

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: 11/26/2012 TIME: 16:14  
 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 HARRISBURG MEDICAL CENTER, INC. (14-0210) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2011 AND ENDING 06/30/2012, 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: 11/26/2012 16:14  
 r2Fsw2O2m:Nfdq9USJKkJak9dtVv70  
 N45IH0z6amaG.n5:QBp4xDelIXmvu  
 l2q01jDgp90TWWtd

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

PI Encryption: 11/26/2012 16:14  
 jfVpVZG6VWu5zmUaS5Qx1u02GyEP0  
 rbIELOrBpzx5iB4XayOONrQPgvmW1  
 NZeM0q9iyM0:4v0j

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 5
1 HOSPITAL		-111,109		50,297	1
2 SUBPROVIDER - IPF		61,734			2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC			72,067		10
10.01 HEALTH CLINIC - RHC II			42,002		10.01
11 HEALTH CLINIC - FOHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-49,375	-909,104	50,297	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: 100 DR WARREN TUTTLE DRIVE P.O. BOX: 1  
 2 CITY: HARRISBURG STATE: IL ZIP CODE: 62946 COUNTY: SALINE 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 XVIII XIX				
						6	7	8		
3	HOSPITAL	HARRISBURG MEDICAL CENTER, IN	14-0210	99914	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF	HARRISBURG MEDICAL CENTER, IN	14-S210	99914	4	06/19/1989	N	P	O	4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	HARRISBURG MEDICAL CENTER, IN	14-U210	99914		11/03/1988	N	P	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTG									11
12	HOSPITAL-BASED HHA	HARRISBURG MEDICAL CENTER, IN	14-7419	99914		08/15/1985	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	ELDRADO PRIMARY CARE	14-3473	14		12/31/2001	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	EQUALITY FAMILY PRACTICE	14-8518	14		09/27/2011	N	O	N	15.01
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2011				TO: 06/30/2012				20
21	TYPE OF CONTROL					2				21

INPATIENT PPS INFORMATION

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

		IN-STATE		OUT-OF-STATE		OTHER	
		MEDICAID PAID	MEDICAID ELIGIBLE UNPAID	MEDICAID PAID	MEDICAID ELIGIBLE UNPAID		MEDICAID HMO
		DAYS	DAYS	DAYS	DAYS	DAYS	
		1	2	3	4	5	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID 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.	2,615	2,674				24
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 PAID 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.			1			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: 07/01/2011	ENDING: 06/30/2012	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:	38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX	
		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	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	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS

		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 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

		Y/N	IME AVERAGE	DIRECT GME AVERAGE	
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)	N			61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS  
 THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER  
 JULY 1, 2009 AND BEFORE JUNE 30, 2010.

64	ENTER IN COLUMN 1, 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
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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
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

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

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ COL.3+COL.4) 5	
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>					
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			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 N	71
<b>INPATIENT REHABILITATION FACILITY PPS</b>					
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				76
<b>LONG TERM CARE HOSPITAL PPS</b>					
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	80
<b>TEFRA PROVIDERS</b>					
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N	86
<b>TITLE V AND XIX INPATIENT SERVICES</b>					
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.				95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.				97
<b>RURAL PROVIDERS</b>					
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			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- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	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: 325,000 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	Y	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 V	TITLE XIX
	1	2	3	4
155	HOSPITAL	N	N	N 155
156	SUBPROVIDER - IPF	N	N	N 156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		165		
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

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

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

(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE	
1		1	2	
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1
FINANCIAL DATA AND REPORTS		Y/N	DATE	V/I
2		1	2	3
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE
4		1	2	3
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N	
6		1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			Y 15

PS&R REPORT DATA		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	10/12/2012	Y	10/12/2012
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

		Y/N	DATE	
		1	2	
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?			36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			37
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.	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:	LAST NAME:	TITLE:	41
42	EMPLOYER:			42
43	PHONE NUMBER:	E-MAIL ADDRESS:		43





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	200	20,385,445		20,385,445	933,001.00	21.85	1
2							2
3		624,350		624,350	6,252.00	99.86	3
4							4
4.01							4.01
5		2,191,519	-179,120	2,012,399	27,239.00	73.88	5
6		771,072		771,072	39,061.00	19.74	6
7	21						7
7.01							7.01
8							8
9	44						9
10		4,927,170	-246,963	4,680,207	134,113.00	34.90	10
11		750,714		750,714	7,990.00	93.96	11
12							12
13							13
14							14
15							15
16							16
17		3,686,370		3,686,370			17
18							18
19		786,364		786,364			19
20							20
21		166,238		166,238			21
22							22
22.01							22.01
23		583,509		583,509			23
24		205,304		205,304			24
25							25
26		83,242		83,242	6,265.00	13.29	26
27		2,744,279	122,471	2,866,750	145,367.00	19.72	27
28		52,969		52,969	1,163.00	45.55	28
29							29
30		503,438		503,438	32,592.00	15.45	30
31		69,146		69,146	6,441.00	10.74	31
32		404,269		404,269	36,667.00	11.03	32
33							33
34		510,906		510,906	41,313.00	12.37	34
35							35
36							36
37							37
38		305,950		305,950	7,999.00	38.25	38
39		36,499		36,499	3,368.00	10.84	39
40		568,912		568,912	14,177.00	40.13	40
41		449,522		449,522	28,839.00	15.59	41
42							42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	16,851,473	179,120	17,030,593	861,612.00	19.77	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	4,927,170	-246,963	4,680,207	134,113.00	34.90	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	11,924,303	426,083	12,350,386	727,499.00	16.98	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	750,714		750,714	7,990.00	93.96	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	3,686,370		3,686,370		29.85%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	16,361,387	426,083	16,787,470	735,489.00	22.82	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	5,729,132	122,471	5,851,603	324,191.00	18.05	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS		1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	571,888	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)	2,706,809	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	56,980	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	34,936	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	408,275	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	1,185,953	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	277,360	18
19 UNEMPLOYMENT INSURANCE		19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	156,309	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	24,395	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	5,422,905	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	4,880	25

PROVIDER CCN: 14-0210 HARRISBURG MEDICAL CENTER, INC  
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
11/26/2012 16:09

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	750,714	1
2	HOSPITAL	750,714	2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II		14.01
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.: 14-7419

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: SALINE

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		2,124			2,124	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		226.00			252.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: .00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			TOTAL 3	
	STAFF 1	CONTRACT 2			
	3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			0.99	0.99	4
5 OTHER ADMINISTRATIVE PERSONNEL					5
6 DIRECT NURSING SERVICE			7.53	7.53	6
7 NURSING SUPERVISOR			0.96	0.96	7
8 PHYSICAL THERAPY SERVICE			1.81	1.81	8
9 PHYSICAL THERAPY SUPERVISOR					9
10 OCCUPATIONAL THERAPY SERVICE			0.13	0.13	10
11 OCCUPATIONAL THERAPY SUPERVISOR					11
12 SPEECH PATHOLOGY SERVICE			0.16	0.16	12
13 SPEECH PATHOLOGY SUPERVISOR					13
14 MEDICAL SOCIAL SERVICE					14
15 MEDICAL SOCIAL SERVICE SUPERVISOR					15
16 HOME HEALTH AIDE			1.02	1.02	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				TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	1,663		76	85	1,824	21
22 SKILLED NURSING VISIT CHARGES	379,164		17,328	19,380	415,872	22
23 PHYSICAL THERAPY VISITS	1,487		19	46	1,552	23
24 PHYSICAL THERAPY VISIT CHARGES	340,523		4,351	10,534	355,408	24
25 OCCUPATIONAL THERAPY VISITS	114			11	125	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	28,158			2,717	30,875	26
27 SPEECH PATHOLOGY VISITS	195			4	199	27
28 SPEECH PATHOLOGY VISIT CHARGES	48,165			988	49,153	28
29 MEDICAL SOCIAL SERVICE VISITS						29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES						30
31 HOME HEALTH AIDE VISITS	9			1	10	31
32 HOME HEALTH AIDE VISIT CHARGES	1,053			117	1,170	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	3,468		95	147	3,710	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	797,063		21,679	33,736	852,478	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	230		33	11	274	36
37 TOTAL NUMBER OF OUTLIER EPISODES						37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	21,032		2,006	327	23,365	38

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		Y/N 1	DATE 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	11/03/1988	2

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4
3	RUX			3
4	RUL			4
5	RVX			5
6	RVL			6
7	RHX			7
8	RHL			8
9	RMX			9
10	RML			10
11	RLX			11
12	RUC			12
13	RUB			13
14	RUA			14
15	RVC			15
16	RVB		6	6 16
17	RVA		10	10 17
18	RHC			18
19	RHB			19
20	RHA		17	17 20
21	RMC		21	21 21
22	RMB		37	37 22
23	RMA		100	100 23
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1			28
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1			34
35	HB2			35
36	HB1			36
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1			40
41	LC2			41
42	LC1			42
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1		5	5 48
49	CC2		7	7 49
50	CC1		26	26 50
51	CB2			51
52	CB1		5	5 52
53	CA2			53
54	CA1		12	12 54
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				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1			2	2 78
199	AAA				199
200	TOTAL			248	248 200

CBSA  
 CBSA AT  
 BEGINNING  
 OF THE COST  
 OF COST  
 REPORTING  
 PERIOD (IF  
 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). 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)

ASSOCIATED  
 WITH  
 DIRECT  
 PATIENT  
 CARE AND  
 RELATED  
 EXPENSES PERCENTAGE EXPENSES?  
 1 2 3

202	STAFFING				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)				207



PROVIDER CCN: 14-0210 HARRISBURG MEDICAL CENTER, INC  
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
11/26/2012 16:09

HOSPITAL-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER  
STATISTICAL DATA

RHC II  
COMPONENT NO: 14-8518

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 183 WEST LN ST 1  
2 CITY: EQUALITY STATE: ILLINOIS ZIP CODE: 62934 COUNTY: SALINE 2  
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 1 2 4  
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) 5  
6 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) 6  
7 APPALACHIAN REGIONAL COMMISSION 7  
8 LOOK-ALIKES 8

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. 1 2 10  
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
11 CLINIC			0008	0005	0008	0005	0008	0005	0008	0005	0008	0005		

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2 12  
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 13

13 ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.  
14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO Y/N V XVIII XIX 15  
IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS) N

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)			0.367497	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)					
2	NET REVENUE FROM MEDICAID			2,597,754	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			20,466,461	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)			7,521,363	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.			4,923,609	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)					
9	NET REVENUE FROM STAND-ALONE SCHIP				9
10	STAND-ALONE SCHIP CHARGES				10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)				11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.				12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)					
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)				13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)				14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)				15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.				16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)					
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE				17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)			4,923,609	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	3,515,989	1,797,224	5,313,213	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	1,292,115	660,474	1,952,589	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	312,678	1,350,460	1,663,138	22
23	COST OF CHARITY CARE	979,437	-689,986	289,451	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM				24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)				25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			4,393,027	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			418,879	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			3,974,148	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,460,487	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,749,938	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			6,673,547	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSIFI-	
		1	2	(COL. 1 +	CATIONS	
				COL. 2)	4	
				COL. 3)		
GENERAL SERVICE COST CENTERS						
1	00100		1,686,367	1,686,367	-982,357	1
2	00200				985,200	2
3	00300					3
4	00400	83,242	5,403,390	5,486,632		4
5	00500	2,744,279	4,690,112	7,434,391	46,106	5
6	00600					6
7	00700					7
8	00800	503,438	627,266	1,130,704		8
9	00900	69,146	88,457	157,603		9
10	01000	404,269	79,551	483,820		10
11	01100	510,906	332,997	843,903		11
12	01200					12
13	01300	305,950	45,360	351,310		13
14	01400	36,499	31,036	67,535		14
15	01500	568,912	31,675	600,587		15
16	01600	449,522	185,349	634,871		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	2,764,129	788,449	3,552,578		30
40	04000	2,178,092	346,265	2,524,357		40
ANCILLARY SERVICE COST CENTERS						
50	05000	474,641	148,947	623,588	-109,191	50
53	05300	624,350	18,785	643,135		53
54	05400	396,318	148,483	544,801	104,986	54
57	05700	217,972	137,025	354,997		57
60	06000	657,344	1,232,768	1,890,112	25,963	60
62.30	06250					62.30
64	06400	33,144	64,945	98,089		64
65	06500	465,216	82,510	547,726		65
66	06600	768,581	17,562	786,143		66
69	06900	58,014	81,912	139,926		69
71	07100		624,852	624,852		71
72	07200				109,191	72
73	07300					73
75	07500	500,489	2,869,365	2,869,365		75
76	03450	116,028	105,835	606,324		76
76.01	03631	184,592	178,023	294,051		76
76.02	03441	53,275	27,425	212,017		76.01
76.03	03141	55,351	70,596	123,871		76.02
76.04	03190	126,058	19,162	74,513		76.03
76.06	03950		9,152	135,210		76.04
76.97	07697					76.06
76.98	07698					76.97
76.99	07699					76.98
OUTPATIENT SERVICE COST CENTERS						
88	08800	1,796,324	278,304	2,074,628	-161,962	88
88.01	08801	177,453	48,719	226,172	65,814	88.01
91	09100	2,108,594	272,657	2,381,251		91
92	09200					92
93	04950	178,016	59,209	237,225		93
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	575,689	99,957	675,646	-48,790	101
SPECIAL PURPOSE COST CENTERS						
118		20,185,833	20,932,467	41,118,300	34,960	118
NONREIMBURSABLE COST CENTERS						
190	19000	68,520	696	69,216		190
192	19200	131,092	31,294	162,386	-46,112	192
192.01	19201					192.01
192.03	19202				11,152	192.03
200		20,385,445	20,964,457	41,349,902		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	704,010	-47,436	656,574	1
2	00200	CAP REL COSTS-MVBLE EQUIP	985,200		985,200	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	5,486,632	-513,488	4,973,144	4
5	00500	ADMINISTRATIVE & GENERAL	7,480,497	-1,886,018	5,594,479	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	1,130,704	83	1,130,787	7
8	00800	LAUNDRY & LINEN SERVICE	157,603		157,603	8
9	00900	HOUSEKEEPING	483,820		483,820	9
10	01000	DIETARY	843,903	-115,210	728,693	10
11	01100	CAFETERIA				11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	351,310		351,310	13
14	01400	CENTRAL SERVICES & SUPPLY	67,535		67,535	14
15	01500	PHARMACY	600,587		600,587	15
16	01600	MEDICAL RECORDS & LIBRARY	634,871	407	635,278	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	3,552,578	-588,409	2,964,169	30
40	04000	SUBPROVIDER - IPF	2,524,357	-259,736	2,264,621	40
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	514,397	184	514,581	50
53	05300	ANESTHESIOLOGY	643,135	-624,350	18,785	53
54	05400	RADIOLOGY-DIAGNOSTIC	649,787		649,787	54
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	354,997		354,997	57
60	06000	LABORATORY	1,916,075	-1,900	1,914,175	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	06400	INTRAVENOUS THERAPY	98,089		98,089	64
65	06500	RESPIRATORY THERAPY	547,726	-7,574	540,152	65
66	06600	PHYSICAL THERAPY	786,143	362	786,505	66
69	06900	ELECTROCARDIOLOGY	139,926	-55,465	84,461	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	624,852		624,852	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	109,191		109,191	72
73	07300	DRUGS CHARGED TO PATIENTS	2,869,365		2,869,365	73
75	07500	ASC (NON-DISTINCT PART)	606,324	-40,133	566,191	75
76	03450	NUCLEAR MEDICINE	294,051		294,051	76
76.01	03631	ULTRASOUND	212,017	34	212,051	76.01
76.02	03441	MAMMOGRAPHY	123,871		123,871	76.02
76.03	03141	CARDIAC REHABILITATION	74,513		74,513	76.03
76.04	03190	FAITH CENTER CHEMOTHERAPY	135,210	-14,839	120,371	76.04
76.06	03950	ROUTINE ANCILLARY				76.06
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC (RHC)	1,912,666	-49,247	1,863,419	88
88.01	08801	RHC II	291,986		291,986	88.01
91	09100	EMERGENCY	2,381,251	-1,353,467	1,027,784	91
92	09200	OBSERVATION BEDS				92
93	04950	DAY PSYCHIATRIC	237,225		237,225	93
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
101	10100	HOME HEALTH AGENCY	626,856	-405	626,451	101
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	41,153,260	-5,556,607	35,596,653	118
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	69,216		69,216	190
192	19200	PHYSICIANS' PRIVATE OFFICES	116,274		116,274	192
192.01	19201	DIALYSIS				192.01
192.03	19202	ORTHO CLINIC	11,152		11,152	192.03
200		TOTAL (SUM OF LINES 118-199)	41,349,902	-5,556,607	35,793,295	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 DEPRECIATION	A	CAP REL COSTS-MVBLE EQUIP	2			953,738 1
2		HOME HEALTH AGENCY	101			11,677 2
3		RURAL HEALTH CLINIC (RHC)	88			50,702 3
4		ADMINISTRATIVE & GENERAL	5			5,393 4
5		ORTHO CLINIC	192.03			11,152 5
6		PHYSICIANS' PRIVATE OFFICES	192			5,627 6
500 TOTAL RECLASSIFICATIONS						1,038,289 500
CODE LETTER - A						
1 IMPLANTABLE SUPPLIES	B	IMPL. DEV. CHARGED TO PATIENT	72			109,191 1
500 TOTAL RECLASSIFICATIONS						109,191 500
CODE LETTER - B						
1 HHA BILLER	C	ADMINISTRATIVE & GENERAL	5		60,467	1
500 TOTAL RECLASSIFICATIONS					60,467	500
CODE LETTER - C						
1 INSURANCE	D	CAP REL COSTS-BLDG & FIXT	1			55,932 1
2		CAP REL COSTS-MVBLE EQUIP	2			31,462 2
500 TOTAL RECLASSIFICATIONS						87,394 500
CODE LETTER - D						
1 EPC BILLING & ADMITTING	E	ADMINISTRATIVE & GENERAL	5		62,004	1
500 TOTAL RECLASSIFICATIONS					62,004	500
CODE LETTER - E						
1 EPC LAB	F	LABORATORY	60		24,208	1
2 EPC RADIOLOGY	F	RADIOLOGY-DIAGNOSTIC	54		100,284	2
500 TOTAL RECLASSIFICATIONS					124,492	500
CODE LETTER - F						
1 EPC APT EXPENSE	G	ADMINISTRATIVE & GENERAL	5			5,636 1
500 TOTAL RECLASSIFICATIONS						5,636 500
CODE LETTER - G						
1 RHC EPC BLDG EXPENSE	H	LABORATORY	60			1,755 1
2		RADIOLOGY-DIAGNOSTIC	54			4,702 2
500 TOTAL RECLASSIFICATIONS						6,457 500
CODE LETTER - H						
1 BUSINESS DEVELOPMENT EXPENSE ALLOC.	I	RHC II	88.01		60,926	4,888 1
500 TOTAL RECLASSIFICATIONS					60,926	4,888 500
CODE LETTER - I						
GRAND TOTAL (INCREASES)					307,889	1,251,855

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 DEPRECIATION	A	CAP REL COSTS-BLDG & FIXT	1		953,738		9 1
2		CAP REL COSTS-BLDG & FIXT	1		11,677		9 2
3		CAP REL COSTS-BLDG & FIXT	1		50,702		9 3
4		CAP REL COSTS-BLDG & FIXT	1		5,393		9 4
5		CAP REL COSTS-BLDG & FIXT	1		11,152		9 5
6		CAP REL COSTS-BLDG & FIXT	1		5,627		9 6
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					1,038,289		500
1 IMPLANTABLE SUPPLIES	B	OPERATING ROOM	50		109,191		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					109,191		500
1 HHA BILLER	C	HOME HEALTH AGENCY	101	60,467			1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C				60,467			500
1 INSURANCE	D	ADMINISTRATIVE & GENERAL	5		55,932		12 1
2		ADMINISTRATIVE & GENERAL	5		31,462		12 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					87,394		500
1 EPC BILLING & ADMITTING	E	RURAL HEALTH CLINIC (RHC)	88	62,004			1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E				62,004			500
1 EPC LAB	F	PHYSICIANS' PRIVATE OFFICES	192	51,739			1
2 EPC RADIOLOGY	F	RURAL HEALTH CLINIC (RHC)	88	72,753			2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F				124,492			500
1 EPC APT EXPENSE	G	RURAL HEALTH CLINIC (RHC)	88		5,636		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					5,636		500
1 RHC EPC BLDG EXPENSE	H	RURAL HEALTH CLINIC (RHC)	88		6,457		1
2							2
500 TOTAL RECLASSIFICATIONS CODE LETTER - H					6,457		500
1 BUSINESS DEVELOPMENT EXPENSE ALLOC.	I	RURAL HEALTH CLINIC (RHC)	88	60,926	4,888		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - I				60,926	4,888		500
GRAND TOTAL (DECREASES)				307,889	1,251,855		

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND	BALANCE	DEPRECIATED
	1	2	3	4	RETIREMENTS	6	ASSETS
					5		7
1 LAND	420,001					420,001	1
2 LAND IMPROVEMENTS	418,509	268,732		268,732	25,420	661,821	2
3 BUILDINGS AND FIXTURES	19,374,106	393,807		393,807	602,424	19,165,489	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	10,504,049	1,267,118		1,267,118	491,794	11,279,373	6
7 HIT DESIGNATED ASSETS		279,505		279,505		279,505	7
8 SUBTOTAL (SUM OF LINES 1-7)	30,716,665	2,209,162		2,209,162	1,119,638	31,806,189	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	30,716,665	2,209,162		2,209,162	1,119,638	31,806,189	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL(1)
						CAPITAL- RELATED	(SUM OF
	9	10	11	(SEE INSTR.)	(SEE INSTR.)	COSTS (SEE	COLS.
				12	13	INSTR.)	9-14)
						14	15
1 CAP REL COSTS-BLDG & FIXT	1,485,780		200,587				1,686,367
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	1,485,780		200,587				1,686,367

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO		INSURANCE	TAXES	OTHER	TOTAL
			(COL. 1 - COL. 2)	RATIO (SEE INSTR.)			CAPITAL- RELATED	(SUM OF
	1	2	3	4	5	6	COSTS	(SUM OF
							RELATED	COLS.
							(SEE	5-7)
							INSTR.)	8
1 CAP REL COSTS-BLDG & FIXT	20,247,311		20,247,311	0.636584				1
2 CAP REL COSTS-MVBLE EQUIP	11,558,878		11,558,878	0.363416				2
3 TOTAL (SUM OF LINES 1-2)	31,806,189		31,806,189	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL(2)
						CAPITAL- RELATED	(SUM OF
	9	10	11	(SEE INSTR.)	(SEE INSTR.)	COSTS (SEE	COLS.
				12	13	INSTR.)	9-14)
						14	15
1 CAP REL COSTS-BLDG & FIXT	447,491		153,151	55,932			656,574
2 CAP REL COSTS-MVBLE EQUIP	953,738			31,462			985,200
3 TOTAL	1,401,229		153,151	87,394			1,641,774

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
			COST CENTER	LINE NO.	WKST A-7 REF
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-47,436	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-3,563	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)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,305,359			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-102,804	DIETARY	10	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	407	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES	B	-2,321	ADMINISTRATIVE & GENERAL	5	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		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 LIFELINE					32
33					33
34 PHYSICIAN RECRUITMENT	A	-200,000	ADMINISTRATIVE & GENERAL	5	34
34.01 PHYSICIAN LOANS	A	-70,600	ADMINISTRATIVE & GENERAL	5	34.01
35 CRNA WAGES	A	-624,350	ANESTHESIOLOGY	53	35
35.01 CRNA BENEFITS	A	-166,264	EMPLOYEE BENEFITS	4	35.01
36 EMERGENCY ROOM PHYS BENEFITS	A	-321,777	EMPLOYEE BENEFITS	4	36
37 PSYCH PHYSICIAN FRINGES	A	-13,515	EMPLOYEE BENEFITS	4	37
37.01 PSYCH PHYSICIAN TRAVEL	A	-4,013	ADMINISTRATIVE & GENERAL	5	37.01
38 DR ENCISO REVENUES					38
39 ER MD MISC EXPENSE	A	-14,374	EMERGENCY	91	39
40 ASC PHYSICIAN BENEFITS	A	-10,067	EMPLOYEE BENEFITS	4	40
41 LAB					41
42 HHC SCREENINGS	B	-405	HOME HEALTH AGENCY	101	42
43 OTHER INCOME	B	-66,254	ADMINISTRATIVE & GENERAL	5	43
44 MEDICAID ASSESSMENT	A	-1,226,424	ADMINISTRATIVE & GENERAL	5	44
45 MISSIONS EXPENSE	A	-609	ADMINISTRATIVE & GENERAL	5	45
45.02 CAPITALIZED INTEREST	A	83	OPERATION OF PLANT	7	45.02
45.03 CAPITALIZED INTEREST	A	362	PHYSICAL THERAPY	66	45.03
45.04 CAPITALIZED INTEREST	A	245	ASC (NON-DISTINCT PART)	75	45.04
45.05 CAPITALIZED INTEREST	A	215	EMERGENCY	91	45.05
45.06 CAPITALIZED INTEREST	A	34	ULTRASOUND	76.01	45.06
45.07 CAPITALIZED INTEREST	A	184	OPERATING ROOM	50	45.07
45.20 PHYSICIAN BILLING WAGES	A	-4,751	ADMINISTRATIVE & GENERAL	5	45.20
45.21 PHYSICIAN BILLING FRINGE BENEFIT	A	-1,265	EMPLOYEE BENEFITS	4	45.21
45.22 DONATED MEALS	A	-12,406	DIETARY	10	45.22
45.24 COMM RELATIONS	A	-24,850	ADMINISTRATIVE & GENERAL	5	45.24
45.25 ALCOHOL	A	-103	ADMINISTRATIVE & GENERAL	5	45.25
45.26 IHA LOBBYING	A	-10,889	ADMINISTRATIVE & GENERAL	5	45.26
45.27 AHA LOBBYING	A	-6,019	ADMINISTRATIVE & GENERAL	5	45.27

ADJUSTMENTS TO EXPENSES

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8	
			COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
45.28 ADVERTISING	A	-248,556	ADMINISTRATIVE & GENERAL	5		45.28
45.32 MISC INCOME	A	-2,250	RESPIRATORY THERAPY	65		45.32
45.34 DUE - ROTARY CLUB	A	-600	EMPLOYEE BENEFITS	4		45.34
45.35 OTHER ADMIN DUES	A	-7,011	ADMINISTRATIVE & GENERAL	5		45.35
45.37 PENALTIES	A	-1,097	ADMINISTRATIVE & GENERAL	5		45.37
45.38 INSURANCE SETTLEMENTS	A	-2,064	ADMINISTRATIVE & GENERAL	5		45.38
45.39 IHREF CONTRIBUTION EXPENSE	A	-6,894	ADMINISTRATIVE & GENERAL	5		45.39
45.40 PSYCH SALARY REIMBURSEMENT	A	-49,247	RURAL HEALTH CLINIC (RHC)	88		45.40
46						46
47						47
48						48
49						49
50 TOTAL (SUM OF LINES 1 THRU 49)		-5,556,607				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.

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

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT			
LINE NO.	2	3	4	5	6	7	8	9			
1	40	SUBPROVIDER - IPF	MEDICAL FEES	250,662	4,900	245,762	138,700	573	38,209	1,910	1
2	40	SUBPROVIDER - IPF	SALARIED-DR	50,751	44,371	6,380	138,700	52	3,468	173	2
3	91	EMERGENCY	SALARIED-DR	1,208,324	1,154,324	54,000	159,800	491	37,722	1,886	3
4	60	LABORATORY	MEDICAL FEES	9,600		9,600	208,000	77	7,700	385	4
5	69	ELECTROCARDIOLOGY	MEDICAL FEES	55,465	55,465						5
6	76.04	FAITH CENTER CHEMOTHERAP	MEDICAL FEES DI	14,839	14,839						6
7	91	EMERGENCY	MEDICAL FEES #4	168,706	168,706						7
8	30	ADULTS & PEDIATRICS	HOSPITALISTS ME	445,409	445,409						8
9	30	ADULTS & PEDIATRICS	HOSPITALISTS PU	143,000	143,000						9
10	65	RESPIRATORY THERAPY	RESP THER MEDIC	5,324	5,324						10
11	75	ASC (NON-DISTINCT PART)	SALARIED-DR	40,378	40,378						11
200		TOTAL		2,392,458	2,076,716	315,742		1,193	87,099	4,354	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
10	11	12	COLUMN 12	14	COLUMN 14	16	17	18	
1	40 SUBPROVIDER - IPF	MEDICAL FEES				38,209	207,553	212,453	1
2	40 SUBPROVIDER - IPF	SALARIED-DR				3,468	2,912	47,283	2
3	91 EMERGENCY	SALARIED-DR				37,722	16,278	1,170,602	3
4	60 LABORATORY	MEDICAL FEES				7,700	1,900	1,900	4
5	69 ELECTROCARDIOLOGY	MEDICAL FEES						55,465	5
6	76.04 FAITH CENTER CHEMOTHERAP	MEDICAL FEES DI						14,839	6
7	91 EMERGENCY	MEDICAL FEES #4						168,706	7
8	30 ADULTS & PEDIATRICS	HOSPITALISTS ME						445,409	8
9	30 ADULTS & PEDIATRICS	HOSPITALISTS PU						143,000	9
10	65 RESPIRATORY THERAPY	RESP THER MEDIC						5,324	10
11	75 ASC (NON-DISTINCT PART)	SALARIED-DR						40,378	11
200	TOTAL					87,099	228,643	2,305,359	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	656,574	656,574				1
2 CAP REL COSTS-MVBLE EQUIP	985,200		985,200			2
4 EMPLOYEE BENEFITS	4,973,144	5,082	1,202	4,979,428		4
5 ADMINISTRATIVE & GENERAL	5,594,479	100,145	366,730	775,971	6,837,325	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,130,787	25,876	13,758	136,496	1,306,917	7
8 LAUNDRY & LINEN SERVICE	157,603	12,638	7,069	18,747	196,057	8
9 HOUSEKEEPING	483,820	3,236		109,609	596,665	9
10 DIETARY	728,693	14,703	5,635	138,521	887,552	10
11 CAFETERIA		8,422			8,422	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	351,310		1,465	82,952	435,727	13
14 CENTRAL SERVICES & SUPPLY	67,535	5,662	41,766	9,896	124,859	14
15 PHARMACY	600,587	11,087	50,392	154,248	816,314	15
16 MEDICAL RECORDS & LIBRARY	635,278	7,737	38,234	121,878	803,127	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	2,964,169	92,064	71,494	749,433	3,877,160	30
40 SUBPROVIDER - IPF	2,264,621	89,381	6,388	577,722	2,938,112	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	514,581	59,108	53,295	128,688	755,672	50
53 ANESTHESIOLOGY	18,785		10,573		29,358	53
54 RADIOLOGY-DIAGNOSTIC	649,787	37,876	46,619	134,643	868,925	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	354,997	4,321	14	59,098	418,430	57
60 LABORATORY	1,914,175	22,126	33,226	184,788	2,154,315	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	98,089			8,986	107,075	64
65 RESPIRATORY THERAPY	540,152		13,276	126,133	688,373	65
66 PHYSICAL THERAPY	786,505	44,804	11,184	208,384	1,050,877	66
69 ELECTROCARDIOLOGY	84,461		5,629	15,729	105,819	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	624,852				624,852	71
72 IMPL. DEV. CHARGED TO PATIENT	109,191				109,191	72
73 DRUGS CHARGED TO PATIENTS	2,869,365				2,869,365	73
75 ASC (NON-DISTINCT PART)	566,191	39,456	30,794	124,749	761,190	75
76 NUCLEAR MEDICINE	294,051		54,290	31,458	379,799	76
76.01 ULTRASOUND	212,051	4,787	41,935	50,048	308,821	76.01
76.02 MAMMOGRAPHY	123,871	2,884	62,355	14,444	203,554	76.02
76.03 CARDIAC REHABILITATION	74,513		8,736	15,007	98,256	76.03
76.04 FAITH CENTER CHEMOTHERAPY	120,371	8,879	2,278	34,178	165,706	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,863,419			420,626	2,284,045	88
88.01 RHC II	291,986			52,603	344,589	88.01
91 EMERGENCY	1,027,784	18,500	6,863	254,316	1,307,463	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	237,225	22,840		48,265	308,330	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	626,451			139,691	766,142	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	35,596,653	650,426	985,200	4,927,307	35,538,384	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	69,216	6,148		18,578	93,942	190
192 PHYSICIANS' PRIVATE OFFICES	116,274			33,543	149,817	192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC	11,152				11,152	192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	35,793,295	656,574	985,200	4,979,428	35,793,295	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	6,837,325					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	308,600	1,615,517				7
8 LAUNDRY & LINEN SERVICE	46,295	30,999	273,351			8
9 HOUSEKEEPING	140,889	7,936		745,490		9
10 DIETARY	209,576	36,064			1,133,192	10
11 CAFETERIA	1,989	20,658			584,010	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	102,887					13
14 CENTRAL SERVICES & SUPPLY	29,483	13,889				14
15 PHARMACY	192,755	27,194		5,968		15
16 MEDICAL RECORDS & LIBRARY	189,641	18,977				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	915,516	225,813	84,607	238,455	297,520	30
40 SUBPROVIDER - IPF	693,771	219,230	38,281	107,717	226,914	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	178,435	144,979	17,865	54,853		50
53 ANESTHESIOLOGY	6,932					53
54 RADIOLOGY-DIAGNOSTIC	205,178	92,902	12,816			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	98,803	10,597				57
60 LABORATORY	508,694	54,271		15,632		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	25,283					64
65 RESPIRATORY THERAPY	162,544	21,615	10,597	12,221		65
66 PHYSICAL THERAPY	248,141	109,895	16,311	14,495		66
69 ELECTROCARDIOLOGY	24,987					69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	147,545					71
72 IMPL. DEV. CHARGED TO PATIENT	25,783					72
73 DRUGS CHARGED TO PATIENTS	677,537					73
75 ASC (NON-DISTINCT PART)	179,738	96,777	39,058	76,169		75
76 NUCLEAR MEDICINE	89,681					76
76.01 ULTRASOUND	72,921	11,741				76.01
76.02 MAMMOGRAPHY	48,065	7,073				76.02
76.03 CARDIAC REHABILITATION	23,201					76.03
76.04 FAITH CENTER CHEMOTHERAPY	39,128	21,778				76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	539,327		16,311	87,253		88
88.01 RHC II	81,367					88.01
91 EMERGENCY	308,729	45,377	24,023	121,927		91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	72,805	56,021				93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	180,908			10,800		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	6,777,134	1,273,786	259,869	745,490	1,108,444	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,182	15,079				190
192 PHYSICIANS' PRIVATE OFFICES	35,376	238,092	13,482		24,748	192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC	2,633	88,560				192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	6,837,325	1,615,517	273,351	745,490	1,133,192	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	615,079					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	8,793	547,407				13
14 CENTRAL SERVICES & SUPPLY	5,825		174,056			14
15 PHARMACY	15,583		1,102	1,058,916		15
16 MEDICAL RECORDS & LIBRARY	31,700		428		1,043,873	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	139,916	197,980	12,003		36,083	30
40 SUBPROVIDER - IPF	111,209	157,361	4,909		99,005	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	39,616	56,057			20,630	50
53 ANESTHESIOLOGY	6,872		1,008		19,798	53
54 RADIOLOGY-DIAGNOSTIC	21,604		1,375		38,204	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	13,098		112		146,606	57
60 LABORATORY	40,488		58,940		193,730	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					27,393	64
65 RESPIRATORY THERAPY	24,441		2,537		39,366	65
66 PHYSICAL THERAPY	28,324		569		36,673	66
69 ELECTROCARDIOLOGY	3,488		144		10,948	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			58,006		45,762	71
72 IMPL. DEV. CHARGED TO PATIENT			7,824		3,421	72
73 DRUGS CHARGED TO PATIENTS				1,058,916	136,157	73
75 ASC (NON-DISTINCT PART)	33,448	47,328	6,448		35,084	75
76 NUCLEAR MEDICINE	4,170		8,838		16,772	76
76.01 ULTRASOUND	13,046		296		25,895	76.01
76.02 MAMMOGRAPHY	2,596		296		7,069	76.02
76.03 CARDIAC REHABILITATION	2,668		164		3,179	76.03
76.04 FAITH CENTER CHEMOTHERAPY	5,522		607		3,798	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			1,861			88
88.01 RHC II			345			88.01
91 EMERGENCY	53,301	75,421	3,832		88,840	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	9,371	13,260	153		9,460	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY			1,922			101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	615,079	547,407	173,719	1,058,916	1,043,873	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			2			190
192 PHYSICIANS' PRIVATE OFFICES			335			192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	615,079	547,407	174,056	1,058,916	1,043,873	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
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	6,025,053		6,025,053	30
40 SUBPROVIDER - IPF	4,596,509		4,596,509	40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1,268,107		1,268,107	50
53 ANESTHESIOLOGY	63,968		63,968	53
54 RADIOLOGY-DIAGNOSTIC	1,241,004		1,241,004	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	687,646		687,646	57
60 LABORATORY	3,026,070		3,026,070	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	159,751		159,751	64
65 RESPIRATORY THERAPY	961,694		961,694	65
66 PHYSICAL THERAPY	1,505,285		1,505,285	66
69 ELECTROCARDIOLOGY	145,386		145,386	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	876,165		876,165	71
72 IMPL. DEV. CHARGED TO PATIENT	146,219		146,219	72
73 DRUGS CHARGED TO PATIENTS	4,741,975		4,741,975	73
75 ASC (NON-DISTINCT PART)	1,275,240		1,275,240	75
76 NUCLEAR MEDICINE	499,260		499,260	76
76.01 ULTRASOUND	432,720		432,720	76.01
76.02 MAMMOGRAPHY	268,653		268,653	76.02
76.03 CARDIAC REHABILITATION	127,468		127,468	76.03
76.04 FAITH CENTER CHEMOTHERAPY	236,539		236,539	76.04
76.06 ROUTINE ANCILLARY				76.06
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	2,928,797		2,928,797	88
88.01 RHC II	426,301		426,301	88.01
91 EMERGENCY	2,028,913		2,028,913	91
92 OBSERVATION BEDS				92
93 DAY PSYCHIATRIC	469,400		469,400	93
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
101 HOME HEALTH AGENCY	959,772		959,772	101
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	35,097,895		35,097,895	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	131,205		131,205	190
192 PHYSICIANS' PRIVATE OFFICES	461,850		461,850	192
192.01 DIALYSIS				192.01
192.03 ORTHO CLINIC	102,345		102,345	192.03
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	35,793,295		35,793,295	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		5,082	1,202	6,284	6,284	4
5 ADMINISTRATIVE & GENERAL	3,544	100,145	366,730	470,419	982	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		25,876	13,758	39,634	172	7
8 LAUNDRY & LINEN SERVICE		12,638	7,069	19,707	24	8
9 HOUSEKEEPING		3,236		3,236	138	9
10 DIETARY		14,703	5,635	20,338	175	10
11 CAFETERIA		8,422		8,422		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			1,465	1,465	105	13
14 CENTRAL SERVICES & SUPPLY		5,662	41,766	47,428	12	14
15 PHARMACY		11,087	50,392	61,479	195	15
16 MEDICAL RECORDS & LIBRARY		7,737	38,234	45,971	154	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	410	92,064	71,494	163,968	945	30
40 SUBPROVIDER - IPF	52	89,381	6,388	95,821	729	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	73,470	59,108	53,295	185,873	162	50
53 ANESTHESIOLOGY			10,573	10,573		53
54 RADIOLOGY-DIAGNOSTIC		37,876	46,619	84,495	170	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		4,321	14	4,335	75	57
60 LABORATORY		22,126	33,226	55,352	233	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					11	64
65 RESPIRATORY THERAPY	18,475	8,812	13,276	40,563	159	65
66 PHYSICAL THERAPY	1,262	44,804	11,184	57,250	263	66
69 ELECTROCARDIOLOGY	21,432		5,629	27,061	20	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)		39,456	30,794	70,250	157	75
76 NUCLEAR MEDICINE			54,290	54,290	40	76
76.01 ULTRASOUND		4,787	41,935	46,722	63	76.01
76.02 MAMMOGRAPHY		2,884	62,355	65,239	18	76.02
76.03 CARDIAC REHABILITATION			8,736	8,736	19	76.03
76.04 FAITH CENTER CHEMOTHERAPY		8,879	2,278	11,157	43	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,544			1,544	531	88
88.01 RHC II					66	88.01
91 EMERGENCY	1,050	18,500	6,863	26,413	321	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC		22,840		22,840	61	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY					176	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	121,239	650,426	985,200	1,756,865	6,219	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,148		6,148	23	190
192 PHYSICIANS' PRIVATE OFFICES					42	192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	121,239	656,574	985,200	1,763,013	6,284	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	471,401					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	21,277	61,083				7
8 LAUNDRY & LINEN SERVICE	3,192	1,172	24,095			8
9 HOUSEKEEPING	9,714	300		13,388		9
10 DIETARY	14,449	1,364			36,326	10
11 CAFETERIA	137	781			18,722	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	7,094					13
14 CENTRAL SERVICES & SUPPLY	2,033	525				14
15 PHARMACY	13,290	1,028		107		15
16 MEDICAL RECORDS & LIBRARY	13,075	718				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	63,116	8,538	7,457	4,283	9,537	30
40 SUBPROVIDER - IPF	47,832	8,289	3,374	1,934	7,274	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	12,302	5,482	1,575	985		50
53 ANESTHESIOLOGY	478					53
54 RADIOLOGY-DIAGNOSTIC	14,146	3,513	1,130			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	6,812	401				57
60 LABORATORY	35,072	2,052		281		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	1,743					64
65 RESPIRATORY THERAPY	11,207	817	934	219		65
66 PHYSICAL THERAPY	17,108	4,155	1,438	260		66
69 ELECTROCARDIOLOGY	1,723					69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	10,173					71
72 IMPL. DEV. CHARGED TO PATIENT	1,778					72
73 DRUGS CHARGED TO PATIENTS	46,713					73
75 ASC (NON-DISTINCT PART)	12,392	3,659	3,443	1,368		75
76 NUCLEAR MEDICINE	6,183					76
76.01 ULTRASOUND		444				76.01
76.02 MAMMOGRAPHY	3,314	267				76.02
76.03 CARDIAC REHABILITATION	1,600					76.03
76.04 FAITH CENTER CHEMOTHERAPY	2,698	823				76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	37,184		1,438	1,567		88
88.01 RHC II	5,610					88.01
91 EMERGENCY	21,285	1,716	2,118	2,190		91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	5,020	2,118				93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	12,473			194		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	467,251	48,162	22,907	13,388	35,533	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,529	570				190
192 PHYSICIANS' PRIVATE OFFICES	2,439	9,003	1,188		793	192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC	182	3,348				192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	471,401	61,083	24,095	13,388	36,326	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	28,062					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	401	9,065				13
14 CENTRAL SERVICES & SUPPLY	266		50,264			14
15 PHARMACY	711		318	77,128		15
16 MEDICAL RECORDS & LIBRARY	1,446		123		61,487	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	6,383	3,278	3,466		2,126	30
40 SUBPROVIDER - IPF	5,074	2,606	1,418		5,833	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,807	928			1,216	50
53 ANESTHESIOLOGY	314		291		1,167	53
54 RADIOLOGY-DIAGNOSTIC	986		397		2,251	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	598		32		8,638	57
60 LABORATORY	1,847		17,023		11,396	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					1,614	64
65 RESPIRATORY THERAPY	1,115		733		2,319	65
66 PHYSICAL THERAPY	1,292		164		2,161	66
69 ELECTROCARDIOLOGY	159		42		645	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			16,751		2,696	71
72 IMPL. DEV. CHARGED TO PATIENT			2,259		202	72
73 DRUGS CHARGED TO PATIENTS				77,128	8,022	73
75 ASC (NON-DISTINCT PART)	1,526	784	1,862		2,067	75
76 NUCLEAR MEDICINE	190		2,552		988	76
76.01 ULTRASOUND	595		85		1,526	76.01
76.02 MAMMOGRAPHY	118		85		417	76.02
76.03 CARDIAC REHABILITATION	122		47		187	76.03
76.04 FAITH CENTER CHEMOTHERAPY	252		175		224	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			537			88
88.01 RHC II			100			88.01
91 EMERGENCY	2,432	1,249	1,107		5,235	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	428	220	44		557	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY			555			101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	28,062	9,065	50,166	77,128	61,487	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			1			190
192 PHYSICIANS' PRIVATE OFFICES			97			192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	28,062	9,065	50,264	77,128	61,487	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCS-SALARY & FRINGES APPRVD				21
22 I&R SRVCS-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	273,097		273,097	30
40 SUBPROVIDER - IPF	180,184		180,184	40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	210,330		210,330	50
53 ANESTHESIOLOGY	12,823		12,823	53
54 RADIOLOGY-DIAGNOSTIC	107,088		107,088	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	20,891		20,891	57
60 LABORATORY	123,256		123,256	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	3,368		3,368	64
65 RESPIRATORY THERAPY	58,066		58,066	65
66 PHYSICAL THERAPY	84,091		84,091	66
69 ELECTROCARDIOLOGY	29,650		29,650	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	29,620		29,620	71
72 IMPL. DEV. CHARGED TO PATIENT	4,239		4,239	72
73 DRUGS CHARGED TO PATIENTS	131,863		131,863	73
75 ASC (NON-DISTINCT PART)	97,508		97,508	75
76 NUCLEAR MEDICINE	64,243		64,243	76
76.01 ULTRASOUND	54,463		54,463	76.01
76.02 MAMMOGRAPHY	69,458		69,458	76.02
76.03 CARDIAC REHABILITATION	10,711		10,711	76.03
76.04 FAITH CENTER CHEMOTHERAPY	15,372		15,372	76.04
76.06 ROUTINE ANCILLARY				76.06
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	42,801		42,801	88
88.01 RHC II	5,776		5,776	88.01
91 EMERGENCY	64,066		64,066	91
92 OBSERVATION BEDS				92
93 DAY PSYCHIATRIC	31,288		31,288	93
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
101 HOME HEALTH AGENCY	13,398		13,398	101
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	1,737,650		1,737,650	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,271		8,271	190
192 PHYSICIANS' PRIVATE OFFICES	13,562		13,562	192
192.01 DIALYSIS				192.01
192.03 ORTHO CLINIC	3,530		3,530	192.03
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	1,763,013		1,763,013	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	68,992					1
2 CAP REL COSTS-MVBLE EQUIP		953,738				2
4 EMPLOYEE BENEFITS	534	1,164	18,365,591			4
5 ADMINISTRATIVE & GENERAL	10,523	355,018	2,861,999	-6,837,325	28,955,970	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,719	13,319	503,438		1,306,917	7
8 LAUNDRY & LINEN SERVICE	1,328	6,843	69,146		196,057	8
9 HOUSEKEEPING	340		404,269		596,665	9
10 DIETARY	1,545	5,455	510,906		887,552	10
11 CAFETERIA	885				8,422	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		1,418	305,950		435,727	13
14 CENTRAL SERVICES & SUPPLY	595	40,432	36,499		124,859	14
15 PHARMACY	1,165	48,783	568,912		816,314	15
16 MEDICAL RECORDS & LIBRARY	813	37,013	449,522		803,127	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	9,674	69,211	2,764,129		3,877,160	30
40 SUBPROVIDER - IPF	9,392	6,184	2,130,808		2,938,112	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,211	51,593	474,641		755,672	50
53 ANESTHESIOLOGY		10,235			29,358	53
54 RADIOLOGY-DIAGNOSTIC	3,980	45,130	496,602		868,925	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	454	14	217,972		418,430	57
60 LABORATORY	2,325	32,165	681,551		2,154,315	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY			33,144		107,075	64
65 RESPIRATORY THERAPY	926	12,852	465,216		688,373	65
66 PHYSICAL THERAPY	4,708	10,827	768,581		1,050,877	66
69 ELECTROCARDIOLOGY		5,449	58,014		105,819	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					624,852	71
72 IMPL. DEV. CHARGED TO PATIENT					109,191	72
73 DRUGS CHARGED TO PATIENTS					2,869,365	73
75 ASC (NON-DISTINCT PART)	4,146	29,811	460,111		761,190	75
76 NUCLEAR MEDICINE		52,556	116,028		379,799	76
76.01 ULTRASOUND	503	40,596	184,592		308,821	76.01
76.02 MAMMOGRAPHY	303	60,364	53,275		203,554	76.02
76.03 CARDIAC REHABILITATION		8,457	55,351		98,256	76.03
76.04 FAITH CENTER CHEMOTHERAPY	933	2,205	126,058		165,706	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			1,551,394		2,284,045	88
88.01 RHC II			194,016		344,589	88.01
91 EMERGENCY	1,944	6,644	937,992		1,307,463	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	2,400		178,016		308,330	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY			515,222		766,142	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	68,346	953,738	18,173,354	-6,837,325	28,701,059	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	646		68,520		93,942	190
192 PHYSICIANS' PRIVATE OFFICES			123,717		149,817	192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC					11,152	192.03

PROVIDER CCN: 14-0210 HARRISBURG MEDICAL CENTER, INC  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	656,574	985,200	4,979,428		6,837,325	202
203 UNIT COST MULT-WS B PT I	9.516669	1.032988	0.271128		0.236128	203
204 COST TO BE ALLOC PER B PT II			6,284		471,401	204
205 UNIT COST MULT-WS B PT II			0.000342		0.016280	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	POUNDS OF	HOURS OF	MEALS	MEALS	
	FEET	LAUNDRY	SERVICE	SERVED	SERVED	
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT	69,210				7
8	LAUNDRY & LINEN SERVICE	1,328	24,635			8
9	HOUSEKEEPING	340		2,623		9
10	DIETARY	1,545			134,896	10
11	CAFETERIA	885			69,521	559,569
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					7,999
14	CENTRAL SERVICES & SUPPLY	595				5,299
15	PHARMACY	1,165		21		14,177
16	MEDICAL RECORDS & LIBRARY	813				28,839
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	9,674	7,625	839	35,417	127,288
40	SUBPROVIDER - IPF	9,392	3,450	379	27,012	101,173
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6,211	1,610	193		36,041
53	ANESTHESIOLOGY					6,252
54	RADIOLOGY-DIAGNOSTIC	3,980	1,155			19,654
57	COMPUTED TOMOGRAPHY (CT) SCAN	454				11,916
60	LABORATORY	2,325		55		36,834
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	INTRAVENOUS THERAPY					64
65	RESPIRATORY THERAPY	926	955	43		22,235
66	PHYSICAL THERAPY	4,708	1,470	51		25,768
69	ELECTROCARDIOLOGY					3,173
71	MEDICAL SUPPLIES CHRGD TO PATIENTS					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
75	ASC (NON-DISTINCT PART)	4,146	3,520	268		30,429
76	NUCLEAR MEDICINE					3,794
76.01	ULTRASOUND	503				11,869
76.02	MAMMOGRAPHY	303				2,362
76.03	CARDIAC REHABILITATION					2,427
76.04	FAITH CENTER CHEMOTHERAPY	933				5,024
76.06	ROUTINE ANCILLARY					
76.97	CARDIAC REHABILITATION					
76.98	HYPERBARIC OXYGEN THERAPY					
76.99	LITHOTRIPSY					
OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)		1,470	307		
88.01	RHC II					
91	EMERGENCY	1,944	2,165	429		48,491
92	OBSERVATION BEDS					
93	DAY PSYCHIATRIC	2,400				8,525
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF					
99.20	OUTPATIENT PHYSICAL THERAPY					
99.30	OUTPATIENT OCCUPATIONAL THERAPY					
99.40	OUTPATIENT SPEECH PATHOLOGY					
101	HOME HEALTH AGENCY			38		
SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	54,570	23,420	2,623	131,950	559,569
NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	646				
192	PHYSICIANS' PRIVATE OFFICES	10,200	1,215		2,946	
192.01	DIALYSIS					
192.03	ORTHO CLINIC	3,794				

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET 7	POUNDS OF LAUNDRY 8	HOURS OF SERVICE 9	MEALS SERVED 10	MEALS SERVED 11	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,615,517	273,351	745,490	1,133,192	615,079	202
203 UNIT COST MULT-WS B PT I	23.342248	11.096042	284.212734	8.400486	1.099201	203
204 COST TO BE ALLOC PER B PT II	61,083	24,095	13,388	36,326	28,062	204
205 UNIT COST MULT-WS B PT II	0.882575	0.978080	5.104079	0.269289	0.050149	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSNG HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY  COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	351,947				13
14 CENTRAL SERVICES & SUPPLY		1,998,880			14
15 PHARMACY		12,661	2,869,365		15
16 MEDICAL RECORDS & LIBRARY		4,910		86,263,541	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	127,288	137,843		2,981,822	30
40 SUBPROVIDER - IPF	101,173	56,373		8,181,533	40
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	36,041			1,704,840	50
53 ANESTHESIOLOGY		11,573		1,636,087	53
54 RADIOLOGY-DIAGNOSTIC		15,790		3,157,090	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		1,282		12,115,157	57
60 LABORATORY		676,904		16,009,555	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY				2,263,713	64
65 RESPIRATORY THERAPY		29,131		3,253,113	65
66 PHYSICAL THERAPY		6,531		3,030,615	66
69 ELECTROCARDIOLOGY		1,655		904,719	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		666,148		3,781,673	71
72 IMPL. DEV. CHARGED TO PATIENT		89,846		282,674	72
73 DRUGS CHARGED TO PATIENTS			2,869,365	11,251,736	73
75 ASC (NON-DISTINCT PART)	30,429	74,050		2,899,258	75
76 NUCLEAR MEDICINE		101,499		1,386,018	76
76.01 ULTRASOUND		3,398		2,139,880	76.01
76.02 MAMMOGRAPHY		3,394		584,169	76.02
76.03 CARDIAC REHABILITATION		1,886		262,704	76.03
76.04 FAITH CENTER CHEMOTHERAPY		6,975		313,821	76.04
76.06 ROUTINE ANCILLARY					76.06
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)		21,367			88
88.01 RHC II		3,959			88.01
91 EMERGENCY	48,491	44,011		7,341,578	91
92 OBSERVATION BEDS					92
93 DAY PSYCHIATRIC	8,525	1,758		781,786	93
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY		22,070			101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	351,947	1,995,014	2,869,365	86,263,541	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
192 PHYSICIANS' PRIVATE OFFICES		3,843			192
192.01 DIALYSIS					192.01
192.03 ORTHO CLINIC					192.03

PROVIDER CCN: 14-0210 HARRISBURG MEDICAL CENTER, INC  
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	COST TO BE ALLOC PER B PT I	547,407	174,056	1,058,916	1,043,873	202
203	UNIT COST MULT-WS B PT I	1.555368	0.087077	0.369042	0.012101	203
204	COST TO BE ALLOC PER B PT II	9,065	50,264	77,128	61,487	204
205	UNIT COST MULT-WS B PT II	0.025757	0.025146	0.026880	0.000713	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	6,025,053		6,025,053		6,025,053	30
40 SUBPROVIDER - IPF	4,596,509		4,596,509	210,465	4,806,974	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,268,107		1,268,107		1,268,107	50
53 ANESTHESIOLOGY	63,968		63,968		63,968	53
54 RADIOLOGY-DIAGNOSTIC	1,241,004		1,241,004		1,241,004	54
57 COMPUTED TOMOGRAPHY (CT) SC	687,646		687,646		687,646	57
60 LABORATORY	3,026,070		3,026,070	1,900	3,027,970	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
64 INTRAVENOUS THERAPY	159,751		159,751		159,751	64
65 RESPIRATORY THERAPY	961,694		961,694		961,694	65
66 PHYSICAL THERAPY	1,505,285		1,505,285		1,505,285	66
69 ELECTROCARDIOLOGY	145,386		145,386		145,386	69
71 MEDICAL SUPPLIES CHRGED TO	876,165		876,165		876,165	71
72 IMPL. DEV. CHARGED TO PATIE	146,219		146,219		146,219	72
73 DRUGS CHARGED TO PATIENTS	4,741,975		4,741,975		4,741,975	73
75 ASC (NON-DISTINCT PART)	1,275,240		1,275,240		1,275,240	75
76 NUCLEAR MEDICINE	499,260		499,260		499,260	76
76.01 ULTRASOUND	432,720		432,720		432,720	76.01
76.02 MAMMOGRAPHY	268,653		268,653		268,653	76.02
76.03 CARDIAC REHABILITATION	127,468		127,468		127,468	76.03
76.04 FAITH CENTER CHEMOTHERAPY	236,539		236,539		236,539	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	2,928,797		2,928,797		2,928,797	88
88.01 RHC II	426,301		426,301		426,301	88.01
91 EMERGENCY	2,028,913		2,028,913	16,278	2,045,191	91
92 OBSERVATION BEDS	2,495,895		2,495,895		2,495,895	92
93 DAY PSYCHIATRIC	469,400		469,400		469,400	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	959,772		959,772		959,772	101
200 SUBTOTAL (SEE INSTRUCTIONS)	37,593,790		37,593,790	228,643	37,822,433	200
201 LESS OBSERVATION BEDS	2,495,895		2,495,895		2,495,895	201
202 TOTAL (SEE INSTRUCTIONS)	35,097,895		35,097,895		35,326,538	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	2,910,843		2,910,843			30
40 SUBPROVIDER - IPF	8,181,533		8,181,533			40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	184,837	1,520,003	1,704,840	0.743828	0.743828	0.743828 50
53 ANESTHESIOLOGY	332,307	1,303,780	1,636,087	0.039098	0.039098	0.039098 53
54 RADIOLOGY-DIAGNOSTIC	287,174	2,869,916	3,157,090	0.393085	0.393085	0.393085 54
57 COMPUTED TOMOGRAPHY (CT) SC	970,078	11,145,079	12,115,157	0.056759	0.056759	0.056759 57
60 LABORATORY	2,399,463	13,809,302	16,208,765	0.186693	0.186693	0.186811 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
64 INTRAVENOUS THERAPY	197,345	2,066,368	2,263,713	0.070570	0.070570	0.070570 64
65 RESPIRATORY THERAPY	1,353,083	1,881,276	3,234,359	0.297337	0.297337	0.297337 65
66 PHYSICAL THERAPY	371,731	2,658,884	3,030,615	0.496693	0.496693	0.496693 66
69 ELECTROCARDIOLOGY	162,440	772,164	934,604	0.155559	0.155559	0.155559 69
71 MEDICAL SUPPLIES CHRGED TO	1,341,119	2,431,850	3,772,969	0.232222	0.232222	0.232222 71
72 IMPL. DEV. CHARGED TO PATIE	8,704	282,674	291,378	0.501819	0.501819	0.501819 72
73 DRUGS CHARGED TO PATIENTS	2,470,608	8,781,128	11,251,736	0.421444	0.421444	0.421444 73
75 ASC (NON-DISTINCT PART)	199,618	2,626,866	2,826,484	0.451175	0.451175	0.451175 75
76 NUCLEAR MEDICINE	37,994	1,348,024	1,386,018	0.360212	0.360212	0.360212 76
76.01 ULTRASOUND	213,795	1,926,085	2,139,880	0.202217	0.202217	0.202217 76.01
76.02 MAMMOGRAPHY		584,169	584,169	0.459889	0.459889	0.459889 76.02
76.03 CARDIAC REHABILITATION	2,000	260,704	262,704	0.485215	0.485215	0.485215 76.03
76.04 FAITH CENTER CHEMOTHERAPY	3,929	243,304	247,233	0.956745	0.956745	0.956745 76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		1,910,452	1,910,452			88
88.01 RHC II		162,569	162,569			88.01
91 EMERGENCY	609,589	6,731,989	7,341,578	0.276359	0.276359	0.278576 91
92 OBSERVATION BEDS	1,260,450	4,696,075	5,956,525	0.419019	0.419019	0.419019 92
93 DAY PSYCHIATRIC	18,064	763,722	781,786	0.600420	0.600420	0.600420 93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		1,212,153	1,212,153			101
200 SUBTOTAL (SEE INSTRUCTIONS)	23,516,704	71,988,536	95,505,240			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	23,516,704	71,988,536	95,505,240			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	SWING-BED	REDUCED CAP-REL COST	TOTAL PATIENT	PER DIEM	INPAT PGM	INPAT PGM	
	(FROM WKST B, PT. II, COL. 26)	ADJUSTMENT	(COL.1 MINUS COL.2)	DAYS	(COL.3 + COL.4)	DAYS	CAP COST (COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	273,097	2,142	270,955	5,511	49.17	2,430	119,483	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF	180,184		180,184	7,811	23.07	2,586	59,659	40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	453,281		451,139	13,322		5,016	179,142	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-0210) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	210,330	1,704,840	0.123372	141,819	17,496	50
53 ANESTHESIOLOGY	12,823	1,636,087	0.007838	142,978	1,121	53
54 RADIOLOGY-DIAGNOSTIC	107,088	3,157,090	0.033920	260,085	8,822	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	20,891	12,115,157	0.001724	874,469	1,508	57
60 LABORATORY	123,256	16,208,765	0.007604	2,110,213	16,046	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY	3,368	2,263,713	0.001488	182,818	272	64
65 RESPIRATORY THERAPY	58,066	3,234,359	0.017953	1,012,362	18,175	65
66 PHYSICAL THERAPY	84,091	3,030,615	0.027747	232,309	6,446	66
69 ELECTROCARDIOLOGY	29,650	934,604	0.031725	144,779	4,593	69
71 MEDICAL SUPPLIES CHRGD TO PA	29,620	3,772,969	0.007851	1,186,257	9,313	71
72 IMPL. DEV. CHARGED TO PATIENT	4,239	291,378	0.014548	6,544	95	72
73 DRUGS CHARGED TO PATIENTS	131,863	11,251,736	0.011719	1,178,752	13,814	73
75 ASC (NON-DISTINCT PART)	97,508	2,826,484	0.034498	170,043	5,866	75
76 NUCLEAR MEDICINE	64,243	1,386,018	0.046351	31,442	1,457	76
76.01 ULTRASOUND	54,463	2,139,880	0.025451	203,446	5,178	76.01
76.02 MAMMOGRAPHY	69,458	584,169	0.118901			76.02
76.03 CARDIAC REHABILITATION	10,711	262,704	0.040772	1,157	47	76.03
76.04 FAITH CENTER CHEMOTHERAPY	15,372	247,233	0.062176	39	2	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	42,801	1,910,452	0.022404			88
88.01 RHC II	5,776	162,569	0.035530			88.01
91 EMERGENCY	64,066	7,341,578	0.008726	460,969	4,022	91
92 OBSERVATION BEDS	114,025	5,956,525	0.019143	891,203	17,060	92
93 DAY PSYCHIATRIC	31,288	781,786	0.040021			93
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	1,384,996	83,200,711		9,231,684	131,333	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 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL. 5 ÷ COL. 6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL. 7 x COL. 8) 9	
30 INPAT ROUTINE SERV COST CTRS					30
ADULTS & PEDIATRICS	5,511		2,430		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	7,811		2,586		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)	13,322		5,016		

APPORIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-0210)	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	ICF/MR	<input checked="" type="checkbox"/>	PPS
APPLICABLE	<input checked="" type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF			<input type="checkbox"/>	TEFRA
BOXES	<input type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF				

  

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN					
	ANESTHETIST	SCHOOL	HEALTH	MEDICAL	COST	COST
	COST			EDUCATION	(SUM OF	(SUM OF
	1	2	3	COST	COLS.1-4)	COLS.2-4)
					5	6
ANCILLARY SERVICE COST CENTERS						
50						50
						53
53						54
						57
54						60
						62.30
57						64
						65
60						66
						69
62.30						71
						72
64						73
						75
65						76
						76.01
66						76.02
						76.03
69						76.04
						76.06
71						76.97
						76.98
72						76.99
73						
75						
76						
76.01						
76.02						
76.03						
76.04						
76.06						
76.97						
76.98						
76.99						
OUTPATIENT SERVICE COST CENTERS						
88						88
						88.01
88.01						91
						92
91						93
92						
93						
OTHER REIMBURSABLE COST CENTERS						
200						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-0210)	[ ] 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)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 8)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9		11		13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,704,840		141,819		386,248	50
53	ANESTHESIOLOGY	1,636,087		142,978		410,845	53
54	RADIOLOGY-DIAGNOSTIC	3,157,090		260,085		1,164,234	54
57	COMPUTED TOMOGRAPHY (CT) SCA	12,115,157		874,469		3,995,487	57
60	LABORATORY	16,208,765		2,110,213		435,362	60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
64	INTRAVENOUS THERAPY	2,263,713		182,818		901,131	64
65	RESPIRATORY THERAPY	3,234,359		1,012,362		665,072	65
66	PHYSICAL THERAPY	3,030,615		232,309			66
69	ELECTROCARDIOLOGY	934,604		144,779		290,765	69
71	MEDICAL SUPPLIES CHRGED TO P	3,772,969		1,186,257		832,918	71
72	IMPL. DEV. CHARGED TO PATIEN	291,378		6,544		172,840	72
73	DRUGS CHARGED TO PATIENTS	11,251,736		1,178,752		4,955,802	73
75	ASC (NON-DISTINCT PART)	2,826,484		170,043		1,118,520	75
76	NUCLEAR MEDICINE	1,386,018		31,442		520,489	76
76.01	ULTRASOUND	2,139,880		203,446		439,405	76.01
76.02	MAMMOGRAPHY	584,169					76.02
76.03	CARDIAC REHABILITATION	262,704		1,157		188,023	76.03
76.04	FAITH CENTER CHEMOTHERAPY	247,233		39		145,993	76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)	1,910,452					88
88.01	RHC II	162,569					88.01
91	EMERGENCY	7,341,578		460,969		1,833,710	91
92	OBSERVATION BEDS	5,956,525		891,203		2,499,426	92
93	DAY PSYCHIATRIC	781,786				173,341	93
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	83,200,711		9,231,684		21,129,611	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-0210) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES		PROGRAM COSTS			
		PPS REIMBURSED	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	COST SERVICES SUBJECT TO DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.743828	386,248			287,302		50
53 ANESTHESIOLOGY	0.039098	410,845			16,063		53
54 RADIOLOGY-DIAGNOSTIC	0.393085	1,164,234			457,643		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.056759	3,995,487			226,780		57
60 LABORATORY	0.186693	435,362			81,279		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64 INTRAVENOUS THERAPY	0.070570	901,131			63,593		64
65 RESPIRATORY THERAPY	0.297337	665,072			197,751		65
66 PHYSICAL THERAPY	0.496693						66
69 ELECTROCARDIOLOGY	0.155559	290,765			45,231		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.232222	832,918			193,422		71
72 IMPL. DEV. CHARGED TO PATIENT	0.501819	172,840			86,734		72
73 DRUGS CHARGED TO PATIENTS	0.421444	4,955,802			2,088,593		73
75 ASC (NON-DISTINCT PART)	0.451175	1,118,520			504,648		75
76 NUCLEAR MEDICINE	0.360212	520,489			187,486		76
76.01 ULTRASOUND	0.202217	439,405			88,855		76.01
76.02 MAMMOGRAPHY	0.459889						76.02
76.03 CARDIAC REHABILITATION	0.485215	188,023			91,232		76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.956745	145,993			139,678		76.04
76.06 ROUTINE ANCILLARY							76.06
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
88.01 RHC II							88.01
91 EMERGENCY	0.276359	1,833,710			506,762		91
92 OBSERVATION BEDS	0.419019	2,499,426			1,047,307		92
93 DAY PSYCHIATRIC	0.600420	173,341			104,077		93
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)		21,129,611			6,414,436		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		21,129,611			6,414,436		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-S210) [ ] 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			
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	210,330	1,704,840	0.123372	458	57		50
53	ANESTHESIOLOGY	12,823	1,636,087	0.007838	28,490	223		53
54	RADIOLOGY-DIAGNOSTIC	107,088	3,157,090	0.033920	18,417	625		54
57	COMPUTED TOMOGRAPHY (CT) SCAN	20,891	12,115,157	0.001724	90,540	156		57
60	LABORATORY	123,256	16,208,765	0.007604	213,209	1,621		60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
64	INTRAVENOUS THERAPY	3,368	2,263,713	0.001488	4,079	6		64
65	RESPIRATORY THERAPY	58,066	3,234,359	0.017953	100,410	1,803		65
66	PHYSICAL THERAPY	84,091	3,030,615	0.027747	21,450	595		66
69	ELECTROCARDIOLOGY	29,650	934,604	0.031725	12,181	386		69
71	MEDICAL SUPPLIES CHRGD TO PA	29,620	3,772,969	0.007851	82,398	647		71
72	IMPL. DEV. CHARGED TO PATIENT	4,239	291,378	0.014548				72
73	DRUGS CHARGED TO PATIENTS	131,863	11,251,736	0.011719	404,423	4,739		73
75	ASC (NON-DISTINCT PART)	97,508	2,826,484	0.034498	2,567	89		75
76	NUCLEAR MEDICINE	64,243	1,386,018	0.046351				76
76.01	ULTRASOUND	54,463	2,139,880	0.025451	6,016	153		76.01
76.02	MAMMOGRAPHY	69,458	584,169	0.118901				76.02
76.03	CARDIAC REHABILITATION	10,711	262,704	0.040772				76.03
76.04	FAITH CENTER CHEMOTHERAPY	15,372	247,233	0.062176				76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)	42,801	1,910,452	0.022404				88
88.01	RHC II	5,776	162,569	0.035530				88.01
91	EMERGENCY	64,066	7,341,578	0.008726	96,269	840		91
92	OBSERVATION BEDS	114,025	5,956,525	0.019143				92
93	DAY PSYCHIATRIC	31,288	781,786	0.040021				93
OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	1,384,996	83,200,711		1,080,907	11,940		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-S210)	[ ]	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				
57	COMPUTED TOMOGRAPHY (CT) SCAN					57				
60	LABORATORY					60				
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30				
64	INTRAVENOUS THERAPY					64				
65	RESPIRATORY THERAPY					65				
66	PHYSICAL THERAPY					66				
69	ELECTROCARDIOLOGY					69				
71	MEDICAL SUPPLIES CHRGD TO PA					71				
72	IMPL. DEV. CHARGED TO PATIENT					72				
73	DRUGS CHARGED TO PATIENTS					73				
75	ASC (NON-DISTINCT PART)					75				
76	NUCLEAR MEDICINE					76				
76.01	ULTRASOUND					76.01				
76.02	MAMMOGRAPHY					76.02				
76.03	CARDIAC REHABILITATION					76.03				
76.04	FAITH CENTER CHEMOTHERAPY					76.04				
76.06	ROUTINE ANCILLARY					76.06				
76.97	CARDIAC REHABILITATION					76.97				
76.98	HYPERBARIC OXYGEN THERAPY					76.98				
76.99	LITHOTRIPSY					76.99				
OUTPATIENT SERVICE COST CENTERS										
88	RURAL HEALTH CLINIC (RHC)					88				
88.01	RHC II					88.01				
91	EMERGENCY					91				
92	OBSERVATION BEDS					92				
93	DAY PSYCHIATRIC					93				
OTHER REIMBURSABLE COST CENTERS										
200	TOTAL (SUM OF LINES 50-199)					200				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ] TITLE V	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[XX] IPF (14-S210)	[ ] 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	1,704,840			458		50
53	ANESTHESIOLOGY	1,636,087			28,490		53
54	RADIOLOGY-DIAGNOSTIC	3,157,090			18,417		54
57	COMPUTED TOMOGRAPHY (CT) SCA	12,115,157			90,540		57
60	LABORATORY	16,208,765			213,209		60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
64	INTRAVENOUS THERAPY	2,263,713			4,079		64
65	RESPIRATORY THERAPY	3,234,359			100,410		65
66	PHYSICAL THERAPY	3,030,615			21,450		66
69	ELECTROCARDIOLOGY	934,604			12,181		69
71	MEDICAL SUPPLIES CHRGD TO P	3,772,969			82,398		71
72	IMPL. DEV. CHARGED TO PATIEN	291,378					72
73	DRUGS CHARGED TO PATIENTS	11,251,736			404,423		73
75	ASC (NON-DISTINCT PART)	2,826,484			2,567		75
76	NUCLEAR MEDICINE	1,386,018					76
76.01	ULTRASOUND	2,139,880			6,016		76.01
76.02	MAMMOGRAPHY	584,169					76.02
76.03	CARDIAC REHABILITATION	262,704					76.03
76.04	FAITH CENTER CHEMOTHERAPY	247,233					76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)	1,910,452					88
88.01	RHC II	162,569					88.01
91	EMERGENCY	7,341,578			96,269		91
92	OBSERVATION BEDS	5,956,525					92
93	DAY PSYCHIATRIC	781,786					93
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	83,200,711			1,080,907		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-S210) [ ] SNF [ ] S/B-SNF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES		PROGRAM COSTS			
		PPS REIMBURSED SERVICES	COST REIMB. SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	COST SERVICES SUBJECT TO DED & COINS		COST SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.743828						50
53 ANESTHESIOLOGY	0.039098						53
54 RADIOLOGY-DIAGNOSTIC	0.393085						54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.056759						57
60 LABORATORY	0.186693						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64 INTRAVENOUS THERAPY	0.070570						64
65 RESPIRATORY THERAPY	0.297337						65
66 PHYSICAL THERAPY	0.496693						66
69 ELECTROCARDIOLOGY	0.155559						69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.232222						71
72 IMPL. DEV. CHARGED TO PATIENT	0.501819						72
73 DRUGS CHARGED TO PATIENTS	0.421444						73
75 ASC (NON-DISTINCT PART)	0.451175						75
76 NUCLEAR MEDICINE	0.360212						76
76.01 ULTRASOUND	0.202217						76.01
76.02 MAMMOGRAPHY	0.459889						76.02
76.03 CARDIAC REHABILITATION	0.485215						76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.956745						76.04
76.06 ROUTINE ANCILLARY							76.06
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
88.01 RHC II							88.01
91 EMERGENCY	0.276359						91
92 OBSERVATION BEDS	0.419019						92
93 DAY PSYCHIATRIC	0.600420						93
OTHER REIMBURSABLE COST CENTERS							
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  
 APPLICABLE  
 BOXES

[ ] TITLE V  
 [ ] TITLE XVIII-PT A  
 [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL	SWING-BED	REDUCED	TOTAL	PER	INPAT	INPAT PGM
	(FROM WKST B, PT. II, COL. 26)	ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)	PATIENT DAYS 4	DIEM (COL.3 ÷ COL.4)	PGM DAYS 6	CAP COST (COL.5 x COL.6) 7
	1	2	3		5		
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	273,097	2,142	270,955	5,511	49.17	347	17,062
31 INTENSIVE CARE UNIT							30
32 CORONARY CARE UNIT							31
33 BURN INTENSIVE CARE UNIT							32
34 SURGICAL INTENSIVE CARE UNIT							33
35 OTHER SPECIAL CARE (SPECIFY)							34
40 SUBPROVIDER - IPF	180,184		180,184	7,811	23.07	2,242	51,723
41 SUBPROVIDER - IRF							40
42 SUBPROVIDER I							41
43 NURSERY							42
44 SKILLED NURSING FACILITY							43
45 NURSING FACILITY							44
200 TOTAL (LINES 30-199)	453,281		451,139	13,322		2,589	68,785

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-0210) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	210,330	1,704,840	0.123372		50
53 ANESTHESIOLOGY	12,823	1,636,087	0.007838		53
54 RADIOLOGY-DIAGNOSTIC	107,088	3,157,090	0.033920		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	20,891	12,115,157	0.001724		57
60 LABORATORY	123,256	16,208,765	0.007604		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
64 INTRAVENOUS THERAPY	3,368	2,263,713	0.001488		64
65 RESPIRATORY THERAPY	58,066	3,234,359	0.017953		65
66 PHYSICAL THERAPY	84,091	3,030,615	0.027747		66
69 ELECTROCARDIOLOGY	29,650	934,604	0.031725		69
71 MEDICAL SUPPLIES CHRGD TO PA	29,620	3,772,969	0.007851		71
72 IMPL. DEV. CHARGED TO PATIENT	4,239	291,378	0.014548		72
73 DRUGS CHARGED TO PATIENTS	131,863	11,251,736	0.011719		73
75 ASC (NON-DISTINCT PART)	97,508	2,826,484	0.034498		75
76 NUCLEAR MEDICINE	64,243	1,386,018	0.046351		76
76.01 ULTRASOUND	54,463	2,139,880	0.025451		76.01
76.02 MAMMOGRAPHY	69,458	584,169	0.118901		76.02
76.03 CARDIAC REHABILITATION	10,711	262,704	0.040772		76.03
76.04 FAITH CENTER CHEMOTHERAPY	15,372	247,233	0.062176		76.04
76.06 ROUTINE ANCILLARY					76.06
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	42,801	1,910,452	0.022404		88
88.01 RHC II	5,776	162,569	0.035530		88.01
91 EMERGENCY	64,066	7,341,578	0.008726		91
92 OBSERVATION BEDS	114,025	5,956,525	0.019143		92
93 DAY PSYCHIATRIC	31,288	781,786	0.040021		93
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	1,384,996	83,200,711			200

PROVIDER CCN: 14-0210 HARRISBURG MEDICAL CENTER, INC  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
 11/26/2012 16:09

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

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

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	5,511		347		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF	7,811		2,242		40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	13,322		2,589		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-0210)	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	ICF/MR	<input type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>		<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF	<input type="checkbox"/>		<input checked="" type="checkbox"/>	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						50				
						53				
53						53				
						54				
54						54				
						57				
57						57				
						60				
60						60				
						62.30				
62.30						62.30				
						64				
64						64				
						65				
65						65				
						66				
66						66				
						69				
69						69				
						71				
71						71				
						72				
72						72				
						73				
73						73				
						75				
75						75				
						76				
76						76				
						76.01				
76.01						76.01				
						76.02				
76.02						76.02				
						76.03				
76.03						76.03				
						76.04				
76.04						76.04				
						76.06				
76.06						76.06				
						76.97				
76.97						76.97				
						76.98				
76.98						76.98				
						76.99				
76.99						76.99				
OUTPATIENT SERVICE COST CENTERS										
88						88				
						88.01				
88.01						88.01				
						91				
91						91				
						92				
92						92				
						93				
93						93				
OTHER REIMBURSABLE COST CENTERS										
200						200				
						200				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-0210)	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] PPS		
APPLICABLE	[ ] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA		
BOXES	[XX] TITLE XIX	[ ] IRF	[ ] NF		[XX] 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 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9		11		13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,704,840					50
53	ANESTHESIOLOGY	1,636,087					53
54	RADIOLOGY-DIAGNOSTIC	3,157,090					54
57	COMPUTED TOMOGRAPHY (CT) SCA	12,115,157					57
60	LABORATORY	16,208,765					60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
64	INTRAVENOUS THERAPY	2,263,713					64
65	RESPIRATORY THERAPY	3,234,359					65
66	PHYSICAL THERAPY	3,030,615					66
69	ELECTROCARDIOLOGY	934,604					69
71	MEDICAL SUPPLIES CHRGED TO P	3,772,969					71
72	IMPL. DEV. CHARGED TO PATIEN	291,378					72
73	DRUGS CHARGED TO PATIENTS	11,251,736					73
75	ASC (NON-DISTINCT PART)	2,826,484					75
76	NUCLEAR MEDICINE	1,386,018					76
76.01	ULTRASOUND	2,139,880					76.01
76.02	MAMMOGRAPHY	584,169					76.02
76.03	CARDIAC REHABILITATION	262,704					76.03
76.04	FAITH CENTER CHEMOTHERAPY	247,233					76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)	1,910,452					88
88.01	RHC II	162,569					88.01
91	EMERGENCY	7,341,578					91
92	OBSERVATION BEDS	5,956,525					92
93	DAY PSYCHIATRIC	781,786					93
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	83,200,711					200



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-S210) [ ] IRF	[ ] SUB (OTHER)	[ ] PPS [ ] TEFRA [XX] OTHER	
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	210,330	1,704,840	0.123372	50
53	ANESTHESIOLOGY	12,823	1,636,087	0.007838	53
54	RADIOLOGY-DIAGNOSTIC	107,088	3,157,090	0.033920	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	20,891	12,115,157	0.001724	57
60	LABORATORY	123,256	16,208,765	0.007604	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA				62.30
64	INTRAVENOUS THERAPY	3,368	2,263,713	0.001488	64
65	RESPIRATORY THERAPY	58,066	3,234,359	0.017953	65
66	PHYSICAL THERAPY	84,091	3,030,615	0.027747	66
69	ELECTROCARDIOLOGY	29,650	934,604	0.031725	69
71	MEDICAL SUPPLIES CHRGED TO PA	29,620	3,772,969	0.007851	71
72	IMPL. DEV. CHARGED TO PATIENT	4,239	291,378	0.014548	72
73	DRUGS CHARGED TO PATIENTS	131,863	11,251,736	0.011719	73
75	ASC (NON-DISTINCT PART)	97,508	2,826,484	0.034498	75
76	NUCLEAR MEDICINE	64,243	1,386,018	0.046351	76
76.01	ULTRASOUND	54,463	2,139,880	0.025451	76.01
76.02	MAMMOGRAPHY	69,458	584,169	0.118901	76.02
76.03	CARDIAC REHABILITATION	10,711	262,704	0.040772	76.03
76.04	FAITH CENTER CHEMOTHERAPY	15,372	247,233	0.062176	76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC (RHC)	42,801	1,910,452	0.022404	88
88.01	RHC II	5,776	162,569	0.035530	88.01
91	EMERGENCY	64,066	7,341,578	0.008726	91
92	OBSERVATION BEDS	114,025	5,956,525	0.019143	92
93	DAY PSYCHIATRIC	31,288	781,786	0.040021	93
OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (SUM OF LINES 50-199)	1,384,996	83,200,711		200



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ] TITLE V	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] PPS	
APPLICABLE	[ ] TITLE XVIII-PT A	[XX] IPF (14-S210)	[ ] SNF		[ ] TEFRA	
BOXES	[XX] TITLE XIX	[ ] IRF	[ ] NF		[XX] 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 PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	13
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,704,840				50
53	ANESTHESIOLOGY	1,636,087				53
54	RADIOLOGY-DIAGNOSTIC	3,157,090				54
57	COMPUTED TOMOGRAPHY (CT) SCA	12,115,157				57
60	LABORATORY	16,208,765				60
62.30	BLOOD CLOTTING FOR HEMOPHILI					62.30
64	INTRAVENOUS THERAPY	2,263,713				64
65	RESPIRATORY THERAPY	3,234,359				65
66	PHYSICAL THERAPY	3,030,615				66
69	ELECTROCARDIOLOGY	934,604				69
71	MEDICAL SUPPLIES CHRGED TO P	3,772,969				71
72	IMPL. DEV. CHARGED TO PATIEN	291,378				72
73	DRUGS CHARGED TO PATIENTS	11,251,736				73
75	ASC (NON-DISTINCT PART)	2,826,484				75
76	NUCLEAR MEDICINE	1,386,018				76
76.01	ULTRASOUND	2,139,880				76.01
76.02	MAMMOGRAPHY	584,169				76.02
76.03	CARDIAC REHABILITATION	262,704				76.03
76.04	FAITH CENTER CHEMOTHERAPY	247,233				76.04
76.06	ROUTINE ANCILLARY					76.06
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	1,910,452				88
88.01	RHC II	162,569				88.01
91	EMERGENCY	7,341,578				91
92	OBSERVATION BEDS	5,956,525				92
93	DAY PSYCHIATRIC	781,786				93
OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	83,200,711				200



COMPUTATION OF INPATIENT OPERATING COST

CHECK  TITLE V-INPT  HOSPITAL (14-0210)  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII-PT A  IPF  SNF  TEFRA  
 BOXES  TITLE XIX-INPT  IRF  NF  OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,759	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,511	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	403	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,807	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	124	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)	124	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)	2,430	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)	124	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)	124	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	116.26	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	116.26	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,025,053	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	23,345	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	23,920	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)	47,265	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,977,788	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,841,311	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	283,979	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,557,332	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.103884	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	704.66	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	911.06	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)	5,977,788	37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0210) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,084.70 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,635,821 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) 2,635,821 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					2,516,148 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					5,151,969 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 119,483 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 131,333 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 250,816 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 4,901,153 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) 23,345 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 23,920 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 47,265 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) 2,301 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 1,084.70 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 2,495,895 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5 (SEE INSTR.)
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST	273,097	5,977,788	0.045685	2,495,895	114,025 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I

CHECK  TITLE V-INPT  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII-PT A  IPF (14-S210)  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)	7,811	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	7,811	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	7,811	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)	2,586	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)	4,806,974	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	4,806,974	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,735,652	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	5,735,652	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.838087	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)	734.30	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)	4,806,974	37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S210)			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF			[ ]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	615.41 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,591,450 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)	40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	1,591,450 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	315,126 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	1,906,576 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	59,659 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	11,940 51
52	TOTAL PROGRAM EXCLUDABLE COST	71,599 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	1,834,977 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

COMPUTATION OF INPATIENT OPERATING COST

CHECK  TITLE V-INPT  HOSPITAL (14-0210)  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII-PT A  IPF  SNF  TEFRA  
 BOXES  TITLE XIX-INPT  IRF  NF  OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,759	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,511	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	403	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,807	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	124	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)	124	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)	347	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	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	116.26	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	116.26	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,025,053	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	23,345	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	23,920	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)	47,265	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,977,788	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,841,311	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	283,979	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,557,332	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.103884	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	704.66	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	911.06	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)	5,977,788	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK  TITLE V-INPT  HOSPITAL (14-0210)  SUB (OTHER)  PFS  
 APPLICABLE  TITLE XVIII-PT A  IPF  TEFRA  
 BOXES  TITLE XIX-INPT  IRF  OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,084.70 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 376,391 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) 376,391 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					376,391 49
PASS-THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					17,062 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					17,062 52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					53
TARGET AMOUNT AND LIMIT COMPUTATION					
54 PROGRAM DISCHARGES					54
55 TARGET AMOUNT PER DISCHARGE					55
56 TARGET AMOUNT (LINE 54 x LINE 55)					56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT					57
58 BONUS PAYMENT (SEE INSTRUCTIONS)					58
59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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) 2,301 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

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST 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
90 CAPITAL-RELATED COST					90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

CHECK  TITLE V-INPT  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII-PT A  IPF (14-S210)  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)	7,811	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	7,811	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	7,811	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)	2,242	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)	4,596,509	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	4,596,509	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,735,652	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	5,735,652	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.801393	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)	734.30	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)	4,596,509	37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S210)			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF			[XX]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	588.47 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,319,350 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)	40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	1,319,350 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	1,319,350 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	51,723 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	51,723 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	53
TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES	54
55	TARGET AMOUNT PER DISCHARGE	55
56	TARGET AMOUNT (LINE 54 x LINE 55)	56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58	BONUS PAYMENT (SEE INSTRUCTIONS)	58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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	[XX]	HOSPITAL (14-0210)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

  

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	(COL.1 x COL.2)
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		2,009,726		30
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.743828	141,819	105,489	50
53 ANESTHESIOLOGY	0.039098	142,978	5,590	53
54 RADIOLOGY-DIAGNOSTIC	0.393085	260,085	102,236	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.056759	874,469	49,634	57
60 LABORATORY	0.186811	2,110,213	394,211	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.070570	182,818	12,901	64
65 RESPIRATORY THERAPY	0.297337	1,012,362	301,013	65
66 PHYSICAL THERAPY	0.496693	232,309	115,386	66
69 ELECTROCARDIOLOGY	0.155559	144,779	22,522	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.232222	1,186,257	275,475	71
72 IMPL. DEV. CHARGED TO PATIENT	0.501819	6,544	3,284	72
73 DRUGS CHARGED TO PATIENTS	0.421444	1,178,752	496,778	73
75 ASC (NON-DISTINCT PART)	0.451175	170,043	76,719	75
76 NUCLEAR MEDICINE	0.360212	31,442	11,326	76
76.01 ULTRASOUND	0.202217	203,446	41,140	76.01
76.02 MAMMOGRAPHY	0.459889			76.02
76.03 CARDIAC REHABILITATION	0.485215	1,157	561	76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.956745	39	37	76.04
76.06 ROUTINE ANCILLARY				76.06
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
91 EMERGENCY	0.278576	460,969	128,415	91
92 OBSERVATION BEDS	0.419019	891,203	373,431	92
93 DAY PSYCHIATRIC	0.600420			93
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		9,231,684	2,516,148	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		9,231,684		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] S/B SNF [XX] PFS  
 APPLICABLE [XX] TITLE XVIII-PT A [XX] IPF (14-S210) [ ] 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
40 SUBPROVIDER - IPF		2,715,997		40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.743828	458	341	50
53 ANESTHESIOLOGY	0.039098	28,490	1,114	53
54 RADIOLOGY-DIAGNOSTIC	0.393085	18,417	7,239	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.056759	90,540	5,139	57
60 LABORATORY	0.186811	213,209	39,830	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.070570	4,079	288	64
65 RESPIRATORY THERAPY	0.297337	100,410	29,856	65
66 PHYSICAL THERAPY	0.496693	21,450	10,654	66
69 ELECTROCARDIOLOGY	0.155559	12,181	1,895	69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.232222	82,398	19,135	71
72 IMPL. DEV. CHARGED TO PATIENT	0.501819			72
73 DRUGS CHARGED TO PATIENTS	0.421444	404,423	170,442	73
75 ASC (NON-DISTINCT PART)	0.451175	2,567	1,158	75
76 NUCLEAR MEDICINE	0.360212			76
76.01 ULTRASOUND	0.202217	6,016	1,217	76.01
76.02 MAMMOGRAPHY	0.459889			76.02
76.03 CARDIAC REHABILITATION	0.485215			76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.956745			76.04
76.06 ROUTINE ANCILLARY				76.06
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
91 EMERGENCY	0.278576	96,269	26,818	91
92 OBSERVATION BEDS	0.419019			92
93 DAY PSYCHIATRIC	0.600420			93
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,080,907	315,126	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,080,907		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B SNF (14-U210) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [ ] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.743828			50
53 ANESTHESIOLOGY	0.039098			53
54 RADIOLOGY-DIAGNOSTIC	0.393085	4,716	1,854	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.056759			57
60 LABORATORY	0.186693	42,235	7,885	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.070570	4,000	282	64
65 RESPIRATORY THERAPY	0.297337	55,051	16,369	65
66 PHYSICAL THERAPY	0.496693	99,408	49,375	66
69 ELECTROCARDIOLOGY	0.155559	514	80	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.232222	39,395	9,148	71
72 IMPL. DEV. CHARGED TO PATIENT	0.501819			72
73 DRUGS CHARGED TO PATIENTS	0.421444	65,457	27,586	73
75 ASC (NON-DISTINCT PART)	0.451175			75
76 NUCLEAR MEDICINE	0.360212			76
76.01 ULTRASOUND	0.202217	1,127	228	76.01
76.02 MAMMOGRAPHY	0.459889			76.02
76.03 CARDIAC REHABILITATION	0.485215			76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.956745			76.04
76.06 ROUTINE ANCILLARY				76.06
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
91 EMERGENCY	0.276359			91
92 OBSERVATION BEDS	0.419019			92
93 DAY PSYCHIATRIC	0.600420			93
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		311,903	112,807	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		311,903		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK  TITLE V  HOSPITAL (14-0210)  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			30
40 SUBPROVIDER - IPF			40
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	0.743828		50
53 ANESTHESIOLOGY	0.039098		53
54 RADIOLOGY-DIAGNOSTIC	0.393085		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.056759		57
60 LABORATORY	0.186693		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
64 INTRAVENOUS THERAPY	0.070570		64
65 RESPIRATORY THERAPY	0.297337		65
66 PHYSICAL THERAPY	0.496693		66
69 ELECTROCARDIOLOGY	0.155559		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.232222		71
72 IMPL. DEV. CHARGED TO PATIENT	0.501819		72
73 DRUGS CHARGED TO PATIENTS	0.421444		73
75 ASC (NON-DISTINCT PART)	0.451175		75
76 NUCLEAR MEDICINE	0.360212		76
76.01 ULTRASOUND	0.202217		76.01
76.02 MAMMOGRAPHY	0.459889		76.02
76.03 CARDIAC REHABILITATION	0.485215		76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.956745		76.04
76.06 ROUTINE ANCILLARY			76.06
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
88 RURAL HEALTH CLINIC (RHC)			88
88.01 RHC II			88.01
91 EMERGENCY	0.276359		91
92 OBSERVATION BEDS	0.419019		92
93 DAY PSYCHIATRIC	0.600420		93
OTHER REIMBURSABLE COST CENTERS			
200 TOTAL (SUM OF LINES 50-94 AND 96-98)			200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			201
202 NET CHARGES (LINE 200 MINUS LINE 201)			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [XX] IPF (14-S210) [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	(COL.1 x COL.2)
INPATIENT ROUTINE SERVICE COST CENTERS			
30 ADULTS & PEDIATRICS			30
40 SUBPROVIDER - IPF			40
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	0.743828		50
53 ANESTHESIOLOGY	0.039098		53
54 RADIOLOGY-DIAGNOSTIC	0.393085		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.056759		57
60 LABORATORY	0.186693		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
64 INTRAVENOUS THERAPY	0.070570		64
65 RESPIRATORY THERAPY	0.297337		65
66 PHYSICAL THERAPY	0.496693		66
69 ELECTROCARDIOLOGY	0.155559		69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.232222		71
72 IMPL. DEV. CHARGED TO PATIENT	0.501819		72
73 DRUGS CHARGED TO PATIENTS	0.421444		73
75 ASC (NON-DISTINCT PART)	0.451175		75
76 NUCLEAR MEDICINE	0.360212		76
76.01 ULTRASOUND	0.202217		76.01
76.02 MAMMOGRAPHY	0.459889		76.02
76.03 CARDIAC REHABILITATION	0.485215		76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.956745		76.04
76.06 ROUTINE ANCILLARY			76.06
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
88 RURAL HEALTH CLINIC (RHC)			88
88.01 RHC II			88.01
91 EMERGENCY	0.276359		91
92 OBSERVATION BEDS	0.419019		92
93 DAY PSYCHIATRIC	0.600420		93
OTHER REIMBURSABLE COST CENTERS			
200 TOTAL (SUM OF LINES 50-94 AND 96-98)			200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			201
202 NET CHARGES (LINE 200 MINUS LINE 201)			202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

CHECK [XX] HOSPITAL (14-0210)  
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	3,742,783	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	16,036	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)	38.10	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)	0.0590	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	1.6477	31
32	SUM OF LINES 30 AND 31	1.7067	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0135	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	50,528	34
40	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)	3,809,347	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	4,502,914	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	4,502,914	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	299,259	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

CHECK  HOSPITAL (14-0210)  
 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)	4,802,173	59
60	PRIMARY PAYER PAYMENTS	10,914	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	4,791,259	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	627,780	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	2,422	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	183,223	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	128,256	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	183,223	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	4,289,313	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	201,587	70.97
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	4,490,900	71
72	INTERIM PAYMENTS	4,602,009	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-111,109	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		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-S210)        [ ] 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 OPPS (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	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		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 [XX] HOSPITAL (14-0210) [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOX: [ ] IRF [ ] SWING BED SNF

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		5,299,009		5,392,868
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
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.				
			04/04/2012	59,500
	07/02/2012	13,200		3.01
				3.02
				3.03
				3.04
				3.05
				3.06
				3.07
				3.08
				3.09
				3.50
	07/02/2012	710,200		NONE
				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)		-697,000		59,500
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		4,602,009		5,452,368
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.				
				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				6.01
				6.02
				6.02
				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		4,490,900		4,429,195
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-S210) [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,853,827		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.					
					NONE	3.01
						3.02
		PROGRAM				3.03
		TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
					NONE	3.50
						3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
						3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			1,853,827		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			NONE	5.01
		TO				5.02
		PROVIDER				5.03
						5.04
						5.05
						5.06
						5.07
						5.08
						5.09
		PROVIDER			NONE	5.50
		TO				5.51
		PROGRAM				5.52
						5.53
						5.54
						5.55
						5.56
						5.57
						5.58
						5.59
						5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER		61,734		6.01
		TO PROGRAM				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			1,915,561		7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:	NPR DATE:	8



CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL (14-0210) [ ] 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	1,112 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,430 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	32 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,210 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	95,505,240 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	5,313,213 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)	1,624,546 8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	1,574,249 30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	50,297 32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK  TITLE V  SWING BED - SNF (14-U210)  
 APPLICABLE  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)	72,333	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	248	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)	72,333	8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	72,333	10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	72,333	12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	566	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)	71,767	15
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19	TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	71,767	19
20	INTERIM PAYMENTS	71,767	20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)		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:  IPF (14-S210)

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS)	2,106,179	1
2	NET IPF PPS OUTLIER PAYMENT	1,808	2
3	NET IPF PPS ECT PAYMENT	19,281	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)	21.341530	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)	2,127,268	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)	2,127,268	16
17	PRIMARY PAYER PAYMENTS	2,445	17
18	SUBTOTAL (LINE 16 LESS LINE 17)	2,124,823	18
19	DEDUCTIBLES	249,260	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	1,875,563	20
21	COINSURANCE	21,736	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	1,853,827	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	88,192	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	61,734	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	88,192	25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	1,915,561	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)	1,915,561	31
32	INTERIM PAYMENTS	1,853,827	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS THE SUM OF LINES 32 AND 33)	61,734	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 VII

CHECK [ ] TITLE V [XX] HOSPITAL (14-0210) [ ] SNF [ ] PPS  
 APPLICABLE [XX] TITLE XIX [ ] IPF [ ] NF [ ] TEFRA  
 BOXES: [ ] IRF [ ] ICF/MR [XX] OTHER  
 [ ] SUB (OTHER)

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

	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	376,391	1
3 MEDICAL AND OTHER SERVICES		2
4 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
5 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	376,391	4
6 INPATIENT PRIMARY PAYER PAYMENTS		5
7 OUTPATIENT PRIMARY PAYER PAYMENTS		6
8 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	376,391	7
9 COMPUTATION OF LESSER OF COST OR CHARGES		
10 REASONABLE CHARGES		
11 ROUTINE SERVICE CHARGES		8
12 ANCILLARY SERVICE CHARGES		9
13 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
14 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
15 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
16 CUSTOMARY CHARGES		
17 AMOUNT ACTUALLY COLLECTED FROM PATIENT'S LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
18 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENT'S LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
19 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000 15
20 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
21 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		17
22 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	376,391	18
23 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
24 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
25 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
26 PROSPECTIVE PAYMENT AMOUNT		
27 OTHER THAN OUTLIER PAYMENTS		22
28 OUTLIER PAYMENTS		23
29 PROGRAM CAPITAL PAYMENTS		24
30 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
31 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
32 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
33 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
34 SUM OF LINES 27 AND 21		29
35 COMPUTATION OF REIMBURSEMENT SETTLEMENT		
36 EXCESS OF REASONABLE COST (FROM LINE 18)		30
37 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
38 DEDUCTIBLES		32
39 COINSURANCE		33
40 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
41 UTILIZATION REVIEW		35
42 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
43 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
44 SUBTOTAL (LINE 36 ± LINE 37)		38
45 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
46 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
47 INTERIM PAYMENTS		41
48 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
49 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SNF [ ] PPS  
 APPLICABLE [XX] TITLE XIX [XX] IPF (14-S210) [ ] NF [ ] TEFRA  
 BOXES: [ ] IRF [ ] ICF/MR [XX] OTHER  
 [ ] SUB (OTHER)

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
1			COMPUTATION OF NET COST OF COVERED SERVICES
2	1,319,350		INPATIENT HOSPITAL SNF/NF SERVICES
3			MEDICAL AND OTHER SERVICES
4	1,319,350		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
	1,319,350		SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)
			COMPUTATION OF LESSER OF COST OR CHARGES
			REASONABLE CHARGES
8			ROUTINE SERVICE CHARGES
9			ANCILLARY SERVICE CHARGES
10			ORGAN ACQUISITION CHARGES, NET OF REVENUE
11			INCENTIVE FROM TARGET AMOUNT COMPUTATION
12			TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)
			CUSTOMARY CHARGES
13			AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
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)
15	1.000000	1.000000	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)
16			TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
17			EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))
18	1,319,350		EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))
19			INTERNS AND RESIDENTS (SEE INSTRUCTIONS)
20			COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)
21			COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)
			PROSPECTIVE PAYMENT AMOUNT
22			OTHER THAN OUTLIER PAYMENTS
23			OUTLIER PAYMENTS
24			PROGRAM CAPITAL PAYMENTS
25			CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)
26			ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS
27			SUBTOTAL (SUM OF LINES 22 THROUGH 26)
28			CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)
29			SUM OF LINES 27 AND 21
			COMPUTATION OF REIMBURSEMENT SETTLEMENT
30			EXCESS OF REASONABLE COST (FROM LINE 18)
31			SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)
32			DEDUCTIBLES
33			COINSURANCE
34			ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)
35			UTILIZATION REVIEW
36			SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)
37			OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)
38			SUBTOTAL (LINE 36 ± LINE 37)
39			DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)
40			TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)
41			INTERIM PAYMENTS
42			BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)
43			PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2

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	2,596,130			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	7,854,084			4
5	OTHER RECEIVABLES	4,036,195			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	600,184			7
8	PREPAID EXPENSES	1,220,085			8
9	OTHER CURRENT ASSETS	71,129			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	16,377,807			11
FIXED ASSETS					
12	LAND	420,001			12
13	LAND IMPROVEMENTS	661,821			13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	19,107,663			15
16	ACCUMULATED DEPRECIATION				16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	11,279,373			19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT				23
24	ACCUMULATED DEPRECIATION				24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS	279,505			27
28	ACCUMULATED DEPRECIATION	-18,412,392			28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	13,335,971			30
OTHER ASSETS					
31	INVESTMENTS	8,525,352			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	445,436			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	8,970,788			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	38,684,566			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,657,297			37
38	SALARIES, WAGES & FEES PAYABLE	2,057,471			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	227,994			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	1,852,758			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	5,795,520			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	4,867,354			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	200,000			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	5,067,354			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	10,862,874			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	27,821,692			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)	27,821,692			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	38,684,566			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		22,906,933							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		4,914,759							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		27,821,692							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 NEW ADDITION TRANSFER ACCOUNT									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)		27,821,692							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 FONDATION LOSS FOR THE YEAR									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)		27,821,692							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	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	2,864,562		2,864,562	1
2 SUBPROVIDER IPF	10,924,621		10,924,621	2
3 SUBPROVIDER IRF				3
5 SWING BED - SNF	329,276		329,276	5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	14,118,459		14,118,459	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT				11
12 CORONARY CARE UNIT				12
13 BURN INTENSIVE CARE UNIT				13
14 SURGICAL INTENSIVE CARE UNIT				14
15 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	14,118,459		14,118,459	17
18 ANCILLARY SERVICES	7,452,070		7,452,070	18
19 OUTPATIENT SERVICES		76,549,520	76,549,520	19
20 RHC		2,073,061	2,073,061	20
20.01 RHC II				20.01
21 FQHC				21
22 HOME HEALTH AGENCY		1,212,153	1,212,153	22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	21,570,529	79,834,734	101,405,263	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		41,349,902	29
30 ADD (SPECIFY)	4,393,026		30
31			31
32			32
33			33
34			34
35 OVER/SHORT			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		4,393,026	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		45,742,928	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	101,405,263	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	56,053,539	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	45,351,724	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	45,742,928	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-391,204	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	30,626	6
7	INCOME FROM INVESTMENTS	46,350	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	3,563	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	102,410	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	2,321	21
22	RENTAL OF HOSPITAL SPACE	68,348	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (PSYCH)	49,247	24
24.01	OTHER (LAB)		24.01
24.02	OTHER (HHC SCREENINGS)	405	24.02
24.03	OTHER (OTHER)	66,346	24.03
24.04	OTHER (CREDENTIALING PROCESS)	2,250	24.04
24.05	OTHER (CASH OVER/SHORT)	395	24.05
24.06	OTHER (MISC)		24.06
24.07	OTHER (FLEXIBLE SPENDING)		24.07
24.08	OTHER (HOLDING VALUE GAINS)	97,102	24.08
24.09	OTHER (GRANTS)	254,746	24.09
24.10	OTHER (GAIN/LOSS ON DISPOSAL)		24.10
24.11	OTHER (EXTRAORDINARY GAIN/LOSS)	2,526,516	24.11
24.12	OTHER (MEANINGFUL USE)	2,074,246	24.12
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	5,324,871	25
26	TOTAL (LINE 5 PLUS LINE 25)	4,933,667	26
27	OTHER EXPENSES (SALE OF MEDICAL RECORDS)	407	27
27.01	OTHER EXPENSES (GAIN/LOSS ON DISPOSAL)	18,410	27.01
27.02	OTHER EXPENSES (MISC)	91	27.02
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	18,908	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	4,914,759	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7419

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	
GENERAL SERVICE COST CENTER							1
1 CAPITAL RELATED-BLDGS & FIXTURES							2
2 CAPITAL RELATED-MOVABLE EQUIPMENT							3
3 PLANT OPERATION & MAINTENANCE							4
4 TRANSPORTATION (SEE INSTRUCTIONS)							5
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	129,000			2,773	42,088	173,861	6
6 SKILLED NURSING CARE	275,679		30,593			306,272	7
7 PHYSICAL THERAPY	106,993		20,934			127,927	8
8 OCCUPATIONAL THERAPY	7,986		1,271			9,257	9
9 SPEECH PATHOLOGY	19,411		1,983			21,394	10
10 MEDICAL SOCIAL SERVICES							11
11 HOME HEALTH AIDE	36,620		315			36,935	12
12 SUPPLIES (SEE INSTRUCTIONS)							13
13 DRUGS							14
14 DME							15
HHA NONREIMBURSABLE SERVICES							16
15 HOME DIALYSIS AIDE SERVICES							17
16 RESPIRATORY THERAPY							18
17 PRIVATE DUTY NURSING							19
18 CLINIC							20
19 HEALTH PROMOTION ACTIVITIES							21
20 DAY CARE PROGRAM							22
21 HOME DELIVERED MEALS PROGRAM							23
22 HOMEMAKER SERVICE							24
23 ALL OTHERS							
24 TOTAL (SUM OF LINES 1-23)	575,689		55,096	2,773	42,088	675,646	

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7419

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	-48,790	125,071	-405	124,666	5
6		306,272		306,272	6
7		127,927		127,927	7
8		9,257		9,257	8
9		21,394		21,394	9
10					10
11		36,935		36,935	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	-48,790	626,856	-405	626,451	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7419

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				
GENERAL SERVICE COST CENTER									
1 CAPITAL RELATED-BLDGS & FIXT									1
2 CAPITAL RELATED-MOVABLE EQUIP									2
3 PLANT OPERATION & MAINTENANCE									3
4 TRANSPORTATION (SEE INSTR.)									4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	124,666					124,666	124,666		5
6 SKILLED NURSING CARE	306,272					306,272	76,219	382,491	6
7 PHYSICAL THERAPY	127,927					127,927	31,700	159,627	7
8 OCCUPATIONAL THERAPY	9,257					9,257	2,294	11,551	8
9 SPEECH PATHOLOGY	21,394					21,394	5,301	26,695	9
10 MEDICAL SOCIAL SERVICES									10
11 HOME HEALTH AIDE	36,935					36,935	9,152	46,087	11
12 SUPPLIES (SEE INSTRUCTIONS)									12
13 DRUGS									13
14 DME									14
HHA NONREIMBURSABLE SERVICES									
15 HOME DIALYSIS AIDE SERVICES									15
16 RESPIRATORY THERAPY									16
17 PRIVATE DUTY NURSING									17
18 CLINIC									18
19 HEALTH PROMOTION ACTIVITIES									19
20 DAY CARE PROGRAM									20
21 HOME DELIVERED MEALS PROGRAM									21
22 HOMEMAKER SERVICE									22
23 ALL OTHERS									23
24 TOTAL (SUM OF LINES 1-23)	626,451					626,451		626,451	24

PROVIDER CCN: 14-0210 HARRISBURG MEDICAL CENTER, INC  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10  
 11/26/2012 16:09

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7419

WORKSHEET H-1  
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCU M COST) 5	
1	GENERAL SERVICE COST CENTER						1
2	CAPITAL RELATED-BLDGS & FIXT						2
3	CAPITAL RELATED-MOVABLE EQUIP						3
4	PLANT OPERATION & MAINTENANCE						4
5	TRANSPORTATION (SEE INSTR.)						5
6	ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES				-124,666	503,095	6
7	SKILLED NURSING CARE				1,310	307,582	7
8	PHYSICAL THERAPY					127,927	8
9	OCCUPATIONAL THERAPY					9,257	9
10	SPEECH PATHOLOGY					21,394	10
11	MEDICAL SOCIAL SERVICES						11
12	HOME HEALTH AIDE					36,935	12
13	SUPPLIES (SEE INSTRUCTIONS)						13
14	DRUGS						14
15	DME						15
16	HHA NONREIMBURSABLE SERVICES						16
17	HOME DIALYSIS AIDE SERVICES						17
18	RESPIRATORY THERAPY						18
19	PRIVATE DUTY NURSING						19
20	CLINIC						20
21	HEALTH PROMOTION ACTIVITIES						21
22	DAY CARE PROGRAM						22
23	HOME DELIVERED MEALS PROGRAM						23
24	HOMEMAKER SERVICE						24
25	ALL OTHERS						25
26	TELEMEDICINE						26
23.50	TOTAL (SUM OF LINES 1-23)				-123,356	503,095	23.50
24	COST TO BE ALLOC (PER W/S H)					124,666	24
25	UNIT COST MULTIPLIER					0.247798	25
26							26







ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7419

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	33,769		33,769			1
2 SKILLED NURSING CARE	565,201		565,201	20,612	585,813	2
3 PHYSICAL THERAPY	233,178		233,178	8,503	241,681	3
4 OCCUPATIONAL THERAPY	16,955		16,955	618	17,573	4
5 SPEECH PATHOLOGY	39,504		39,504	1,441	40,945	5
6 MEDICAL SOCIAL SERVICES						6
7 HOME HEALTH AIDE	69,243		69,243	2,525	71,768	7
8 SUPPLIES	1,922		1,922	70	1,992	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)	959,772		959,772	33,769	959,772	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.				0.036467		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7419

WORKSHEET H-2  
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET
	1	2	3	4	4A	5	6	7
1 ADMINISTRATIVE AND GENERAL				68,534		18,581		1
2 SKILLED NURSING CARE				275,679		457,235		2
3 PHYSICAL THERAPY				106,993		188,636		3
4 OCCUPATIONAL THERAPY				7,986		13,716		4
5 SPEECH PATHOLOGY				19,410		31,958		5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE				36,620		56,016		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)				515,222		766,142		20
21 TOTAL COST TO BE ALLOCATED				139,691		180,908		21
22 UNIT COST MULTIPLIER								22
22 UNIT COST MULTIPLIER				0.271128		0.236129		22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7419

WORKSHEET H-2  
 PART II

HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS SERVED 11	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15
1 ADMINISTRATIVE AND GENERAL			38					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							22,070	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)			38				22,070	20
21 TOTAL COST TO BE ALLOCATED			10,800				1,922	21
22 UNIT COST MULTIPLIER							0.087087	22
22 UNIT COST MULTIPLIER			284.210526					22



APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7419

WORKSHEET H-3  
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)		(COL.3 ÷ COL.4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	585,813		585,813	3,009	194.69	1
2	PHYSICAL THERAPY	3	241,681		241,681	2,059	117.38	2
3	OCCUPATIONAL THERAPY	4	17,573		17,573	125	140.58	3
4	SPEECH PATHOLOGY	5	40,945		40,945	195	209.97	4
5	MEDICAL SOCIAL SERVICES	6						5
6	HOME HEALTH AIDE	7	71,768		71,768	31	2,315.10	6
7	TOTAL (SUM OF LINES 1-6)		957,780		957,780	5,419		7

PATIENT SERVICES

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

SUPPLIES AND DRUGS COST COMPUTATIONS		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	
OTHER PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	(FROM HHA RECORD)	(COL.3 ÷ COL.4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	1,992		1,992	23,365	0.085256	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7419

WORKSHEET H-3  
 PARTS I & II  
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART B			PART B			
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
	6	7	8	9	10	11	12
1 SKILLED NURSING CARE	1,113	711		216,690	138,425		355,115
2 PHYSICAL THERAPY	975	577		114,446	67,728		182,174
3 OCCUPATIONAL THERAPY	54	71		7,591	9,981		17,572
4 SPEECH PATHOLOGY	121	78		25,406	16,378		41,784
5 MEDICAL SOCIAL SERVICES							5
6 HOME HEALTH AIDE	6	4		13,891	9,260		23,151
7 TOTAL (SUM OF LINES 1-6)	2,269	1,441		378,024	241,772		619,796

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
		PART A	PART B				
		1	2	3	4	8	9
8 SKILLED NURSING CARE	99914	1,113	711			8	
9 PHYSICAL THERAPY	99914	975	577			9	
10 OCCUPATIONAL THERAPY	99914	54	71			10	
11 SPEECH PATHOLOGY	99914	121	78			11	
12 MEDICAL SOCIAL SERVICES	99914					12	
13 HOME HEALTH AIDE	99914	6	4			13	
14 TOTAL (SUM OF LINES 8-13)		2,269	1,441			14	

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES			
	PART B			PART B			
OTHER PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
	6	7	8	9	10	11	
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	2	3	4	
1 PHYSICAL THERAPY	66	0.496693			COL 2, LINE 2
2 OCCUPATIONAL THERAPY	67				COL 2, LINE 3
3 SPEECH PATHOLOGY	68				COL 2, LINE 4
4 MEDICAL SUPPLIES CHRGED TO PAT	71	0.232222			COL 2, LINE 15
5 DRUGS CHARGED TO PATIENTS	73	0.421444			COL 2, LINE 16

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 14-7419

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 A 1	----- PART B -----		
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
	2	3	3	
1 REASONABLE COST OF PART A & PART B SERVICES				1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)				2
3 TOTAL CHARGES	535,459			2
CUSTOMARY CHARGES				
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)				3
5 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
6 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				5
7 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	535,459			6
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)	535,459			7
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)				8
10 PRIMARY PAYER PAYMENTS				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART B		
	SERVICES 1	SERVICES 2	
11 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	404,100	253,391	11
13 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			12
14 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	5,163	6,412	13
15 TOTAL PPS REIMBURSEMENT - PEP EPISODES	11,750	4,428	14
16 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			15
17 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
18 TOTAL OTHER PAYMENTS			17
19 DME PAYMENTS			18
20 OXYGEN PAYMENTS			19
21 PROSTHETIC AND ORTHOTIC PAYMENTS			20
22 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
23 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	421,013	264,231	22
24 EXCESS REASONABLE COST (FROM LINE 8)			23
25 SUBTOTAL (LINE 22 MINUS LINE 23)	421,013	264,231	24
26 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
27 NET COST (LINE 24 MINUS LINE 25)	421,013	264,231	26
28 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
29 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
30 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	421,013	264,231	29
31 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
32 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	421,013	264,231	31
33 INTERIM PAYMENTS (SEE INSTRUCTIONS)	421,013	264,231	32
34 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
35 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
36 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.: 14-7419

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		421,013		264,231	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.					
		NONE		NONE	3.01
					3.02
	PROGRAM				3.03
	TO				3.04
	PROVIDER				3.05
					3.06
					3.07
					3.08
					3.09
		NONE		NONE	3.50
					3.51
	PROVIDER				3.52
	TO				3.53
	PROGRAM				3.54
					3.55
					3.56
					3.57
					3.58
					3.59
					3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		421,013		264,231	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			NONE	5.01
	TO				5.02
	PROVIDER				5.03
					5.04
					5.05
					5.06
					5.07
					5.08
					5.09
	PROVIDER			NONE	5.50
	TO				5.51
	PROGRAM				5.52
					5.53
					5.54
					5.55
					5.56
					5.57
					5.58
					5.59
					5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)					
	PROGRAM				6.01
	TO				
	PROVIDER				
	PROVIDER				
	TO				6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		421,013		264,231	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK  TITLE V  HOSPITAL ((14-021)  PPS  
 APPLICABLE  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	298,515	1
3	CAPITAL DRG OUTLIER PAYMENTS	744	2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	8.77	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)	299,259	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
40 SUBPROVIDER - IPF					40
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
64 INTRAVENOUS THERAPY					64
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
75 ASC (NON-DISTINCT PART)					75
76 NUCLEAR MEDICINE					76
76.01 ULTRASOUND					76.01
76.02 MAMMOGRAPHY					76.02
76.03 CARDIAC REHABILITATION					76.03
76.04 FAITH CENTER CHEMOTHERAPY					76.04
76.06 ROUTINE ANCILLARY					76.06
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
92 OBSERVATION BEDS					92
93 DAY PSYCHIATRIC					93
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
192.01 DIALYSIS					192.01
192.03 ORTHO CLINIC					192.03
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

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
 FEDERALLY QUALIFIED HEALTH CENTER COSTS

RHC I  
 COMPONENT NO: 14-3473

WORKSHEET M-1

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7		
FACILITY HEALTH CARE STAFF COSTS									
1	PHYSICIAN	507,170	507,170		507,170		507,170	1	
2	PHYSICIAN ASSISTANT	64,925	64,925		64,925		64,925	2	
3	NURSE PRACTITIONER	251,327	251,327		251,327		251,327	3	
4	VISITING NURSE							4	
5	OTHER NURSE	216,072	216,072		216,072		216,072	5	
6	CLINICAL PSYCHOLOGIST	137,991	137,991		137,991	-49,247	88,744	6	
7	CLINICAL SOCIAL WORKER	54,297	54,297		54,297		54,297	7	
8	LABORATORY TECHNICIAN	23,660	23,660	-23,619	41		41	8	
9	OTHER FACILITY HEALTH CARE STAFF COSTS	49,136	49,136	-49,133	3		3	9	
10	SUBTOTAL (SUM OF LINES 1-9)	1,304,578	1,304,578	-72,752	1,231,826	-49,247	1,182,579	10	
COSTS UNDER AGREEMENT									
11	PHYSICIAN SERVICES UNDER AGREEMENT							11	
12	PHYSICIAN SUPERVISION UNDER AGREEMENT							12	
13	OTHER COSTS UNDER AGREEMENT							13	
14	SUBTOTAL (SUM OF LINES 11-13)							14	
OTHER HEALTH CARE COSTS									
15	MEDICAL SUPPLIES		22,626		22,626		22,626	15	
16	TRANSPORTATION (HEALTH CARE STAFF)		20,602		20,602		20,602	16	
17	DEPRECIATION-MEDICAL EQUIPMENT			50,702	50,702		50,702	17	
18	PROFESSIONAL LIABILITY INSURANCE							18	
19	OTHER HEALTH CARE COSTS							19	
20	ALLOWABLE GME COSTS							20	
21	SUBTOTAL (SUM OF LINES 15-20)		43,228	50,702	93,930		93,930	21	
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,304,578	43,228	1,347,806	-22,050	1,325,756	-49,247	1,276,509	22
COSTS OTHER THAN RHC/FQHC SERVICES									
23	PHARMACY							23	
24	DENTAL							24	
25	OPTOMETRY							25	
26	ALL OTHER NONREIMBURSABLE COSTS							26	
27	NONALLOWABLE GME COSTS							27	
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)							28	
FACILITY OVERHEAD									
29	FACILITY COSTS		76,502	-12,093	64,409		64,409	29	
30	ADMINISTRATIVE COSTS	491,746	158,574	-127,819	522,501		522,501	30	
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	491,746	235,076	-139,912	586,910		586,910	31	
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,796,324	278,304	2,074,628	-161,962	1,912,666	-49,247	1,863,419	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I  
 COMPONENT NO: 14-3473

WORKSHEET M-2

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	1.96	6,862	4,200	8,232	1
2	PHYSICIAN ASSISTANTS	0.80	1,090	2,100	1,680	2
3	NURSE PRACTITIONERS	2.56	6,566	2,100	5,376	3
4	SUBTOTAL (SUM OF LINES 1-3)	5.32	14,518		15,288	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST	1.80	942		942	6
7	CLINICAL SOCIAL WORKER	0.98	930		930	7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	8.10	16,390		17,160	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				1,276,509	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				1,276,509	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				586,910	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				1,065,378	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				1,652,288	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				1,652,288	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				1,652,288	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				2,928,797	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I  
 COMPONENT NO: 14-3473

WORKSHEET M-3

CHECK [ XX ] RHC [ ] TITLE V [ ] TITLE XIX  
 APPLICABLE BOXES: [ ] FQHC [ XX ] TITLE XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	2,928,797	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	16,990	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	2,911,807	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	17,160	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	17,160	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	169.69	7

CALCULATION OF LIMIT(1)  
 PRIOR TO ON OR AFTER  
 JANUARY 1 JANUARY 1 (SEE INSTR.)  
 1 2 3

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	169.69	169.69	169.69 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	2,153	2,154	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	365,343	365,512	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	126	127	12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	21,381	21,551	13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	14,699	16,163	14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)			15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	380,042	381,675	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)		270,030	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)		1,233	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		3,478	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		570,740	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		574,218	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		44,814	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		108,401	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		574,218	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		10,294	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		584,512	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		584,512	26
27	INTERIM PAYMENTS		512,445	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		72,067	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			30

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I  
 COMPONENT NO: 14-3473

WORKSHEET M-4

CHECK [ XX ] RHC [ ] TITLE V [ ] TITLE XIX  
 APPLICABLE BOXES: [ ] FQHC [ XX ] TITLE XVIII

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,182,579	1,182,579	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000088	0.000747	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	104	883	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	1,666	4,752	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,770	5,635	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,276,509	1,276,509	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,652,288	1,652,288	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001387	0.004414	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	2,292	7,293	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	4,062	12,928	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	28	413	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	145.07	31.30	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	25	213	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	3,627	6,667	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		16,990	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		10,294	16



ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
 FEDERALLY QUALIFIED HEALTH CENTER COSTS

RHC II  
 COMPONENT NO: 14-8518

WORKSHEET M-1

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	28,089		28,089		28,089		28,089	1
2 PHYSICIAN ASSISTANT	88,471		88,471		88,471		88,471	2
3 NURSE PRACTITIONER	963		963		963		963	3
4 VISITING NURSE								4
5 OTHER NURSE	35,211		35,211		35,211		35,211	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9) COSTS UNDER AGREEMENT	152,734		152,734		152,734		152,734	10
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS								14
15 MEDICAL SUPPLIES		4,003	4,003		4,003		4,003	15
16 TRANSPORTATION (HEALTH CARE STAFF)		1,169	1,169		1,169		1,169	16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		5,172	5,172		5,172		5,172	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21) COSTS OTHER THAN RHC/FQHC SERVICES	152,734	5,172	157,906		157,906		157,906	22
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS		42,222	42,222		42,222		42,222	29
30 ADMINISTRATIVE COSTS	24,719	1,325	26,044	65,814	91,858		91,858	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	24,719	43,547	68,266	65,814	134,080		134,080	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	177,453	48,719	226,172	65,814	291,986		291,986	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC II  
 COMPONENT NO: 14-8518

WORKSHEET M-2

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	0.01	31	4,200	42	1
2	PHYSICIAN ASSISTANTS	0.88	1,623	2,100	1,848	2
3	NURSE PRACTITIONERS	0.01	5	2,100	21	3
4	SUBTOTAL (SUM OF LINES 1-3)	0.90	1,659		1,911	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.90	1,659		1,911	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				157,906	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				157,906	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				134,080	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				134,315	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				268,395	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				268,395	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				268,395	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				426,301	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC II  
 COMPONENT NO: 14-8518

WORKSHEET M-3

CHECK [ XX ] RHC [ ] TITLE V [ ] TITLE XIX  
 APPLICABLE BOXES: [ ] FQHC [ XX ] TITLE XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	426,301	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	1,383	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	424,918	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	1,911	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	1,911	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	222.35	7

CALCULATION OF LIMIT(1)  
 PRIOR TO ON OR AFTER  
 JANUARY 1 JANUARY 1 (SEE INSTR.)  
 1 2 3

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	222.35	222.35	222.35 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	186	186	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	41,357	41,357	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)			14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)			15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	41,357	41,357	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)		23,310	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)			16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)			16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		63,478	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		63,478	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		3,367	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		8,650	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		63,478	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		874	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		64,352	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		64,352	26
27	INTERIM PAYMENTS		22,350	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		42,002	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			30

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC II  
 COMPONENT NO: 14-8518

WORKSHEET M-4

CHECK [ XX ] RHC [ ] TITLE V [ ] TITLE XIX  
 APPLICABLE BOXES: [ ] FQHC [ XX ] TITLE XVIII

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	152,734	152,734	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000088	0.000747	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	13	114	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	178	207	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	191	321	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	157,906	157,906	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	268,395	268,395	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001210	0.002033	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	325	546	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	516	867	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	3	18	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	172.00	48.17	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	2	11	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	344	530	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		1,383	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		874	16



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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	44.09		6.30				50.39 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	8.32	22.66					30.98 50
53 ANESTHESIOLOGY	8.74	25.11					33.85 53
54 RADIOLOGY-DIAGNOSTIC	8.24	36.88					45.12 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	7.22	32.98					40.20 57
60 LABORATORY	13.02	2.69					15.71 60
64 INTRAVENOUS THERAPY	8.08	39.81					47.89 64
65 RESPIRATORY THERAPY	31.30	20.56					51.86 65
66 PHYSICAL THERAPY	7.67						7.67 66
69 ELECTROCARDIOLOGY	15.49	31.11					46.60 69
71 MEDICAL SUPPLIES CHRGED TO PATI	31.44	22.08					53.52 71
72 IMPL. DEV. CHARGED TO PATIENT	2.25	59.32					61.57 72
73 DRUGS CHARGED TO PATIENTS	10.48	44.04					54.52 73
75 ASC (NON-DISTINCT PART)	6.02	39.57					45.59 75
76 NUCLEAR MEDICINE	2.27	37.55					39.82 76
76.01 ULTRASOUND	9.51	20.53					30.04 76.01
76.03 CARDIAC REHABILITATION	0.44	71.57					72.01 76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.02	59.05					59.07 76.04
91 EMERGENCY	6.28	24.98					31.26 91
92 OBSERVATION BEDS	14.96	41.96					56.92 92
93 DAY PSYCHIATRIC		22.17					22.17 93
200 TOTAL CHARGES	11.10	25.40					36.50 200

\*\*\*\*\* 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	33.11		28.70				61.81 40
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	0.03						0.03 50
53 ANESTHESIOLOGY	1.74						1.74 53
54 RADIOLOGY-DIAGNOSTIC	0.58						0.58 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.75						0.75 57
60 LABORATORY	1.32						1.32 60
64 INTRAVENOUS THERAPY	0.18						0.18 64
65 RESPIRATORY THERAPY	3.10						3.10 65
66 PHYSICAL THERAPY	0.71						0.71 66
69 ELECTROCARDIOLOGY	1.30						1.30 69
71 MEDICAL SUPPLIES CHRGD TO PATI	2.18						2.18 71
73 DRUGS CHARGED TO PATIENTS	3.59						3.59 73
75 ASC (NON-DISTINCT PART)	0.09						0.09 75
76.01 ULTRASOUND	0.28						0.28 76.01
91 EMERGENCY	1.31						1.31 91
200 TOTAL CHARGES	1.30						1.30 200

\*\*\*\*\* 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	0.15						0.15 54
60 LABORATORY	0.26						0.26 60
64 INTRAVENOUS THERAPY	0.18						0.18 64
65 RESPIRATORY THERAPY	1.70						1.70 65
66 PHYSICAL THERAPY	3.28						3.28 66
69 ELECTROCARDIOLOGY	0.05						0.05 69
71 MEDICAL SUPPLIES CHRGED TO PATI	1.04						1.04 71
73 DRUGS CHARGED TO PATIENTS	0.58						0.58 73
76.01 ULTRASOUND	0.05						0.05 76.01
200 TOTAL CHARGES	0.37						0.37 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
1 GENERAL SERVICE COST CENTERS							
2 CAP REL COSTS-BLDG & FIXT	656,574	1.83	-656,574	-4.01			1
3 CAP REL COSTS-MVBLE EQUIP	985,200	2.75	-985,200	-6.02			2
4 OTHER CAPITAL RELATED COSTS							3
5 EMPLOYEE BENEFITS	4,973,144	13.89	-4,973,144	-30.39			4
6 ADMINISTRATIVE & GENERAL	5,594,479	15.63	-5,594,479	-34.19			5
7 MAINTENANCE & REPAIRS							6
8 OPERATION OF PLANT	1,130,787	3.16	-1,130,787	-6.91			7
9 LAUNDRY & LINEN SERVICE	157,603	0.44	-157,603	-0.96			8
10 HOUSEKEEPING	483,820	1.35	-483,820	-2.96			9
11 DIETARY	728,693	2.04	-728,693	-4.45			10
12 CAFETERIA							11
13 MAINTENANCE OF PERSONNEL							12
14 NURSING ADMINISTRATION	351,310	0.98	-351,310	-2.15			13
15 CENTRAL SERVICES & SUPPLY	67,535	0.19	-67,535	-0.41			14
16 PHARMACY	600,587	1.68	-600,587	-3.67			15
17 MEDICAL RECORDS & LIBRARY	635,278	1.77	-635,278	-3.88			16
18 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
30 INPATIENT ROUTINE SERV COST CENTERS							
40 ADULTS & PEDIATRICS	2,964,169	8.28	3,060,884	18.70	6,025,053	16.83	30
40 SUBPROVIDER - IPF	2,264,621	6.33	2,331,888	14.25	4,596,509	12.84	40
50 ANCILLARY SERVICE COST CENTERS							
53 OPERATING ROOM	514,581	1.44	753,526	4.60	1,268,107	3.54	50
54 ANESTHESIOLOGY	18,785	0.05	45,183	0.28	63,968	0.18	53
55 RADIOLOGY-DIAGNOSTIC	649,787	1.82	591,217	3.61	1,241,004	3.47	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	354,997	0.99	332,649	2.03	687,646	1.92	57
60 LABORATORY	1,914,175	5.35	1,111,895	6.79	3,026,070	8.45	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64 INTRAVENOUS THERAPY	98,089	0.27	61,662	0.38	159,751	0.45	64
65 RESPIRATORY THERAPY	540,152	1.51	421,542	2.58	961,694	2.69	65
66 PHYSICAL THERAPY	786,505	2.20	718,780	4.39	1,505,285	4.21	66
69 ELECTROCARDIOLOGY	84,461	0.24	60,925	0.37	145,386	0.41	69
71 MEDICAL SUPPLIES CHRGD TO PATI	624,852	1.75	251,313	1.54	876,165	2.45	71
72 IMPL. DEV. CHARGED TO PATIENT	109,191	0.31	37,028	0.23	146,219	0.41	72
73 DRUGS CHARGED TO PATIENTS	2,869,365	8.02	1,872,610	11.44	4,741,975	13.25	73
75 ASC (NON-DISTINCT PART)	566,191	1.58	709,049	4.33	1,275,240	3.56	75
76 NUCLEAR MEDICINE	294,051	0.82	205,209	1.25	499,260	1.39	76
76.01 ULTRASOUND	212,051	0.59	220,669	1.35	432,720	1.21	76.01
76.02 MAMMOGRAPHY	123,871	0.35	144,782	0.88	268,653	0.75	76.02
76.03 CARDIAC REHABILITATION	74,513	0.21	52,955	0.32	127,468	0.36	76.03
76.04 FAITH CENTER CHEMOTHERAPY	120,371	0.34	116,168	0.71	236,539	0.66	76.04
76.06 ROUTINE ANCILLARY							76.06
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
88 RURAL HEALTH CLINIC (RHC)	1,863,419	5.21	1,065,378	6.51	2,928,797	8.18	88
88.01 RHC II	291,986	0.82	134,315	0.82	426,301	1.19	88.01
91 EMERGENCY	1,027,784	2.87	1,001,129	6.12	2,028,913	5.67	91
92 OBSERVATION BEDS							92
93 DAY PSYCHIATRIC	237,225	0.66	232,175	1.42	469,400	1.31	93
99.10 OTHER REIMBURSABLE COST CENTERS							
99.20 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	626,451	1.75	333,321	2.04	959,772	2.68	101
190 SPECIAL PURPOSE COST CENTERS							
190 NONREIMBURSABLE COST CENTERS							
190 GIFT, FLOWER, COFFEE SHOP & CAN	69,216	0.19	61,989	0.38	131,205	0.37	190
192 PHYSICIANS' PRIVATE OFFICES	116,274	0.32	345,576	2.11	461,850	1.29	192
192.01 DIALYSIS							192.01
192.03 ORTHO CLINIC	11,152	0.03	91,193	0.56	102,345	0.29	192.03
200 CROSS FOOT ADJUSTMENTS							200
201 NEGATIVE COST CENTER							201
202 TOTAL	35,793,295	100.00			35,793,295	100.00	202

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	TOTAL	RATIO	INPATIENT	MEDICARE		
	RELATED		CAPITAL				PROGRAM
	COSTS	CHARGES	COST TO	CHARGES	PPS CAPITAL		
	1	2	CHARGES	4	COSTS	5	
			3				
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	210,330	1,704,840	0.123372	141,819	17,496	50
53	ANESTHESIOLOGY	12,823	1,636,087	0.007838	142,978	1,121	53
54	RADIOLOGY-DIAGNOSTIC	107,088	3,157,090	0.033920	260,085	8,822	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	20,891	12,115,157	0.001724	874,469	1,508	57
60	LABORATORY	123,256	16,208,765	0.007604	2,110,213	16,046	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	3,368	2,263,713	0.001488	182,818	272	64
65	RESPIRATORY THERAPY	58,066	3,234,359	0.017953	1,012,362	18,175	65
66	PHYSICAL THERAPY	84,091	3,030,615	0.027747	232,309	6,446	66
69	ELECTROCARDIOLOGY	29,650	934,604	0.031725	144,779	4,593	69
71	MEDICAL SUPPLIES CHRGED TO PATI	29,620	3,772,969	0.007851	1,186,257	9,313	71
72	IMPL. DEV. CHARGED TO PATIENT	4,239	291,378	0.014548	6,544	95	72
73	DRUGS CHARGED TO PATIENTS	131,863	11,251,736	0.011719	1,178,752	13,814	73
75	ASC (NON-DISTINCT PART)	97,508	2,826,484	0.034498	170,043	5,866	75
76	NUCLEAR MEDICINE	64,243	1,386,018	0.046351	31,442	1,457	76
76.01	ULTRASOUND	54,463	2,139,880	0.025451	203,446	5,178	76.01
76.02	MAMMOGRAPHY	69,458	584,169	0.118901			76.02
76.03	CARDIAC REHABILITATION	10,711	262,704	0.040772	1,157	47	76.03
76.04	FAITH CENTER CHEMOTHERAPY	15,372	247,233	0.062176	39	2	76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	RURAL HEALTH CLINIC (RHC)	42,801	1,910,452	0.022404			88
88.01	RHC II	5,776	162,569	0.035530			88.01
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	64,066	7,341,578	0.008726	460,969	4,022	91
92	OBSERVATION BEDS	114,025	5,956,525	0.019143	891,203	17,060	92
93	DAY PSYCHIATRIC	31,288	781,786	0.040021			93
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL	1,384,996	83,200,711		9,231,684	131,333	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	273,097	2,142	270,955	5,511	49.17	2,430	119,483 30
200	TOTAL	273,097	2,142	270,955	5,511		2,430	119,483 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								119,483
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								131,333
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								250,816
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								785
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								2,430
PER DISCHARGE CAPITAL COSTS								319.51
PER DIEM CAPITAL COSTS								103.22

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)	4,901,153
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	11,241,410
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.436

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))	1,906,576
2. TOTAL MEDICARE CHARGES (WKST D-3 LINE 40 COLUMN 2 PLUS WKST D-3 LINE 202 COLUMN 2) (SEE CR 5619)	3,796,904
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.502

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)	250,816
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.022

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)	6,414,436
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)	21,129,611
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.304