

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: _____ TIME: _____
 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 LAKEVIEW SPECIALTY HOSPITAL & REHAB (52-2005) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2012 AND ENDING 12/31/2012, 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.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		188,885	17		3,434,611	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		188,885	17		3,434,611	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: 1701 SHARP ROAD
 2 CITY: WATERFORD

STATE: WI

P.O.BOX:
 ZIP CODE: 53185

COUNTY: RACINE

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	LAKEVIEW SPECIALTY HOSPITAL &	52-2005	39540	2	10/01/1996	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC	CBRF/CCI UNIT	-							11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2012			TO: 12/31/2012					20
21	TYPE OF CONTROL				4					21

INPATIENT PPS INFORMATION

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

		IN-STATE		OUT-OF-STATE		OUT-OF-STATE		MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6		
		MEDICAID PAID DAYS 1	ELIGIBLE UNPAID DAYS 2	MEDICAID PAID DAYS 3	ELIGIBLE UNPAID DAYS 4	MEDICAID ELIGIBLE DAYS 5	MEDICAID DAYS 6				
24	IF THIS PROVIDER IS AN IPHS 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.									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.					1				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.					1				27	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.									35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					BEGINNING:		ENDING:		36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.									37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					BEGINNING:		ENDING:		38	
39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)									1	2
										N	N 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	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
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	
1	2	3	4	5	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTES NONPROVIDER SITE 3	UNWEIGHTED FTES IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5		
INPATIENT PSYCHIATRIC FACILITY PPS						
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.				N	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.					71
INPATIENT REHABILITATION FACILITY PPS						
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.				N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.					76
LONG TERM CARE HOSPITAL PPS						
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.				Y	80
TEFRA PROVIDERS						
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.				N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.				N	86
TITLE V AND XIX INPATIENT SERVICES						
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.				N	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	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	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				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	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					97
RURAL PROVIDERS						
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?				N	105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.					106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.					107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.				N	108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- SICAL	OCCUP- ATIONAL	RESPI- RATORY	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 15-18 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.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 100,060 PAID LOSSES: 50,578 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.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 Y	2 309000	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: LAKEVIEW MANAGEMENT INC. CONTRACTOR'S NAME: WPS CONTRACTOR'S NUMBER: 52280			141
142	STREET: P.O. BOX P.O. BOX: 462			142
143	CITY: FREEDOM STATE: NH ZIP CODE: 03836			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.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

	TITLE XVIII		TITLE	TITLE
	PART A	PART B	V	XIX
	1	2	3	4
155	HOSPITAL	N	N	N 155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

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

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

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

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

168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),
ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168

169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH
(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1	2	1	
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N			
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1	2		
6	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.			N 15	
PS&R REPORT DATA		PART A		PART B	
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/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	05/14/2013	Y	05/14/2013
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- 41 FIRST NAME: THOMAS LAST NAME: STITT TITLE: VICE PRESIDENT, FINA 41
- 42 EMPLOYER: HEALTH DIMENSIONS GROUP 42
- 43 PHONE NUMBER: 763-225-8639 E-MAIL ADDRESS: TOMS@HGDG1.COM 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	TOTAL SALARIES (SEE INSTRUCTIONS)	200			583,918.00	1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A ADMINISTRATIVE					4
4.01	PHYSICIAN-PART A - TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)					7.01
8	HOME OFFICE PERSONNEL					8
9	SNF	44				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	3,021,039	127,437		209,028.00	10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)	214,805			4,924.00	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE					15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING WAGE-RELATED COSTS					16
17	WAGE-RELATED COSTS (CORE)	2,178,131	-30,045			17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS	712,239	30,045			19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A - ADMINISTRATIVE					22
22.01	PHYSICIAN PART A - TEACHING					22.01
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM) OVERHEAD COSTS - DIRECT SALARIES					25
26	EMPLOYEE BENEFITS	191,318			8,756.00	26
27	ADMINISTRATIVE & GENERAL	2,084,213	-452,069		44,609.00	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS	326,088	44,884		18,393.00	29
30	OPERATION OF PLANT					30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING	199,086	14,961		20,543.00	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY	406,096			28,585.00	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA					36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION					38
39	CENTRAL SERVICES AND SUPPLY	70,561			4,100.00	39
40	PHARMACY	417,203			12,954.00	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	74,916			4,962.00	41
42	SOCIAL SERVICE	991			80.00	42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	12,259,820		12,259,820	583,918.00	21.00	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	3,021,039	127,437	3,148,476	209,028.00	15.06	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	9,238,781	-127,437	9,111,344	374,890.00	24.30	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	214,805		214,805	4,924.00	43.62	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	2,178,131	-30,045	2,148,086		23.58%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	11,631,717	-157,482	11,474,235	379,814.00	30.21	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,770,472	-392,224	3,378,248	142,982.00	23.63	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
RETIREMENT COST			
1	401K EMPLOYER CONTRIBUTIONS	65,318	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)			
5	401K/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST			
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	649,030	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	1,164	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11,131	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	130	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	1,083,752	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	837,175	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	238,071	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	4,600	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,890,371	24
PART B - OTHER THAN CORE RELATED COST			
25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT	
0		LABOR	COST	
		1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	214,805	2,148,086	1
2	HOSPITAL	214,805	2,148,086	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
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		1,670,347	1,670,347	-74,249	1
2	00200				150,926	2
3	00300					3
4	00400	191,318	1,910,086	2,101,404	-2,874	4
5.01	00590	1,498,991	2,273,040	3,772,031	-364,025	5.01
5.02	00570	147,528	14,811	160,339	-78,336	5.02
5.03	00580	437,694	1,622,997	2,060,691	-127,497	5.03
6	00600	326,088	582,943	909,031	48,924	6
7	00700					7
8	00800		79,678	79,678		8
9	00900	199,086	77,021	276,107	15,570	9
10	01000	406,096	414,998	821,094	-372	10
11	01100					11
12	01200					12
13	01300					13
14	01400	70,561	460,484	531,045	-436,608	14
15	01500	417,203	1,129,727	1,546,930	-166	15
16	01600	74,916	56,264	131,180		16
17	01700	991	123	1,114		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	4,200,036	2,113,222	6,313,258	95,257	30
31.01	03101					31.01
46	04600	2,582,693	763,744	3,346,437	112,170	46
ANCILLARY SERVICE COST CENTERS						
54	05400		78,445	78,445	18,327	54
60	06000		143,702	143,702	11,070	60
62.30	06250					62.30
65	06500	386,581	193,277	579,858	-64,846	65
66	06600				321,888	66
67	06700	881,692	110,006	991,698	-634,055	67
68	06800				305,656	68
71	07100				612,952	71
73	07300				6,315	73
74	07400				76,123	74
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	196,410	36,968	233,378	-2,883	95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
118		12,017,884	13,729,883	25,747,767	-10,733	118
NONREIMBURSABLE COST CENTERS						
192	19200	241,936	34,764	276,700	10,733	192
194	07950					194
200		12,259,820	13,764,647	26,024,467		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	1,596,098	19,050	1,615,148	1
2	00200	150,926	9,136	160,062	2
3	00300				3
4	00400	2,098,530		2,098,530	4
5.01	00590	3,408,006	-574,215	2,833,791	5.01
5.02	00570	82,003	-41,278	40,725	5.02
5.03	00580	1,933,194	-1,130,000	803,194	5.03
6	00600	957,955		957,955	6
7	00700				7
8	00800	79,678		79,678	8
9	00900	291,677		291,677	9
10	01000	820,722	-58,588	762,134	10
11	01100				11
12	01200				12
13	01300				13
14	01400	94,437		94,437	14
15	01500	1,546,764		1,546,764	15
16	01600	131,180	-3,206	127,974	16
17	01700	1,114		1,114	17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	6,408,515	-918,604	5,489,911	30
31.01	03101				31.01
46	04600	3,458,607		3,458,607	46
ANCILLARY SERVICE COST CENTERS					
54	05400	96,772		96,772	54
60	06000	154,772		154,772	60
62.30	06250				62.30
65	06500	515,012		515,012	65
66	06600	321,888		321,888	66
67	06700	357,643		357,643	67
68	06800	305,656		305,656	68
71	07100	612,952		612,952	71
73	07300	6,315		6,315	73
74	07400	76,123		76,123	74
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
95	09500	230,495		230,495	95
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
SPECIAL PURPOSE COST CENTERS					
118		25,737,034	-2,697,705	23,039,329	118
NONREIMBURSABLE COST CENTERS					
192	19200	287,433		287,433	192
194	07950				194
200		26,024,467	-2,697,705	23,326,762	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 EQUIPMENT DEPRECIATION	A	CAP REL COSTS-MVBLE EQUIP	2			150,926 1
500 TOTAL RECLASSIFICATIONS						150,926 500
CODE LETTER - A						
1 CHARGEABLE MED SUPPLIES	B	MEDICAL SUPPLIES CHRGED TO PA	71			609,204 1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
500 TOTAL RECLASSIFICATIONS						609,204 500
CODE LETTER - B						
1 INSURANCE	C	CAP REL COSTS-BLDG & FIXT	1			76,677 1
500 TOTAL RECLASSIFICATIONS						76,677 500
CODE LETTER - C						
1 OUTPATIENT SALARIES	D	PHYSICAL THERAPY	66		295,810	25,263 1
2		SPEECH PATHOLOGY	68		280,178	23,928 2
500 TOTAL RECLASSIFICATIONS					575,988	49,191 500
CODE LETTER - D						
1 PURCHASED SERVICES	E	RADIOLOGY-DIAGNOSTIC	54			18,327 1
2		LABORATORY	60			10,077 2
3		RESPIRATORY THERAPY	65			4,687 3
4		PHYSICAL THERAPY	66			815 4
5		OCCUPATIONAL THERAPY	67			781 5
6		SPEECH PATHOLOGY	68			1,550 6
7		MEDICAL SUPPLIES CHRGED TO PA	71			3,748 7
8		DRUGS CHARGED TO PATIENTS	73			6,315 8
9		RENAL DIALYSIS	74			76,123 9
500 TOTAL RECLASSIFICATIONS						122,423 500
CODE LETTER - E						
1 CLINIC MEDICAL DIRECTOR	F	PHYSICIANS' PRIVATE OFFICES	192		12,480	987 1
500 TOTAL RECLASSIFICATIONS					12,480	987 500
CODE LETTER - F						
1 LAB	G	LABORATORY	60			2,874 1
500 TOTAL RECLASSIFICATIONS						2,874 500
CODE LETTER - G						
1 HOSPITAL SPECIFIC SALARY & BENEFITS	H	ADULTS & PEDIATRICS	30		277,267	25,358 1
2						2
3						3
500 TOTAL RECLASSIFICATIONS					277,267	25,358 500
CODE LETTER - H						
1 RCC ADMINISTRATOR	I	OTHER LONG TERM CARE	46		114,957	10,346 1
500 TOTAL RECLASSIFICATIONS					114,957	10,346 500
CODE LETTER - I						
1 EOC DIRECTOR	J	MAINTENANCE & REPAIRS	6		44,884	4,040 1
2		HOUSEKEEPING	9		14,961	1,347 2
500 TOTAL RECLASSIFICATIONS					59,845	5,387 500
CODE LETTER - J						
GRAND TOTAL (INCREASES)					1,040,537	1,053,373

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 EQUIPMENT DEPRECIATION	A	CAP REL COSTS-BLDG & FIXT	1		150,926		9 1
500 TOTAL RECLASSIFICATIONS					150,926		500
CODE LETTER - A							
1 CHARGEABLE MED SUPPLIES	B	ADMINISTRATIVE & GENERAL	5.01			8	1
2		BUSINESS OFFICE	5.03			13	2
3		HOUSEKEEPING	9			738	3
4		DIETARY	10			372	4
5		CENTRAL SERVICES & SUPPLY	14			436,608	5
6		PHARMACY	15			166	6
7		ADULTS & PEDIATRICS	30			71,478	7
8		OTHER LONG TERM CARE	46			13,133	8
9		LABORATORY	60			1,881	9
10		RESPIRATORY THERAPY	65			69,533	10
11		OCCUPATIONAL THERAPY	67			9,657	11
12		AMBULANCE SERVICES	95			2,883	12
13		PHYSICIANS' PRIVATE OFFICES	192			2,734	13
500 TOTAL RECLASSIFICATIONS						609,204	500
CODE LETTER - B							
1 INSURANCE	C	BUSINESS OFFICE	5.03			76,677	12 1
500 TOTAL RECLASSIFICATIONS						76,677	500
CODE LETTER - C							
1 OUTPATIENT SALARIES	D	OCCUPATIONAL THERAPY	67		575,988	49,191	1
2							2
500 TOTAL RECLASSIFICATIONS					575,988	49,191	500
CODE LETTER - D							
1 PURCHASED SERVICES	E	ADULTS & PEDIATRICS	30			122,423	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500 TOTAL RECLASSIFICATIONS						122,423	500
CODE LETTER - E							
1 CLINIC MEDICAL DIRECTOR	F	ADULTS & PEDIATRICS	30		12,480	987	1
500 TOTAL RECLASSIFICATIONS					12,480	987	500
CODE LETTER - F							
1 LAB	G	EMPLOYEE BENEFITS	4			2,874	1
500 TOTAL RECLASSIFICATIONS						2,874	500
CODE LETTER - G							
1 HOSPITAL SPECIFIC SALARY & BENEFITS	H	ADMITTING	5.02		71,497	6,839	1
2		ADMINISTRATIVE & GENERAL	5.01		159,158	14,324	2
3		BUSINESS OFFICE	5.03		46,612	4,195	3
500 TOTAL RECLASSIFICATIONS					277,267	25,358	500
CODE LETTER - H							
1 RCC ADMINISTRATOR	I	ADMINISTRATIVE & GENERAL	5.01		114,957	10,346	1
500 TOTAL RECLASSIFICATIONS					114,957	10,346	500
CODE LETTER - I							
1 EOC DIRECTOR	J	ADMINISTRATIVE & GENERAL	5.01		59,845	5,387	1
2							2
500 TOTAL RECLASSIFICATIONS					59,845	5,387	500
CODE LETTER - J							
GRAND TOTAL (DECREASES)					1,040,537	1,053,373	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS	633,055	6,300		6,300		639,355		4
5 FIXED EQUIPMENT	249,036	15,935		15,935		264,971		5
6 MOVABLE EQUIPMENT	971,772	181,301		181,301		1,153,073		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	1,853,863	203,536		203,536		2,057,399		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	1,853,863	203,536		203,536		2,057,399		10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	208,092	1,335,696			126,559		1,670,347
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	208,092	1,335,696			126,559		1,670,347

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	639,355		639,355	0.310759				1
2 CAP REL COSTS-MVBLE EQUIP	1,418,044		1,418,044	0.689241				2
3 TOTAL (SUM OF LINES 1-2)	2,057,399		2,057,399	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	76,216	1,335,696		76,677	126,559		1,615,148
2 CAP REL COSTS-MVBLE EQUIP	160,062						160,062
3 TOTAL	236,278	1,335,696		76,677	126,559		1,775,210

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-471,861			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-900,027			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-47,411	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	-3,206	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES	B	-11,177	DIETARY	10	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)	B	-5,420	BUSINESS OFFICE	5.03	21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 MISCELLANEOUS INCOME	B	-9,173	ADMINISTRATIVE & GENERAL	5.01	33
34 RENTAL INCOME	B	-7,424	ADMINISTRATIVE & GENERAL	5.01	34
35 MARKET INCOME	B	-8,244	ADMINISTRATIVE & GENERAL	5.01	35
36 MEDICAL DIRECTOR PART B OTHER COST	A	-9,945	ADULTS & PEDIATRICS	30	36
37 PATIENT REFERRAL SERVICES	A	-41,278	ADMITTING	5.02	37
38 INCOME TAX	A	378,839	ADMINISTRATIVE & GENERAL	5.01	38
39 HOSPITAL ASSESSMENT	A	-208,127	ADULTS & PEDIATRICS	30	39
40 RELATED PARTY INTEREST	A	-1,124,580	BUSINESS OFFICE	5.03	40
41 PATIENT REFERRAL SERVICES	A	-50,392	ADULTS & PEDIATRICS	30	41
42 BUSINESS DEVELOPMENT	A	-178,279	ADULTS & PEDIATRICS	30	42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,697,705			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. 1	COST CENTER 2	EXPENSE ITEMS 3	AMOUNT OF ALLOWABLE COST 4	AMOUNT (INCL IN WKST A, COL. 5) 5	NET ADJ- USTMENTS (COL. 4-5) 6	WKST A-7 REF 7
1	5.01	ADMINISTRATIVE & GENERAL	2,247,055	3,175,268	-928,213	1
2	2	CAP REL COSTS-MVBLE EQUIP	9,136		9,136	9 2
3	1	CAP REL COSTS-BLDG & FIXT	19,050		19,050	9 3
4						4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.	2,275,241	3,175,268	-900,027	5

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

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

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

SYMBOL (1) 1	NAME 2	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
		PERCENT OF OWNERSHIP 3	NAME 4	PERCENT OF OWNERSHIP 5	TYPE OF BUSINESS 6
B			LAKEVIEW MANAGEMENT INC.		

- (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	LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
	1	2	3	4	5	6	7	8	9
	1	30 ADULTS & PEDIATRICS	MEDICAL DIRECTO	125,736	125,736				1
	2	30 ADULTS & PEDIATRICS	AGGREGATE	346,125	346,125				2
	200	TOTAL		471,861	471,861				200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION	CAP	CAP	EMPLOYEE	SUBTOTAL	
	(FROM WKST A, COL.7) 0	BLDGS + FIXTURES 1	MOVABLE EQUIPMENT 2	BENEFITS 4		
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,615,148	1,615,148				1
2 CAP REL COSTS-MVBLE EQUIP	160,062		160,062			2
4 EMPLOYEE BENEFITS	2,098,530	10,805		2,109,335		4
5.01 ADMINISTRATIVE & GENERAL	2,833,791	494,597	67,482	216,867	3,612,737	5.01
5.02 ADMITTING	40,725	13,921		14,153	68,799	5.02
5.03 BUSINESS OFFICE	803,194	27,780	262	72,799	904,035	5.03
6 MAINTENANCE & REPAIRS	957,955	204,375	9,777	69,055	1,241,162	6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	79,678	29,915	370		109,963	8
9 HOUSEKEEPING	291,677	25,411		39,844	356,932	9
10 DIETARY	762,134	95,683	5,097	75,594	938,508	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY	94,437	3,463		13,135	111,035	14
15 PHARMACY	1,546,764	11,708		77,661	1,636,133	15
16 MEDICAL RECORDS & LIBRARY	127,974	11,621		13,945	153,540	16
17 SOCIAL SERVICE	1,114			184	1,298	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	5,489,911	157,536	40,772	755,026	6,443,245	30
31.01 INTENSIVE CARE UNIT						31.01
46 OTHER LONG TERM CARE	3,458,607	351,253	13,833	441,067	4,264,760	46
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	96,772		456		97,228	54
60 LABORATORY	154,772	5,155	6,687		166,614	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	515,012	5,659	2,314	71,961	594,946	65
66 PHYSICAL THERAPY	321,888	50,831	538	55,064	428,321	66
67 OCCUPATIONAL THERAPY	357,643	64,691		56,906	479,240	67
68 SPEECH PATHOLOGY	305,656	5,797		52,154	363,607	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	612,952				612,952	71
73 DRUGS CHARGED TO PATIENTS	6,315		2,179		8,494	73
74 RENAL DIALYSIS	76,123	4,053			80,176	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	230,495	2,760		36,561	269,816	95
99.10 CORF						99.10
99.20 OPT						99.20
99.30 CMHC						99.30
99.40 OPT						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	23,039,329	1,577,014	149,767	2,061,976	22,943,541	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	287,433	38,134	10,295	47,359	383,221	192
194 EDUCATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	23,326,762	1,615,148	160,062	2,109,335	23,326,762	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5.01	ADMITTING 5.02	BUSINESS O FFICE 5.03	MAIN- TENANCE & REPAIRS 6	LAUNDRY & LINEN SERVICE 8	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & GENERAL	3,612,737					5.01
5.02 ADMITTING	12,608	81,407				5.02
5.03 BUSINESS OFFICE	165,671		1,069,706			5.03
6 MAINTENANCE & REPAIRS	227,452			1,468,614		6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	20,151			50,869	180,983	8
9 HOUSEKEEPING	65,410			43,210		9
10 DIETARY	171,988			162,702	801	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY	20,348			5,888		14
15 PHARMACY	299,833			19,908		15
16 MEDICAL RECORDS & LIBRARY	28,137			19,760		16
17 SOCIAL SERVICE	238					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,180,772	21,578	275,836	267,879	121,436	30
31.01 INTENSIVE CARE UNIT						31.01
46 OTHER LONG TERM CARE	781,547	22,918	293,254	597,284	58,626	46
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	17,818	219	2,799			54
60 LABORATORY	30,533	2,003	25,606	8,766		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	109,028	6,647	84,968	9,622		65
66 PHYSICAL THERAPY	78,493	2,708	34,612	86,435	120	66
67 OCCUPATIONAL THERAPY	87,824	2,829	36,164	110,003		67
68 SPEECH PATHOLOGY	66,634	2,015	25,756	9,858		68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	112,328	10,908	139,438			71
73 DRUGS CHARGED TO PATIENTS	1,557	9,353	119,559			73
74 RENAL DIALYSIS	14,693	229	2,931	6,892		74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	49,446		6,670	4,693		95
99.10 CORF						99.10
99.20 OPT						99.20
99.30 CMHC						99.30
99.40 OPT						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	3,542,509	81,407	1,047,593	1,403,769	180,983	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	70,228		22,113	64,845		192
194 EDUCATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	3,612,737	81,407	1,069,706	1,468,614	180,983	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	9	10	14	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & GENERAL						5.01
5.02 ADMITTING						5.02
5.03 BUSINESS OFFICE						5.03
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	465,552					9
10 DIETARY	55,107	1,329,106				10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY	1,994		139,265			14
15 PHARMACY	6,743			1,962,617		15
16 MEDICAL RECORDS & LIBRARY	6,693				208,130	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	90,730	542,326			69,180	30
31.01 INTENSIVE CARE UNIT						31.01
46 OTHER LONG TERM CARE	202,299	786,780			20,625	46
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC					702	54
60 LABORATORY	2,969				6,421	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,259				21,308	65
66 PHYSICAL THERAPY	29,275				8,680	66
67 OCCUPATIONAL THERAPY	37,258				9,069	67
68 SPEECH PATHOLOGY	3,339				6,459	68
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			139,265		34,968	71
73 DRUGS CHARGED TO PATIENTS				1,962,617	29,983	73
74 RENAL DIALYSIS	2,334				735	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,589					95
99.10 CORF						99.10
99.20 OPT						99.20
99.30 CMHC						99.30
99.40 OPT						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	443,589	1,329,106	139,265	1,962,617	208,130	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	21,963					192
194 EDUCATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	465,552	1,329,106	139,265	1,962,617	208,130	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 ADMINISTRATIVE & GENERAL					5.01
5.02 ADMITTING					5.02
5.03 BUSINESS OFFICE					5.03
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	1,536				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	627	9,013,609		9,013,609	30
31.01 INTENSIVE CARE UNIT					31.01
46 OTHER LONG TERM CARE	909	7,029,002		7,029,002	46
ANCILLARY SERVICE COST CENTERS					
54 RADIOLOGY-DIAGNOSTIC		118,766		118,766	54
60 LABORATORY		242,912		242,912	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		829,778		829,778	65
66 PHYSICAL THERAPY		668,644		668,644	66
67 OCCUPATIONAL THERAPY		762,387		762,387	67
68 SPEECH PATHOLOGY		477,668		477,668	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		1,049,859		1,049,859	71
73 DRUGS CHARGED TO PATIENTS		2,131,563		2,131,563	73
74 RENAL DIALYSIS		107,990		107,990	74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		332,214		332,214	95
99.10 CORF					99.10
99.20 OPT					99.20
99.30 CMHC					99.30
99.40 OPT					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	1,536	22,764,392		22,764,392	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES		562,370		562,370	192
194 EDUCATION					194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	1,536	23,326,762		23,326,762	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS + FIXTURES	MOVABLE EQUIPMENT		BENEFITS	
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4		10,805		10,805	10,805	4
5.01		494,597	67,482	562,079	1,111	5.01
5.02		13,921		13,921	73	5.02
5.03		27,780	262	28,042	373	5.03
6		204,375	9,777	214,152	354	6
7						7
8		29,915	370	30,285		8
9		25,411		25,411	204	9
10		95,683	5,097	100,780	387	10
11						11
12						12
13						13
14		3,463		3,463	67	14
15		11,708		11,708	398	15
16		11,621		11,621	71	16
17					1	17
19						19
20						20
21						21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	157,671	157,536	40,772	355,979	3,866	30
31.01						31.01
46	4,337	351,253	13,833	369,423	2,260	46
ANCILLARY SERVICE COST CENTERS						
54			456	456		54
60	799	5,155	6,687	12,641		60
62.30						62.30
65	13,646	5,659	2,314	21,619	369	65
66		50,831	538	51,369	282	66
67	1,747	64,691		66,438	292	67
68		5,797		5,797	267	68
71						71
73			2,179	2,179		73
74		4,053		4,053		74
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
92						92
OTHER REIMBURSABLE COST CENTERS						
95	2,730	2,760		5,490	187	95
99.10						99.10
99.20						99.20
99.30						99.30
99.40						99.40
SPECIAL PURPOSE COST CENTERS						
118	180,930	1,577,014	149,767	1,907,711	10,562	118
NONREIMBURSABLE COST CENTERS						
192	1,892	38,134	10,295	50,321	243	192
194						194
200						200
201						201
202	182,822	1,615,148	160,062	1,958,032	10,805	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5.01	ADMITTING 5.02	BUSINESS O FFICE 5.03	MAIN- TENANCE & REPAIRS 6	LAUNDRY & LINEN SERVICE 8	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & GENERAL	563,190					5.01
5.02 ADMITTING	1,965	15,959				5.02
5.03 BUSINESS OFFICE	25,826		54,241			5.03
6 MAINTENANCE & REPAIRS	35,458			249,964		6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	3,141			8,658	42,084	8
9 HOUSEKEEPING	10,197			7,355		9
10 DIETARY	26,811			27,693	186	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY	3,172			1,002		14
15 PHARMACY	46,741			3,388		15
16 MEDICAL RECORDS & LIBRARY	4,386			3,363		16
17 SOCIAL SERVICE	37					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	184,071	4,228	13,985	45,594	28,238	30
31.01 INTENSIVE CARE UNIT						31.01
46 OTHER LONG TERM CARE	121,836	4,499	14,874	101,659	13,632	46
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	2,778	43	142			54
60 LABORATORY	4,760	392	1,298	1,492		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	16,996	1,302	4,308	1,638		65
66 PHYSICAL THERAPY	12,236	531	1,755	14,712	28	66
67 OCCUPATIONAL THERAPY	13,691	554	1,834	18,723		67
68 SPEECH PATHOLOGY	10,388	395	1,306	1,678		68
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	17,511	2,137	7,069			71
73 DRUGS CHARGED TO PATIENTS	243	1,833	6,062			73
74 RENAL DIALYSIS	2,290	45	149	1,173		74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	7,708		338	799		95
99.10 CORF						99.10
99.20 OPT						99.20
99.30 CMHC						99.30
99.40 OPT						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	552,242	15,959	53,120	238,927	42,084	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	10,948		1,121	11,037		192
194 EDUCATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	563,190	15,959	54,241	249,964	42,084	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	9	10	14	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & GENERAL						5.01
5.02 ADMITTING						5.02
5.03 BUSINESS OFFICE						5.03
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	43,167					9
10 DIETARY	5,110	160,967				10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY	185		7,889			14
15 PHARMACY	625			62,860		15
16 MEDICAL RECORDS & LIBRARY	621				20,062	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	8,413	65,681			6,655	30
31.01 INTENSIVE CARE UNIT						31.01
46 OTHER LONG TERM CARE	18,758	95,286			1,990	46
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC					68	54
60 LABORATORY	275				620	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	302				2,056	65
66 PHYSICAL THERAPY	2,714				837	66
67 OCCUPATIONAL THERAPY	3,455				875	67
68 SPEECH PATHOLOGY	310				623	68
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			7,889		3,374	71
73 DRUGS CHARGED TO PATIENTS				62,860	2,893	73
74 RENAL DIALYSIS	216				71	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	147					95
99.10 CORF						99.10
99.20 OPT						99.20
99.30 CMHC						99.30
99.40 OPT						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	41,131	160,967	7,889	62,860	20,062	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	2,036					192
194 EDUCATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	43,167	160,967	7,889	62,860	20,062	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 ADMINISTRATIVE & GENERAL					5.01
5.02 ADMITTING					5.02
5.03 BUSINESS OFFICE					5.03
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	38				17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	16	716,726		716,726	30
31.01 INTENSIVE CARE UNIT					31.01
46 OTHER LONG TERM CARE	22	744,239		744,239	46
ANCILLARY SERVICE COST CENTERS					
54 RADIOLOGY-DIAGNOSTIC		3,487		3,487	54
60 LABORATORY		21,478		21,478	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		48,590		48,590	65
66 PHYSICAL THERAPY		84,464		84,464	66
67 OCCUPATIONAL THERAPY		105,862		105,862	67
68 SPEECH PATHOLOGY		20,764		20,764	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		37,980		37,980	71
73 DRUGS CHARGED TO PATIENTS		76,070		76,070	73
74 RENAL DIALYSIS		7,997		7,997	74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		14,669		14,669	95
99.10 CORF					99.10
99.20 OPT					99.20
99.30 CMHC					99.30
99.40 OPT					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	38	1,882,326		1,882,326	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES		75,706		75,706	192
194 EDUCATION					194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	38	1,958,032		1,958,032	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS + FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT EQUIPMENT COST	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A.01	5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	186,105					1
2 CAP REL COSTS-MVBLE EQUIP		1,418,044				2
4 EMPLOYEE BENEFITS	1,245		11,331,557			4
5.01 ADMINISTRATIVE & GENERAL	56,990	597,850	1,165,030	-3,612,737	19,714,025	5.01
5.02 ADMITTING	1,604		76,031		68,799	5.02
5.03 BUSINESS OFFICE	3,201	2,318	391,082		904,035	5.03
6 MAINTENANCE & REPAIRS	23,549	86,615	370,972		1,241,162	6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE	3,447	3,274			109,963	8
9 HOUSEKEEPING	2,928		214,047		356,932	9
10 DIETARY	11,025	45,159	406,096		938,508	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY	399		70,561		111,035	14
15 PHARMACY	1,349		417,203		1,636,133	15
16 MEDICAL RECORDS & LIBRARY	1,339		74,916		153,540	16
17 SOCIAL SERVICE			991		1,298	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	18,152	361,216	4,056,075		6,443,245	30
31.01 INTENSIVE CARE UNIT						31.01
46 OTHER LONG TERM CARE	40,473	122,554	2,369,454		4,264,760	46
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC		4,042			97,228	54
60 LABORATORY	594	59,244			166,614	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	652	20,500	386,581		594,946	65
66 PHYSICAL THERAPY	5,857	4,763	295,810		428,321	66
67 OCCUPATIONAL THERAPY	7,454		305,704		479,240	67
68 SPEECH PATHOLOGY	668		280,178		363,607	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					612,952	71
73 DRUGS CHARGED TO PATIENTS		19,301			8,494	73
74 RENAL DIALYSIS	467				80,176	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	318		196,410		269,816	95
99.10 CORF						99.10
99.20 OPT						99.20
99.30 CMHC						99.30
99.40 OPT						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	181,711	1,326,836	11,077,141	-3,612,737	19,330,804	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	4,394	91,208	254,416		383,221	192
194 EDUCATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,615,148	160,062	2,109,335		3,612,737	202
203 UNIT COST MULT-WS B PT I	8.678692	0.112875	0.186147		0.183257	203
204 COST TO BE ALLOC PER B PT II			10,805		563,190	204
205 UNIT COST MULT-WS B PT II			0.000954		0.028568	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	ADMITTING	BUSINESS O	MAIN-	LAUNDRY	HOUSE-	
	GROSS	FFICE	TENANCE &	& LINEN	KEEPING	
	REVENUE	GROSS	REPAIRS	SERVICE	SQUARE	
	5.02	REVENUE	SQUARE	LAUNDRY	FEET	
		5.03	FEET	POUNDS	9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & GENERAL						5.01
5.02 ADMITTING	53,362,898					5.02
5.03 BUSINESS OFFICE		54,838,410				5.03
6 MAINTENANCE & REPAIRS			99,516			6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE			3,447	221,937		8
9 HOUSEKEEPING			2,928		93,141	9
10 DIETARY			11,025	982	11,025	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY			399		399	14
15 PHARMACY			1,349		1,349	15
16 MEDICAL RECORDS & LIBRARY			1,339		1,339	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	14,140,365	14,140,365	18,152	148,916	18,152	30
31.01 INTENSIVE CARE UNIT						31.01
46 OTHER LONG TERM CARE	15,034,735	15,034,735	40,473	71,892	40,473	46
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	143,477	143,477				54
60 LABORATORY	1,312,644	1,312,644	594		594	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	4,355,752	4,355,752	652		652	65
66 PHYSICAL THERAPY	1,774,331	1,774,331	5,857	147	5,857	66
67 OCCUPATIONAL THERAPY	1,853,897	1,853,897	7,454		7,454	67
68 SPEECH PATHOLOGY	1,320,351	1,320,351	668		668	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	7,148,082	7,148,082				71
73 DRUGS CHARGED TO PATIENTS	6,129,031	6,129,031				73
74 RENAL DIALYSIS	150,233	150,233	467		467	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		341,942	318		318	95
99.10 CORF						99.10
99.20 OPT						99.20
99.30 CMHC						99.30
99.40 OPT						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	53,362,898	53,704,840	95,122	221,937	88,747	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		1,133,570	4,394		4,394	192
194 EDUCATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	81,407	1,069,706	1,468,614	180,983	465,552	202
203 UNIT COST MULT-WS B PT I	0.001526	0.019507	14.757567	0.815470	4.998357	203
204 COST TO BE ALLOC PER B PT II	15,959	54,241	249,964	42,084	43,167	204
205 UNIT COST MULT-WS B PT II	0.000299	0.000989	2.511797	0.189621	0.463459	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	DIETARY	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	MEALS SERVED	COSTED REQUIS.	COSTED REQUIS.	GROSS REVENUE	MEALS SERVED	
	10	14	15	16	17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & GENERAL						5.01
5.02 ADMITTING						5.02
5.03 BUSINESS OFFICE						5.03
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	24,135					10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY		100				14
15 PHARMACY			100			15
16 MEDICAL RECORDS & LIBRARY				42,544,261		16
17 SOCIAL SERVICE					24,135	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	9,848			14,140,365	9,848	30
31.01 INTENSIVE CARE UNIT						31.01
46 OTHER LONG TERM CARE	14,287			4,216,098	14,287	46
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC				143,477		54
60 LABORATORY				1,312,644		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY				4,355,752		65
66 PHYSICAL THERAPY				1,774,331		66
67 OCCUPATIONAL THERAPY				1,853,897		67
68 SPEECH PATHOLOGY				1,320,351		68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		100		7,148,082		71
73 DRUGS CHARGED TO PATIENTS			100	6,129,031		73
74 RENAL DIALYSIS				150,233		74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
99.10 CORF						99.10
99.20 OPT						99.20
99.30 CMHC						99.30
99.40 OPT						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	24,135	100	100	42,544,261	24,135	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 EDUCATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,329,106	139,265	1,962,617	208,130	1,536	202
203 UNIT COST MULT-WS B PT I	55.069650	1,392.650000	19,626.170000	0.004892	0.063642	203
204 COST TO BE ALLOC PER B PT II	160,967	7,889	62,860	20,062	38	204
205 UNIT COST MULT-WS B PT II	6.669443	78.890000	628.600000	0.000472	0.001574	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

GENERAL SERVICE COST CENTERS	
1 CAP REL COSTS-BLDG & FIXT	1
2 CAP REL COSTS-MVBLE EQUIP	2
4 EMPLOYEE BENEFITS	4
5.01 ADMINISTRATIVE & GENERAL	5.01
5.02 ADMITTING	5.02
5.03 BUSINESS OFFICE	5.03
6 MAINTENANCE & REPAIRS	6
7 OPERATION OF PLANT	7
8 LAUNDRY & LINEN SERVICE	8
9 HOUSEKEEPING	9
10 DIETARY	10
11 CAFETERIA	11
12 MAINTENANCE OF PERSONNEL	12
13 NURSING ADMINISTRATION	13
14 CENTRAL SERVICES & SUPPLY	14
15 PHARMACY	15
16 MEDICAL RECORDS & LIBRARY	16
17 SOCIAL SERVICE	17
19 NONPHYSICIAN ANESTHETISTS	19
20 NURSING SCHOOL	20
21 I&R SRVCES-SALARY & FRINGES APPRVD	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23 PARAMED ED PRGM-(SPECIFY)	23
INPATIENT ROUTINE SERV COST CENTERS	
30 ADULTS & PEDIATRICS	30
31.01 INTENSIVE CARE UNIT	31.01
46 OTHER LONG TERM CARE	46
ANCILLARY SERVICE COST CENTERS	
54 RADIOLOGY-DIAGNOSTIC	54
60 LABORATORY	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65 RESPIRATORY THERAPY	65
66 PHYSICAL THERAPY	66
67 OCCUPATIONAL THERAPY	67
68 SPEECH PATHOLOGY	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	71
73 DRUGS CHARGED TO PATIENTS	73
74 RENAL DIALYSIS	74
76.97 CARDIAC REHABILITATION	76.97
76.98 HYPERBARIC OXYGEN THERAPY	76.98
76.99 LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS	
92 OBSERVATION BEDS	92
OTHER REIMBURSABLE COST CENTERS	
95 AMBULANCE SERVICES	95
99.10 CORF	99.10
99.20 OPT	99.20
99.30 CMHC	99.30
99.40 OPT	99.40
SPECIAL PURPOSE COST CENTERS	
118 SUBTOTALS (SUM OF LINES 1-117)	118
NONREIMBURSABLE COST CENTERS	
192 PHYSICIANS' PRIVATE OFFICES	192
194 EDUCATION	194
200 CROSS FOOT ADJUSTMENTS	200
201 NEGATIVE COST CENTER	201
202 COST TO BE ALLOC PER B PT I	202
203 UNIT COST MULT-WS B PT I	203
204 COST TO BE ALLOC PER B PT II	204
205 UNIT COST MULT-WS B PT II	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (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	9,013,609		9,013,609		9,013,609	30
31.01 INTENSIVE CARE UNIT						31.01
46 OTHER LONG TERM CARE	7,029,002		7,029,002		7,029,002	46
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	118,766		118,766		118,766	54
60 LABORATORY	242,912		242,912		242,912	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	829,778		829,778		829,778	65
66 PHYSICAL THERAPY	668,644		668,644		668,644	66
67 OCCUPATIONAL THERAPY	762,387		762,387		762,387	67
68 SPEECH PATHOLOGY	477,668		477,668		477,668	68
71 MEDICAL SUPPLIES CHRGED TO	1,049,859		1,049,859		1,049,859	71
73 DRUGS CHARGED TO PATIENTS	2,131,563		2,131,563		2,131,563	73
74 RENAL DIALYSIS	107,990		107,990		107,990	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	332,214		332,214		332,214	95
99.10 CORF						99.10
99.20 OPT						99.20
99.30 CMHC						99.30
99.40 OPT						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	22,764,392		22,764,392		22,764,392	200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	22,764,392		22,764,392		22,764,392	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	14,140,365		14,140,365			30
31.01 INTENSIVE CARE UNIT						31.01
46 OTHER LONG TERM CARE	15,034,735		15,034,735			46
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	135,817	7,660	143,477	0.827770	0.827770	0.827770 54
60 LABORATORY	1,176,237	136,407	1,312,644	0.185056	0.185056	0.185056 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	4,355,584	167	4,355,751	0.190502	0.190502	0.190502 65
66 PHYSICAL THERAPY	1,394,367	379,964	1,774,331	0.376843	0.376843	0.376843 66
67 OCCUPATIONAL THERAPY	1,612,472	241,425	1,853,897	0.411235	0.411235	0.411235 67
68 SPEECH PATHOLOGY	1,151,535	168,816	1,320,351	0.361773	0.361773	0.361773 68
71 MEDICAL SUPPLIES CHRGED TO	7,145,558	2,524	7,148,082	0.146873	0.146873	0.146873 71
73 DRUGS CHARGED TO PATIENTS	6,128,826	205	6,129,031	0.347781	0.347781	0.347781 73
74 RENAL DIALYSIS	150,233		150,233	0.718817	0.718817	0.718817 74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		341,942	341,942	0.971551	0.971551	0.971551 95
99.10 CORF						99.10
99.20 OPT						99.20
99.30 CMHC						99.30
99.40 OPT						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	52,425,729	1,279,110	53,704,839			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	52,425,729	1,279,110	53,704,839			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM (COL. 3 + COL. 4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL. 5 x COL. 6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL. 1 MINUS COL. 2)					
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	716,726		716,726	9,848	72.78	3,949	287,408	30
31 INTENSIVE CARE UNIT								31
31.01 INTENSIVE CARE UNIT								31.01
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	716,726		716,726	9,848		3,949	287,408	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (52-2005) [] 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						
54 RADIOLOGY-DIAGNOSTIC	3,487	143,477	0.024304	68,402	1,662	54
60 LABORATORY	21,478	1,312,644	0.016362	508,302	8,317	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	48,590	4,355,751	0.011155	2,057,771	22,954	65
66 PHYSICAL THERAPY	84,464	1,774,331	0.047603	559,345	26,627	66
67 OCCUPATIONAL THERAPY	105,862	1,853,897	0.057102	612,297	34,963	67
68 SPEECH PATHOLOGY	20,764	1,320,351	0.015726	316,381	4,975	68
71 MEDICAL SUPPLIES CHRGD TO PA	37,980	7,148,082	0.005313	2,981,837	15,842	71
73 DRUGS CHARGED TO PATIENTS	76,070	6,129,031	0.012411	2,513,281	31,192	73
74 RENAL DIALYSIS	7,997	150,233	0.053231	78,020	4,153	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)	406,692	24,187,797		9,695,636	150,685	200

PROVIDER CCN: 52-2005 LAKEVIEW SPECIALTY HOSPITAL &
PERIOD FROM 01/01/2012 TO 12/31/2012

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

VERSION: 2012.11
05/23/2013 20:23

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
31.01 INTENSIVE CARE UNIT					31.01
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 52-2005 LAKEVIEW SPECIALTY HOSPITAL &
 PERIOD FROM 01/01/2012 TO 12/31/2012

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

VERSION: 2012.11
 05/23/2013 20:23

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 + COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	9,848		3,949		30
31 INTENSIVE CARE UNIT					31
31.01 INTENSIVE CARE UNIT					31.01
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)	9,848		3,949		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (52-2005) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGED TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[XX] HOSPITAL (52-2005) [] IPF [] IRF	[] SUB (OTHER) [] SNF [] NF	[] ICF/MR	[XX] PPS [] TEFRA		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	143,477		68,402			54
60	LABORATORY	1,312,644		508,302			60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	4,355,751		2,057,771			65
66	PHYSICAL THERAPY	1,774,331		559,345			66
67	OCCUPATIONAL THERAPY	1,853,897		612,297			67
68	SPEECH PATHOLOGY	1,320,351		316,381		594	68
71	MEDICAL SUPPLIES CHRGED TO P	7,148,082		2,981,837			71
73	DRUGS CHARGED TO PATIENTS	6,129,031		2,513,281			73
74	RENAL DIALYSIS	150,233		78,020			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	24,187,797		9,695,636		594	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (52-2005) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
54 RADIOLOGY-DIAGNOSTIC	0.827770						54
60 LABORATORY	0.185056						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.190502						65
66 PHYSICAL THERAPY	0.376843						66
67 OCCUPATIONAL THERAPY	0.411235						67
68 SPEECH PATHOLOGY	0.361773	594			215		68
71 MEDICAL SUPPLIES CHRGED TO PATI	0.146873						71
73 DRUGS CHARGED TO PATIENTS	0.347781						73
74 RENAL DIALYSIS	0.718817						74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.971551						95
200 SUBTOTAL (SEE INSTRUCTIONS)		594			215		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		594			215		202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM (COL. 3 + COL. 4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL. 5 x COL. 6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL. 1 MINUS COL. 2)					
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	716,726		716,726	9,848	72.78	2,463	179,257	30
31 INTENSIVE CARE UNIT								31
31.01 INTENSIVE CARE UNIT								31.01
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	716,726		716,726	9,848		2,463	179,257	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (52-2005) [] IPF [] 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						
54	RADIOLOGY-DIAGNOSTIC	3,487	143,477	0.024304	18,485	449
60	LABORATORY	21,478	1,312,644	0.016362	182,527	2,987
62.30	BLOOD CLOTTING FOR HEMOPHILIA					
65	RESPIRATORY THERAPY	48,590	4,355,751	0.011155	691,173	7,710
66	PHYSICAL THERAPY	84,464	1,774,331	0.047603	283,507	13,496
67	OCCUPATIONAL THERAPY	105,862	1,853,897	0.057102	333,684	19,054
68	SPEECH PATHOLOGY	20,764	1,320,351	0.015726	221,778	3,488
71	MEDICAL SUPPLIES CHRGED TO PA	37,980	7,148,082	0.005313	1,506,078	8,002
73	DRUGS CHARGED TO PATIENTS	76,070	6,129,031	0.012411	1,299,656	16,130
74	RENAL DIALYSIS	7,997	150,233	0.053231	2,866	153
76.97	CARDIAC REHABILITATION					
76.98	HYPERBARIC OXYGEN THERAPY					
76.99	LITHOTRIPSY					
OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES					
200	TOTAL (SUM OF LINES 50-199)	406,692	24,187,797		4,539,754	71,469

PROVIDER CCN: 52-2005 LAKEVIEW SPECIALTY HOSPITAL &
PERIOD FROM 01/01/2012 TO 12/31/2012

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

VERSION: 2012.11
05/23/2013 20:23

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
31.01 INTENSIVE CARE UNIT					31.01
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 52-2005 LAKEVIEW SPECIALTY HOSPITAL &
 PERIOD FROM 01/01/2012 TO 12/31/2012

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

VERSION: 2012.11
 05/23/2013 20:23

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	9,848		2,463		30
31 INTENSIVE CARE UNIT					31
31.01 INTENSIVE CARE UNIT					31.01
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)	9,848		2,463		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (52-2005) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGED TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (52-2005) [] IPF [] IRF	[] SUB (OTHER) [] SNF [] NF	[] ICF/MR	[] PPS [] TEFRA [XX] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	143,477			18,485		54
60	LABORATORY	1,312,644			182,527		60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	4,355,751			691,173		65
66	PHYSICAL THERAPY	1,774,331			283,507		66
67	OCCUPATIONAL THERAPY	1,853,897			333,684		67
68	SPEECH PATHOLOGY	1,320,351			221,778		68
71	MEDICAL SUPPLIES CHRGED TO P	7,148,082			1,506,078		71
73	DRUGS CHARGED TO PATIENTS	6,129,031			1,299,656		73
74	RENAL DIALYSIS	150,233			2,866		74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	341,942					95
200	TOTAL (SUM OF LINES 50-199)	24,187,797			4,539,754		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (52-2005) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	----- PROGRAM CHARGES -----				----- PROGRAM COSTS -----		
	COST TO		COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT	
FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO	
PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
54 RADIOLOGY-DIAGNOSTIC	0.827770						54
60 LABORATORY	0.185056						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.190502						65
66 PHYSICAL THERAPY	0.376843						66
67 OCCUPATIONAL THERAPY	0.411235						67
68 SPEECH PATHOLOGY	0.361773						68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.146873						71
73 DRUGS CHARGED TO PATIENTS	0.347781						73
74 RENAL DIALYSIS	0.718817						74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.971551						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (52-2005) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	9,848	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,848	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,848	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,949	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)	9,013,609	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	9,013,609	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	14,140,365	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	14,140,365	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.637438	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	1,435.86	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)	9,013,609	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (52-2005) [] 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) 915.27 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 3,614,401 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) 3,614,401 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
 43.01 INTENSIVE CARE UNIT 43.01
 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) 2,487,839 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 6,102,240 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 287,408 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 150,685 51
 52 TOTAL PROGRAM EXCLUDABLE COST 438,093 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 5,664,147 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) 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 915.27 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1			
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 (52-2005) 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)	9,848	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,848	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,848	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)	2,463	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)	9,013,609	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	9,013,609	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	14,140,365	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	14,140,365	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.637438	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	1,435.86	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)	9,013,609	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[XX]	HOSPITAL (52-2005)	[]	SUB (OTHER)	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF			[]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[]	IRF			[XX]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	915.27 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	2,254,310 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)	2,254,310 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
43.01	INTENSIVE CARE UNIT	43.01
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)	1,180,301 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	3,434,611 49

PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	179,257 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	71,469 51
52	TOTAL PROGRAM EXCLUDABLE COST	250,726 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)	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

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (52-2005) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		5,480,998			30
31.01 INTENSIVE CARE UNIT					31.01
ANCILLARY SERVICE COST CENTERS					
54 RADIOLOGY-DIAGNOSTIC	0.827770	68,402	56,621		54
60 LABORATORY	0.185056	508,302	94,064		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.190502	2,057,771	392,009		65
66 PHYSICAL THERAPY	0.376843	559,345	210,785		66
67 OCCUPATIONAL THERAPY	0.411235	612,297	251,798		67
68 SPEECH PATHOLOGY	0.361773	316,381	114,458		68
71 MEDICAL SUPPLIES CHRGED TO PATI	0.146873	2,981,837	437,951		71
73 DRUGS CHARGED TO PATIENTS	0.347781	2,513,281	874,071		73
74 RENAL DIALYSIS	0.718817	78,020	56,082		74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		9,695,636	2,487,839		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		9,695,636			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (52-2005) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] 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)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		3,461,633		30
31.01 INTENSIVE CARE UNIT				31.01
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	0.827770	18,485	15,301	54
60 LABORATORY	0.185056	182,527	33,778	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.190502	691,173	131,670	65
66 PHYSICAL THERAPY	0.376843	283,507	106,838	66
67 OCCUPATIONAL THERAPY	0.411235	333,684	137,223	67
68 SPEECH PATHOLOGY	0.361773	221,778	80,233	68
71 MEDICAL SUPPLIES CHRGED TO PATI	0.146873	1,506,078	221,202	71
73 DRUGS CHARGED TO PATIENTS	0.347781	1,299,656	451,996	73
74 RENAL DIALYSIS	0.718817	2,866	2,060	74
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,539,754	1,180,301	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,539,754		202

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (52-2005) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT		
					1	2
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		5,190,810		115	1	
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2	
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 07/04/2012	125,800		NONE	3.01	
	.02				3.02	
	PROGRAM .03				3.03	
	TO .04				3.04	
	PROVIDER .05				3.05	
	.06				3.06	
	.07				3.07	
	.08				3.08	
	.09				3.09	
	.50 01/02/2013	164,500		NONE	3.50	
	.51				3.51	
	PROVIDER .52				3.52	
	TO .53				3.53	
	PROGRAM .54				3.54	
	.55				3.55	
	.56				3.56	
	.57				3.57	
	.58				3.58	
	.59				3.59	
	.99				3.99	
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-38,700				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		5,152,110		115	4	

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01	
	TO .02				5.02	
	PROVIDER .03				5.03	
	.04				5.04	
	.05				5.05	
	.06				5.06	
	.07				5.07	
	.08				5.08	
	.09				5.09	
	PROVIDER .50	NONE		NONE	5.50	
	TO .51				5.51	
	PROGRAM .52				5.52	
	.53				5.53	
	.54				5.54	
	.55				5.55	
	.56				5.56	
	.57				5.57	
	.58				5.58	
	.59				5.59	
	.99				5.99	
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01	188,885		17	6.01	
	TO .02				6.02	
	PROVIDER .03					
	PROVIDER .04					
	TO .05					
	PROGRAM .06					
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		5,340,995		132	7	
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:		8

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (52-2005) [] 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
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	9,848
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	4
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	5
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	6
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	7

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART IV

CHECK [XX] HOSPITAL (52-2005)
APPLICABLE BOX:

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	3,766,282	1
2	OUTLIER PAYMENTS	2,146,641	2
3	TOTAL PPS PAYMENTS (SUM OF LINES 1 AND 2)	5,912,923	3
4	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (SEE INSTRUCTIONS)		4
5	ORGAN ACQUISITION		5
6	COST OF TEACHING PHYSICIANS		6
7	SUBTOTAL (SEE INSTRUCTIONS)	5,912,923	7
8	PRIMARY PAYER PAYMENTS	56,444	8
9	SUBTOTAL (LINE 7 LESS LINE 8)	5,856,479	9
10	DEDUCTIBLES	8,020	10
11	SUBTOTAL (LINE 9 MINUS LINE 10)	5,848,459	11
12	COINSURANCE	512,060	12
13	SUBTOTAL (LINE 11 MINUS LINE 12)	5,336,399	13
14	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	6,566	14
15	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	4,596	15
16	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	183	16
17	SUBTOTAL (SUM OF LINES 13 AND 15)	5,340,995	17
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING LTCH ONLY)		18
19	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		19
20	OUTLIER PAYMENTS RECONCILIATION		20
21	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		21
22	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	5,340,995	22
23	INTERIM PAYMENTS	5,152,110	23
24	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		24
25	BALANCE DUE PROVIDER/PROGRAM (LINE 22 MINUS THE SUM OF LINES 23 AND 24)	188,885	25
26	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		26

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL PPS PAYMENT AND OUTLIER AMOUNT FROM WORKSHEET E-3, PART IV, LINE 3 (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 (52-2005) [] 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
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES	3,434,611	1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	3,434,611	4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	3,434,611	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES	4,539,754	9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	4,539,754	12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	4,539,754	16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	1,105,143	17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	3,434,611	21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21	3,434,611	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	3,434,611	31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	3,434,611	36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)	3,434,611	38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	3,434,611	40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	3,434,611	42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	141,518			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	6,624,164			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-975,173			6
7	INVENTORY	264,083			7
8	PREPAID EXPENSES	76,124			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	6,130,716			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS				15
16	ACCUMULATED DEPRECIATION				16
17	LEASEHOLD IMPROVEMENTS	639,355			17
18	ACCUMULATED AMORTIZATION	-360,458			18
19	FIXED EQUIPMENT	264,971			19
20	ACCUMULATED DEPRECIATION	-199,404			20
21	AUTOMOBILES AND TRUCKS	185,049			21
22	ACCUMULATED DEPRECIATION	-174,818			22
23	MAJOR MOVABLE EQUIPMENT	968,024			23
24	ACCUMULATED DEPRECIATION	-624,673			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	698,046			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	6,828,762			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,593,681			37
38	SALARIES, WAGES & FEES PAYABLE	947,411			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	701,801			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	3,242,893			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	19,302,257			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	19,302,257			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	22,545,150			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	-15,716,388			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)	-15,716,388			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	6,828,762			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		-15,183,137							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		-533,251							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		-15,716,388							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 COMMON STOCK									5
6 ADDITIONAL PAID-IN CAPITAL									6
7 ROUNDING									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		-15,716,388							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		-15,716,388							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	14,033,300		14,033,300	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE	15,034,735		15,034,735	9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	29,068,035		29,068,035	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
11 INTENSIVE CARE UNIT				11
11.01 INTENSIVE CARE UNIT				11.01
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)	29,068,035		29,068,035	17
18 ANCILLARY SERVICES	23,357,695	1,279,111	24,636,806	18
19 OUTPATIENT SERVICES		1,133,570	1,133,570	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	52,425,730	2,412,681	54,838,411	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		26,024,467	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		26,024,467	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	54,838,411	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	29,439,249	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	25,399,162	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	26,024,467	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-625,305	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	47,411	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	7,424	15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	3,206	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	8,244	20
21	RENTAL OF VENDING MACHINES	11,177	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (INTEREST INCOME)	5,420	24
24.01	OTHER (MISCELLANEOUS INCOME)	9,172	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	92,054	25
26	TOTAL (LINE 5 PLUS LINE 25)	-533,251	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-533,251	29

***** 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	40.10		25.01				65.11 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	47.67		12.88				60.55 54
60 LABORATORY	38.72		13.91				52.63 60
65 RESPIRATORY THERAPY	47.24		15.87				63.11 65
66 PHYSICAL THERAPY	31.52		15.98				47.50 66
67 OCCUPATIONAL THERAPY	33.03		18.00				51.03 67
68 SPEECH PATHOLOGY	23.96	0.04	16.80				40.80 68
71 MEDICAL SUPPLIES CHRGED TO PATI	41.72		21.07				62.79 71
73 DRUGS CHARGED TO PATIENTS	41.01		21.20				62.21 73
74 RENAL DIALYSIS	51.93		1.91				53.84 74
200 TOTAL CHARGES	39.53		18.51				58.04 200

COST CENTER	---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,615,148	6.92	-1,615,148	-14.15		1
2	CAP REL COSTS-MVBLE EQUIP	160,062	0.69	-160,062	-1.40		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	2,098,530	9.00	-2,098,530	-18.39		4
5.01	ADMINISTRATIVE & GENERAL	2,833,791	12.15	-2,833,791	-24.83		5.01
5.02	ADMITTING	40,725	0.17	-40,725	-0.36		5.02
5.03	BUSINESS OFFICE	803,194	3.44	-803,194	-7.04		5.03
6	MAINTENANCE & REPAIRS	957,955	4.11	-957,955	-8.39		6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	79,678	0.34	-79,678	-0.70		8
9	HOUSEKEEPING	291,677	1.25	-291,677	-2.56		9
10	DIETARY	762,134	3.27	-762,134	-6.68		10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY	94,437	0.40	-94,437	-0.83		14
15	PHARMACY	1,546,764	6.63	-1,546,764	-13.55		15
16	MEDICAL RECORDS & LIBRARY	127,974	0.55	-127,974	-1.12		16
17	SOCIAL SERVICE	1,114		-1,114	-0.01		17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APP						21
22	I&R SRVCES-OTHER PRGM COSTS APP						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,489,911	23.53	3,523,698	30.87	9,013,609	38.64
31.01	INTENSIVE CARE UNIT						31.01
46	OTHER LONG TERM CARE	3,458,607	14.83	3,570,395	31.28	7,029,002	30.13
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	96,772	0.41	21,994	0.19	118,766	0.51
60	LABORATORY	154,772	0.66	88,140	0.77	242,912	1.04
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	515,012	2.21	314,766	2.76	829,778	3.56
66	PHYSICAL THERAPY	321,888	1.38	346,756	3.04	668,644	2.87
67	OCCUPATIONAL THERAPY	357,643	1.53	404,744	3.55	762,387	3.27
68	SPEECH PATHOLOGY	305,656	1.31	172,012	1.51	477,668	2.05
71	MEDICAL SUPPLIES CHRGD TO PATI	612,952	2.63	436,907	3.83	1,049,859	4.50
73	DRUGS CHARGED TO PATIENTS	6,315	0.03	2,125,248	18.62	2,131,563	9.14
74	RENAL DIALYSIS	76,123	0.33	31,867	0.28	107,990	0.46
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	230,495	0.99	101,719	0.89	332,214	1.42
OUTPATIENT SERVICE COST CENTERS							
99.10	CORF						99.10
99.20	OPT						99.20
99.30	CMHC						99.30
99.40	OPT						99.40
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	287,433	1.23	274,937	2.41	562,370	2.41
194	EDUCATION						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	23,326,762	100.00			23,326,762	100.00

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	3,487	143,477	0.024304	68,402	1,662	54
60 LABORATORY	21,478	1,312,644	0.016362	508,302	8,317	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	48,590	4,355,751	0.011155	2,057,771	22,954	65
66 PHYSICAL THERAPY	84,464	1,774,331	0.047603	559,345	26,627	66
67 OCCUPATIONAL THERAPY	105,862	1,853,897	0.057102	612,297	34,963	67
68 SPEECH PATHOLOGY	20,764	1,320,351	0.015726	316,381	4,975	68
71 MEDICAL SUPPLIES CHRGD TO PATI	37,980	7,148,082	0.005313	2,981,837	15,842	71
73 DRUGS CHARGED TO PATIENTS	76,070	6,129,031	0.012411	2,513,281	31,192	73
74 RENAL DIALYSIS	7,997	150,233	0.053231	78,020	4,153	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL	406,692	24,187,797		9,695,636	150,685	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	SWING-BED	REDUCED	TOTAL	PER	INPATIENT	MEDICARE
	RELATED	ADJUSTMENT	CAPITAL	PATIENT			INPATIENT
	COSTS	AMOUNT	RELATED	DAYS	DIEM	PROGRAM	PPS CAPITAL
	1	2	COST	4	5	DAYS	COSTS
			3			6	7
INPATIENT ROUTINE SERVICE COST CENTERS							
30 ADULTS & PEDIATRICS	716,726		716,726	9,848	72.78	3,949	287,408 30
31.01 INTENSIVE CARE UNIT							31.01
200 TOTAL	716,726		716,726	9,848		3,949	287,408 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS							287,408
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS							150,685
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS							438,093
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)							126
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)							3,949
PER DISCHARGE CAPITAL COSTS							3,476.93
PER DIEM CAPITAL COSTS							110.94

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)	5,664,147
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	15,176,634
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.373

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)	438,093
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.029

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

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