECLASSIFICATIONS						336,433 500
CODE LETTER - B						
1 OTHER CAPITAL RELATED	C	CAP REL COSTS-BLDG & FIXT	1			51,059 1
2		CAP REL COSTS-MVBLE EQUIP	2			12,830 2
500 TOTAL RECLASSIFICATIONS						63,889 500
CODE LETTER - C						
1 RECLASS MEDICAL SUPPLIES	D	IMPL. DEV. CHARGED TO PATIENT	72			167,162 1
500 TOTAL RECLASSIFICATIONS						167,162 500
CODE LETTER - D						
GRAND TOTAL (INCREASES)					363,072	1,066,967

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7	
			LINE #	SALARY	OTHER	REF.	
	1	6	7	8	9	10	
1 RECLASS CAFETERIA	A	DIETARY	10	363,072	499,483		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A				363,072	499,483		500
1 INTEREST EXPENSE	B	INTEREST EXPENSE	113		336,433		11 1
2							11 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					336,433		500
1 OTHER CAPITAL RELATED	C	ADMINISTRATIVE & GENERAL	5		63,889		12 1
2							12 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					63,889		500
1 RECLASS MEDICAL SUPPLIES	D	MEDICAL SUPPLIES CHRGED TO PA	71		167,162		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					167,162		500
GRAND TOTAL (DECREASES)				363,072	1,066,967		

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	39,483	500		500		39,983		1
2 LAND IMPROVEMENTS	462,487	48,010		48,010		510,497		2
3 BUILDINGS AND FIXTURES	13,917,731	462,527		462,527	754	14,379,504		3
4 BUILDING IMPROVEMENTS	9,774,651					9,774,651		4
5 FIXED EQUIPMENT	2,604,855				95,960	2,508,895		5
6 MOVABLE EQUIPMENT	14,838,958	627,745		627,745	357,146	15,109,557		6
7 HIT DESIGNATED ASSETS		413,959		413,959		413,959		7
8 SUBTOTAL (SUM OF LINES 1-7)	41,638,165	1,552,741		1,552,741	453,860	42,737,046		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	41,638,165	1,552,741		1,552,741	453,860	42,737,046		10

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

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	539,859						539,859 1
2 CAP REL COSTS-MVBLE EQUIP	1,263,020						1,263,020 2
3 TOTAL (SUM OF LINES 1-2)	1,802,879						1,802,879 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL				TOTAL (SUM OF COLS. 5-7) 8
	GROSS ASSETS 1	CAPITALIZED LEASES 2	FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	
1 CAP REL COSTS-BLDG & FIXT	27,213,530		27,213,530	0.636767				1
2 CAP REL COSTS-MVBLE EQUIP	15,523,516		15,523,516	0.363233				2
3 TOTAL (SUM OF LINES 1-2)	42,737,046		42,737,046	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	539,859		278,528	51,059			869,446 1
2 CAP REL COSTS-MVBLE EQUIP	1,263,020		14,756	12,830			1,290,606 2
3 TOTAL	1,802,879		293,284	63,889			2,160,052 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

LINE NO.	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7
				COST CENTER	LINE NO.	
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-41,358	CAP REL COSTS-BLDG & FIXT	1	11 1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-2,139	CAP REL COSTS-MVBLE EQUIP	2	11 2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-3,707	ADMINISTRATIVE & GENERAL	5	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	-28,377	ADMINISTRATIVE & GENERAL	5	7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9	PARKING LOT (CHAPTER 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-718,225			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	B	-214,113	LAUNDRY & LINEN SERVICE	8	13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-199,446	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-8,367	CENTRAL SERVICES & SUPPLY	14	16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-35	PHARMACY	15	17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-1,855	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20	VENDING MACHINES	B	-18,188	CAFETERIA	11	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		RESPIRATORY THERAPY	65	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	SPECIAL FUNCTIONS	B	-38,580	CAFETERIA	11	33
34	GUEST ROOM	B	-170	ADULTS & PEDIATRICS	30	34
35	MISC INCOME	B	-43,969	ADMINISTRATIVE & GENERAL	5	35
36	RETURNED CHECKS	B	-726	ADMINISTRATIVE & GENERAL	5	36
37	DIETARY CONSULTATION	B	-334	ADMINISTRATIVE & GENERAL	5	37
38	PHYSICIAN RECRUITMENT	A	-635,547	ADMINISTRATIVE & GENERAL	5	38
39	CRNA SALARIES	A	-790,284	ANESTHESIOLOGY	53	39
40	CRNA BENEFITS	A	-252,891	EMPLOYEE BENEFITS	4	40
41	LOBBYING DUES	A	-15,689	ADMINISTRATIVE & GENERAL	5	41
42	CAPITAL INTEREST LAPSING	A	348	CAP REL COSTS-MVBLE EQUIP	2	11 42
43	FOUNDATION SALARIES	A	-67,179	ADMINISTRATIVE & GENERAL	5	43
44	FOUNDATION BENEFITS	A	-21,497	EMPLOYEE BENEFITS	4	44
45	FOUNDATION OTHER	A	-8,291	ADMINISTRATIVE & GENERAL	5	45
46	ADVERTISING	A	-202,820	ADMINISTRATIVE & GENERAL	5	46
47	PROVIDER TAX ASSESSMENT	A	-1,252,657	ADMINISTRATIVE & GENERAL	5	47
48	BAD DEBT EXPENSE	A	-2,384,563	ADMINISTRATIVE & GENERAL	5	48
49						49
50	TOTAL (SUM OF LINES 1 THRU 49)		-6,950,659			50
	TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						
2						
3						
4						
5	TOTALS (SUM OF LINES 1-4)					
	TRANSFER COL. 6, LINE 5 TO					
	WKST A-8, COL. 2, LINE 12.					

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2			3	4	5	6	7	8	9	
1	40	SUBPROVIDER - IPF	AGGREGATE	196,190	100,190	96,000	138,700	640	42,677	2,134	1
2	60	LABORATORY	AGGREGATE	102,670	20,534	82,136	208,000	1,248	124,800	6,240	2
3	91	EMERGENCY	AGGREGATE	544,178	544,178		159,800				3
4	44	SKILLED NURSING FACILITY	AGGREGATE	30,000		30,000	159,800	416	31,960	1,598	4
5	31	INTENSIVE CARE UNIT	AGGREGATE	30,000		30,000	159,800	416	31,960	1,598	5
200		TOTAL		903,038	664,902	238,136		2,720	231,397	11,570	200

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	40	SUBPROVIDER - IPF	AGGREGATE				42,677	53,323	153,513	1
2	60	LABORATORY	AGGREGATE				124,800		20,534	2
3	91	EMERGENCY	AGGREGATE						544,178	3
4	44	SKILLED NURSING FACILITY	AGGREGATE				31,960			4
5	31	INTENSIVE CARE UNIT	AGGREGATE				31,960			5
200		TOTAL					231,397	53,323	718,225	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	NEW CAP RE L COSTS-BL DG & FIXT 1	NEW CAP RE L COSTS-MV BLE EQUIP 2	EMPLOYEE B ENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	869,446	869,446				1
2 CAP REL COSTS-MVBLE EQUIP	1,290,606		1,290,606			2
4 EMPLOYEE BENEFITS	6,130,929	3,076	838	6,134,843		4
5 ADMINISTRATIVE & GENERAL	3,391,050	93,308	205,337	578,127	4,267,822	5
6 MAINTENANCE & REPAIRS	807,913	12,730	41,833	172,701	1,035,177	6
7 OPERATION OF PLANT	472,575	44,277			516,852	7
8 LAUNDRY & LINEN SERVICE	91,388	18,259	14,938	78,432	203,017	8
9 HOUSEKEEPING	504,548	2,076	3,474	132,102	642,200	9
10 DIETARY	454,612	38,305	3,119	81,292	577,328	10
11 CAFETERIA	606,341	10,867	5,794	110,873	733,875	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,130,423	37,994	45,892	363,008	1,577,317	13
14 CENTRAL SERVICES & SUPPLY	362,695	26,914	21,547	27,008	438,164	14
15 PHARMACY	2,051,849	14,555	82,867	158,326	2,307,597	15
16 MEDICAL RECORDS & LIBRARY	814,290	11,310	16,534	184,612	1,026,746	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,072,128	166,985	82,530	663,610	2,985,253	30
31 INTENSIVE CARE UNIT	766,891	35,415	31,486	240,590	1,074,382	31
40 SUBPROVIDER - IPF	752,209	41,687	2,383	236,876	1,033,155	40
43 NURSERY	212,144	5,005	3,286	68,787	289,222	43
44 SKILLED NURSING FACILITY	1,117,837	51,014	9,885	343,775	1,522,511	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	874,140	59,018	89,026	224,169	1,246,353	50
53 ANESTHESIOLOGY	21,264	350	26,314		47,928	53
54 RADIOLOGY-DIAGNOSTIC	830,790	40,032	219,134	221,029	1,310,985	54
56 RADIOISOTOPE	216,596	3,797	889	190	221,472	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	254,047	3,786	226,048	38,850	522,731	57
58 MAGNETIC RESONANCE IMAGING (MRI)	190,985				190,985	58
60 LABORATORY	2,202,728	39,873	22,972	328,826	2,594,399	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	28,050				28,050	64
65 RESPIRATORY THERAPY	379,260	4,589	2,897	127,327	514,073	65
66 PHYSICAL THERAPY	1,303,603	29,137	10,941	407,348	1,751,029	66
68 SPEECH PATHOLOGY	180,943	1,131	195	59,935	242,204	68
69 ELECTROCARDIOLOGY	166,473	1,967	5,916		174,356	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,136,519				1,136,519	71
72 IMPL. DEV. CHARGED TO PATIENT	167,162				167,162	72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	676,592	18,642	32,157	216,571	943,962	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	625,040	27,045	74,544	170,717	897,346	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	834,388	7,283	447	230,987	1,073,105	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	429,419	7,283	446	70,402	507,550	116
118 SUBTOTALS (SUM OF LINES 1-117)	34,417,873	857,710	1,283,669	5,536,470	33,800,827	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	2,233,086	10,927	6,937	591,747	2,842,697	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER	19,785	809		6,626	27,220	194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	36,670,744	869,446	1,290,606	6,134,843	36,670,744	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL 5	MAINTENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSEKEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	4,267,822					5
6 MAINTENANCE & REPAIRS	136,344	1,171,521				6
7 OPERATION OF PLANT	68,075	68,222	653,149			7
8 LAUNDRY & LINEN SERVICE	26,740	28,134	16,655	274,546		8
9 HOUSEKEEPING	84,585	3,199	1,894	20,439	752,317	9
10 DIETARY	76,040	59,021	34,940	2,590		10
11 CAFETERIA	96,659	16,744	9,912	4,809		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	207,750	58,541	34,656		5,179	13
14 CENTRAL SERVICES & SUPPLY	57,711	41,469	24,549	4,023	15,319	14
15 PHARMACY	303,936	22,426	13,276		1,745	15
16 MEDICAL RECORDS & LIBRARY	135,234	17,426	10,316		872	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	393,193	257,288	152,315	79,806	210,759	30
31 INTENSIVE CARE UNIT	141,508	54,568	32,304	17,291	50,863	31
40 SUBPROVIDER - IPF	136,078	64,232	38,025	8,789	66,509	40
43 NURSERY	38,094	7,711	4,565	3,752	13,738	43
44 SKILLED NURSING FACILITY	200,531	78,602	46,532	80,262	124,296	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	164,158	90,935	53,833	24,385	74,577	50
53 ANESTHESIOLOGY	6,313	539	319		4,634	53
54 RADIOLOGY-DIAGNOSTIC	172,671	61,681	36,515	4,418	38,216	54
56 RADIOISOTOPE	29,170	5,851	3,464	462	4,743	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	68,849	5,834	3,454	43	4,852	57
58 MAGNETIC RESONANCE IMAGING (MRI)	25,155					58
60 LABORATORY	341,711	61,437	36,371	225	18,317	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	3,694					64
65 RESPIRATORY THERAPY	67,709	7,071	4,186		872	65
66 PHYSICAL THERAPY	230,630	44,895	26,578	3,930	21,697	66
68 SPEECH PATHOLOGY	31,901	1,743	1,032			68
69 ELECTROCARDIOLOGY	22,965	3,031	1,794		3,216	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	149,692					71
72 IMPL. DEV. CHARGED TO PATIENT	22,017					72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	124,330	28,723	17,004	16,590	52,662	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	118,190	41,671	24,669	2,487	1,417	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	141,340	11,222	6,643		10,031	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	66,850	11,222	6,643		10,031	116
118 SUBTOTALS (SUM OF LINES 1-117)	3,889,823	1,153,438	642,444	274,301	734,545	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	374,414	16,837	9,967	245	17,772	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER	3,585	1,246	738			194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,267,822	1,171,521	653,149	274,546	752,317	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	749,919					10
11 CAFETERIA		861,999				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		149,353	2,032,796			13
14 CENTRAL SERVICES & SUPPLY		16,502		597,737		14
15 PHARMACY		18,459			2,667,439	15
16 MEDICAL RECORDS & LIBRARY		104,883				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	204,897	82,228	613,282		1,481	30
31 INTENSIVE CARE UNIT	51,226	27,130	179,421		300	31
40 SUBPROVIDER - IPF	88,152	43,911	217,189		21	40
43 NURSERY		2,797	53,582			43
44 SKILLED NURSING FACILITY	405,644	37,758	379,424		143	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		60,692	171,929		1,173	50
53 ANESTHESIOLOGY		1,958	54,346		25,319	53
54 RADIOLOGY-DIAGNOSTIC		28,808			88	54
56 RADIOISOTOPE		2,797				56
57 COMPUTED TOMOGRAPHY (CT) SCAN		4,475			143	57
58 MAGNETIC RESONANCE IMAGING (MRI)						58
60 LABORATORY		46,428			2,829	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					53,660	64
65 RESPIRATORY THERAPY		29,927			103,667	65
66 PHYSICAL THERAPY		50,903			580	66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				520,031		71
72 IMPL. DEV. CHARGED TO PATIENT				77,706		72
73 DRUGS CHARGED TO PATIENTS					2,410,069	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		22,375	171,687		878	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		42,233	191,936		4,262	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		22,375			614	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE		11,747			55	116
118 SUBTOTALS (SUM OF LINES 1-117)	749,919	807,739	2,032,796	597,737	2,605,282	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		54,260			62,157	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER						194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	749,919	861,999	2,032,796	597,737	2,667,439	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RE CORDS & LI BRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	1,295,477				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	407,267	5,387,769		5,387,769	30
31 INTENSIVE CARE UNIT	100,495	1,729,488		1,729,488	31
40 SUBPROVIDER - IPF	26,824	1,722,885		1,722,885	40
43 NURSERY	10,201	423,662		423,662	43
44 SKILLED NURSING FACILITY	20,023	2,895,726		2,895,726	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	78,960	1,966,995		1,966,995	50
53 ANESTHESIOLOGY		141,356		141,356	53
54 RADIOLOGY-DIAGNOSTIC	8,841	1,662,223		1,662,223	54
56 RADIOISOTOPE		267,959		267,959	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	9,037	619,418		619,418	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,768	217,908		217,908	58
60 LABORATORY	66,871	3,168,588		3,168,588	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY		85,404		85,404	64
65 RESPIRATORY THERAPY		727,505		727,505	65
66 PHYSICAL THERAPY	3,400	2,133,642		2,133,642	66
68 SPEECH PATHOLOGY		276,880		276,880	68
69 ELECTROCARDIOLOGY	18,890	224,252		224,252	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		1,806,242		1,806,242	71
72 IMPL. DEV. CHARGED TO PATIENT		266,885		266,885	72
73 DRUGS CHARGED TO PATIENTS		2,410,069		2,410,069	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	195,701	1,573,912		1,573,912	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	2,645	1,326,856		1,326,856	95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY		1,265,330		1,265,330	101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
116 HOSPICE		614,098		614,098	116
118 SUBTOTALS (SUM OF LINES 1-117)	950,923	32,915,052		32,915,052	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES	344,554	3,722,903		3,722,903	192
194 OTHER NONREIMBURSABLE					194
194.01 MEMORY DISORDER		32,789		32,789	194.01
194.02 ASSISTED LIVING					194.02
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	1,295,477	36,670,744		36,670,744	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION		DIR ASSGND CAP-REL COSTS 0	NEW CAP RE L COSTS-BL DG & FIXT 1	NEW CAP RE L COSTS-MV BLE EQUIP 2	SUBTOTAL 2A	EMPLOYEE B ENEFFITS 4	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS		3,076	838	3,914	3,914	4
5	ADMINISTRATIVE & GENERAL	5,691	93,308	205,337	304,336	369	5
6	MAINTENANCE & REPAIRS		12,730	41,833	54,563	110	6
7	OPERATION OF PLANT		44,277		44,277		7
8	LAUNDRY & LINEN SERVICE		18,259	14,938	33,197	50	8
9	HOUSEKEEPING		2,076	3,474	5,550	84	9
10	DIETARY		38,305	3,119	41,424	52	10
11	CAFETERIA		10,867	5,794	16,661	71	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		37,994	45,892	83,886	231	13
14	CENTRAL SERVICES & SUPPLY		26,914	21,547	48,461	17	14
15	PHARMACY		14,555	82,867	97,422	101	15
16	MEDICAL RECORDS & LIBRARY		11,310	16,534	27,844	118	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	16,088	166,985	82,530	265,603	426	30
31	INTENSIVE CARE UNIT	1,911	35,415	31,486	68,812	153	31
40	SUBPROVIDER - IPF		41,687	2,383	44,070	151	40
43	NURSERY		5,005	3,286	8,291	44	43
44	SKILLED NURSING FACILITY	10,161	51,014	9,885	71,060	219	44
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	78,880	59,018	89,026	226,924	143	50
53	ANESTHESIOLOGY		350	26,314	26,664		53
54	RADIOLOGY-DIAGNOSTIC		40,032	219,134	259,166	141	54
56	RADIOISOTOPE		3,797	889	4,686		56
57	COMPUTED TOMOGRAPHY (CT) SCAN		3,786	226,048	229,834	25	57
58	MAGNETIC RESONANCE IMAGING (MRI)						58
60	LABORATORY	49,968	39,873	22,972	112,813	210	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY						64
65	RESPIRATORY THERAPY	6,091	4,589	2,897	13,577	81	65
66	PHYSICAL THERAPY		29,137	10,941	40,078	260	66
68	SPEECH PATHOLOGY		1,131	195	1,326	38	68
69	ELECTROCARDIOLOGY		1,967	5,916	7,883		69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		18,642	32,157	50,799	138	91
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		27,045	74,544	101,589	109	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY		7,283	447	7,730	147	101
SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE						113
116	HOSPICE	61,405	7,283	446	69,134	45	116
118	SUBTOTALS (SUM OF LINES 1-117)	230,195	857,710	1,283,669	2,371,574	3,533	118
NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	1,667	10,927	6,937	19,531	377	192
194	OTHER NONREIMBURSABLE						194
194.01	MEMORY DISORDER		809		809	4	194.01
194.02	ASSISTED LIVING						194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	231,862	869,446	1,290,606	2,391,914	3,914	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	5	6	7	8	9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	304,705					5
6 MAINTENANCE & REPAIRS	9,735	64,408				6
7 OPERATION OF PLANT	4,860	3,751	52,888			7
8 LAUNDRY & LINEN SERVICE	1,909	1,547	1,349	38,052		8
9 HOUSEKEEPING	6,039	176	153	2,833	14,835	9
10 DIETARY	5,429	3,245	2,829	359		10
11 CAFETERIA	6,901	921	803	666		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	14,833	3,218	2,806		102	13
14 CENTRAL SERVICES & SUPPLY	4,120	2,280	1,988	558	302	14
15 PHARMACY	21,701	1,233	1,075		34	15
16 MEDICAL RECORDS & LIBRARY	9,656	958	835		17	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	28,059	14,144	12,332	11,061	4,156	30
31 INTENSIVE CARE UNIT	10,103	3,000	2,616	2,397	1,003	31
40 SUBPROVIDER - IPF	9,716	3,531	3,079	1,218	1,312	40
43 NURSERY	2,720	424	370	520	271	43
44 SKILLED NURSING FACILITY	14,318	4,321	3,768	11,124	2,451	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	11,721	4,999	4,359	3,380	1,471	50
53 ANESTHESIOLOGY	451	30	26		91	53
54 RADIOLOGY-DIAGNOSTIC	12,329	3,391	2,957	612	754	54
56 RADIOISOTOPE	2,083	322	280	64	94	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	4,916	321	280	6	96	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,796					58
60 LABORATORY	24,398	3,378	2,945	31	361	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	264					64
65 RESPIRATORY THERAPY	4,834	389	339		17	65
66 PHYSICAL THERAPY	16,467	2,468	2,152	545	428	66
68 SPEECH PATHOLOGY	2,278	96	84			68
69 ELECTROCARDIOLOGY	1,640	167	145		63	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	10,688					71
72 IMPL. DEV. CHARGED TO PATIENT	1,572					72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	8,877	1,579	1,377	2,299	1,038	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	8,439	2,291	1,998	345	28	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	10,091	617	538		198	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	4,773	617	538		198	116
118 SUBTOTALS (SUM OF LINES 1-117)	277,716	63,414	52,021	38,018	14,485	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	26,733	926	807	34	350	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER	256	68	60			194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	304,705	64,408	52,888	38,052	14,835	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	53,338					10
11 CAFETERIA		26,023				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		4,511	109,587			13
14 CENTRAL SERVICES & SUPPLY				58,224		14
15 PHARMACY		557			122,123	15
16 MEDICAL RECORDS & LIBRARY		3,166				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	14,573	2,482	33,071		68	30
31 INTENSIVE CARE UNIT	3,643	819	9,671		14	31
40 SUBPROVIDER - IPF	6,270	1,326	11,707		1	40
43 NURSERY		84	2,888			43
44 SKILLED NURSING FACILITY	28,852	1,140	20,452		7	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		1,832	9,268		54	50
53 ANESTHESIOLOGY		59	2,929		1,159	53
54 RADIOLOGY-DIAGNOSTIC		870			4	54
56 RADIOISOTOPE		84				56
57 COMPUTED TOMOGRAPHY (CT) SCAN		135			7	57
58 MAGNETIC RESONANCE IMAGING (MRI)						58
60 LABORATORY		1,402			130	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					2,457	64
65 RESPIRATORY THERAPY		903			4,747	65
66 PHYSICAL THERAPY		1,537			27	66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				50,655		71
72 IMPL. DEV. CHARGED TO PATIENT				7,569		72
73 DRUGS CHARGED TO PATIENTS					110,336	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		675	9,255		40	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		1,275	10,346		195	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		675			28	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE		355			3	116
118 SUBTOTALS (SUM OF LINES 1-117)	53,338	24,385	109,587	58,224	119,277	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		1,638			2,846	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER						194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	53,338	26,023	109,587	58,224	122,123	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RE CORDS & LI BRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1					1
2					2
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16	42,594				16
17					17
19					19
20					20
21					21
22					22
23					23
INPATIENT ROUTINE SERV COST CENTERS					
30	13,391	399,366		399,366	30
31	3,304	105,535		105,535	31
40	882	83,263		83,263	40
43	335	15,947		15,947	43
44	658	158,370		158,370	44
ANCILLARY SERVICE COST CENTERS					
50	2,596	266,747		266,747	50
53		31,409		31,409	53
54	291	280,515		280,515	54
56		7,613		7,613	56
57	297	235,917		235,917	57
58	58	1,854		1,854	58
60	2,199	147,867		147,867	60
62.30					62.30
64		2,721		2,721	64
65		24,887		24,887	65
66	112	64,074		64,074	66
68		3,822		3,822	68
69	621	10,519		10,519	69
71		61,343		61,343	71
72		9,141		9,141	72
73		110,336		110,336	73
76.97					76.97
76.98					76.98
76.99					76.99
OUTPATIENT SERVICE COST CENTERS					
91	6,434	82,511		82,511	91
92					92
OTHER REIMBURSABLE COST CENTERS					
95	87	126,702		126,702	95
99.10					99.10
99.20					99.20
99.30					99.30
99.40					99.40
101		20,024		20,024	101
SPECIAL PURPOSE COST CENTERS					
113					113
116		75,663		75,663	116
118	31,265	2,326,146		2,326,146	118
NONREIMBURSABLE COST CENTERS					
192	11,329	64,571		64,571	192
194					194
194.01		1,197		1,197	194.01
194.02					194.02
200					200
201					201
202	42,594	2,391,914		2,391,914	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET 1	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE -NEW 2	EMPLOYEE B ENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINISTRA TIVE & GEN ERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	159,134					1
2 CAP REL COSTS-MVBLE EQUIP		1,269,502				2
4 EMPLOYEE BENEFITS	563	824	17,700,109			4
5 ADMINISTRATIVE & GENERAL	17,078	201,979	1,668,000	-4,267,822	32,402,922	5
6 MAINTENANCE & REPAIRS	2,330	41,149	498,274		1,035,177	6
7 OPERATION OF PLANT	8,104				516,852	7
8 LAUNDRY & LINEN SERVICE	3,342	14,694	226,289		203,017	8
9 HOUSEKEEPING	380	3,417	381,139		642,200	9
10 DIETARY	7,011	3,068	234,543		577,328	10
11 CAFETERIA	1,989	5,699	319,887		733,875	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	6,954	45,142	1,047,342		1,577,317	13
14 CENTRAL SERVICES & SUPPLY	4,926	21,195	77,922		438,164	14
15 PHARMACY	2,664	81,512	456,799		2,307,597	15
16 MEDICAL RECORDS & LIBRARY	2,070	16,264	532,638		1,026,746	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	30,563	81,180	1,914,627		2,985,253	30
31 INTENSIVE CARE UNIT	6,482	30,971	694,144		1,074,382	31
40 SUBPROVIDER - IPF	7,630	2,344	683,430		1,033,155	40
43 NURSERY	916	3,232	198,464		289,222	43
44 SKILLED NURSING FACILITY	9,337	9,723	991,852		1,522,511	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	10,802	87,570	646,768		1,246,353	50
53 ANESTHESIOLOGY	64	25,884			47,928	53
54 RADIOLOGY-DIAGNOSTIC	7,327	215,551	637,708		1,310,985	54
56 RADIOISOTOPE	695	874	547		221,472	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	693	222,352	112,088		522,731	57
58 MAGNETIC RESONANCE IMAGING (MRI)					190,985	58
60 LABORATORY	7,298	22,596	948,721		2,594,399	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					28,050	64
65 RESPIRATORY THERAPY	840	2,850	367,360		514,073	65
66 PHYSICAL THERAPY	5,333	10,762	1,175,273		1,751,029	66
68 SPEECH PATHOLOGY	207	192	172,924		242,204	68
69 ELECTROCARDIOLOGY	360	5,819			174,356	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					1,136,519	71
72 IMPL. DEV. CHARGED TO PATIENT					167,162	72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	3,412	31,631	624,846		943,962	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	4,950	73,325	492,549		897,346	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,333	440	666,440		1,073,105	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	1,333	439	203,122		507,550	116
118 SUBTOTALS (SUM OF LINES 1-117)	156,986	1,262,678	15,973,696	-4,267,822	29,533,005	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	2,000	6,824	1,707,296		2,842,697	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER	148		19,117		27,220	194.01
194.02 ASSISTED LIVING						194.02

PROVIDER CCN: 14-0147 RICHLAND MEMORIAL HOSPITAL
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/13/2013 17:37

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET 1	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE -NEW 2	EMPLOYEE B ENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINISTRA TIVE & GEN ERAL ACCUM COST 5	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	869,446	1,290,606	6,134,843		4,267,822	202
203 UNIT COST MULT-WS B PT I	5.463609	1.016624	0.346599		0.131711	203
204 COST TO BE ALLOC PER B PT II			3,914		304,705	204
205 UNIT COST MULT-WS B PT II			0.000221		0.009404	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAINTENANCE & REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE ICE LAUNDRY POUNDS 8	HOUSEKEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	139,163					6
7 OPERATION OF PLANT	8,104	131,059				7
8 LAUNDRY & LINEN SERVICE	3,342	3,342	600,399			8
9 HOUSEKEEPING	380	380	44,698	690,000		9
10 DIETARY	7,011	7,011	5,663		84,952	10
11 CAFETERIA	1,989	1,989	10,516			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	6,954	6,954		4,750		13
14 CENTRAL SERVICES & SUPPLY	4,926	4,926	8,798	14,050		14
15 PHARMACY	2,664	2,664		1,600		15
16 MEDICAL RECORDS & LIBRARY	2,070	2,070		800		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	30,563	30,563	174,527	193,300	23,211	30
31 INTENSIVE CARE UNIT	6,482	6,482	37,813	46,650	5,803	31
40 SUBPROVIDER - IPF	7,630	7,630	19,220	61,000	9,986	40
43 NURSERY	916	916	8,206	12,600		43
44 SKILLED NURSING FACILITY	9,337	9,337	175,525	114,000	45,952	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	10,802	10,802	53,327	68,400		50
53 ANESTHESIOLOGY	64	64		4,250		53
54 RADIOLOGY-DIAGNOSTIC	7,327	7,327	9,661	35,050		54
56 RADIOISOTOPE	695	695	1,011	4,350		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	693	693	95	4,450		57
58 MAGNETIC RESONANCE IMAGING (MRI)						58
60 LABORATORY	7,298	7,298	491	16,800		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY	840	840		800		65
66 PHYSICAL THERAPY	5,333	5,333	8,594	19,900		66
68 SPEECH PATHOLOGY	207	207				68
69 ELECTROCARDIOLOGY	360	360		2,950		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	3,412	3,412	36,280	48,300		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	4,950	4,950	5,438	1,300		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,333	1,333		9,200		101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	1,333	1,333		9,200		116
118 SUBTOTALS (SUM OF LINES 1-117)	137,015	128,911	599,863	673,700	84,952	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	2,000	2,000	536	16,300		192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER	148	148				194.01
194.02 ASSISTED LIVING						194.02

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAINTENANCE & REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE ICE LAUNDRY POUNDS 8	HOUSEKEEPING HOURS OF SERVICE 9	DIETARY MEALS SERV 10	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,171,521	653,149	274,546	752,317	749,919	202
203 UNIT COST MULT-WS B PT I	8.418337	4.983626	0.457273	1.090314	8.827561	203
204 COST TO BE ALLOC PER B PT II	64,408	52,888	38,052	14,835	53,338	204
205 UNIT COST MULT-WS B PT II	0.462824	0.403543	0.063378	0.021500	0.627860	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA CAFE MEALS SERV 11	NURSING AD MINISTRATI ON DIRECT NURSING HO 13	CENTRAL SE RVICES & S UPPLY CS COSTED REQUIS 14	PHARMACY PHARM COSTED REQ 15	MEDICAL RE CORDS & LI BRARY TIME SPENT 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	3,082					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	534	31,120,800				13
14 CENTRAL SERVICES & SUPPLY	59		100			14
15 PHARMACY	66			139,437,900		15
16 MEDICAL RECORDS & LIBRARY	375				85,725	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	294	9,389,100		77,400	26,950	30
31 INTENSIVE CARE UNIT	97	2,746,800		15,700	6,650	31
40 SUBPROVIDER - IPF	157	3,325,000		1,100	1,775	40
43 NURSERY	10	820,300			675	43
44 SKILLED NURSING FACILITY	135	5,808,700		7,500	1,325	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	217	2,632,100		61,300	5,225	50
53 ANESTHESIOLOGY	7	832,000		1,323,500		53
54 RADIOLOGY-DIAGNOSTIC	103			4,600	585	54
56 RADIOISOTOPE	10					56
57 COMPUTED TOMOGRAPHY (CT) SCAN	16			7,500	598	57
58 MAGNETIC RESONANCE IMAGING (MRI)					117	58
60 LABORATORY	166			147,900	4,425	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY				2,805,000		64
65 RESPIRATORY THERAPY	107			5,419,100		65
66 PHYSICAL THERAPY	182			30,300	225	66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY					1,250	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			87			71
72 IMPL. DEV. CHARGED TO PATIENT			13			72
73 DRUGS CHARGED TO PATIENTS				125,984,100		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	80	2,628,400		45,900	12,950	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	151	2,938,400		222,800	175	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	80			32,100		101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	42			2,900		116
118 SUBTOTALS (SUM OF LINES 1-117)	2,888	31,120,800	100	136,188,700	62,925	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	194			3,249,200	22,800	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER						194.01
194.02 ASSISTED LIVING						194.02

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA CAFE MEALS SERV 11	NURSING AD MINISTRATI ON DIRECT NURSING HO 13	CENTRAL SE RVICES & S UPPLY CS COSTED REQUIS 14	PHARMACY PHARM COSTED REQ 15	MEDICAL RE CORDS & LI BRARY TIME SPENT 16	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	861,999	2,032,796	597,737	2,667,439	1,295,477	202
203 UNIT COST MULT-WS B PT I	279.688189	0.065320	5,977.370000	0.019130	15.112009	203
204 COST TO BE ALLOC PER B PT II	26,023	109,587	58,224	122,123	42,594	204
205 UNIT COST MULT-WS B PT II	8.443543	0.003521	582.240000	0.000876	0.496868	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

	GENERAL SERVICE COST CENTERS	
1	CAP REL COSTS-BLDG & FIXT	1
2	CAP REL COSTS-MVBLE EQUIP	2
4	EMPLOYEE BENEFITS	4
5	ADMINISTRATIVE & GENERAL	5
6	MAINTENANCE & REPAIRS	6
7	OPERATION OF PLANT	7
8	LAUNDRY & LINEN SERVICE	8
9	HOUSEKEEPING	9
10	DIETARY	10
11	CAFETERIA	11
12	MAINTENANCE OF PERSONNEL	12
13	NURSING ADMINISTRATION	13
14	CENTRAL SERVICES & SUPPLY	14
15	PHARMACY	15
16	MEDICAL RECORDS & LIBRARY	16
17	SOCIAL SERVICE	17
19	NONPHYSICIAN ANESTHETISTS	19
20	NURSING SCHOOL	20
21	I&R 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
31	INTENSIVE CARE UNIT	31
40	SUBPROVIDER - IPF	40
43	NURSERY	43
44	SKILLED NURSING FACILITY	44
	ANCILLARY SERVICE COST CENTERS	
50	OPERATING ROOM	50
53	ANESTHESIOLOGY	53
54	RADIOLOGY-DIAGNOSTIC	54
56	RADIOISOTOPE	56
57	COMPUTED TOMOGRAPHY (CT) SCAN	57
58	MAGNETIC RESONANCE IMAGING (MRI)	58
60	LABORATORY	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64	INTRAVENOUS THERAPY	64
65	RESPIRATORY THERAPY	65
66	PHYSICAL THERAPY	66
68	SPEECH PATHOLOGY	68
69	ELECTROCARDIOLOGY	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	71
72	IMPL. DEV. CHARGED TO PATIENT	72
73	DRUGS CHARGED TO PATIENTS	73
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
	OUTPATIENT SERVICE COST CENTERS	
91	EMERGENCY	91
92	OBSERVATION BEDS	92
	OTHER REIMBURSABLE COST CENTERS	
95	AMBULANCE SERVICES	95
99.10	CORF	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	99.40
101	HOME HEALTH AGENCY	101
	SPECIAL PURPOSE COST CENTERS	
116	HOSPICE	116
118	SUBTOTALS (SUM OF LINES 1-117)	118
	NONREIMBURSABLE COST CENTERS	
192	PHYSICIANS' PRIVATE OFFICES	192
194	OTHER NONREIMBURSABLE	194
194.01	MEMORY DISORDER	194.01
194.02	ASSISTED LIVING	194.02

PROVIDER CCN: 14-0147 RICHLAND MEMORIAL HOSPITAL
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/13/2013 17:37

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,387,769		5,387,769		5,387,769	30
31 INTENSIVE CARE UNIT	1,729,488		1,729,488		1,729,488	31
40 SUBPROVIDER - IPF	1,722,885		1,722,885	53,323	1,776,208	40
43 NURSERY	423,662		423,662		423,662	43
44 SKILLED NURSING FACILITY	2,895,726		2,895,726		2,895,726	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,966,995		1,966,995		1,966,995	50
53 ANESTHESIOLOGY	141,356		141,356		141,356	53
54 RADIOLOGY-DIAGNOSTIC	1,662,223		1,662,223		1,662,223	54
56 RADIOISOTOPE	267,959		267,959		267,959	56
57 COMPUTED TOMOGRAPHY (CT) SC	619,418		619,418		619,418	57
58 MAGNETIC RESONANCE IMAGING	217,908		217,908		217,908	58
60 LABORATORY	3,168,588		3,168,588		3,168,588	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
64 INTRAVENOUS THERAPY	85,404		85,404		85,404	64
65 RESPIRATORY THERAPY	727,505		727,505		727,505	65
66 PHYSICAL THERAPY	2,133,642		2,133,642		2,133,642	66
68 SPEECH PATHOLOGY	276,880		276,880		276,880	68
69 ELECTROCARDIOLOGY	224,252		224,252		224,252	69
71 MEDICAL SUPPLIES CHRGD TO	1,806,242		1,806,242		1,806,242	71
72 IMPL. DEV. CHARGED TO PATIE	266,885		266,885		266,885	72
73 DRUGS CHARGED TO PATIENTS	2,410,069		2,410,069		2,410,069	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,573,912		1,573,912		1,573,912	91
92 OBSERVATION BEDS	595,224		595,224		595,224	92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,326,856		1,326,856		1,326,856	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,265,330		1,265,330		1,265,330	101
113 INTEREST EXPENSE						113
116 HOSPICE	614,098		614,098		614,098	116
200 SUBTOTAL (SEE INSTRUCTIONS)	33,510,276		33,510,276	53,323	33,563,599	200
201 LESS OBSERVATION BEDS	595,224		595,224		595,224	201
202 TOTAL (SEE INSTRUCTIONS)	32,915,052		32,915,052		32,968,375	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	5,299,929		5,299,929			30
31 INTENSIVE CARE UNIT	1,502,634		1,502,634			31
40 SUBPROVIDER - IPF	2,256,949		2,256,949			40
43 NURSERY	542,532		542,532			43
44 SKILLED NURSING FACILITY	2,095,040		2,095,040			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,309,121	9,460,968	12,770,089	0.154031	0.154031	0.154031 50
53 ANESTHESIOLOGY	2,282,020	2,637,515	4,919,535	0.028734	0.028734	0.028734 53
54 RADIOLOGY-DIAGNOSTIC	1,244,047	6,065,546	7,309,593	0.227403	0.227403	0.227403 54
56 RADIOISOTOPE	263,016	2,586,369	2,849,385	0.094041	0.094041	0.094041 56
57 COMPUTED TOMOGRAPHY (CT) SC	1,293,522	6,231,926	7,525,448	0.082310	0.082310	0.082310 57
58 MAGNETIC RESONANCE IMAGING	142,662	1,297,630	1,440,292	0.151294	0.151294	0.151294 58
60 LABORATORY	4,920,765	15,932,885	20,853,650	0.151944	0.151944	0.151944 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
64 INTRAVENOUS THERAPY	729,976	168,338	898,314	0.095071	0.095071	0.095071 64
65 RESPIRATORY THERAPY	2,504,121	508,425	3,012,546	0.241492	0.241492	0.241492 65
66 PHYSICAL THERAPY	2,524,298	4,352,116	6,876,414	0.310284	0.310284	0.310284 66
68 SPEECH PATHOLOGY	256,812	406,487	663,299	0.417429	0.417429	0.417429 68
69 ELECTROCARDIOLOGY	348,897	2,012,898	2,361,795	0.094950	0.094950	0.094950 69
71 MEDICAL SUPPLIES CHRGED TO	2,845,778	2,145,875	4,991,653	0.361852	0.361852	0.361852 71
72 IMPL. DEV. CHARGED TO PATIE	136,201	408,524	544,725	0.489944	0.489944	0.489944 72
73 DRUGS CHARGED TO PATIENTS	6,551,011	4,108,959	10,659,970	0.226086	0.226086	0.226086 73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	1,303,186	5,868,978	7,172,164	0.219447	0.219447	0.219447 91
92 OBSERVATION BEDS	366,309	1,024,313	1,390,622	0.428027	0.428027	0.428027 92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	117,294	1,669,075	1,786,369	0.742767	0.742767	0.742767 95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		2,521,271	2,521,271			101
113 INTEREST EXPENSE						113
116 HOSPICE		1,375,722	1,375,722			116
200 SUBTOTAL (SEE INSTRUCTIONS)	42,836,120	70,783,820	113,619,940			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	42,836,120	70,783,820	113,619,940			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	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	CAP-REL COST (COL.1 MINUS COL.2)					
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	399,366	5,274	394,092	5,529	71.28	3,026	215,693	30
31 INTENSIVE CARE UNIT	105,535		105,535	1,228	85.94	756	64,971	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	83,263		83,263	2,245	37.09	634	23,515	40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY	15,947		15,947	643	24.80			43
44 SKILLED NURSING FACILITY	158,370		158,370	10,331	15.33	3,097	47,477	44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	762,481		757,207	19,976		7,513	351,656	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[XX] HOSPITAL (14-0147) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
50	ANCILLARY SERVICE COST CENTERS						
	OPERATING ROOM	266,747	12,770,089	0.020888	857,750	17,917	50
53	ANESTHESIOLOGY	31,409	4,919,535	0.006385	249,644	1,594	53
54	RADIOLOGY-DIAGNOSTIC	280,515	7,309,593	0.038376	1,039,693	39,899	54
56	RADIOISOTOPE	7,613	2,849,385	0.002672	208,057	556	56
57	COMPUTED TOMOGRAPHY (CT) SCAN	235,917	7,525,448	0.031349	977,616	30,647	57
58	MAGNETIC RESONANCE IMAGING (M	1,854	1,440,292	0.001287	78,283	101	58
60	LABORATORY	147,867	20,853,650	0.007091	3,715,936	26,350	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
64	INTRAVENOUS THERAPY	2,721	898,314	0.003029	375,833	1,138	64
65	RESPIRATORY THERAPY	24,887	3,012,546	0.008261	1,551,622	12,818	65
66	PHYSICAL THERAPY	64,074	6,876,414	0.009318	492,671	4,591	66
68	SPEECH PATHOLOGY	3,822	663,299	0.005762	80,952	466	68
69	ELECTROCARDIOLOGY	10,519	2,361,795	0.004454	285,299	1,271	69
71	MEDICAL SUPPLIES CHRGD TO PA	61,343	4,991,653	0.012289	939,089	11,540	71
72	IMPL. DEV. CHARGED TO PATIENT	9,141	544,725	0.016781	38,051	639	72
73	DRUGS CHARGED TO PATIENTS	110,336	10,659,970	0.010350	3,192,055	33,038	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	82,511	7,172,164	0.011504	943,224	10,851	91
92	OBSERVATION BEDS	44,711	1,390,622	0.032152	135,119	4,344	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	1,385,987	96,239,494		15,160,894	197,760	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	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					31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					33
33 BURN INTENSIVE CARE UNIT					34
34 SURGICAL INTENSIVE CARE UNIT					35
35 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)					

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	5,529		3,026		30
31	INTENSIVE CARE UNIT	1,228		756		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	2,245		634		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	643				43
44	SKILLED NURSING FACILITY	10,331		3,097		44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	19,976		7,513		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0147) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
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 (14-0147) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	12,770,089			857,750		3,160,147	50
53 ANESTHESIOLOGY	4,919,535			249,644		620,839	53
54 RADIOLOGY-DIAGNOSTIC	7,309,593			1,039,693		2,205,335	54
56 RADIOISOTOPE	2,849,385			208,057		1,423,816	56
57 COMPUTED TOMOGRAPHY (CT) SCA	7,525,448			977,616		2,376,558	57
58 MAGNETIC RESONANCE IMAGING (	1,440,292			78,283		460,733	58
60 LABORATORY	20,853,650			3,715,936		933,728	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
64 INTRAVENOUS THERAPY	898,314			375,833		141,373	64
65 RESPIRATORY THERAPY	3,012,546			1,551,622		323,581	65
66 PHYSICAL THERAPY	6,876,414			492,671			66
68 SPEECH PATHOLOGY	663,299			80,952		18,797	68
69 ELECTROCARDIOLOGY	2,361,795			285,299		956,742	69
71 MEDICAL SUPPLIES CHRGED TO P	4,991,653			939,089		806,607	71
72 IMPL. DEV. CHARGED TO PATIEN	544,725			38,051		247,229	72
73 DRUGS CHARGED TO PATIENTS	10,659,970			3,192,055		1,760,660	73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	7,172,164			943,224		1,438,897	91
92 OBSERVATION BEDS	1,390,622			135,119		266,221	92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES							95
200 TOTAL (SUM OF LINES 50-199)	96,239,494			15,160,894		17,141,263	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0147) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.154031	3,160,147			486,761			50
53 ANESTHESIOLOGY	0.028734	620,839			17,839			53
54 RADIOLOGY-DIAGNOSTIC	0.227403	2,205,335			501,500			54
56 RADIOISOTOPE	0.094041	1,423,816			133,897			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310	2,376,558			195,614			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294	460,733			69,706			58
60 LABORATORY	0.151944	933,728			141,874			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64 INTRAVENOUS THERAPY	0.095071	141,373			13,440			64
65 RESPIRATORY THERAPY	0.241492	323,581			78,142			65
66 PHYSICAL THERAPY	0.310284							66
68 SPEECH PATHOLOGY	0.417429	18,797			7,846			68
69 ELECTROCARDIOLOGY	0.094950	956,742			90,843			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.361852	806,607			291,872			71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944	247,229			121,128			72
73 DRUGS CHARGED TO PATIENTS	0.226086	1,760,660		11,818	398,061		2,672	73
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.219447	1,438,897			315,762			91
92 OBSERVATION BEDS	0.428027	266,221			113,950			92
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	0.742767							95
200 SUBTOTAL (SEE INSTRUCTIONS)		17,141,263		11,818	2,978,235		2,672	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		17,141,263		11,818	2,978,235		2,672	202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[] HOSPITAL [XX] IPF (14-S147) [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA			
		CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	266,747	12,770,089	0.020888			50
53	ANESTHESIOLOGY	31,409	4,919,535	0.006385			53
54	RADIOLOGY-DIAGNOSTIC	280,515	7,309,593	0.038376	4,271	164	54
56	RADIOISOTOPE	7,613	2,849,385	0.002672			56
57	COMPUTED TOMOGRAPHY (CT) SCAN	235,917	7,525,448	0.031349	1,564	49	57
58	MAGNETIC RESONANCE IMAGING (M	1,854	1,440,292	0.001287	3,328	4	58
60	LABORATORY	147,867	20,853,650	0.007091	62,356	442	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
64	INTRAVENOUS THERAPY	2,721	898,314	0.003029	96		64
65	RESPIRATORY THERAPY	24,887	3,012,546	0.008261	5,367	44	65
66	PHYSICAL THERAPY	64,074	6,876,414	0.009318	5,601	52	66
68	SPEECH PATHOLOGY	3,822	663,299	0.005762			68
69	ELECTROCARDIOLOGY	10,519	2,361,795	0.004454	3,139	14	69
71	MEDICAL SUPPLIES CHRGED TO PA	61,343	4,991,653	0.012289	3,591	44	71
72	IMPL. DEV. CHARGED TO PATIENT	9,141	544,725	0.016781			72
73	DRUGS CHARGED TO PATIENTS	110,336	10,659,970	0.010350	233,231	2,414	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	82,511	7,172,164	0.011504	40,965	471	91
92	OBSERVATION BEDS	44,711	1,390,622	0.032152			92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	1,385,987	96,239,494		363,509	3,698	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[XX] PPS	
APPLICABLE	[XX] TITLE XVIII-PT A	[XX] IPF (14-S147)	[] SNF		[] TEFRA	
BOXES	[] TITLE XIX	[] IRF	[] NF			
COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM					50
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC					54
56	RADIOISOTOPE					56
57	COMPUTED TOMOGRAPHY (CT) SCAN					57
58	MAGNETIC RESONANCE IMAGING (M					58
60	LABORATORY					60
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
64	INTRAVENOUS THERAPY					64
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
68	SPEECH PATHOLOGY					68
69	ELECTROCARDIOLOGY					69
71	MEDICAL SUPPLIES CHRGD TO PA					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY					91
92	OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES					95
200	TOTAL (SUM OF LINES 50-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[XX] IPF (14-S147)	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
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	12,770,089					50
53	ANESTHESIOLOGY	4,919,535					53
54	RADIOLOGY-DIAGNOSTIC	7,309,593			4,271		54
56	RADIOISOTOPE	2,849,385					56
57	COMPUTED TOMOGRAPHY (CT) SCA	7,525,448			1,564		57
58	MAGNETIC RESONANCE IMAGING (	1,440,292			3,328		58
60	LABORATORY	20,853,650			62,356		60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
64	INTRAVENOUS THERAPY	898,314			96		64
65	RESPIRATORY THERAPY	3,012,546			5,367		65
66	PHYSICAL THERAPY	6,876,414			5,601		66
68	SPEECH PATHOLOGY	663,299					68
69	ELECTROCARDIOLOGY	2,361,795			3,139		69
71	MEDICAL SUPPLIES CHRGED TO P	4,991,653			3,591		71
72	IMPL. DEV. CHARGED TO PATIEN	544,725					72
73	DRUGS CHARGED TO PATIENTS	10,659,970			233,231		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	7,172,164			40,965		91
92	OBSERVATION BEDS	1,390,622					92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	96,239,494			363,509		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [XX] IPF (14-S147) [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.154031							50
53 ANESTHESIOLOGY	0.028734							53
54 RADIOLOGY-DIAGNOSTIC	0.227403							54
56 RADIOISOTOPE	0.094041							56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310							57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294							58
60 LABORATORY	0.151944							60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64 INTRAVENOUS THERAPY	0.095071							64
65 RESPIRATORY THERAPY	0.241492							65
66 PHYSICAL THERAPY	0.310284							66
68 SPEECH PATHOLOGY	0.417429							68
69 ELECTROCARDIOLOGY	0.094950							69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.361852							71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944							72
73 DRUGS CHARGED TO PATIENTS	0.226086							73
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.219447							91
92 OBSERVATION BEDS	0.428027							92
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	0.742767							95
200 SUBTOTAL (SEE INSTRUCTIONS)								200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)								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-U147)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES	COST REIMB. SUBJECT TO DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.154031						50	
53 ANESTHESIOLOGY	0.028734						53	
54 RADIOLOGY-DIAGNOSTIC	0.227403						54	
56 RADIOISOTOPE	0.094041						56	
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310						57	
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294						58	
60 LABORATORY	0.151944						60	
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
64 INTRAVENOUS THERAPY	0.095071						64	
65 RESPIRATORY THERAPY	0.241492						65	
66 PHYSICAL THERAPY	0.310284						66	
68 SPEECH PATHOLOGY	0.417429						68	
69 ELECTROCARDIOLOGY	0.094950						69	
71 MEDICAL SUPPLIES CHRGD TO PATI	0.361852						71	
72 IMPL. DEV. CHARGED TO PATIENT	0.489944						72	
73 DRUGS CHARGED TO PATIENTS	0.226086						73	
76.97 CARDIAC REHABILITATION							76.97	
76.98 HYPERBARIC OXYGEN THERAPY							76.98	
76.99 LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.219447						91	
92 OBSERVATION BEDS	0.428027						92	
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	0.742767						95	
200 SUBTOTAL (SEE INSTRUCTIONS)							200	
201 LESS PBP CLINIC LAB SERVICES							201	
202 NET CHARGES (LINE 200 - LINE 201)							202	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5580) [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1						SCHOOL 2	HEALTH 3	MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[XX] PPS	
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[XX] SNF (14-5580)		[] TEFRA	
BOXES	[] TITLE XIX	[] IRF	[] NF			
	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 (COL. 9 x COL. 12)
COST CENTER DESCRIPTION	7	8	9	10	11	12
						13
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	12,770,089				50
53	ANESTHESIOLOGY	4,919,535				53
54	RADIOLOGY-DIAGNOSTIC	7,309,593			63,012	54
56	RADIOISOTOPE	2,849,385			7,034	56
57	COMPUTED TOMOGRAPHY (CT) SCA	7,525,448			30,412	57
58	MAGNETIC RESONANCE IMAGING (	1,440,292			18,384	58
60	LABORATORY	20,853,650			283,462	60
62.30	BLOOD CLOTTING FOR HEMOPHILI					62.30
64	INTRAVENOUS THERAPY	898,314			40,583	64
65	RESPIRATORY THERAPY	3,012,546			585,044	65
66	PHYSICAL THERAPY	6,876,414			1,665,905	66
68	SPEECH PATHOLOGY	663,299			108,403	68
69	ELECTROCARDIOLOGY	2,361,795			7,571	69
71	MEDICAL SUPPLIES CHRGED TO P	4,991,653			161,957	71
72	IMPL. DEV. CHARGED TO PATIEN	544,725				72
73	DRUGS CHARGED TO PATIENTS	10,659,970			1,104,889	73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	7,172,164				91
92	OBSERVATION BEDS	1,390,622			2,487	92
OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES					95
200	TOTAL (SUM OF LINES 50-199)	96,239,494			4,079,143	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [XX] SNF (14-5580) [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.154031							50
53 ANESTHESIOLOGY	0.028734							53
54 RADIOLOGY-DIAGNOSTIC	0.227403							54
56 RADIOISOTOPE	0.094041							56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310							57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294							58
60 LABORATORY	0.151944							60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64 INTRAVENOUS THERAPY	0.095071							64
65 RESPIRATORY THERAPY	0.241492							65
66 PHYSICAL THERAPY	0.310284							66
68 SPEECH PATHOLOGY	0.417429							68
69 ELECTROCARDIOLOGY	0.094950							69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.361852							71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944							72
73 DRUGS CHARGED TO PATIENTS	0.226086							73
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.219447							91
92 OBSERVATION BEDS	0.428027							92
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	0.742767							95
200 SUBTOTAL (SEE INSTRUCTIONS)								200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)			
	1	2	3		5			
30 INPAT ROUTINE SERV COST CTRS								
31 ADULTS & PEDIATRICS	399,366	5,274	394,092	5,529	71.28	723	51,535	30
32 INTENSIVE CARE UNIT	105,535		105,535	1,228	85.94	181	15,555	31
33 CORONARY CARE UNIT								32
34 BURN INTENSIVE CARE UNIT								33
35 SURGICAL INTENSIVE CARE UNIT								34
40 OTHER SPECIAL CARE (SPECIFY)								35
41 SUBPROVIDER - IPF	83,263		83,263	2,245	37.09	766	28,411	40
42 SUBPROVIDER - IRF								41
43 SUBPROVIDER I								42
44 NURSERY	15,947		15,947	643	24.80	402	9,970	43
45 SKILLED NURSING FACILITY	158,370		158,370	10,331	15.33			44
200 NURSING FACILITY								45
TOTAL (LINES 30-199)	762,481		757,207	19,976		2,072	105,471	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-0147) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
50	ANCILLARY SERVICE COST CENTERS						
	OPERATING ROOM	266,747	12,770,089	0.020888	1,873,401	39,132	50
53	ANESTHESIOLOGY	31,409	4,919,535	0.006385	253,643	1,620	53
54	RADIOLOGY-DIAGNOSTIC	280,515	7,309,593	0.038376	91,127	3,497	54
56	RADIOISOTOPE	7,613	2,849,385	0.002672	8,518	23	56
57	COMPUTED TOMOGRAPHY (CT) SCAN	235,917	7,525,448	0.031349	201,212	6,308	57
58	MAGNETIC RESONANCE IMAGING (M	1,854	1,440,292	0.001287	15,742	20	58
60	LABORATORY	147,867	20,853,650	0.007091	682,990	4,843	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
64	INTRAVENOUS THERAPY	2,721	898,314	0.003029	81		64
65	RESPIRATORY THERAPY	24,887	3,012,546	0.008261	85,518	706	65
66	PHYSICAL THERAPY	64,074	6,876,414	0.009318	15,690	146	66
68	SPEECH PATHOLOGY	3,822	663,299	0.005762	48,208	278	68
69	ELECTROCARDIOLOGY	10,519	2,361,795	0.004454	47,340	211	69
71	MEDICAL SUPPLIES CHRGD TO PA	61,343	4,991,653	0.012289	623,902	7,667	71
72	IMPL. DEV. CHARGED TO PATIENT	9,141	544,725	0.016781	21,040	353	72
73	DRUGS CHARGED TO PATIENTS	110,336	10,659,970	0.010350	796,643	8,245	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	82,511	7,172,164	0.011504	2,988	34	91
92	OBSERVATION BEDS	44,711	1,390,622	0.032152	20,582	662	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	1,385,987	96,239,494		4,788,625	73,745	200

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] 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	5,529		723		30
31	INTENSIVE CARE UNIT	1,228		181		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	2,245		766		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	643		402		43
44	SKILLED NURSING FACILITY	10,331				44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	19,976		2,072		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0147) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1						SCHOOL 2	HEALTH 3	MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
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 (14-0147)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[XX] TITLE XIX	[] IRF	[] NF		[] OTHER		
	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	12,770,089			1,873,401		50
53	ANESTHESIOLOGY	4,919,535			253,643		53
54	RADIOLOGY-DIAGNOSTIC	7,309,593			91,127		54
56	RADIOISOTOPE	2,849,385			8,518		56
57	COMPUTED TOMOGRAPHY (CT) SCA	7,525,448			201,212		57
58	MAGNETIC RESONANCE IMAGING (	1,440,292			15,742		58
60	LABORATORY	20,853,650			682,990		60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
64	INTRAVENOUS THERAPY	898,314			81		64
65	RESPIRATORY THERAPY	3,012,546			85,518		65
66	PHYSICAL THERAPY	6,876,414			15,690		66
68	SPEECH PATHOLOGY	663,299			48,208		68
69	ELECTROCARDIOLOGY	2,361,795			47,340		69
71	MEDICAL SUPPLIES CHRGED TO P	4,991,653			623,902		71
72	IMPL. DEV. CHARGED TO PATIEN	544,725			21,040		72
73	DRUGS CHARGED TO PATIENTS	10,659,970			796,643		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	7,172,164			2,988		91
92	OBSERVATION BEDS	1,390,622			20,582		92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	1,786,369					95
200	TOTAL (SUM OF LINES 50-199)	96,239,494			4,788,625		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0147) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7
50 ANCILLARY SERVICE COST CENTERS								50
50 OPERATING ROOM	0.154031							50
53 ANESTHESIOLOGY	0.028734							53
54 RADIOLOGY-DIAGNOSTIC	0.227403							54
56 RADIOISOTOPE	0.094041							56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310							57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294							58
60 LABORATORY	0.151944							60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64 INTRAVENOUS THERAPY	0.095071							64
65 RESPIRATORY THERAPY	0.241492							65
66 PHYSICAL THERAPY	0.310284							66
68 SPEECH PATHOLOGY	0.417429							68
69 ELECTROCARDIOLOGY	0.094950							69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.361852							71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944							72
73 DRUGS CHARGED TO PATIENTS	0.226086							73
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
91 OUTPATIENT SERVICE COST CENTERS								91
91 EMERGENCY	0.219447							91
92 OBSERVATION BEDS	0.428027							92
95 OTHER REIMBURSABLE COST CENTERS								95
95 AMBULANCE SERVICES	0.742767							95
200 SUBTOTAL (SEE INSTRUCTIONS)								200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[] HOSPITAL [XX] IPF (14-S147) [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER				
		CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 + COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)		
	COST CENTER DESCRIPTION	1	2	3	4	5		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	266,747	12,770,089	0.020888				50
53	ANESTHESIOLOGY	31,409	4,919,535	0.006385				53
54	RADIOLOGY-DIAGNOSTIC	280,515	7,309,593	0.038376				54
56	RADIOISOTOPE	7,613	2,849,385	0.002672				56
57	COMPUTED TOMOGRAPHY (CT) SCAN	235,917	7,525,448	0.031349				57
58	MAGNETIC RESONANCE IMAGING (M	1,854	1,440,292	0.001287				58
60	LABORATORY	147,867	20,853,650	0.007091				60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
64	INTRAVENOUS THERAPY	2,721	898,314	0.003029				64
65	RESPIRATORY THERAPY	24,887	3,012,546	0.008261				65
66	PHYSICAL THERAPY	64,074	6,876,414	0.009318				66
68	SPEECH PATHOLOGY	3,822	663,299	0.005762				68
69	ELECTROCARDIOLOGY	10,519	2,361,795	0.004454				69
71	MEDICAL SUPPLIES CHRGED TO PA	61,343	4,991,653	0.012289				71
72	IMPL. DEV. CHARGED TO PATIENT	9,141	544,725	0.016781				72
73	DRUGS CHARGED TO PATIENTS	110,336	10,659,970	0.010350				73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	82,511	7,172,164	0.011504				91
92	OBSERVATION BEDS	44,711	1,390,622	0.032152				92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (SUM OF LINES 50-199)	1,385,987	96,239,494					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[XX] PPS	
APPLICABLE	[] TITLE XVIII-PT A	[XX] IPF (14-S147)	[] SNF		[] TEFRA	
BOXES	[XX] TITLE XIX	[] IRF	[] NF		[] OTHER	
COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM					50
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC					54
56	RADIOISOTOPE					56
57	COMPUTED TOMOGRAPHY (CT) SCAN					57
58	MAGNETIC RESONANCE IMAGING (M					58
60	LABORATORY					60
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
64	INTRAVENOUS THERAPY					64
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
68	SPEECH PATHOLOGY					68
69	ELECTROCARDIOLOGY					69
71	MEDICAL SUPPLIES CHRGED TO PA					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY					91
92	OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES					95
200	TOTAL (SUM OF LINES 50-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[] TITLE XVIII-PT A	[XX] IPF (14-S147)	[] 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	12,770,089					50
53	ANESTHESIOLOGY	4,919,535					53
54	RADIOLOGY-DIAGNOSTIC	7,309,593					54
56	RADIOISOTOPE	2,849,385					56
57	COMPUTED TOMOGRAPHY (CT) SCA	7,525,448					57
58	MAGNETIC RESONANCE IMAGING (	1,440,292					58
60	LABORATORY	20,853,650					60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
64	INTRAVENOUS THERAPY	898,314					64
65	RESPIRATORY THERAPY	3,012,546					65
66	PHYSICAL THERAPY	6,876,414					66
68	SPEECH PATHOLOGY	663,299					68
69	ELECTROCARDIOLOGY	2,361,795					69
71	MEDICAL SUPPLIES CHRGED TO P	4,991,653					71
72	IMPL. DEV. CHARGED TO PATIEN	544,725					72
73	DRUGS CHARGED TO PATIENTS	10,659,970					73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	7,172,164					91
92	OBSERVATION BEDS	1,390,622					92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	1,786,369					95
200	TOTAL (SUM OF LINES 50-199)	96,239,494					200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [XX] IPF (14-S147) [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES	COST REIMB. SUBJECT TO DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SUBJECT TO DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.154031							50
53 ANESTHESIOLOGY	0.028734							53
54 RADIOLOGY-DIAGNOSTIC	0.227403							54
56 RADIOISOTOPE	0.094041							56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310							57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294							58
60 LABORATORY	0.151944							60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64 INTRAVENOUS THERAPY	0.095071							64
65 RESPIRATORY THERAPY	0.241492							65
66 PHYSICAL THERAPY	0.310284							66
68 SPEECH PATHOLOGY	0.417429							68
69 ELECTROCARDIOLOGY	0.094950							69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.361852							71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944							72
73 DRUGS CHARGED TO PATIENTS	0.226086							73
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.219447							91
92 OBSERVATION BEDS	0.428027							92
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	0.742767							95
200 SUBTOTAL (SEE INSTRUCTIONS)								200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)								202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0147) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,914	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,529	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	30	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,880	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	87	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)	261	6
7	SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	9	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)	28	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,026	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)	87	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)	261	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	188.27	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	192.90	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	119.75	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	119.75	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,387,769	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	16,379	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	50,347	23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	1,078	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	3,353	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	71,157	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,316,612	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,436,630	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	25,200	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,411,430	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.547042	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	840.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	699.06	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	140.94	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	218.04	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	6,541	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,310,071	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0147) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS 961.59 38
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 2,909,771 39
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 40
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 2,909,771 41
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)

	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
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
44 INTENSIVE CARE UNIT	1,729,488	1,228	1,408.38	756	1,064,735	43
45 CORONARY CARE UNIT						44
46 BURN INTENSIVE CARE UNIT						45
47 SURGICAL INTENSIVE CARE UNIT						46
48 OTHER SPECIAL CARE (SPECIFY)						47
49 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					3,021,354	48
TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					6,995,860	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 280,664 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 197,760 51
 52 TOTAL PROGRAM EXCLUDABLE COST 478,424 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 6,517,436 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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 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 INSTRUCTIONS) (TITLE XVIII ONLY) 16,379 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 50,347 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66,726 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) 619 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 961.59 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 595,224 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	399,366	5,316,612	0.075117	595,224	44,711	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S147) [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	2,245	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,245	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	548	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,697	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	634	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,776,208	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,776,208	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,250,393	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	532,108	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,718,285	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.789288	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	971.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,012.54	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	1,776,208	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S147) [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

38	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	791.18	38
39	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	501,608	39
40	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)		40
41	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)	501,608	41
48	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	77,439	48
49	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	579,047	49
	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)		
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	23,515	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	3,698	51
52	TOTAL PROGRAM EXCLUDABLE COST	27,213	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	551,834	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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)		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 INSTRUCTIONS) (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5580) [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	10,331	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	10,331	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,331	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,097	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,895,726	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,895,726	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,805,275	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,805,275	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.604036	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)	174.74	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)	2,895,726	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5580) [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	2,895,726	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	280.29	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	868,058	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	868,058	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	868,058	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	1,080,828	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	1,948,886	86

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0147) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,914	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,529	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	30	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,880	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	87	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)	261	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	9	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)	28	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	723	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)	643	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	402	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	188.27	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	192.90	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	119.75	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	119.75	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,387,769	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	16,379	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	50,347	23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	1,078	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	3,353	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	71,157	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,316,612	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,436,630	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	25,200	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,411,430	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.547042	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	840.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	699.06	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	140.94	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	218.04	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	6,541	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,310,071	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0147) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 961.59 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 695,230 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) 695,230 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 + COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	423,662	643	658.88	402	264,870 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	1,729,488	1,228	1,408.38	181	254,917 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)					915,884 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,130,901 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 77,060 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 73,745 51
 52 TOTAL PROGRAM EXCLUDABLE COST 150,805 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 1,980,096 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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 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 INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (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) 619 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S147) [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	2,245	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,245	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	548	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,697	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	766	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,776,208	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,776,208	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,250,393	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	532,108	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,718,285	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.789288	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	971.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,012.54	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	1,776,208	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [XX] IPF (14-S147) [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	791.18 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	606,044 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)	606,044 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	606,044 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	28,411 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	28,411 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	577,633 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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)	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 INSTRUCTIONS) (TITLE XVIII ONLY)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-0147) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		2,220,632		30
31 INTENSIVE CARE UNIT		1,212,061		31
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.154031	857,750	132,120	50
53 ANESTHESIOLOGY	0.028734	249,644	7,173	53
54 RADIOLOGY-DIAGNOSTIC	0.227403	1,039,693	236,429	54
56 RADIOISOTOPE	0.094041	208,057	19,566	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310	977,616	80,468	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294	78,283	11,844	58
60 LABORATORY	0.151944	3,715,936	564,614	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.095071	375,833	35,731	64
65 RESPIRATORY THERAPY	0.241492	1,551,622	374,704	65
66 PHYSICAL THERAPY	0.310284	492,671	152,868	66
68 SPEECH PATHOLOGY	0.417429	80,952	33,792	68
69 ELECTROCARDIOLOGY	0.094950	285,299	27,089	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.361852	939,089	339,811	71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944	38,051	18,643	72
73 DRUGS CHARGED TO PATIENTS	0.226086	3,192,055	721,679	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.219447	943,224	206,988	91
92 OBSERVATION BEDS	0.428027	135,119	57,835	92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		15,160,894	3,021,354	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		15,160,894		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S147) [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
40 SUBPROVIDER - IPF		615,402		40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.154031			50
53 ANESTHESIOLOGY	0.028734			53
54 RADIOLOGY-DIAGNOSTIC	0.227403	4,271	971	54
56 RADIOISOTOPE	0.094041			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310	1,564	129	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294	3,328	504	58
60 LABORATORY	0.151944	62,356	9,475	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.095071	96	9	64
65 RESPIRATORY THERAPY	0.241492	5,367	1,296	65
66 PHYSICAL THERAPY	0.310284	5,601	1,738	66
68 SPEECH PATHOLOGY	0.417429			68
69 ELECTROCARDIOLOGY	0.094950	3,139	298	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.361852	3,591	1,299	71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944			72
73 DRUGS CHARGED TO PATIENTS	0.226086	233,231	52,730	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.219447	40,965	8,990	91
92 OBSERVATION BEDS	0.428027			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		363,509	77,439	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		363,509		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) S/B SNF (14-U147) PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.154031			50
53 ANESTHESIOLOGY	0.028734			53
54 RADIOLOGY-DIAGNOSTIC	0.227403	11,866	2,698	54
56 RADIOISOTOPE	0.094041			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310	17,459	1,437	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294			58
60 LABORATORY	0.151944	80,176	12,182	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.095071	14,981	1,424	64
65 RESPIRATORY THERAPY	0.241492	97,785	23,614	65
66 PHYSICAL THERAPY	0.310284	128,691	39,931	66
68 SPEECH PATHOLOGY	0.417429	12,021	5,018	68
69 ELECTROCARDIOLOGY	0.094950	1,308	124	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.361852	33,219	12,020	71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944			72
73 DRUGS CHARGED TO PATIENTS	0.226086	200,002	45,218	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.219447			91
92 OBSERVATION BEDS	0.428027			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		597,508	143,666	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		597,508		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5580) [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.154031			50
53 ANESTHESIOLOGY	0.028734			53
54 RADIOLOGY-DIAGNOSTIC	0.227403	63,012	14,329	54
56 RADIOISOTOPE	0.094041	7,034	661	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310	30,412	2,503	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294	18,384	2,781	58
60 LABORATORY	0.151944	283,462	43,070	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.095071	40,583	3,858	64
65 RESPIRATORY THERAPY	0.241492	585,044	141,283	65
66 PHYSICAL THERAPY	0.310284	1,665,905	516,904	66
68 SPEECH PATHOLOGY	0.417429	108,403	45,251	68
69 ELECTROCARDIOLOGY	0.094950	7,571	719	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.361852	161,957	58,604	71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944			72
73 DRUGS CHARGED TO PATIENTS	0.226086	1,104,889	249,800	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.219447			91
92 OBSERVATION BEDS	0.428027	2,487	1,065	92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,079,143	1,080,828	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,079,143		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-0147) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		738,550		30
31 INTENSIVE CARE UNIT		8,916		31
40 SUBPROVIDER - IPF				40
43 NURSERY		270,411		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.154031	1,873,401	288,562	50
53 ANESTHESIOLOGY	0.028734	253,643	7,288	53
54 RADIOLOGY-DIAGNOSTIC	0.227403	91,127	20,723	54
56 RADIOISOTOPE	0.094041	8,518	801	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310	201,212	16,562	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294	15,742	2,382	58
60 LABORATORY	0.151944	682,990	103,776	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.095071	81	8	64
65 RESPIRATORY THERAPY	0.241492	85,518	20,652	65
66 PHYSICAL THERAPY	0.310284	15,690	4,868	66
68 SPEECH PATHOLOGY	0.417429	48,208	20,123	68
69 ELECTROCARDIOLOGY	0.094950	47,340	4,495	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.361852	623,902	225,760	71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944	21,040	10,308	72
73 DRUGS CHARGED TO PATIENTS	0.226086	796,643	180,110	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.219447	2,988	656	91
92 OBSERVATION BEDS	0.428027	20,582	8,810	92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,788,625	915,884	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,788,625		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF (14-S147) SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	(COL.1 x COL.2)
			3
INPATIENT ROUTINE SERVICE COST CENTERS			
30 ADULTS & PEDIATRICS			30
31 INTENSIVE CARE UNIT			31
40 SUBPROVIDER - IPF			40
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	0.154031		50
53 ANESTHESIOLOGY	0.028734		53
54 RADIOLOGY-DIAGNOSTIC	0.227403		54
56 RADIOISOTOPE	0.094041		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.082310		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.151294		58
60 LABORATORY	0.151944		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
64 INTRAVENOUS THERAPY	0.095071		64
65 RESPIRATORY THERAPY	0.241492		65
66 PHYSICAL THERAPY	0.310284		66
68 SPEECH PATHOLOGY	0.417429		68
69 ELECTROCARDIOLOGY	0.094950		69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.361852		71
72 IMPL. DEV. CHARGED TO PATIENT	0.489944		72
73 DRUGS CHARGED TO PATIENTS	0.226086		73
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
91 EMERGENCY	0.219447		91
92 OBSERVATION BEDS	0.428027		92
OTHER REIMBURSABLE COST CENTERS			
95 AMBULANCE SERVICES			95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)			200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			201
202 NET CHARGES (LINE 200 MINUS LINE 201)			202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

CHECK [XX] HOSPITAL (14-0147)
 APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	4,434,392	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	65,407	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	44.26	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0355	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.2228	31
32	SUM OF LINES 30 AND 31	0.2583	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1052	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	466,498	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	4,966,297	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	5,128,186	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	5,087,714	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	358,143	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

CHECK HOSPITAL (14-0147)
 APPLICABLE BOX: SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	5,445,857	59
60	PRIMARY PAYER PAYMENTS	2,909	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	5,442,948	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	718,156	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	3,179	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	238,513	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	166,959	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	200,816	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	4,888,572	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.97	LOW VOLUME PAYMENT ADJUSTMENT - 2	441,946	70.97
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	5,330,518	71
72	INTERIM PAYMENTS	5,349,130	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-18,612	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	89,000	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: [] HOSPITAL [XX] IPF (14-S147) [] IRF
 [] SUB (OTHER) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[XX] HOSPITAL (14-0147) [] IPF [] IRF	[] SUB (OTHER) [] SNF [] SWING BED SNF	INPATIENT		PART B		AMOUNT 4	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4		
DESCRIPTION								
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			5,288,015			2,252,331	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.			NONE			NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01 05/18/2012	61,115	05/18/2012		38,730	3.01
		PROGRAM	.02					3.02
		TO PROVIDER	.03					3.03
		PROGRAM	.04					3.04
		TO PROVIDER	.05					3.05
		PROGRAM	.06					3.06
		TO PROVIDER	.07					3.07
		PROGRAM	.08					3.08
		TO PROVIDER	.09					3.09
		PROGRAM	.50	NONE			NONE	3.50
		TO PROVIDER	.51					3.51
		PROGRAM	.52					3.52
		TO PROVIDER	.53					3.53
		PROGRAM	.54					3.54
		TO PROVIDER	.55					3.55
		PROGRAM	.56					3.56
		TO PROVIDER	.57					3.57
		PROGRAM	.58					3.58
		TO PROVIDER	.59					3.59
		PROGRAM	.99	61,115			38,730	3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)			61,115			38,730	
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			5,349,130			2,291,061	4
TO BE COMPLETED BY CONTRACTOR								
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		PROGRAM .01		NONE		NONE	5.01
		TO PROVIDER	.02					5.02
		PROGRAM	.03					5.03
		TO PROVIDER	.04					5.04
		PROGRAM	.05					5.05
		TO PROVIDER	.06					5.06
		PROGRAM	.07					5.07
		TO PROVIDER	.08					5.08
		PROGRAM	.09					5.09
		TO PROVIDER	.50		NONE		NONE	5.50
		PROGRAM	.51					5.51
		TO PROVIDER	.52					5.52
		PROGRAM	.53					5.53
		TO PROVIDER	.54					5.54
		PROGRAM	.55					5.55
		TO PROVIDER	.56					5.56
		PROGRAM	.57					5.57
		TO PROVIDER	.58					5.58
		PROGRAM	.59					5.59
		TO PROVIDER	.99					5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)							
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT		PROGRAM .01					6.01
		TO PROVIDER	.02					6.02
		PROGRAM	.01					6.01
		TO PROVIDER	.02		-18,612		-46,574	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			5,330,518			2,244,487	7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:			NPR DATE:	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL [XX] IPF (14-S147) [] IRF	[] SUB (OTHER) [] SNF [] SWING BED SNF	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
DESCRIPTION						
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			406,116		1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.			NONE	NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE	NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			406,116		4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE	NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT		PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM	5,606		6.01 6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			411,722		7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:	NPR DATE:	8

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-U147)	INPATIENT PART A	PART B	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
DESCRIPTION									
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER					100,099			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.								
		.01				NONE		NONE	3.01
		.02							3.02
		.03	PROGRAM						3.03
		.04	TO						3.04
		.05	PROVIDER						3.05
		.06							3.06
		.07							3.07
		.08							3.08
		.09							3.09
		.50				NONE		NONE	3.50
		.51							3.51
		.52	PROVIDER						3.52
		.53	TO						3.53
		.54	PROGRAM						3.54
		.55							3.55
		.56							3.56
		.57							3.57
		.58							3.58
		.59							3.59
		.99							3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)								
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)					100,099			4
TO BE COMPLETED BY CONTRACTOR									
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.								
		.01	PROGRAM			NONE		NONE	5.01
		.02	TO						5.02
		.03	PROVIDER						5.03
		.04							5.04
		.05							5.05
		.06							5.06
		.07							5.07
		.08							5.08
		.09							5.09
		.50	PROVIDER			NONE		NONE	5.50
		.51	TO						5.51
		.52	PROGRAM						5.52
		.53							5.53
		.54							5.54
		.55							5.55
		.56							5.56
		.57							5.57
		.58							5.58
		.59							5.59
		.99							5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)								
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT								
		.01	PROGRAM						
			TO			18,316			6.01
			PROVIDER						
			PROVIDER						
		.02	TO						6.02
			PROGRAM						
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					118,415			7
8	NAME OF CONTRACTOR:					CONTRACTOR NUMBER:		NPR DATE:	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [XX] SNF (14-5580)
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		996,429			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
	.01	NONE		NONE	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		996,429			4
TO BE COMPLETED BY CONTRACTOR					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
	PROGRAM .01	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT					
	PROGRAM .01				6.01
	TO .02				6.02
	PROVIDER .01				6.01
	PROVIDER .02				6.02
	PROGRAM .01				6.01
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		996,429			7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:		8

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0147) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

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	1,886	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	3,782	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	23	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	6,138	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	113,619,940	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	8,663,446	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,441,069	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	1,396,213	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	44,856	32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-U147)
 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)	111,909	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)		3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	348	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)	111,909	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	111,909	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	111,909	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	11,810	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)	100,099	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	18,316	17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	118,415	19
20 INTERIM PAYMENTS	100,099	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	18,316	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

CHECK [] HOSPITAL
 APPLICABLE BOX: [XX] IPF (14-S147)

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS)	508,690	1
2	NET IPF PPS OUTLIER PAYMENT	2,016	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER \$412.424(d)(1)(iii) (F)(1) OR (2) (SEE INSTRUCTIONS)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	6.133880	9
10	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (\text{LINE 8}/\text{LINE 9})) \text{ RAISED TO THE POWER OF } .5150 - 1\}$		10
11	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	510,706	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	510,706	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (LINE 16 LESS LINE 17)	510,706	18
19	DEDUCTIBLES	93,270	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	417,436	20
21	COINSURANCE	11,320	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	406,116	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	8,009	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	5,606	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	411,722	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IPF ONLY)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	411,722	31
32	INTERIM PAYMENTS	406,116	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS THE SUM OF LINES 32 AND 33)	5,606	34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

PROSPECTIVE PAYMENT AMOUNT		
1 RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	1,126,861	1
2 ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3 ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4 SUBTOTAL (SUM OF LINES 1-3)	1,126,861	4
COMPUTATION OF NET COST OF COVERED SERVICES		
5 MEDICAL AND OTHER SERVICES		5
6 DEDUCTIBLES		6
7 COINSURANCE	130,432	7
8 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		8
9 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		9
10 ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		10
11 UTILIZATION REVIEW		11
12 SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	996,429	12
13 INPATIENT PRIMARY PAYER PAYMENTS		13
14 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		14
15 SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	996,429	15
16 INTERIM PAYMENTS	996,429	16
17 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
18 BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)		18
19 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK TITLE V HOSPITAL (14-0147) SNF PPS
 APPLICABLE TITLE XIX IPF NF TEFRA
 BOXES: IRF ICF/MR OTHER
 SUB (OTHER)

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
1			COMPUTATION OF NET COST OF COVERED SERVICES
2			INPATIENT HOSPITAL SNF/NF SERVICES
3			MEDICAL AND OTHER SERVICES
4			ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)
5			SUBTOTAL (SUM OF LINES 1, 2 AND 3)
6			INPATIENT PRIMARY PAYER PAYMENTS
7			OUTPATIENT PRIMARY PAYER PAYMENTS
8			SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)
9			COMPUTATION OF LESSER OF COST OR CHARGES
10			REASONABLE CHARGES
11			ROUTINE SERVICE CHARGES
12	4,788,625		ANCILLARY SERVICE CHARGES
13			ORGAN ACQUISITION CHARGES, NET OF REVENUE
14			INCENTIVE FROM TARGET AMOUNT COMPUTATION
15	4,788,625		TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)
16			CUSTOMARY CHARGES
17			AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
18			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)
19	1.000000	1.000000	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)
20	4,788,625		TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
21	4,788,625		EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))
22			EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))
23			INTERNS AND RESIDENTS (SEE INSTRUCTIONS)
24			COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)
25			COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)
26			PROSPECTIVE PAYMENT AMOUNT
27			OTHER THAN OUTLIER PAYMENTS
28			OUTLIER PAYMENTS
29			PROGRAM CAPITAL PAYMENTS
30			CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)
31			ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS
32			SUBTOTAL (SUM OF LINES 22 THROUGH 26)
33			CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)
34			SUM OF LINES 27 AND 21
35			COMPUTATION OF REIMBURSEMENT SETTLEMENT
36			EXCESS OF REASONABLE COST (FROM LINE 18)
37			SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)
38			DEDUCTIBLES
39			COINSURANCE
40			ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)
41			UTILIZATION REVIEW
42			SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)
43			OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)
44			SUBTOTAL (LINE 36 ± LINE 37)
45			DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)
46			TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)
47			INTERIM PAYMENTS
48			BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)
49			PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK TITLE V HOSPITAL SNF PPS
 APPLICABLE TITLE XIX IPF (14-S147) NF TEFRA
 BOXES: IRF ICF/MR OTHER
 SUB (OTHER)

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

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

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	3,396,280			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	6,103,436			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7 INVENTORY	456,385			7
8 PREPAID EXPENSES	706,659			8
9 OTHER CURRENT ASSETS	951,321			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	11,614,081			11
FIXED ASSETS				
12 LAND	39,983			12
13 LAND IMPROVEMENTS	510,497			13
14 ACCUMULATED DEPRECIATION	-459,692			14
15 BUILDINGS	24,206,336			15
16 ACCUMULATED DEPRECIATION	-16,176,163			16
17 LEASEHOLD IMPROVEMENTS				17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT	2,508,895			19
20 ACCUMULATED DEPRECIATION	-2,230,792			20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	15,523,517			23
24 ACCUMULATED DEPRECIATION	-10,913,694			24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS				27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	13,008,887			30
OTHER ASSETS				
31 INVESTMENTS	6,912,588			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	212,116			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	7,124,704			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	31,747,672			36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	1,233,860			37
38 SALARIES, WAGES & FEES PAYABLE	2,111,713			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	332,643			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	1,224,153			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	4,902,369			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	7,320,983			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES				49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	7,320,983			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	12,223,352			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	19,524,320			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)	19,524,320			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	31,747,672			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		17,526,938							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		1,997,382							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		19,524,320							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		19,524,320							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									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)		19,524,320							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				
2 HOSPITAL	5,357,914		5,357,914	1
3 SUBPROVIDER IPF	2,250,393		2,250,393	2
4 SUBPROVIDER IRF				3
5 SWING BED - SNF	137,445		137,445	5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY	2,095,040		2,095,040	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	9,840,792		9,840,792	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
12 INTENSIVE CARE UNIT	1,531,913		1,531,913	11
13 CORONARY CARE UNIT				12
14 BURN INTENSIVE CARE UNIT				13
15 SURGICAL INTENSIVE CARE UNIT				14
16 OTHER SPECIAL CARE (SPECIFY)				15
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	1,531,913		1,531,913	16
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	11,372,705		11,372,705	17
19 ANCILLARY SERVICES	30,110,095	67,982,540	98,092,635	18
20 OUTPATIENT SERVICES		4,193,118	4,193,118	19
21 RHC				20
22 FQHC				21
23 HOME HEALTH AGENCY		3,896,068	3,896,068	22
24 AMBULANCE	117,294	1,669,075	1,786,369	23
25 ASC				25
26 HOSPICE				26
27 OTHER	1,396,888	800,187	2,197,075	27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	42,996,982	78,540,988	121,537,970	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		43,621,403	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 BAD DEBT EXP. DEDUCTED FROM REVENUE	-2,384,563		37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)		-2,384,563	42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		41,236,840	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	121,537,970	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	82,574,808	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	38,963,162	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	41,236,840	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-2,273,678	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,328,941	6
7	INCOME FROM INVESTMENTS	50,615	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	3,707	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	214,113	13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	238,360	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	8,367	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	35	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	1,855	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	18,188	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (PROPERTY TAX REVENUE)	384,177	24
24.01	OTHER (EHR MEANINGFUL USE)	1,850,951	24.01
24.02	OTHER (GRANTS)	38,818	24.02
24.03	OTHER (OTHER)	132,933	24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	4,271,060	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,997,382	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	1,997,382	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7187

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6
1						1
2						2
3						3
4						4
5	107,414		4,020		73,714	185,148
6	481,781		53,830			535,611
7			17,722			17,722
8			4,598			4,598
9			1,315			1,315
10	6,026					6,026
11	71,219		12,749			83,968
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24	666,440		94,234		73,714	834,388

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7187

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5		185,148		185,148	5
6		535,611		535,611	6
7		17,722		17,722	7
8		4,598		4,598	8
9		1,315		1,315	9
10		6,026		6,026	10
11		83,968		83,968	11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24		834,388		834,388	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7187

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	0	1	2	3	4				
1									1
2									2
3									3
4									4
5	185,148					185,148	185,148		5
6	535,611					535,611	152,744	688,355	6
7	17,722					17,722	5,054	22,776	7
8	4,598					4,598	1,311	5,909	8
9	1,315					1,315	375	1,690	9
10	6,026					6,026	1,718	7,744	10
11	83,968					83,968	23,946	107,914	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	834,388					834,388		834,388	24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7187

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET)	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE)	PLANT OPERATN & MAINT (SQUARE FEET)	TRANSPORT- ATION (MILEAGE)	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
	1	2	3	4			
1							1
2							2
3							3
4							4
5					-185,148	649,240	5
6						535,611	6
7						17,722	7
8						4,598	8
9						1,315	9
10						6,026	10
11						83,968	11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
23.50							23.50
24					-185,148	649,240	24
25						185,148	25
26						0.285177	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7187

WORKSHEET H-2
 PART I

HHA COST CENTER	HHA TRIAL BALANCE 0	NEW CAP RE L COSTS-BL DG & FIXT 1	NEW CAP RE L COSTS-MV BLE EQUIP 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS. 0-4) 4A	ADMINISTRATIVE & GENERAL 5	MAINTENANCE & REPAIR 6	
1 ADMINISTRATIVE AND GENERAL		7,283	447		37,229	44,959	5,922	11,222	1
2 SKILLED NURSING CARE	688,355				166,985	855,340	112,657		2
3 PHYSICAL THERAPY	22,776					22,776	3,000		3
4 OCCUPATIONAL THERAPY	5,909					5,909	778		4
5 SPEECH PATHOLOGY	1,690					1,690	223		5
6 MEDICAL SOCIAL SERVICES	7,744				2,089	9,833	1,295		6
7 HOME HEALTH AIDE	107,914				24,684	132,598	17,465		7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
20 TOTAL (SUM OF LINES 1-19)	834,388	7,283	447		230,987	1,073,105	141,340	11,222	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7187

WORKSHEET H-2
 PART I

HHA COST CENTER	OPERATION OF PLANT	LAUNDRY & LINEN SERV NG ICE	HOUSEKEEPI DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	
	7	8	9	10	11	12	13	14
1 ADMINISTRATIVE AND GENERAL	6,643		10,031		22,375			
2 SKILLED NURSING CARE								
3 PHYSICAL THERAPY								
4 OCCUPATIONAL THERAPY								
5 SPEECH PATHOLOGY								
6 MEDICAL SOCIAL SERVICES								
7 HOME HEALTH AIDE								
8 SUPPLIES								
9 DRUGS								
10 DME								
11 HOME DIALYSIS AIDE SERVICES								
12 RESPIRATORY THERAPY								
13 PRIVATE DUTY NURSING								
14 CLINIC								
15 HEALTH PROMOTION ACTIVITIES								
16 DAY CARE PROGRAM								
17 HOME DELIVERED MEALS PROGRAM								
18 HOMEMAKER SERVICE								
19 ALL OTHERS								
20 TOTAL (SUM OF LINES 1-19)	6,643		10,031		22,375			
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.								

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7187

WORKSHEET H-2
 PART I

HHA COST CENTER	PHARMACY 15	MEDICAL RE CORDS & LI BRARY 16	SOCIAL & LI SERVICE 17	NONPHYSIC. ANESTHET. 19	NURSING SCHOOL 20	I&R SALARY & FRINGES 21	I&R PROGRAM COSTS 22	PARAMED EDUCATION 23	
1 ADMINISTRATIVE AND GENERAL	614								1
2 SKILLED NURSING CARE									2
3 PHYSICAL THERAPY									3
4 OCCUPATIONAL THERAPY									4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE									7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
20 TOTAL (SUM OF LINES 1-19)	614								20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7187

WORKSHEET H-2
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (SUM OF COL. 4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	101,766		101,766			1
2 SKILLED NURSING CARE	967,997		967,997	84,662	1,052,659	2
3 PHYSICAL THERAPY	25,776		25,776	2,254	28,030	3
4 OCCUPATIONAL THERAPY	6,687		6,687	585	7,272	4
5 SPEECH PATHOLOGY	1,913		1,913	167	2,080	5
6 MEDICAL SOCIAL SERVICES	11,128		11,128	973	12,101	6
7 HOME HEALTH AIDE	150,063		150,063	13,125	163,188	7
8 SUPPLIES						8
9 DRUGS						9
10 DME						10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY						12
13 PRIVATE DUTY NURSING						13
14 CLINIC						14
15 HEALTH PROMOTION ACTIVITIES						15
16 DAY CARE PROGRAM						16
17 HOME DELIVERED MEALS PROGRAM						17
18 HOMEMAKER SERVICE						18
19 ALL OTHERS						19
20 TOTAL (SUM OF LINES 1-19)	1,265,330		1,265,330	101,766	1,265,330	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.087461		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7187

WORKSHEET H-2
 PART II

HHA COST CENTER	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE	OTHER CAP REL COSTS NOT USED	EMPLOYEE B ENEFITS GROSS SALARIES	RECON- CILIATION	ADMINISTRA TIVE & GEN ERAL ACCUM COST	MAINTENANC E & REPAIR S SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4	4A	5	6	7	
1 ADMINISTRATIVE AND GENERAL	1,333	440		107,414		44,959	1,333	1,333	1
2 SKILLED NURSING CARE				481,781		855,340			2
3 PHYSICAL THERAPY						22,776			3
4 OCCUPATIONAL THERAPY						5,909			4
5 SPEECH PATHOLOGY						1,690			5
6 MEDICAL SOCIAL SERVICES				6,026		9,833			6
7 HOME HEALTH AIDE				71,219		132,598			7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)	1,333	440		666,440		1,073,105	1,333	1,333	20
21 TOTAL COST TO BE ALLOCATED	7,283	447		230,987		141,340	11,222	6,643	21
22 UNIT COST MULTIPLIER	5.463616						8.418605		22
22 UNIT COST MULTIPLIER		1.015909		0.346598		0.131711		4.983496	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7187

WORKSHEET H-2
 PART II

HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS	HOUSEKEEPING HOURS OF SERVICE	DIETARY MEALS	CAFETERIA CAFE MEALS	MAINTENANCE OF PERSONNEL NUMBER	NURSING ADMINISTRATION DIRECT NURSING HOURS	CENTRAL SERVICES & SUPPLY CS COSTED REQUIS	PHARMACY PHARM COSTED REQ	
	8	9	10	11	12	13	14	15	
1 ADMINISTRATIVE AND GENERAL		9,200		80				32,100	1
2 SKILLED NURSING CARE									2
3 PHYSICAL THERAPY									3
4 OCCUPATIONAL THERAPY									4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE									7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)		9,200		80				32,100	20
21 TOTAL COST TO BE ALLOCATED		10,031		22,375				614	21
22 UNIT COST MULTIPLIER									22
22 UNIT COST MULTIPLIER		1.090326		279.687500				0.019128	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7187

WORKSHEET H-2
 PART II

HHA COST CENTER	MEDICAL RE CORDS & LI BRARY TIME SPENT	SOCIAL LI SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	
	16	17	19	20	21	22	23	
1 ADMINISTRATIVE AND GENERAL								1
2 SKILLED NURSING CARE								2
3 PHYSICAL THERAPY								3
4 OCCUPATIONAL THERAPY								4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE								7
8 SUPPLIES								8
9 DRUGS								9
10 DME								10
11 HOME DIALYSIS AIDE SERVICES								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIES								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGRAM								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTAL (SUM OF LINES 1-19)								20
21 TOTAL COST TO BE ALLOCATED								21
22 UNIT COST MULTIPLIER								22
22 UNIT COST MULTIPLIER								22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7187

WORKSHEET H-3
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	AVERAGE	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	ANCILLARY COSTS (FROM PART II)	COSTS COLS. 1+2)	VISITS	COST PER VISIT (COL.3 ÷ COL.4)	
1	SKILLED NURSING CARE	2	1,052,659	2	1,052,659	6,891	152.76	1
2	PHYSICAL THERAPY	3	28,030	207,551	235,581	2,754	85.54	2
3	OCCUPATIONAL THERAPY	4	7,272		7,272	518	14.04	3
4	SPEECH PATHOLOGY	5	2,080	7,464	9,544	98	97.39	4
5	MEDICAL SOCIAL SERVICES	6	12,101		12,101	81	149.40	5
6	HOME HEALTH AIDE	7	163,188		163,188	1,801	90.61	6
7	TOTAL (SUM OF LINES 1-6)		1,265,330	215,015	1,480,345	12,143		7

PATIENT SERVICES

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

SUPPLIES AND DRUGS
 COST COMPUTATIONS

OTHER PATIENT SERVICES		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	RATIO	
		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	ANCILLARY COSTS (FROM PART II)	COSTS COLS. 1+2)	CHARGES (FROM HHA RECORD)	(COL.3 ÷ COL.4)	
15	COST OF MEDICAL SUPPLIES	8		46,573	46,573	128,706	0.361856	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7187

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART B			PART B			
	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR		NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR		
	PART A	PART A		PART A	PART A		
	6	7		9	10	11	12
1 SKILLED NURSING CARE	2,868	2,744		438,116	419,173		857,289
2 PHYSICAL THERAPY	1,399	913		119,670	78,098		197,768
3 OCCUPATIONAL THERAPY	238	195		3,342	2,738		6,080
4 SPEECH PATHOLOGY	22	14		2,143	1,363		3,506
5 MEDICAL SOCIAL SERVICES	49	27		7,321	4,034		11,355
6 HOME HEALTH AIDE	545	1,232		49,382	111,632		161,014
7 TOTAL (SUM OF LINES 1-6)	5,121	5,125		619,974	617,038		1,237,012

PATIENT SERVICES	PROGRAM VISITS			CBSA NO.	COST OF SERVICES		
	PART B				PART B		
	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR		NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR		
	PART A	PART A		PART A	PART A		
	1	2		3	4		
8 SKILLED NURSING CARE	99914	2,868		2	2,744		8
9 PHYSICAL THERAPY	99914	1,399		3	913		9
10 OCCUPATIONAL THERAPY	99914	238		4	195		10
11 SPEECH PATHOLOGY	99914	22		5	14		11
12 MEDICAL SOCIAL SERVICES	99914	49		6	27		12
13 HOME HEALTH AIDE	99914	545		7	1,232		13
14 TOTAL (SUM OF LINES 8-13)	5,121	5,125		8	5,125		14

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

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

FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
1 PHYSICAL THERAPY	0.310284	668,905	207,551	COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY				COL 2, LINE 3	2
3 SPEECH PATHOLOGY	0.417429	17,880	7,464	COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHRGED TO PAT	0.361852	128,706	46,573	COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	0.226086			COL 2, LINE 16	5

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 14-7187

WORKSHEET H-4
 PARTS I & II

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

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	624,900	529,047	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	40,028	27,992	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	6,609	11,113	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	3,728	9,686	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	10,257	16,530	15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	685,522	594,368	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	685,522	594,368	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	685,522	594,368	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	685,522	594,368	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	685,522	594,368	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	685,522	594,368	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

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

HHA NO.: 14-7187

WORKSHEET H-5

DESCRIPTION	PART A		PART B		
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		685,522		594,368	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		685,522		594,368	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM				6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		685,522		594,368	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:		8

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE NO.: 14-1542

WORKSHEET K

	SALARIES (FROM WKST K-1)	EMPLOYEE BENEFITS (FROM WKST K-2)	TRANS- PORTATION (SEE INSTR.)	CONTRACTED SERVICES (FROM WKST K-3)	OTHER	TOTAL (COLS. 1-5)
	1	2	3	4	5	6
1 GENERAL SERVICE COST CENTER						
2 CAPITAL RELATED COSTS-BLDG AND FIXT.						1
3 CAPITAL RELATED COSTS-MOVABLE EQUIP.						2
4 PLANT OPERATION AND MAINTENANCE						3
5 TRANSPORTATION - STAFF						4
6 VOLUNTEER SERVICE COORDINATION						5
7 ADMINISTRATIVE AND GENERAL	26,672		1,281		193,477	221,430 6
8 INPATIENT CARE SERVICE						7
9 INPATIENT - GENERAL CARE						8
10 INPATIENT - RESPITE CARE						9
11 VISITING SERVICES						10
12 PHYSICIAN SERVICES	113,999		23,893			137,892 10
13 NURSING CARE						11
14 NURSING CARE-CONTINUOUS HOME CARE						12
15 PHYSICAL THERAPY						13
16 OCCUPATIONAL THERAPY						14
17 SPEECH/LANGUAGE PATHOLOGY						15
18 MEDICAL SOCIAL SERVICES	41,565					41,565 15
19 SPIRITUAL COUNSELING						16
20 DIETARY COUNSELING						17
21 COUNSELING - OTHER						18
22 HOME HEALTH AIDE AND HOMEMAKER	20,886		7,646			28,532 19
23 HH AIDE & HOMEMAKER-CONT. HOME CARE						20
24 OTHER						21
25 OTHER HOSPICE SERVICE COSTS						22
26 DRUGS, BIOLOGICAL & INFUSION THERAPY						23
27 ANALGESICS						24
28 SEDATIVES/HYPNOTICS						25
29 OTHER - SPECIFY						26
30 DURABLE MEDICAL EQUIPMENT/OXYGEN						27
31 PATIENT TRANSPORTATION						28
32 IMAGING SERVICES						29
33 LABS AND DIAGNOSTICS						30
34 MEDICAL SUPPLIES						31
35 OUTPATIENT SERVICES (INCLUDING E/R DEPT.)						32
36 RADIATION THERAPY						33
37 CHEMOTHERAPY						34
38 OTHER						35
39 HOSPICE NONREIMBURSABLE SERVICE						36
40 BEREAVEMENT PROGRAM COSTS						37
41 VOLUNTEER PROGRAM COSTS						38
42 FUNDRAISING						39
43 OTHER PROGRAM COSTS						40
44 TOTAL (SUM OF LINES 1-38)	203,122		32,820		193,477	429,419 39

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS		HOSPICE NO.: 14-1542			WORKSHEET K (CONTINUED)
	RECLASSIFI- CATION 7	SUBTOTAL (COL. 6 ± COL. 7) 8	ADJUST- MENTS 9	TOTAL (COL. 8 ± COL. 9) 10	
1	GENERAL SERVICE COST CENTER				1
2	CAPITAL RELATED COSTS-BLDG AND FIXT.				2
3	CAPITAL RELATED COSTS-MOVABLE EQUIP.				3
4	PLANT OPERATION AND MAINTENANCE				4
5	TRANSPORTATION - STAFF				5
6	VOLUNTEER SERVICE COORDINATION				6
7	ADMINISTRATIVE AND GENERAL	221,430		221,430	7
8	INPATIENT CARE SERVICE				8
9	INPATIENT - GENERAL CARE				9
10	INPATIENT - RESPITE CARE				10
11	VISITING SERVICES				11
12	PHYSICIAN SERVICES				12
13	NURSING CARE	137,892		137,892	13
14	NURSING CARE-CONTINUOUS HOME CARE				14
15	PHYSICAL THERAPY				15
16	OCCUPATIONAL THERAPY				16
17	SPEECH/LANGUAGE PATHOLOGY				17
18	MEDICAL SOCIAL SERVICES	41,565		41,565	18
19	SPIRITUAL COUNSELING				19
20	DIETARY COUNSELING				20
21	COUNSELING - OTHER				21
22	HOME HEALTH AIDE AND HOMEMAKER	28,532		28,532	22
23	HH AIDE & HOMEMAKER-CONT. HOME CARE				23
24	OTHER				24
25	OTHER HOSPICE SERVICE COSTS				25
26	DRUGS, BIOLOGICAL & INFUSION THERAPY				26
27	ANALGESICS				27
28	SEDATIVES/HYPNOTICS				28
29	OTHER - SPECIFY				29
30	DURABLE MEDICAL EQUIPMENT/OXYGEN				30
31	PATIENT TRANSPORTATION				31
32	IMAGING SERVICES				32
33	LABS AND DIAGNOSTICS				33
34	MEDICAL SUPPLIES				34
35	OUTPATIENT SERVICES (INCLUDING E/R DEPT.)				35
36	RADIATION THERAPY				36
37	CHEMOTHERAPY				37
38	OTHER				38
39	HOSPICE NONREIMBURSABLE SERVICE				39
	BEREAVEMENT PROGRAM COSTS				
	VOLUNTEER PROGRAM COSTS				
	FUNDRAISING				
	OTHER PROGRAM COSTS				
	TOTAL (SUM OF LINES 1-38)	429,419		429,419	

HOSPICE COMPENSATION ANALYSIS - SALARIES AND WAGES

HOSPICE NO.: 14-1542

WORKSHEET K-1

	ADMINI- STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER- VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9
1	GENERAL SERVICE COST CENTER								1
2	CAP REL COSTS-BLDG AND FIXT.								2
3	CAP REL COSTS-MOVABLE EQUIP.								3
4	PLANT OPERATION & MAINT.								4
5	TRANSPORTATION - STAFF								5
6	VOLUNTEER SERVICE COORD.								6
7	ADMINISTRATIVE AND GENERAL			26,672					26,672
8	INPATIENT CARE SERVICE								7
9	INPATIENT - GENERAL CARE								8
10	INPATIENT - RESPITE CARE								9
11	VISITING SERVICES								10
12	PHYSICIAN SERVICES								11
13	NURSING CARE				113,999				113,999
14	NURSING CARE-CONT.HOME CARE								12
15	PHYSICAL THERAPY								13
16	OCCUPATIONAL THERAPY								14
17	SPEECH/LANGUAGE PATHOLOGY								15
18	MEDICAL SOCIAL SERVICES		41,565						41,565
19	SPIRITUAL COUNSELING								16
20	DIETARY COUNSELING								17
21	COUNSELING - OTHER								18
22	HH AIDE AND HOMEMAKER						20,886		20,886
23	HH AIDE & HMKR-CONT.HME CARE								20
24	OTHER								21
25	OTHER HOSPICE SERVICE COSTS								22
26	DRUGS, BIOL. & INFUS. THER.								23
27	ANALGESICS								24
28	SEDATIVES / HYPNOTICS								25
29	OTHER - SPECIFY								26
30	DURABLE MED. EQUIP./OXYGEN								27
31	PATIENT TRANSPORTATION								28
32	IMAGING SERVICES								29
33	LABS AND DIAGNOSTICS								30
34	MEDICAL SUPPLIES								31
35	OUTPAT.SERV.(INCL.E/R DEPT.)								32
36	RADIATION THERAPY								33
37	CHEMOTHERAPY								34
38	OTHER								35
39	HOSPICE NONREIMBURSABLE SERVICE								36
40	BEREAVEMENT PROGRAM COSTS								37
41	VOLUNTEER PROGRAM COSTS								38
42	FUNDRAISING								39
43	OTHER PROGRAM COSTS								40
44	TOTAL (SUM OF LINES 1-38)		41,565	26,672	113,999		20,886		203,122

HOSPICE COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE NO.: 14-1542

WORKSHEET K-2

	ADMINI- STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER- VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9
1									1
2	GENERAL SERVICE COST CENTER								2
3	CAP REL COSTS-BLDG AND FIXT.								3
4	CAP REL COSTS-MOVABLE EQUIP.								4
5	PLANT OPERATION & MAINT.								5
6	TRANSPORTATION - STAFF								6
7	VOLUNTEER SERVICE COORD.								7
8	ADMINISTRATIVE AND GENERAL								8
9	INPATIENT CARE SERVICE								9
10	INPATIENT - GENERAL CARE								10
11	INPATIENT - RESPITE CARE								11
12	VISITING SERVICES								12
13	PHYSICIAN SERVICES								13
14	NURSING CARE								14
15	NURSING CARE-CONT.HOME CARE								15
16	PHYSICAL THERAPY								16
17	OCCUPATIONAL THERAPY								17
18	SPEECH/LANGUAGE PATHOLOGY								18
19	MEDICAL SOCIAL SERVICES								19
20	SPIRITUAL COUNSELING								20
21	DIETARY COUNSELING								21
22	COUNSELING - OTHER								22
23	HH AIDE AND HOME MAKER								23
24	HH AIDE & HMKR-CONT.HME CARE								24
25	OTHER								25
26	OTHER HOSPICE SERVICE COSTS								26
27	DRUGS, BIOL. & INFUS. THER.								27
28	ANALGESICS								28
29	SEDATIVES / HYPNOTICS								29
30	OTHER - SPECIFY								30
31	DURABLE MED. EQUIP./OXYGEN								31
32	PATIENT TRANSPORTATION								32
33	IMAGING SERVICES								33
34	LABS AND DIAGNOSTICS								34
35	MEDICAL SUPPLIES								35
36	OUTPAT.SERV.(INCL.E/R DEPT.)								36
37	RADIATION THERAPY								37
38	CHEMOTHERAPY								38
39	OTHER								39
35	HOSPICE NONREIMBURSABLE SERVICE								35
36	BEREAVEMENT PROGRAM COSTS								36
37	VOLUNTEER PROGRAM COSTS								37
38	FUNDRAISING								38
39	OTHER PROGRAM COSTS								39
39	TOTAL (SUM OF LINES 1-38)								39

HOSPICE COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE NO.: 14-1542

WORKSHEET K-3

	ADMINI- STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER- VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9
1									1
2	GENERAL SERVICE COST CENTER								2
3	CAP REL COSTS-BLDG AND FIXT.								3
4	CAP REL COSTS-MOVABLE EQUIP.								4
5	PLANT OPERATION & MAINT.								5
6	TRANSPORTATION - STAFF								6
7	VOLUNTEER SERVICE COORD.								7
8	ADMINISTRATIVE AND GENERAL								8
9	INPATIENT CARE SERVICE								9
10	INPATIENT - GENERAL CARE								10
11	INPATIENT - RESPITE CARE								11
12	VISITING SERVICES								12
13	PHYSICIAN SERVICES								13
14	NURSING CARE								14
15	NURSING CARE-CONT.HOME CARE								15
16	PHYSICAL THERAPY								16
17	OCCUPATIONAL THERAPY								17
18	SPEECH/LANGUAGE PATHOLOGY								18
19	MEDICAL SOCIAL SERVICES								19
20	SPIRITUAL COUNSELING								20
21	DIETARY COUNSELING								21
22	COUNSELING - OTHER								22
23	HH AIDE AND HOMEMAKER								23
24	HH AIDE & HMKR-CONT.HME CARE								24
25	OTHER								25
26	OTHER HOSPICE SERVICE COSTS								26
27	DRUGS, BIOL. & INFUS. THER.								27
28	ANALGESICS								28
29	SEDATIVES / HYPNOTICS								29
30	OTHER - SPECIFY								30
31	DURABLE MED. EQUIP./OXYGEN								31
32	PATIENT TRANSPORTATION								32
33	IMAGING SERVICES								33
34	LABS AND DIAGNOSTICS								34
35	MEDICAL SUPPLIES								35
36	OUTPAT.SERV.(INCL.E/R DEPT.)								36
37	RADIATION THERAPY								37
38	CHEMOTHERAPY								38
39	OTHER								39
40	HOSPICE NONREIMBURSABLE SERVICE								40
41	BEREAVEMENT PROGRAM COSTS								41
42	VOLUNTEER PROGRAM COSTS								42
43	FUNDRAISING								43
44	OTHER PROGRAM COSTS								44
45	TOTAL (SUM OF LINES 1-39)								45

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE NO.: 14-1542

WORKSHEET K-4
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS & FIXTURES	CAP REL BLDG COSTS EQUIPMENT	PLANT OPERATN & MAINT	TRANSPOR- TATION	VOLUNTEER SERV. CO- ORDINATOR	SUBTOTAL (COLS.0-5) 5A	ADMIN & GENERAL 6	TOTAL (COL.5 ± COL.6) 7
1									1
2									2
3									3
4									4
5									5
6	221,430						221,430	221,430	6
7									7
8									8
9									9
10	137,892						137,892	146,803	10
11									11
12									12
13									13
14									14
15	41,565						41,565	44,251	15
16									16
17									17
18									18
19	28,532						28,532	30,376	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36									36
37									37
38									38
39	429,419						429,419		39
								429,419	

COST ALLOCATION - HOSPICE STATISTICAL BASIS

HOSPICE NO.: 14-1542

WORKSHEET K-4
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET)	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE)	PLANT OPERATN & MAINT (SQUARE FEET)	TRANSPOR- TATION (MILEAGE)	VOLUNTEER SERV. CO- ORDINATOR (HOURS)	RECONCIL- IATION 6A	ADMIN & GENERAL (ACCUM COST) 6	
	1	2	3	4	5		6	
1								1
2								2
3								3
4								4
5								5
6						-221,430	207,989	6
7								7
8								8
9								9
10							137,892	10
11								11
12								12
13								13
14								14
15							41,565	15
16								16
17								17
18								18
19							28,532	19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36								36
37								37
38								38
39							221,430	39
40							1.064624	40

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART I

HOSPICE COST CENTER	HOSPICE TRIAL BALANCE 0	NEW CAP RE L COSTS-BL DG & FIXT 1	NEW CAP RE L COSTS-MV BLE EQUIP 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS 4	SUBTOTAL 4A	ADMINISTRATIVE & GENERAL 5	MAINTENANCE & REPAIRS 6	
1 ADMINISTRATIVE AND GENERAL		7,283	446		9,245	16,974	2,236	11,222	1
2 INPATIENT - GENERAL CARE									2
3 INPATIENT - RESPITE CARE									3
4 PHYSICIAN SERVICES									4
5 NURSING CARE	284,695				39,512	324,207	42,702		5
6 NURSING CARE-CONTINUOUS HOM									6
7 PHYSICAL THERAPY									7
8 OCCUPATIONAL THERAPY									8
9 SPEECH/LANGUAGE PATHOLOGY									9
10 MEDICAL SOCIAL SERV. - DIRE	85,816				14,406	100,222	13,200		10
11 SPIRITUAL COUNSELING									11
12 DIETARY COUNSELING									12
13 COUNSELING - OTHER									13
14 HOME HLTH AIDE & HOMEMAKERS	58,908				7,239	66,147	8,712		14
15 HH AIDE & HMKR-CONT. HOME C									15
16 OTHER									16
17 DRUGS,BIOLOGICALS & INFUSIO									17
18 ANALGESICS									18
19 SEDATIVES / HYPNOTICS									19
20 OTHER - SPECIFY									20
21 DURABLE MED. EQUIP./OXYGEN									21
22 PATIENT TRANSPORTATION									22
23 IMAGING SERVICES									23
24 LABS AND DIAGNOSTICS									24
25 MEDICAL SUPPLIES									25
26 OUTPAT. SERV.(INCL.E/R DEPT									26
27 RADIATION THERAPY									27
28 CHEMOTHERAPY									28
29 OTHER									29
30 BEREAVEMENT PROGRAM COSTS									30
31 VOLUNTEER PROGRAM COSTS									31
32 FUNDRAISING									32
33 OTHER PROGRAM COSTS									33
34 TOTALS (SUM OF LINES 1-33)	429,419	7,283	446		70,402	507,550	66,850	11,222	34
35 UNIT COST MULTIPLIER									35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART I

HOSPICE COST CENTER	OPERATION	LAUNDRY & HOUSEKEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY		
	7	8	9	10	11	12	13		14
1	ADMINISTRATIVE AND GENERAL	6,643		10,031		11,747			1
2	INPATIENT - GENERAL CARE								2
3	INPATIENT - RESPITE CARE								3
4	PHYSICIAN SERVICES								4
5	NURSING CARE								5
6	NURSING CARE--CONTINUOUS HOM								6
7	PHYSICAL THERAPY								7
8	OCCUPATIONAL THERAPY								8
9	SPEECH/LANGUAGE PATHOLOGY								9
10	MEDICAL SOCIAL SERV. - DIRE								10
11	SPIRITUAL COUNSELING								11
12	DIETARY COUNSELING								12
13	COUNSELING - OTHER								13
14	HOME HLTH AIDE & HOMEMAKERS								14
15	HH AIDE & HMKR--CONT. HOME C								15
16	OTHER								16
17	DRUGS,BIOLOGICALS & INFUSIO								17
18	ANALGESICS								18
19	SEDATIVES / HYPNOTICS								19
20	OTHER - SPECIFY								20
21	DURABLE MED. EQUIP./OXYGEN								21
22	PATIENT TRANSPORTATION								22
23	IMAGING SERVICES								23
24	LABS AND DIAGNOSTICS								24
25	MEDICAL SUPPLIES								25
26	OUTPAT. SERV.(INCL.E/R DEPT								26
27	RADIATION THERAPY								27
28	CHEMOTHERAPY								28
29	OTHER								29
30	BEREAVEMENT PROGRAM COSTS								30
31	VOLUNTEER PROGRAM COSTS								31
32	FUNDRAISING								32
33	OTHER PROGRAM COSTS								33
34	TOTALS (SUM OF LINES 1-33)	6,643		10,031		11,747			34
35	UNIT COST MULTIPLIER								35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART I

HOSPICE COST CENTER	PHARMACY 15	MEDICAL RE CORDS & LI SERVICE BRARY 16	SOCIAL SERVICE 17	NONPHYSIC. ANESTHET. 19	NURSING SCHOOL 20	I&R SALARY & FRINGES 21	I&R PROGRAM COSTS 22	PARAMED EDUCATION 23	
1 ADMINISTRATIVE AND GENERAL	55								1
2 INPATIENT - GENERAL CARE									2
3 INPATIENT - RESPITE CARE									3
4 PHYSICIAN SERVICES									4
5 NURSING CARE									5
6 NURSING CARE-CONTINUOUS HOM									6
7 PHYSICAL THERAPY									7
8 OCCUPATIONAL THERAPY									8
9 SPEECH/LANGUAGE PATHOLOGY									9
10 MEDICAL SOCIAL SERV. - DIRE									10
11 SPIRITUAL COUNSELING									11
12 DIETARY COUNSELING									12
13 COUNSELING - OTHER									13
14 HOME HLTH AIDE & HOMEMAKERS									14
15 HH AIDE & HMKR-CONT. HOME C									15
16 OTHER									16
17 DRUGS,BIOLOGICALS & INFUSIO									17
18 ANALGESICS									18
19 SEDATIVES / HYPNOTICS									19
20 OTHER - SPECIFY									20
21 DURABLE MED. EQUIP./OXYGEN									21
22 PATIENT TRANSPORTATION									22
23 IMAGING SERVICES									23
24 LABS AND DIAGNOSTICS									24
25 MEDICAL SUPPLIES									25
26 OUTPAT. SERV.(INCL.E/R DEPT									26
27 RADIATION THERAPY									27
28 CHEMOTHERAPY									28
29 OTHER									29
30 BEREAVEMENT PROGRAM COSTS									30
31 VOLUNTEER PROGRAM COSTS									31
32 FUNDRAISING									32
33 OTHER PROGRAM COSTS									33
34 TOTALS (SUM OF LINES 1-33)	55								34
35 UNIT COST MULTIPLIER									35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART I

HOSPICE COST CENTER	SUBTOTAL (COLS. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (COLS. 24 ± 25) 26	ALLOC HOSP A&G (SEE PART II) 27	TOTAL HOSP COSTS (COL 26 ± 27) 28	
1 ADMINISTRATIVE AND GENERAL	58,908		58,908			1
2 INPATIENT - GENERAL CARE						2
3 INPATIENT - RESPITE CARE						3
4 PHYSICIAN SERVICES						4
5 NURSING CARE	366,909		366,909	38,930	405,839	5
6 NURSING CARE--CONTINUOUS HOM						6
7 PHYSICAL THERAPY						7
8 OCCUPATIONAL THERAPY						8
9 SPEECH/LANGUAGE PATHOLOGY						9
10 MEDICAL SOCIAL SERV. - DIRE	113,422		113,422	12,035	125,457	10
11 SPIRITUAL COUNSELING						11
12 DIETARY COUNSELING						12
13 COUNSELING - OTHER						13
14 HOME HLTH AIDE & HOMEMAKERS	74,859		74,859	7,943	82,802	14
15 HH AIDE & HMKR-CONT. HOME C						15
16 OTHER						16
17 DRUGS,BIOLOGICALS & INFUSIO						17
18 ANALGESICS						18
19 SEDATIVES / HYPNOTICS						19
20 OTHER - SPECIFY						20
21 DURABLE MED. EQUIP./OXYGEN						21
22 PATIENT TRANSPORTATION						22
23 IMAGING SERVICES						23
24 LABS AND DIAGNOSTICS						24
25 MEDICAL SUPPLIES						25
26 OUTPAT. SERV.(INCL.E/R DEPT						26
27 RADIATION THERAPY						27
28 CHEMOTHERAPY						28
29 OTHER						29
30 BEREAVEMENT PROGRAM COSTS						30
31 VOLUNTEER PROGRAM COSTS						31
32 FUNDRAISING						32
33 OTHER PROGRAM COSTS						33
34 TOTALS (SUM OF LINES 1-33)	614,098		614,098		614,098	34
35 UNIT COST MULTIPLIER				0.106104		35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE -NEW	OTHER CAP REL COSTS NOT USED	EMPLOYEE B ENEFITS GROSS SALARIES	RECON- CILIATION 4A	ADMINISTRA TIVE & GEN ERAL ACCUM COST	MAINTENANC E & REPAIR S SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4		5	6	7	
1 ADMINISTRATIVE AND GENERAL	1,333	439		26,672		16,974	1,333	1,333	1
2 INPATIENT - GENERAL CARE									2
3 INPATIENT - RESPITE CARE									3
4 PHYSICIAN SERVICES									4
5 NURSING CARE				113,999		324,207			5
6 NURSING CARE-CONTINUOUS HOM									6
7 PHYSICAL THERAPY									7
8 OCCUPATIONAL THERAPY									8
9 SPEECH/LANGUAGE PATHOLOGY									9
10 MEDICAL SOCIAL SERV. - DIRE				41,565		100,222			10
11 SPIRITUAL COUNSELING									11
12 DIETARY COUNSELING									12
13 COUNSELING - OTHER									13
14 HOME HLTH AIDE & HOMEMAKERS				20,886		66,147			14
15 HH AIDE & HMKR-CONT. HOME C									15
16 OTHER									16
17 DRUGS,BIOLOGICALS & INFUSIO									17
18 ANALGESICS									18
19 SEDATIVES / HYPNOTICS									19
20 OTHER - SPECIFY									20
21 DURABLE MED. EQUIP./OXYGEN									21
22 PATIENT TRANSPORTATION									22
23 IMAGING SERVICES									23
24 LABS AND DIAGNOSTICS									24
25 MEDICAL SUPPLIES									25
26 OUTPAT. SERV.(INCL.E/R DEPT									26
27 RADIATION THERAPY									27
28 CHEMOTHERAPY									28
29 OTHER									29
30 BEREAVEMENT PROGRAM COSTS									30
31 VOLUNTEER PROGRAM COSTS									31
32 FUNDRAISING									32
33 OTHER PROGRAM COSTS									33
34 TOTALS (SUM OF LINES 1-33)	1,333	439		203,122		507,550	1,333	1,333	34
35 TOTAL COST TO BE ALLOCATED	7,283	446		70,402		66,850	11,222	6,643	35
36 UNIT COST MULTIPLIER	5.463616	1.015945		0.346600		0.131711	8.418605	4.983496	36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	LAUNDRY & HOUSEKEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING AD MINISTRATI ON	CENTRAL RVICES & SUPPLY	SE PHARMACY	
	LAUNDRY POUNDS	HOURS OF SERVICE	DIETARY MEALS SERV	CAFE MEALS SERV	NUMBER HOUSED	DIRECT NURSING HO	CS COSTED REQUIS COSTED	
	8	9	10	11	12	13	14	15
1 ADMINISTRATIVE AND GENERAL		9,200		42				2,900
2 INPATIENT - GENERAL CARE								
3 INPATIENT - RESPITE CARE								
4 PHYSICIAN SERVICES								
5 NURSING CARE								
6 NURSING CARE-CONTINUOUS HOM								
7 PHYSICAL THERAPY								
8 OCCUPATIONAL THERAPY								
9 SPEECH/LANGUAGE PATHOLOGY								
10 MEDICAL SOCIAL SERV. - DIRE								
11 SPIRITUAL COUNSELING								
12 DIETARY COUNSELING								
13 COUNSELING - OTHER								
14 HOME HLTH AIDE & HOMEMAKERS								
15 HH AIDE & HMKR-CONT. HOME C								
16 OTHER								
17 DRUGS, BIOLOGICALS & INFUSIO								
18 ANALGESICS								
19 SEDATIVES / HYPNOTICS								
20 OTHER - SPECIFY								
21 DURABLE MED. EQUIP./OXYGEN								
22 PATIENT TRANSPORTATION								
23 IMAGING SERVICES								
24 LABS AND DIAGNOSTICS								
25 MEDICAL SUPPLIES								
26 OUTPAT. SERV. (INCL.E/R DEPT								
27 RADIATION THERAPY								
28 CHEMOTHERAPY								
29 OTHER								
30 BEREAVEMENT PROGRAM COSTS								
31 VOLUNTEER PROGRAM COSTS								
32 FUNDRAISING								
33 OTHER PROGRAM COSTS								
34 TOTALS (SUM OF LINES 1-33)		9,200		42				2,900
35 TOTAL COST TO BE ALLOCATED		10,031		11,747				55
36 UNIT COST MULTIPLIER		1.090326		279.690476				0.018966

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	MEDICAL RE CORDS & LI BRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	
	16	17	19	20	21	22	23	
1 ADMINISTRATIVE AND GENERAL								1
2 INPATIENT - GENERAL CARE								2
3 INPATIENT - RESPITE CARE								3
4 PHYSICIAN SERVICES								4
5 NURSING CARE								5
6 NURSING CARE-CONTINUOUS HOM								6
7 PHYSICAL THERAPY								7
8 OCCUPATIONAL THERAPY								8
9 SPEECH/LANGUAGE PATHOLOGY								9
10 MEDICAL SOCIAL SERV. - DIRE								10
11 SPIRITUAL COUNSELING								11
12 DIETARY COUNSELING								12
13 COUNSELING - OTHER								13
14 HOME HLTH AIDE & HOMEMAKERS								14
15 HH AIDE & HMKR-CONT. HOME C								15
16 OTHER								16
17 DRUGS,BIOLOGICALS & INFUSIO								17
18 ANALGESICS								18
19 SEDATIVES / HYPNOTICS								19
20 OTHER - SPECIFY								20
21 DURABLE MED. EQUIP./OXYGEN								21
22 PATIENT TRANSPORTATION								22
23 IMAGING SERVICES								23
24 LABS AND DIAGNOSTICS								24
25 MEDICAL SUPPLIES								25
26 OUTPAT. SERV.(INCL.E/R DEPT								26
27 RADIATION THERAPY								27
28 CHEMOTHERAPY								28
29 OTHER								29
30 BEREAVEMENT PROGRAM COSTS								30
31 VOLUNTEER PROGRAM COSTS								31
32 FUNDRAISING								32
33 OTHER PROGRAM COSTS								33
34 TOTALS (SUM OF LINES 1-33)								34
35 TOTAL COST TO BE ALLOCATED								35
36 UNIT COST MULTIPLIER								36

APPORTIONMENT OF HOSPICE SHARED SERVICES

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	WKST C, PART I, COL. 9, LINE 0	COST TO CHARGE RATIO 1	TOTAL HOSPICE CHARGES (PROVIDER RECORDS) 2	HOSPICE SHARED ANCILLARY COSTS (COL.1 x 2) 3	
ANCILLARY SERVICE COST CENTERS					
1	PHYSICAL THERAPY	66	0.310284		1
2	OCCUPATIONAL THERAPY	67			2
3	SPEECH/LANGUAGE PATHOLOGY	68	0.417429		3
4	DRUGS, BIOLOGICALS AND INFUSION	73	0.226086		4
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96			5
6	LABS AND DIAGNOSTICS	60	0.151944		6
7	MEDICAL SUPPLIES	71	0.361852		7
8	OUTPATIENT SERVICES (INCL. E/R DEPT)	93			8
9	RADIATION THERAPY	55			9
10	OTHER ANCILLARY (SPECIFY)	76			10
10.97	CARDIAC REHABILITATION	76.97			10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98			10.98
10.99	LITHOTRIPSY	76.99			10.99
11	TOTALS (SUM OF LINES 1-10)				11

CALCULATION OF HOSPICE PER DIEM COST

HOSPICE NO.: 14-1542

WORKSHEET K-6

COMPUTATION OF PER DIEM COST		TITLE XVIII 1	TITLE XIX 2	OTHER 3	TOTAL 4	
1	TOTAL COST (SEE INSTRUCTIONS)				614,098	1
2	TOTAL UNDUPLICATED DAYS (WKST S-9, COL. 6, LINE 5)				4,873	2
3	AVERAGE COST PER DIEM (LINE 1 DIVIDED BY LINE 2)				126.02	3
4	UNDUPLICATED MEDICARE DAYS (WKST S-9, COL. 1, LINE 5)	3,854				4
5	AGGREGATE MEDICARE COST (LINE 3 TIMES LINE 4)	485,681				5
6	UNDUPLICATED MEDICAID DAYS (WKST S-9, COL. 2, LINE 5)		441			6
7	AGGREGATE MEDICAID COST (LINE 3 TIMES LINE 6)		55,575			7
8	UNDUPLICATED SNF DAYS (WKST S-9, COL. 3, LINE 5)					8
9	AGGREGATE SNF COST (LINE 3 TIMES LINE 8)					9
10	UNDUPLICATED NF DAYS (WKST S-9, COL. 4, LINE 5)					10
11	AGGREGATE NF COST (LINE 3 TIMES LINE 10)					11
12	OTHER UNDUPLICATED DAYS (WKST S-9, COL. 5, LINE 5)			578		12
13	AGGREGATE COST FOR OTHER DAYS (LINE 3 TIMES LINE 12)			72,840		13

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-014) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT			
2	CAPITAL DRG OTHER THAN OUTLIER	353,267		1
3	CAPITAL DRG OUTLIER PAYMENTS	4,876		2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	16.77		3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)			4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)			5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)			6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)			7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)			8
10	SUM OF LINES 7 AND 8			9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)			10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)			11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	358,143		12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-014) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
40 SUBPROVIDER - IPF					40
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
56 RADIOISOTOPE					56
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
58 MAGNETIC RESONANCE IMAGING (MR					58
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
64 INTRAVENOUS THERAPY					64
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
116 HOSPICE					116
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES					192
194 OTHER NONREIMBURSABLE					194
194.01 MEMORY DISORDER					194.01
194.02 ASSISTED LIVING					194.02
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL	7
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6		
UTILIZATION PERCENTAGES BASED ON DAYS								
30 ADULTS & PEDIATRICS	54.73		13.08				67.81	30
31 INTENSIVE CARE UNIT	61.56		14.74				76.30	31
43 NURSERY			62.52				62.52	43
UTILIZATION PERCENTAGES BASED ON CHARGES								
50 OPERATING ROOM	6.72	24.75	14.67				46.14	50
53 ANESTHESIOLOGY	5.07	12.62	5.16				22.85	53
54 RADIOLOGY-DIAGNOSTIC	14.22	30.17	1.25				45.64	54
56 RADIOISOTOPE	7.30	49.97	0.30				57.57	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	12.99	31.58	2.67				47.24	57
58 MAGNETIC RESONANCE IMAGING (MRI)	5.44	31.99	1.09				38.52	58
60 LABORATORY	17.82	4.48	3.28				25.58	60
64 INTRAVENOUS THERAPY	41.84	15.74	0.01				57.59	64
65 RESPIRATORY THERAPY	51.51	10.74	2.84				65.09	65
66 PHYSICAL THERAPY	7.16		0.23				7.39	66
68 SPEECH PATHOLOGY	12.20	2.83	7.27				22.30	68
69 ELECTROCARDIOLOGY	12.08	40.51	2.00				54.59	69
71 MEDICAL SUPPLIES CHRGED TO PATI	18.81	16.16	12.50				47.47	71
72 IMPL. DEV. CHARGED TO PATIENT	6.99	45.39	3.86				56.24	72
73 DRUGS CHARGED TO PATIENTS	29.94	16.63	7.47				54.04	73
91 EMERGENCY	13.15	20.06	0.04				33.25	91
92 OBSERVATION BEDS	9.72	19.14	1.48				30.34	92
200 TOTAL CHARGES	15.47	17.50	4.89				37.86	200

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

SUBPROVIDER-IPF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
40 SUBPROVIDER - IPF	28.24		34.12				62.36 40
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	0.06						0.06 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.02						0.02 57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.23						0.23 58
60 LABORATORY	0.30						0.30 60
64 INTRAVENOUS THERAPY	0.01						0.01 64
65 RESPIRATORY THERAPY	0.18						0.18 65
66 PHYSICAL THERAPY	0.08						0.08 66
69 ELECTROCARDIOLOGY	0.13						0.13 69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.07						0.07 71
73 DRUGS CHARGED TO PATIENTS	2.19						2.19 73
91 EMERGENCY	0.57						0.57 91
200 TOTAL CHARGES	0.37						0.37 200

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

SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
44 SKILLED NURSING FACILITY	29.98						29.98 44
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	0.86						0.86 54
56 RADIOISOTOPE	0.25						0.25 56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.40						0.40 57
58 MAGNETIC RESONANCE IMAGING (MRI)	1.28						1.28 58
60 LABORATORY	1.36						1.36 60
64 INTRAVENOUS THERAPY	4.52						4.52 64
65 RESPIRATORY THERAPY	19.42						19.42 65
66 PHYSICAL THERAPY	24.23						24.23 66
68 SPEECH PATHOLOGY	16.34						16.34 68
69 ELECTROCARDIOLOGY	0.32						0.32 69
71 MEDICAL SUPPLIES CHRGED TO PATI	3.24						3.24 71
73 DRUGS CHARGED TO PATIENTS	10.36						10.36 73
92 OBSERVATION BEDS	0.18						0.18 92
200 TOTAL CHARGES	4.16						4.16 200

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

SWING-BED SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON CHARGES							
54	RADIOLOGY-DIAGNOSTIC	0.16					0.16 54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.23					0.23 57
60	LABORATORY	0.38					0.38 60
64	INTRAVENOUS THERAPY	1.67					1.67 64
65	RESPIRATORY THERAPY	3.25					3.25 65
66	PHYSICAL THERAPY	1.87					1.87 66
68	SPEECH PATHOLOGY	1.81					1.81 68
69	ELECTROCARDIOLOGY	0.06					0.06 69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.67					0.67 71
73	DRUGS CHARGED TO PATIENTS	1.88					1.88 73
200	TOTAL CHARGES	0.61					0.61 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1 CAP REL COSTS-BLDG & FIXT	869,446	2.37	-869,446	-4.58			1
2 CAP REL COSTS-MVBLE EQUIP	1,290,606	3.52	-1,290,606	-6.80			2
3 OTHER CAPITAL RELATED COSTS							3
4 EMPLOYEE BENEFITS	6,130,929	16.72	-6,130,929	-32.30			4
5 ADMINISTRATIVE & GENERAL	3,391,050	9.25	-3,391,050	-17.87			5
6 MAINTENANCE & REPAIRS	807,913	2.20	-807,913	-4.26			6
7 OPERATION OF PLANT	472,575	1.29	-472,575	-2.49			7
8 LAUNDRY & LINEN SERVICE	91,388	0.25	-91,388	-0.48			8
9 HOUSEKEEPING	504,548	1.38	-504,548	-2.66			9
10 DIETARY	454,612	1.24	-454,612	-2.40			10
11 CAFETERIA	606,341	1.65	-606,341	-3.19			11
12 MAINTENANCE OF PERSONNEL							12
13 NURSING ADMINISTRATION	1,130,423	3.08	-1,130,423	-5.96			13
14 CENTRAL SERVICES & SUPPLY	362,695	0.99	-362,695	-1.91			14
15 PHARMACY	2,051,849	5.60	-2,051,849	-10.81			15
16 MEDICAL RECORDS & LIBRARY	814,290	2.22	-814,290	-4.29			16
17 SOCIAL SERVICE							17
19 NONPHYSICIAN ANESTHETISTS							19
20 NURSING SCHOOL							20
21 I&R SRVCES-SALARY & FRINGES APP							21
22 I&R SRVCES-OTHER PRGM COSTS APP							22
23 PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS							
30 ADULTS & PEDIATRICS	2,072,128	5.65	3,315,641	17.47	5,387,769	14.69	30
31 INTENSIVE CARE UNIT	766,891	2.09	962,597	5.07	1,729,488	4.72	31
40 SUBPROVIDER - IPF	752,209	2.05	970,676	5.11	1,722,885	4.70	40
43 NURSERY	212,144	0.58	211,518	1.11	423,662	1.16	43
44 SKILLED NURSING FACILITY	1,117,837	3.05	1,777,889	9.37	2,895,726	7.90	44
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	874,140	2.38	1,092,855	5.76	1,966,995	5.36	50
53 ANESTHESIOLOGY	21,264	0.06	120,092	0.63	141,356	0.39	53
54 RADIOLOGY-DIAGNOSTIC	830,790	2.27	831,433	4.38	1,662,223	4.53	54
56 RADIOISOTOPE	216,596	0.59	51,363	0.27	267,959	0.73	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	254,047	0.69	365,371	1.93	619,418	1.69	57
58 MAGNETIC RESONANCE IMAGING (MRI)	190,985	0.52	26,923	0.14	217,908	0.59	58
60 LABORATORY	2,202,728	6.01	965,860	5.09	3,168,588	8.64	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64 INTRAVENOUS THERAPY	28,050	0.08	57,354	0.30	85,404	0.23	64
65 RESPIRATORY THERAPY	379,260	1.03	348,245	1.83	727,505	1.98	65
66 PHYSICAL THERAPY	1,303,603	3.55	830,039	4.37	2,133,642	5.82	66
68 SPEECH PATHOLOGY	180,943	0.49	95,937	0.51	276,880	0.76	68
69 ELECTROCARDIOLOGY	166,473	0.45	57,779	0.30	224,252	0.61	69
71 MEDICAL SUPPLIES CHRGD TO PATI	1,136,519	3.10	669,723	3.53	1,806,242	4.93	71
72 IMPL. DEV. CHARGED TO PATIENT	167,162	0.46	99,723	0.53	266,885	0.73	72
73 DRUGS CHARGED TO PATIENTS			2,410,069	12.70	2,410,069	6.57	73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
91 EMERGENCY	676,592	1.85	897,320	4.73	1,573,912	4.29	91
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	625,040	1.70	701,816	3.70	1,326,856	3.62	95
OUTPATIENT SERVICE COST CENTERS							
99.10 CORF							99.10
99.20 OUTPATIENT PHYSICAL THERAPY							99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40 OUTPATIENT SPEECH PATHOLOGY							99.40
101 HOME HEALTH AGENCY	834,388	2.28	430,942	2.27	1,265,330	3.45	101
SPECIAL PURPOSE COST CENTERS							
116 HOSPICE	429,419	1.17	184,679	0.97	614,098	1.67	116
NONREIMBURSABLE COST CENTERS							
192 PHYSICIANS' PRIVATE OFFICES	2,233,086	6.09	1,489,817	7.85	3,722,903	10.15	192
194 OTHER NONREIMBURSABLE							194
194.01 MEMORY DISORDER	19,785	0.05	13,004	0.07	32,789	0.09	194.01
194.02 ASSISTED LIVING							194.02
200 CROSS FOOT ADJUSTMENTS							200
201 NEGATIVE COST CENTER							201
202 TOTAL	36,670,744	100.00			36,670,744	100.00	202

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	266,747	12,770,089	0.020888	857,750	17,917	50
53 ANESTHESIOLOGY	31,409	4,919,535	0.006385	249,644	1,594	53
54 RADIOLOGY-DIAGNOSTIC	280,515	7,309,593	0.038376	1,039,693	39,899	54
56 RADIOISOTOPE	7,613	2,849,385	0.002672	208,057	556	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	235,917	7,525,448	0.031349	977,616	30,647	57
58 MAGNETIC RESONANCE IMAGING (MRI)	1,854	1,440,292	0.001287	78,283	101	58
60 LABORATORY	147,867	20,853,650	0.007091	3,715,936	26,350	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	2,721	898,314	0.003029	375,833	1,138	64
65 RESPIRATORY THERAPY	24,887	3,012,546	0.008261	1,551,622	12,818	65
66 PHYSICAL THERAPY	64,074	6,876,414	0.009318	492,671	4,591	66
68 SPEECH PATHOLOGY	3,822	663,299	0.005762	80,952	466	68
69 ELECTROCARDIOLOGY	10,519	2,361,795	0.004454	285,299	1,271	69
71 MEDICAL SUPPLIES CHRGD TO PATI	61,343	4,991,653	0.012289	939,089	11,540	71
72 IMPL. DEV. CHARGED TO PATIENT	9,141	544,725	0.016781	38,051	639	72
73 DRUGS CHARGED TO PATIENTS	110,336	10,659,970	0.010350	3,192,055	33,038	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	82,511	7,172,164	0.011504	943,224	10,851	91
92 OBSERVATION BEDS	44,711	1,390,622	0.032152	135,119	4,344	92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL	1,385,987	96,239,494		15,160,894	197,760	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION		CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	REDUCED CAPITAL RELATED COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7
INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	399,366	5,274	394,092	5,529	71.28	3,026	215,693 30
31	INTENSIVE CARE UNIT	105,535		105,535	1,228	85.94	756	64,971 31
200	TOTAL	504,901	5,274	499,627	6,757		3,782	280,664 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								280,664
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								197,760
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								478,424
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								954
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								3,782
PER DISCHARGE CAPITAL COSTS								501.49
PER DIEM CAPITAL COSTS								126.50

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	6,517,436
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	18,593,587
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.351

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 9 LINE 41 + WKST D PART IV COL 11 LINE 200))	579,047
2. TOTAL MEDICARE CHARGES (WKST D-3 LINE 40 COLUMN 2 PLUS WKST D-3 LINE 202 COLUMN 2) (SEE CR 5619)	978,911
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.592

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 30-35, COLUMN 7 + WKST D PART II, LINE 200, COLUMN 5)	478,424
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.026

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	2,970,389
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	17,122,466
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.173

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3 Part IV, Line 4)

EXHIBIT 3

STEP 1: Determine the 3-Year Averaging Period		
1	Wage index fiscal year ending date	1
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	5
STEP 2 (OPTIONAL): Adjust Averaging Period for a New Plan (SEE INSTRUCTIONS)		
6	Effective date of pension plan	6
7	First day of the provider cost reporting period containing the pension plan effective date	7
8	Starting date of the adjusted averaging period (date on Line 7, adjusted to first of month)	8
If this date occurs after the period shown on line 2, stop here and see instructions.		
STEP 3: Average Pension Contributions During the Averaging Period		
9	Beginning date of averaging period from Line 4 or Line 8, as applicable	9
10	Ending date of averaging period from Line 5	10
11	Enter provider contributions made during averaging period on Lines 9 & 10	11
11.01	Deposit Date(s) Contribution(s)	11.01
12	Total calendar months included in averaging period (36 unless Step 2 completed)	12
13	Total contributions made during averaging period	13
14	Average monthly contribution (Line 13 divided by Line 12)	14
15	Number of months in provider cost reporting period on Line 2	15
16	Average pension contributions (Line 14 times Line 15)	16
STEP 4: Total Pension Cost for Wage Index		
17	Annual prefunding installment (SEE INSTRUCTIONS)	17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	19

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97)

EXHIBIT 4

	Amounts From E Part A (1)	Prior to 10/1/10 or after 9/30/12 Pre/Post Entitlement (2)	10/01/2010 through 09/30/2011 (3)	10/01/2011 through 09/30/2012 (4)	(Columns 2 through 4) TOTAL (5)	
1	DRG Amounts Other than Outlier Payments (E Part A Line 1)	4,434,392		4,434,392	4,434,392	1
2	Outlier payments for discharges (E Part A Line 2 - see instructions)	65,407		65,407	65,407	2
3	Operating outlier reconciliation (E Part A Line 2.01)					3
4	Managed Care Simulated Payments (E Part A Line 3)					4
5	INDIRECT MEDICAL EDUCATION ADJUSTMENT Amount from Worksheet E Part A, Line 21 (see instructions)					5
6	IME payment adjustment (E Part A Line 22 - see instructions)					6
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422					
7	Amount from Worksheet E Part A, Line 27 (see instructions)					7
8	IME add-on adjustment (E Part A Line 28 - see instructions)					8
9	Total IME payment (sum of lines 6 and 8 - ties to E Part A Line 29)					9
10	DISPROPORTIONATE SHARE ADJUSTMENT Allowable disproportionate share percentage (E Part A Line 33 - see instructions)	0.1052	0.1052	0.1052	0.1052	10
11	Disproportionate share adjustment (E Part A Line 34 - see instructions)	466,498		466,498	466,498	11
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES					
12	Total ESRD additional payment (E Part A Line 46 - see instructions)					12
13	Subtotal (ties to E Part A Line 47 - see instructions)	4,966,297		4,966,297	4,966,297	13
14	Hospital specific payments (SCH/MDH, small rural hospitals only (E Part A Line 48 - see instructions))	5,128,186		5,183,793	5,183,793	14
15	Total payment for inpatient operating costs - E Part A Line 49 (SCH/MDH see instructions)	5,087,714		5,129,419	5,129,419	15
16	Payment for inpatient program capital (E Part A Line 50 - from Worksheet L Part I, as applicable)	358,143		358,143	358,143	16
17	Special add-on payments for new technologies (E Part A Line 54)					17
18	Capital outlier reconciliation adjustment amount (E Part A Line 93 - see instructions)					18
19	SUBTOTAL (SEE INSTRUCTIONS)			5,487,562	5,487,562	19
20	CAPITAL PAYMENTS (FROM WORKSHEET L PART I) Capital DRG other than outlier (L Part I Line 1)	353,267		353,267	353,267	20
21	Capital DRG outlier payments (L Part I Line 2)	4,876		4,876	4,876	21
22	Indirect medical education percentage (L Part I Line 5 - see instructions)					22
23	Indirect medical education adjustment (line 20 times line 22 - ties to L Part I Line 6)					23
24	Allowable disproportionate share percentage (L Part I Line 10 - see instructions)					24
25	Disproportionate share adjustment (line 20 times line 24 - ties to L Part I Line 11)					25
26	Total prospective capital payments (sum of lines 20, 21, 22 and 25 - ties to L Part I Line 12)	358,143		358,143	358,143	26
27	LOW VOLUME ADJUSTMENT Low volume adjustment factor (enter into Column 3 and/or 4 as applicable - enter as a six-place ratio: 10%=0.100000, 20.3214%=0.203214)			0.0805		27
28	Low volume adjustment (Line 19 times Line 27 - transfer amount to Worksheet E Part A Line 70.96) (FY 2011)					28
29	Low volume adjustment (Line 19 times Line 27 - transfer amount to Worksheet E Part A Line 70.97) (FY 2012)			441,946	441,946	29