

RICHLAND MEMORIAL HOSPITAL
OLNEY, ILLINOIS
MEDICARE COST REPORT
YEAR ENDED SEPTEMBER 30, 2013

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

Re: Provider: Richland Memorial Hospital
Provider Numbers: 14-0147, 14-S147, 14-U147, 14-5580, 14-7187, 14-1542
Period ended: 09/30/2013
Protested amounts claimed on submitted cost report.

Dear Sir or Madam:

The Provider contends that its base-year hospital-specific rate, applied to calculate the payments to the Provider during this cost reporting period, is artificially low because of the application of a cumulative budget neutrality factor that encompasses all budget neutrality adjustments made prior to the base year. As reflected in the attached calculation, the Provider estimates that the reimbursement impact of this issue for this cost reporting period is \$88,000.

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

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

Richland Memorial Hospital
Hospital Specific Rate Recalculation
September 30, 2013

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

HSP difference for September 30, 2010	109.74
2011 Update Factor	1.0235
2012 Update Factor	1.0190
2013 Update Factor	1.0180
2011 Budget Neutrality	0.996731
2012 Budget Neutrality	0.997903
2013 Budget Neutrality	0.998431
2012 Rural Floor Add-on	1.009
2013 Document & Coding	<u>0.948</u>
2012 difference	110.68
DRG weight	<u>1,065.12</u>
	117,885
MDH payment factor	<u>0.75</u>
	<u><u>88,413</u></u>
Rounded	<u><u>88,000</u></u>

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
 CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 02/19/2014 TIME: 15:52
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY RICHLAND MEMORIAL HOSPITAL (14-0147) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2012 AND ENDING 09/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 02/19/2014 15:52
 JJZ6ullfRTNpfgILvQP3BW4eqwyqT0
 DV1rY027aUy5nJRBv8ZvRMURCyyVca
 juJk1T43ZG0E:yVy

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

 TITLE

 DATE

PI Encryption: 02/19/2014 15:52
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 PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1	HOSPITAL	111,875	26,434	7,416		1
2	SUBPROVIDER - IPF	7,734				2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF	5,207				5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY	241				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	125,057	26,434	7,416		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 OMD 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 (CONT)

TEACHING HOSPITALS		1	2	3		
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56	
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57	
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58	
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59	
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER \$413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(SEE INSTRUCTIONS)	Y/N N	IME	DIRECT GME	61	
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01	
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY FTEs, AND PRIMARY CARE FTEs ADDED UNDER SECTION 5503). (SEE INSTRUCTIONS)				61.02	
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03	
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04	
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05	
61.06	ENTER THE AMOUNT OF ACA \$5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06	
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
		PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED IME FTE COUNT 3	UNWEIGHTED DIRECT GME FTE COUNT 4	61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					61.20
	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	

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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.		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
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)				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)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	5
PROGRAM NAME	PROGRAM CODE	3	4	5	
1	2				
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		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
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)				66
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)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	5
PROGRAM NAME	PROGRAM CODE	3	4	5	
1	2				
INPATIENT PSYCHIATRIC FACILITY PPS					
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			N N	71
INPATIENT REHABILITATION FACILITY PPS					
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				76
LONG TERM CARE HOSPITAL PPS					
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	80
TEFRA PROVIDERS					
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N	86

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

		V	XIX	
		1	2	
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.		N	108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	109
MISCELLANEOUS COST REPORTING INFORMATION				
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.		N	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.		Y	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.		2	118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 437,415 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.		N	118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.		N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.		Y	121
TRANSPLANT CENTER INFORMATION				
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.		N	125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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 2 140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141 NAME: CONTRACTOR'S NAME: CONTRACTOR'S NUMBER: 141
 142 STREET: P.O. BOX: 142
 143 CITY: STATE: ZIP CODE: 143
 144 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y 144
 145 IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO. N 145
 146 HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2. N 146
 147 WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO. N 147
 148 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO. N 148
 149 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO. N 149

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

	TITLE XVIII		TITLE V	TITLE XIX
	PART A	PART B		
155 HOSPITAL	1	2	3	4
156 SUBPROVIDER - IPF	N	N		N 155
157 SUBPROVIDER - IRF	N	N		N 156
158 SUBPROVIDER - (OTHER)	N	N		157
159 SNF	N	N		158
160 HHA	N	N		159
161 CMHC		N		160
161.10 CORF				161
				161.10

MULTICAMPUS

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

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

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

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. Y 167
 168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 0.75 168
 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. 10/01/2012 09/30/2013 169
 170 IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS) 170

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

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
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 N	2	1	
FINANCIAL DATA AND REPORTS					
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.	1 N	2	V/I 3	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
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 Y	2 A	3 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					
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		Y/N 1 N	2 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/N Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 Y	2 11/16/2013	3 Y	4 11/16/2013
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? 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. Y/N DATE 38
- 39 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. 39
- 40 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 40

COST REPORT PREPARER CONTACT INFORMATION

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

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

LINE NO.	COMPONENT	WKST A LINE NO.	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS			TITLE XVIII 6	TITLE XIX 7	TOTAL ALL PATIENTS 8	TRIPS 9
			NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4				
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS) (SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30	39	14,235		2,840	864	4,786	1
2	HMO AND OTHER (SEE INSTRUCTIONS)					61	154		2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF					264		264	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		39	14,235		3,104	864	5,050	7
8	INTENSIVE CARE UNIT	31	8	2,920		1,090	25	1,430	8
9	CORONARY CARE UNIT	32							9
10	BURN INTENSIVE CARE UNIT	33							10
11	SURGICAL INTENSIVE CARE UNIT	34							11
12	OTHER SPECIAL CARE (SPECIFY)	35							12
13	NURSERY	43					349	633	13
14	TOTAL (SEE INSTRUCTIONS)		47	17,155		4,194	1,238	7,113	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF	40	10	3,650		543	621	2,165	16
17	SUBPROVIDER - IRF	41							17
18	SUBPROVIDER I	42							18
19	SKILLED NURSING FACILITY	44	34	12,410		2,999		10,270	19
20	NURSING FACILITY	45							20
21	OTHER LONG TERM CARE	46							21
22	HOME HEALTH AGENCY	101				9,805		11,519	22
23	ASC (DISTINCT PART)	115							23
24	HOSPICE (DISTINCT PART)	116	1	365					24
24.10	HOSPICE (NON-DISTINCT PART)	30							24.10
25	CMHC	99							25
26	RHC	88							26
27	TOTAL (SUM OF LINES 14-26)		92						27
28	OBSERVATION BED DAYS						152	896	28
29	AMBULANCE TRIPS					1,070			29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								30
31	EMPLOYEE DISCOUNT DAYS-IRF								31
32	LABOR & DELIVERY DAYS (SEE INSTR.)								32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)								32.01
33	LTCH NON-COVERED DAYS								33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

LINE NO.	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---			DISCHARGES			TOTAL ALL PATIENTS
			TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	
1		1	9	10	11	12	13	14	15
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS) (SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30					1,009	378	1,966
2	HMO AND OTHER (SEE INSTRUCTIONS)						17		2
3	HMO IPF								3
4	HMO IRF								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)								7
8	INTENSIVE CARE UNIT	31							8
9	CORONARY CARE UNIT	32							9
10	BURN INTENSIVE CARE UNIT	33							10
11	SURGICAL INTENSIVE CARE UNIT	34							11
12	OTHER SPECIAL CARE (SPECIFY)	35							12
13	NURSERY	43							13
14	TOTAL (SEE INSTRUCTIONS)			373.36			1,009	378	1,966
15	CAH VISITS								15
16	SUBPROVIDER - IPF	40		16.24			109	160	507
17	SUBPROVIDER - IRF	41							17
18	SUBPROVIDER I	42							18
19	SKILLED NURSING FACILITY	44		27.78					19
20	NURSING FACILITY	45							20
21	OTHER LONG TERM CARE	46							21
22	HOME HEALTH AGENCY	101		15.05					22
23	ASC (DISTINCT PART)	115							23
24	HOSPICE (DISTINCT PART)	116		4.86					24
24.10	HOSPICE (NON-DISTINCT PART)	30							24.10
25	CMHC	99							25
26	RHC	88							26
27	TOTAL (SUM OF LINES 14-26)			437.29					27
28	OBSERVATION BED DAYS								28
29	AMBULANCE TRIPS								29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								30
31	EMPLOYEE DISCOUNT DAYS-IRF								31
32	LABOR & DELIVERY DAYS (SEE INSTR.)								32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)								32.01
33	LTCH NON-COVERED DAYS								33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)		
	1	2	3	4	5	6		
SALARIES								
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200		20,859,738	909,513.00	22.94	1	
2	NON-PHYSICIAN ANESTHETIST PART A						2	
3	NON-PHYSICIAN ANESTHETIST PART B	807,349		807,349	8,320.00	97.04	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	988,989	988,989	57,775.00	17.12	9	
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		5,271,315	5,271,315	177,239.00	29.74	10	
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		269,756	269,756	4,096.00	65.86	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)		4,755,136	4,755,136			17	
18	WAGE-RELATED COSTS (OTHER)						18	
19	EXCLUDED AREAS		1,536,778	1,536,778			19	
20	NON-PHYSICIAN ANESTHETIST PART A						20	
21	NON-PHYSICIAN ANESTHETIST PART B		152,378	152,378			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)						25	
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		221,393	221,393	8,416.00	26.31	26	
27	ADMINISTRATIVE & GENERAL		1,891,155	1,891,155	107,971.00	17.52	27	
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		32,000	32,000	375.00	85.33	28	
29	MAINTENANCE & REPAIRS		506,840	506,840	25,381.00	19.97	29	
30	OPERATION OF PLANT						30	
31	LAUNDRY & LINEN SERVICE		215,389	215,389	17,948.00	12.00	31	
32	HOUSEKEEPING		380,152	380,152	35,492.00	10.71	32	
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33	
34	DIETARY		560,820	-371,873	188,947	18,392.00	10.27	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)			371,873	371,873	35,700.00	10.42	35
36	CAFETERIA						36	
37	MAINTENANCE OF PERSONNEL						37	
38	NURSING ADMINISTRATION		1,157,746	1,157,746	39,987.00	28.95	38	
39	CENTRAL SERVICES AND SUPPLY		80,186	80,186	6,248.00	12.83	39	
40	PHARMACY		414,808	414,808	13,112.00	31.64	40	
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		554,415	554,415	32,783.00	16.91	41	
42	SOCIAL SERVICE						42	
43	OTHER GENERAL SERVICE						43	

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	20,084,389		20,084,389	901,568.00	22.28	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	6,260,304		6,260,304	235,014.00	26.64	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	13,824,085		13,824,085	666,554.00	20.74	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	269,756		269,756	4,096.00	65.86	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	4,755,136		4,755,136		34.40	5
6	TOTAL (SUM OF LINES 3 THRU 5)	18,848,977		18,848,977	670,650.00	28.11	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	6,014,904		6,014,904	341,805.00	17.60	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
RETIREMENT COST			
1	401K EMPLOYER CONTRIBUTIONS	641,404	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)			
5	401K/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST			
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	3,751,557	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)		11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	316,510	15
16	RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES			
17	FICA-EMPLOYERS PORTION ONLY	1,154,966	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	270,113	18
19	UNEMPLOYMENT INSURANCE	56,433	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		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	82,149	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	6,273,132	24
PART B - OTHER THAN CORE RELATED COST			
25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)	171,162	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	490,124	1
2	HOSPITAL	269,756	2
3	SUBPROVIDER - IPF	189,300	3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF	30,000	8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA	1,068	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

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7187

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA		COUNTY:					
DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5		
1 HOME HEALTH AIDE HOURS		5,275		48	5,323	1	
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		304.00	41.00	43.00	388.00	2	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00		----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			TOTAL		
		STAFF 1	CONTRACT 2	3			
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)						3	
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			2.80		2.80	4	
5 OTHER ADMINISTRATIVE PERSONNEL			1.40		1.40	5	
6 DIRECT NURSING SERVICE			10.90		10.90	6	
7 NURSING SUPERVISOR						7	
8 PHYSICAL THERAPY SERVICE						8	
9 PHYSICAL THERAPY SUPERVISOR						9	
10 OCCUPATIONAL THERAPY SERVICE						10	
11 OCCUPATIONAL THERAPY SUPERVISOR						11	
12 SPEECH PATHOLOGY SERVICE						12	
13 SPEECH PATHOLOGY SUPERVISOR						13	
14 MEDICAL SOCIAL SERVICE						14	
15 MEDICAL SOCIAL SERVICE SUPERVISOR						15	
16 HOME HEALTH AIDE			2.60		2.60	16	
17 HOME HEALTH AIDE SUPERVISOR						17	
18 OTHER (SPECIFY)						18	

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

PPS ACTIVITY		FULL EPISODES				TOTAL (COLS. 1-4)	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4	5		
21 SKILLED NURSING VISITS	4,034	797	164	112	5,107	21	
22 SKILLED NURSING VISIT CHARGES	876,421	174,077	32,910	23,412	1,106,820	22	
23 PHYSICAL THERAPY VISITS	2,328	70	21	38	2,457	23	
24 PHYSICAL THERAPY VISIT CHARGES	511,340	15,509	4,642	8,419	539,910	24	
25 OCCUPATIONAL THERAPY VISITS	572	45		18	635	25	
26 OCCUPATIONAL THERAPY VISIT CHARGES	125,413	9,939		3,975	139,327	26	
27 SPEECH PATHOLOGY VISITS	92	30	1	6	129	27	
28 SPEECH PATHOLOGY VISIT CHARGES	20,310	6,626	221	1,325	28,482	28	
29 MEDICAL SOCIAL SERVICE VISITS	43	2			45	29	
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	13,048	599			13,647	30	
31 HOME HEALTH AIDE VISITS	1,275	122	5	30	1,432	31	
32 HOME HEALTH AIDE VISIT CHARGES	162,171	15,486	643	3,729	182,029	32	
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	8,344	1,066	191	204	9,805	33	
34 OTHER CHARGES						34	
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	1,708,703	222,236	38,416	40,860	2,010,215	35	
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	428		67	11	506	36	
37 TOTAL NUMBER OF OUTLIER EPISODES		20		.2	22	37	
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	53,568	12,266	5,542	964	72,340	38	

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

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

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4
3	RUX			3
4	RUL			4
5	RVX			5
6	RVL			6
7	RHX	24		24 7
8	RHL	31		31 8
9	RMX	22		22 9
10	RML	29		29 10
11	RLX			11
12	RUC	49		49 12
13	RUB			13
14	RUA	65		65 14
15	RVC	235		235 15
16	RVB	191		191 16
17	RVA	384		384 17
18	RHC	386	25	411 18
19	RHB	188	7	195 19
20	RHA	654	26	680 20
21	RMC	133	20	153 21
22	RMB	67	4	71 22
23	RMA	212	41	253 23
24	RLB			24
25	RLA	4		4 25
26	ES3			26
27	ES2			27
28	ES1	25	26	51 28
29	HE2			29
30	HE1	6	5	11 30
31	HD2	7		7 31
32	HD1	19	1	20 32
33	HC2		5	5 33
34	HC1	29		29 34
35	HB2		9	9 35
36	HB1	139	12	151 36
37	LE2			37
38	LE1			38
39	LD2		12	12 39
40	LD1			40
41	LC2			41
42	LC1			42
43	LB2			43
44	LB1			44
45	CE2		6	6 45
46	CE1		3	3 46
47	CD2		1	1 47
48	CD1	16	5	21 48
49	CC2			49
50	CC1	10	2	12 50
51	CB2		1	1 51
52	CB1	22	34	56 52
53	CA2		6	6 53
54	CA1	34	13	47 54
55	SE3			55
56	SE2			56
57	SE1			57
58	SSC			58
59	SSB			59
60	SSA			60
61	IB2			61
62	IB1			62
63	IA1			63
64	IA2			64
65	BB2			65
66	BB1	4		4 66
67	BA2			67
68	BA1			68

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1		1		1 72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1		7		7 76
77	PA2				77
78	PA1		6		6 78
199	AAA				199
200	TOTAL		2,999	264	3,263 200

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

SNF SERVICES

201 ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY,
 IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN
 EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE). 00014 00014 201

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

		EXPENSES	PERCENTAGE	ASSOCIATED	
		1	2	WITH	
				DIRECT	
				PATIENT	
				CARE AND	
				RELATED	
				EXPENSES?	
				3	
202	STAFFING	1,315,066	60.98%	Y	202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING	5,015	0.23%	Y	205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	2,156,606			207

HOSPICE IDENTIFICATION DATA

HOSPICE NO.: 14-1542

WORKSHEET S-9
 PARTS I & II

PART I - ENROLLMENT DAYS

		----- UNDUPLICATED DAYS -----					
		TITLE XVIII	TITLE XIX	TITLE XVIII SKILLED NURSING FACILITY	TITLE XIX NURSING FACILITY	ALL OTHER	TOTAL (SUM OF COLS. 1, 2 & 5) 6
		1	2	3	4	5	6
1	CONTINUOUS HOME CARE						1
2	ROUTINE HOME CARE	4,440	27			264	4,731
3	INPATIENT RESPITE CARE						3
4	GENERAL INPATIENT CARE						4
5	TOTAL HOSPICE DAYS	4,440	27			264	4,731

PART II - CENSUS DATA

		TITLE XVIII	TITLE XIX	TITLE XVIII SKILLED NURSING FACILITY	TITLE XIX NURSING FACILITY	ALL OTHER	TOTAL (SUM OF COLS. 1, 2 & 5) 6
		1	2	3	4	5	6
6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	78	6			8	92
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE						7
8	AVERAGE LENGTH OF STAY (LINE 5/LINE 6)	56.92	4.50			33.00	51.42
9	UNDUPLICATED CENSUS COUNT						9

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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1 COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8) 0.270639 1

MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)

2 NET REVENUE FROM MEDICAID 1,980,947 2
 3 DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID? Y 3
 4 IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID? Y 4
 5 IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID 5
 6 MEDICAID CHARGES 23,636,166 6
 7 MEDICAID COST (LINE 1 TIMES LINE 6) 6,396,871 7
 8 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) 4,415,924 8
 IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)

9 NET REVENUE FROM STAND-ALONE SCHIP 9
 10 STAND-ALONE SCHIP CHARGES 10
 11 STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10) 11
 12 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) 12
 IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)

13 NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9) 13
 14 CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10) 14
 15 STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14) 15
 16 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) 16
 IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.

UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)

17 PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE 17
 18 GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS 18
 19 TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16) 4,415,924 19

	UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3
20 TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	1,210,980	4,050,746	5,261,726 20
21 COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	327,739	1,096,290	1,424,029 21
22 PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	30,767	68,292	99,059 22
23 COST OF CHARITY CARE	296,972	1,027,998	1,324,970 23
24 DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM			N 24
25 IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)			25
26 TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			2,448,203 26
27 MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			339,183 27
28 NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			2,109,020 28
29 COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			570,783 29
30 COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,895,753 30
31 TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			6,311,677 31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		551,623	551,623	362,574	1
2	00200		1,122,239	1,122,239	17,860	2
3	00300					3
4	00400		221,393	6,952,033		4
5	00500	1,891,155	6,730,640	8,275,706	-70,433	5
6	00600	506,840	6,384,551	913,318		6
7	00700		406,478	472,203		7
8	00800	215,389	472,203	311,997		8
9	00900	380,152	96,608	529,002		9
10	01000	560,820	148,850	1,355,086	-898,542	10
11	01100		794,266		898,542	11
12	01200					12
13	01300	1,157,746	205,884	1,363,630		13
14	01400	80,186	28,802	108,988		14
15	01500	414,808	1,657,015	2,071,823		15
16	01600	554,415	271,741	826,156		16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,887,024	151,357	2,038,381		30
31	03100	683,251	41,685	724,936		31
40	04000	656,927	213,781	870,708		40
43	04300	214,720	21,864	236,584		43
44	04400	988,989	113,290	1,102,279		44
ANCILLARY SERVICE COST CENTERS						
50	05000	665,593	335,898	1,001,491		50
53	05300	807,349	28,694	836,043		53
54	05400	644,357	266,033	910,390		54
56	05600	20,717	172,577	193,294		56
57	05700	109,459	109,573	219,032		57
58	05800		210,420	210,420		58
60	06000	1,009,970	1,355,403	2,365,373		60
62.30	06250					62.30
64	06400		22,733	22,733		64
65	06500	382,787	12,622	395,409		65
66	06600	1,369,327	86,617	1,455,944		66
68	06800	172,511	6,565	179,076		68
69	06900		178,914	178,914		69
71	07100		1,616,992	1,616,992	-198,810	71
72	07200				198,810	72
73	07300					73
74	07400					74
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	649,465	870,856	1,520,321		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
95	09500	499,153	130,248	629,401		95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	700,300	169,900	870,200		101
SPECIAL PURPOSE COST CENTERS						
113	11300		310,001	310,001	-310,001	113
116	11600	207,078	182,571	389,649		116
118		17,651,881	25,479,494	43,131,375		118
NONREIMBURSABLE COST CENTERS						
192	19200	3,187,348	443,129	3,630,477		192
194	07950					194
194.01	07952	20,509	1,099	21,608		194.01
194.02	07953					194.02
200		20,859,738	25,923,722	46,783,460		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	914,197	-27,083	887,114	1
2	00200	1,140,099	-78	1,140,021	2
3	00300				3
4	00400	6,952,033	-277,140	6,674,893	4
5	00500	8,205,273	-4,659,131	3,546,142	5
6	00600	913,318		913,318	6
7	00700	472,203		472,203	7
8	00800	311,997	-173,900	138,097	8
9	00900	529,002		529,002	9
10	01000	456,544		456,544	10
11	01100	898,542	-260,298	638,244	11
12	01200				12
13	01300	1,363,630		1,363,630	13
14	01400	108,988	-10,582	98,406	14
15	01500	2,071,823	-2,061	2,069,762	15
16	01600	826,156	-3,353	822,803	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	2,038,381	-82	2,038,299	30
31	03100	724,936		724,936	31
40	04000	870,708	-146,623	724,085	40
43	04300	236,584		236,584	43
44	04400	1,102,279		1,102,279	44
ANCILLARY SERVICE COST CENTERS					
50	05000	1,001,491		1,001,491	50
53	05300	836,043	-807,349	28,694	53
54	05400	910,390		910,390	54
56	05600	193,294		193,294	56
57	05700	219,032		219,032	57
58	05800	210,420		210,420	58
60	06000	2,365,373	-19,973	2,345,400	60
62.30	06250				62.30
64	06400	22,733		22,733	64
65	06500	395,409		395,409	65
66	06600	1,455,944		1,455,944	66
68	06800	179,076		179,076	68
69	06900	178,914		178,914	69
71	07100	1,418,182		1,418,182	71
72	07200	198,810		198,810	72
73	07300				73
74	07400				74
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
91	09100	1,520,321	-792,102	728,219	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
94	09400				94
95	09500	629,401		629,401	95
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
101	10100	870,200	-1,050	869,150	101
SPECIAL PURPOSE COST CENTERS					
113	11300				113
116	11600	389,649		389,649	116
118		43,131,375	-7,180,805	35,950,570	118
NONREIMBURSABLE COST CENTERS					
192	19200	3,630,477		3,630,477	192
194	07950				194
194.01	07952	21,608		21,608	194.01
194.02	07953				194.02
200		46,783,460	-7,180,805	39,602,655	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 RECLASS CAFETERIA	A	CAFETERIA	11		371,873	526,669 1
500 TOTAL RECLASSIFICATIONS					371,873	526,669 500
CODE LETTER - A						
1 INTEREST EXPENSE	B	CAP REL COSTS-BLDG & FIXT	1			309,114 1
2		CAP REL COSTS-MVBLE EQUIP	2			887 2
500 TOTAL RECLASSIFICATIONS						310,001 500
CODE LETTER - B						
1 OTHER CAPITAL RELATED	C	CAP REL COSTS-BLDG & FIXT	1			53,460 1
2		CAP REL COSTS-MVBLE EQUIP	2			16,973 2
500 TOTAL RECLASSIFICATIONS						70,433 500
CODE LETTER - C						
1 RECLASS MEDICAL SUPPLIES	D	IMPL. DEV. CHARGED TO PATIENT	72			198,810 1
500 TOTAL RECLASSIFICATIONS						198,810 500
CODE LETTER - D						
GRAND TOTAL (INCREASES)					371,873	1,105,913

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7	
			LINE #	SALARY	OTHER	REF.	
	1	6	7	8	9	10	
1 RECLASS CAFETERIA	A	DIETARY	10	371,873	526,669		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A				371,873	526,669		500
1 INTEREST EXPENSE	B	INTEREST EXPENSE	113		310,001		11 1
2							11 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					310,001		500
1 OTHER CAPITAL RELATED	C	ADMINISTRATIVE & GENERAL	5		70,433		12 1
2							12 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					70,433		500
1 RECLASS MEDICAL SUPPLIES	D	MEDICAL SUPPLIES CHARGED TO P	71		198,810		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					198,810		500
GRAND TOTAL (DECREASES)				371,873	1,105,913		

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	39,983					39,983		1
2 LAND IMPROVEMENTS	510,497					510,497		2
3 BUILDINGS AND FIXTURES	14,379,504	288,165		288,165	47,030	14,620,639		3
4 BUILDING IMPROVEMENTS	9,774,651				170,679	9,603,972		4
5 FIXED EQUIPMENT	2,508,895				52,629	2,456,266		5
6 MOVABLE EQUIPMENT	15,109,557	1,487,521		1,487,521	466,877	16,130,201		6
7 HIT DESIGNATED ASSETS	413,959	319,411		319,411		733,370		7
8 SUBTOTAL (SUM OF LINES 1-7)	42,737,046	2,095,097		2,095,097	737,215	44,094,928		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	42,737,046	2,095,097		2,095,097	737,215	44,094,928		10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	551,623						551,623 1
2 CAP REL COSTS-MVBLE EQUIP	1,122,239						1,122,239 2
3 TOTAL (SUM OF LINES 1-2)	1,673,862						1,673,862 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	27,231,357		27,231,357	0.617562				1
2 CAP REL COSTS-MVBLE EQUIP	16,863,571		16,863,571	0.382438				2
3 TOTAL (SUM OF LINES 1-2)	44,094,928		44,094,928	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	551,623		282,031	53,460			887,114 1
2 CAP REL COSTS-MVBLE EQUIP	1,122,239		809	16,973			1,140,021 2
3 TOTAL	1,673,862		282,840	70,433			2,027,135 3

ADJUSTMENTS TO EXPENSES

LINE NO.	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8	
				COST CENTER	LINE NO.	REF	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-27,083	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-78	CAP REL COSTS-MVBLE EQUIP	2	11	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-6,249	ADMINISTRATIVE & GENERAL	5		4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-32,846	ADMINISTRATIVE & GENERAL	5		7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-958,698				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE	B	-173,900	LAUNDRY & LINEN SERVICE	8		13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-208,115	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-10,582	CENTRAL SERVICES & SUPPLY	14		16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-2,061	PHARMACY	15		17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-3,353	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						19
20	VENDING MACHINES	B	-13,721	CAFETERIA	11		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND SPECIAL FUNCTIONS	B	-38,462	CAFETERIA	11		32
33	GUEST ROOM	B	-82	ADULTS & PEDIATRICS	30		33
34	MISC INCOME	B	-48,783	ADMINISTRATIVE & GENERAL	5		34
35	RETURNED CHECKS	B	-20	ADMINISTRATIVE & GENERAL	5		35
36	DIETARY CONSULTATION	B	-226	ADMINISTRATIVE & GENERAL	5		36
37	PHYSICIAN RECRUITMENT	A	-146,034	ADMINISTRATIVE & GENERAL	5		37
38	CRNA SALARIES	A	-807,349	ANESTHESIOLOGY	53		38
39	CRNA BENEFITS	A	-255,445	EMPLOYEE BENEFITS DEPARTMENT	4		39
40	LOBBYING DUES	A	-16,408	ADMINISTRATIVE & GENERAL	5		40
41	FOUNDATION SALARIES	A	-67,797	ADMINISTRATIVE & GENERAL	5		41
42	FOUNDATION BENEFITS	A	-21,695	EMPLOYEE BENEFITS DEPARTMENT	4		42
43	FOUNDATION OTHER	A	-9,194	ADMINISTRATIVE & GENERAL	5		43
44	ADVERTISING	A	-248,230	ADMINISTRATIVE & GENERAL	5		44
45	PROVIDER TAX ASSESSMENT	A	-1,525,967	ADMINISTRATIVE & GENERAL	5		45
46	BAD DEBT EXPENSE	A	-2,448,203	ADMINISTRATIVE & GENERAL	5		46
47	RENTAL INCOME	B	-800	ADMINISTRATIVE & GENERAL	5		47
48	HHA VEHICLE REIMBURSEMENT	B	-1,050	HOME HEALTH AGENCY	101		48
49.01	MISC NP CLINIC REVENUE	B	-540	ADMINISTRATIVE & GENERAL	5		49
49.02	MISC PT REVENUE	B	-27,036	ADMINISTRATIVE & GENERAL	5		49.01
49.03	INTEREST RECIEPTS	B	-80,798	ADMINISTRATIVE & GENERAL	5		49.02
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-7,180,805				49.03
							50

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

WORKSHEET A-8-1

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

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

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

6
7
8
9
10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2		3	4	5	6	7	8	9	
1	40 SUBPROVIDER - IPF	AGGREGATE	189,300	93,300	96,000	138,700	640	42,677	2,134	1
2	60 LABORATORY	AGGREGATE	99,863	19,973	79,890	208,000	1,248	124,800	6,240	2
3	91 EMERGENCY	AGGREGATE	792,102	792,102		159,800				3
4	44 SKILLED NURSING FACILITY	AGGREGATE	30,000		30,000	159,800	416	31,960	1,598	4
200	TOTAL		1,111,265	905,375	205,890		2,304	199,437	9,972	200

PROVIDER CCN: 14-0147 RICHLAND MEMORIAL HOSPITAL
 PERIOD FROM 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11
 02/11/2014 09:36

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO. 10	11		12	COLUMN 12	14	COLUMN 14	16	17	18	
1	40	SUBPROVIDER - IPF	AGGREGATE				42,677	53,323	146,623	1
2	60	LABORATORY	AGGREGATE				124,800		19,973	2
3	91	EMERGENCY	AGGREGATE						792,102	3
4	44	SKILLED NURSING FACILITY	AGGREGATE				31,960			4
200		TOTAL					199,437	53,323	958,698	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	NEW CAP RE L COSTS-BL DG & FIXT 1	NEW CAP RE L COSTS-MV BLE EQUIP 2	EMPLOYEE B ENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	887,114	887,114				1
2 CAP REL COSTS-MVBLE EQUIP	1,140,021		1,140,021			2
4 EMPLOYEE BENEFITS DEPARTMENT	6,674,893	2,859	837	6,678,589		4
5 ADMINISTRATIVE & GENERAL	3,546,142	86,711	245,082	611,093	4,489,028	5
6 MAINTENANCE & REPAIRS	913,318	11,830	42,501	171,420	1,139,069	6
7 OPERATION OF PLANT	472,203	41,147			513,350	7
8 LAUNDRY & LINEN SERVICE	138,097	16,968	17,263	72,848	245,176	8
9 HOUSEKEEPING	529,002	1,929	1,395	128,573	660,899	9
10 DIETARY	456,544	35,597	4,468	63,905	560,514	10
11 CAFETERIA	638,244	10,099	8,671	125,773	782,787	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,363,630	35,308	72,322	391,566	1,862,826	13
14 CENTRAL SERVICES & SUPPLY	98,406	25,011	21,497	27,120	172,034	14
15 PHARMACY	2,069,762	13,526	88,139	140,294	2,311,721	15
16 MEDICAL RECORDS & LIBRARY	822,803	10,510	4,569	187,511	1,025,393	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,038,299	141,207	82,160	638,218	2,899,884	30
31 INTENSIVE CARE UNIT	724,936	32,911	32,003	231,085	1,020,935	31
40 SUBPROVIDER - IPF	724,085	38,740	831	222,182	985,838	40
43 NURSERY	236,584	4,651	992	72,621	314,848	43
44 SKILLED NURSING FACILITY	1,102,279	47,407	4,645	334,490	1,488,821	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,001,491	54,846	101,614	225,113	1,383,064	50
53 ANESTHESIOLOGY	28,694	325	26,250		55,269	53
54 RADIOLOGY-DIAGNOSTIC	910,390	39,649	149,747	217,931	1,317,717	54
56 RADIOISOTOPE	193,294	3,529	838	7,007	204,668	56
57 CT SCAN	219,032	3,519	39,559	37,021	299,131	57
58 MRI	210,420				210,420	58
60 LABORATORY	2,345,400	37,054	22,987	341,586	2,747,027	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	22,733				22,733	64
65 RESPIRATORY THERAPY	395,409	4,265	3,339	129,464	532,477	65
66 PHYSICAL THERAPY	1,455,944	27,077	11,335	463,126	1,957,482	66
68 SPEECH PATHOLOGY	179,076	1,051		58,346	238,473	68
69 ELECTROCARDIOLOGY	178,914	1,828	5,060		185,802	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,418,182				1,418,182	71
72 IMPL. DEV. CHARGED TO PATIENTS	198,810				198,810	72
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						
91 EMERGENCY	728,219	17,324	76,635	219,658	1,041,836	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES	629,401	25,133	67,006	168,821	890,361	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	869,150	6,768	287	236,851	1,113,056	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	389,649	6,768	44	70,037	466,498	116
118 SUBTOTALS (SUM OF LINES 1-117)	35,950,570	785,547	1,132,076	5,593,660	34,756,129	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	3,630,477	100,816	7,863	1,077,993	4,817,149	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER	21,608	751	82	6,936	29,377	194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	39,602,655	887,114	1,140,021	6,678,589	39,602,655	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL 5	MAINTENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSEKEEPING 9	
GENERAL SERVICE COST CENTERS						1
1 CAP REL COSTS-BLDG & FIXT						2
2 CAP REL COSTS-MVBLE EQUIP						4
4 EMPLOYEE BENEFITS DEPARTMENT						5
5 ADMINISTRATIVE & GENERAL	4,489,028					6
6 MAINTENANCE & REPAIRS	145,622	1,284,691				7
7 OPERATION OF PLANT	65,628	67,278	646,256			8
8 LAUNDRY & LINEN SERVICE	31,344	27,745	14,728	318,993		9
9 HOUSEKEEPING	84,491	3,155	1,675	21,034	771,254	10
10 DIETARY	71,658	58,204	30,897	2,105		11
11 CAFETERIA	100,074	16,512	8,765	4,087		12
12 MAINTENANCE OF PERSONNEL						13
13 NURSING ADMINISTRATION	238,149	57,731	30,646		4,996	14
14 CENTRAL SERVICES & SUPPLY	21,993	40,895	21,709	4,547	15,597	15
15 PHARMACY	295,537	22,116	11,740		1,776	16
16 MEDICAL RECORDS & LIBRARY	131,089	17,185	9,122		888	17
17 SOCIAL SERVICE						19
19 NONPHYSICIAN ANESTHETISTS						20
20 NURSING SCHOOL						21
21 I&R SERVICES-SALARY & FRINGES APPRVD						22
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						23
23 PARAMED ED PRGM-(SPECIFY)						
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	370,730	230,878	122,563	93,962	219,582	30
31 INTENSIVE CARE UNIT	130,519	53,812	28,566	23,535	52,287	31
40 SUBPROVIDER - IPF	126,032	63,343	33,625	9,665	64,165	40
43 NURSERY	40,251	7,604	4,037	3,711	13,876	43
44 SKILLED NURSING FACILITY	190,335	77,514	41,148	91,346	124,777	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	176,815	89,676	47,604	28,692	79,373	50
53 ANESTHESIOLOGY	7,066	531	282		4,440	53
54 RADIOLOGY-DIAGNOSTIC	168,461	64,829	34,414	6,002	38,410	54
56 RADIOISOTOPE	26,165	5,770	3,063	687	4,607	56
57 CT SCAN	38,242	5,753	3,054	26	4,885	57
58 MRI	26,901					58
60 LABORATORY	351,188	60,586	32,162	701	19,538	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	2,906					64
65 RESPIRATORY THERAPY	68,073	6,973	3,702		888	65
66 PHYSICAL THERAPY	250,250	44,273	23,502	4,672	21,703	66
68 SPEECH PATHOLOGY	30,487	1,718	912			68
69 ELECTROCARDIOLOGY	23,753	2,989	1,586		3,330	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	181,305					71
72 IMPL. DEV. CHARGED TO PATIENTS	25,416					72
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						
91 EMERGENCY	133,191	28,326	15,036	21,410	55,506	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES	113,826	41,094	21,814	2,551	1,332	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	142,296	11,066	5,874		10,324	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE		11,066	5,874		10,324	113
116 HOSPICE	59,639					116
118 SUBTOTALS (SUM OF LINES 1-117)	3,869,432	1,118,622	558,100	318,733	752,604	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	615,840	164,840	87,504	260	18,650	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER	3,756	1,229	652			194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,489,028	1,284,691	646,256	318,993	771,254	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	
	10	11	13	14	15	
1 GENERAL SERVICE COST CENTERS						1
2 CAP REL COSTS-BLDG & FIXT						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	723,378					10
11 CAFETERIA		912,225				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		117,946	2,312,294			13
14 CENTRAL SERVICES & SUPPLY		28,307		305,082		14
15 PHARMACY		31,677			2,674,567	15
16 MEDICAL RECORDS & LIBRARY		62,006				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	202,678	127,379	694,810		1,365	30
31 INTENSIVE CARE UNIT	60,543	31,340	204,769		461	31
40 SUBPROVIDER - IPF	80,114	32,014	249,509		16	40
43 NURSERY		8,762	65,750			43
44 SKILLED NURSING FACILITY	380,043	29,655	426,680		65	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		61,669	191,063		787	50
53 ANESTHESIOLOGY		17,860	61,445		34,050	53
54 RADIOLOGY-DIAGNOSTIC		27,970			300	54
56 RADIOISOTOPE		6,066			27	56
57 CT SCAN		13,143			51	57
58 MRI						58
60 LABORATORY		53,581			53	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					45,167	64
65 RESPIRATORY THERAPY		37,743			83,456	65
66 PHYSICAL THERAPY		83,236			479	66
68 SPEECH PATHOLOGY		13,816			2	68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS				265,421		71
72 IMPL. DEV. CHARGED TO PATIENTS				39,661		72
73 DRUGS CHARGED TO PATIENTS					2,471,861	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						
91 EMERGENCY		32,351	200,759		953	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES		34,036	217,509		5,406	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		14,827			243	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE		4,381				116
118 SUBTOTALS (SUM OF LINES 1-117)	723,378	869,765	2,312,294	305,082	2,644,742	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		42,460			29,825	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER						194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	723,378	912,225	2,312,294	305,082	2,674,567	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RE CORDS & LI BRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	16	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	1,245,683				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES APPRVD					21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	389,121	5,352,952		5,352,952	30
31 INTENSIVE CARE UNIT	76,228	1,682,995		1,682,995	31
40 SUBPROVIDER - IPF	16,728	1,661,049		1,661,049	40
43 NURSERY	6,273	465,112		465,112	43
44 SKILLED NURSING FACILITY	28,894	2,879,278		2,879,278	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	108,924	2,167,667		2,167,667	50
53 ANESTHESIOLOGY		180,943		180,943	53
54 RADIOLOGY-DIAGNOSTIC	342	1,658,445		1,658,445	54
56 RADIOISOTOPE		251,053		251,053	56
57 CT SCAN	357	364,642		364,642	57
58 MRI	61	237,382		237,382	58
60 LABORATORY	570	3,265,406		3,265,406	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY		70,806		70,806	64
65 RESPIRATORY THERAPY		733,312		733,312	65
66 PHYSICAL THERAPY	2,281	2,387,878		2,387,878	66
68 SPEECH PATHOLOGY		285,408		285,408	68
69 ELECTROCARDIOLOGY		217,460		217,460	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,864,908		1,864,908	71
72 IMPL. DEV. CHARGED TO PATIENTS		263,887		263,887	72
73 DRUGS CHARGED TO PATIENTS		2,471,861		2,471,861	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					
91 EMERGENCY	133,446	1,662,814		1,662,814	91
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
95 AMBULANCE SERVICES	1,141	1,329,070		1,329,070	95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY		1,297,686		1,297,686	101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
116 HOSPICE		557,782		557,782	116
118 SUBTOTALS (SUM OF LINES 1-117)	764,366	33,309,796		33,309,796	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES	481,317	6,257,845		6,257,845	192
194 OTHER NONREIMBURSABLE					194
194.01 MEMORY DISORDER		35,014		35,014	194.01
194.02 ASSISTED LIVING					194.02
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	1,245,683	39,602,655		39,602,655	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP RE L COSTS-BL DG & FIXT 1	NEW CAP RE L COSTS-MV BLE EQUIP 2	SUBTOTAL 2A	EMPLOYEE B ENEFITS DEPARTMENT 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT		2,859	837	3,696	3,696	4
5 ADMINISTRATIVE & GENERAL	2,685	86,711	245,082	334,478	338	5
6 MAINTENANCE & REPAIRS		11,830	42,501	54,331	95	6
7 OPERATION OF PLANT		41,147		41,147		7
8 LAUNDRY & LINEN SERVICE		16,968	17,263	34,231	40	8
9 HOUSEKEEPING		1,929	1,395	3,324	71	9
10 DIETARY		35,597	4,468	40,065	35	10
11 CAFETERIA		10,099	8,671	18,770	70	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		35,308	72,322	107,630	216	13
14 CENTRAL SERVICES & SUPPLY		25,011	21,497	46,508	15	14
15 PHARMACY		13,526	88,139	101,665	78	15
16 MEDICAL RECORDS & LIBRARY		10,510	4,569	15,079	104	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	9,750	141,207	82,160	233,117	353	30
31 INTENSIVE CARE UNIT	108	32,911	32,003	65,022	128	31
40 SUBPROVIDER - IPF		38,740	831	39,571	123	40
43 NURSERY		4,651	992	5,643	40	43
44 SKILLED NURSING FACILITY	6,036	47,407	4,645	58,088	185	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	164,807	54,846	101,614	321,267	124	50
53 ANESTHESIOLOGY		325	26,250	26,575		53
54 RADIOLOGY-DIAGNOSTIC		39,649	149,747	189,396	120	54
56 RADIOISOTOPE		3,529	838	4,367	4	56
57 CT SCAN		3,519	39,559	43,078	20	57
58 MRI						58
60 LABORATORY	52,648	37,054	22,987	112,689	189	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY	6,000	4,265	3,339	13,604	72	65
66 PHYSICAL THERAPY		27,077	11,335	38,412	256	66
68 SPEECH PATHOLOGY		1,051		1,051	32	68
69 ELECTROCARDIOLOGY		1,828	5,060	6,888		69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
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						
91 EMERGENCY		17,324	76,635	93,959	121	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES		25,133	67,006	92,139	93	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	18,644	6,768	287	25,699	131	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	59,481	6,768	44	66,293	39	116
118 SUBTOTALS (SUM OF LINES 1-117)	320,159	785,547	1,132,076	2,237,782	3,092	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	712	100,816	7,863	109,391	600	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER		751	82	833	4	194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	320,871	887,114	1,140,021	2,348,006	3,696	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	5	6	7	8	9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	334,816					5
6 MAINTENANCE & REPAIRS	10,861	65,287				6
7 OPERATION OF PLANT	4,895	3,419	49,461			7
8 LAUNDRY & LINEN SERVICE	2,338	1,410	1,127	39,146		8
9 HOUSEKEEPING	6,302	160	128	2,581	12,566	9
10 DIETARY	5,345	2,958	2,365	258		10
11 CAFETERIA	7,464	839	671	502		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	17,762	2,934	2,345		81	13
14 CENTRAL SERVICES & SUPPLY	1,640	2,078	1,661	558	254	14
15 PHARMACY	22,042	1,124	899		29	15
16 MEDICAL RECORDS & LIBRARY	9,777	873	698		14	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	27,650	11,737	9,381	11,532	3,580	30
31 INTENSIVE CARE UNIT	9,735	2,735	2,186	2,888	852	31
40 SUBPROVIDER - IPF	9,400	3,219	2,573	1,186	1,045	40
43 NURSERY	3,002	386	309	455	226	43
44 SKILLED NURSING FACILITY	14,196	3,939	3,149	11,210	2,033	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	13,188	4,557	3,643	3,521	1,293	50
53 ANESTHESIOLOGY	527	27	22		72	53
54 RADIOLOGY-DIAGNOSTIC	12,564	3,295	2,634	737	626	54
56 RADIOISOTOPE	1,952	293	234	84	75	56
57 CT SCAN	2,852	292	234	3	80	57
58 MRI	2,006					58
60 LABORATORY	26,193	3,079	2,461	86	318	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	217					64
65 RESPIRATORY THERAPY	5,077	354	283		14	65
66 PHYSICAL THERAPY	18,665	2,250	1,799	573	354	66
68 SPEECH PATHOLOGY	2,274	87	70			68
69 ELECTROCARDIOLOGY	1,772	152	121		54	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,522					71
72 IMPL. DEV. CHARGED TO PATIENTS	1,896					72
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						
91 EMERGENCY	9,934	1,439	1,151	2,627	904	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES	8,490	2,088	1,670	313	22	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	10,613	562	450		168	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE	4,448	562	450		168	116
118 SUBTOTALS (SUM OF LINES 1-117)	288,599	56,848	42,714	39,114	12,262	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	45,937	8,377	6,697	32	304	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER	280	62	50			194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	334,816	65,287	49,461	39,146	12,566	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	51,026					10
11 CAFETERIA		28,316				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		3,661	134,629			13
14 CENTRAL SERVICES & SUPPLY		879		53,593		14
15 PHARMACY		983			126,820	15
16 MEDICAL RECORDS & LIBRARY		1,925				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	14,297	3,954	40,451		65	30
31 INTENSIVE CARE UNIT	4,271	973	11,923		22	31
40 SUBPROVIDER - IPF	5,651	994	14,528		1	40
43 NURSERY		272	3,828			43
44 SKILLED NURSING FACILITY	26,807	921	24,843		3	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		1,914	11,125			37
53 ANESTHESIOLOGY		554	3,578			50
54 RADIOLOGY-DIAGNOSTIC		868			1,614	53
56 RADIOISOTOPE		188			14	54
57 CT SCAN		408			1	56
58 MRI					2	57
60 LABORATORY		1,663				58
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					3	60
64 INTRAVENOUS THERAPY						62.30
65 RESPIRATORY THERAPY		1,172			2,142	64
66 PHYSICAL THERAPY		2,584			3,957	65
68 SPEECH PATHOLOGY		429			23	66
69 ELECTROCARDIOLOGY						68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS				46,626		69
72 IMPL. DEV. CHARGED TO PATIENTS				6,967		71
73 DRUGS CHARGED TO PATIENTS						72
74 RENAL DIALYSIS					117,209	73
76.97 CARDIAC REHABILITATION						74
76.98 HYPERBARIC OXYGEN THERAPY						76.97
76.99 LITHOTRIPSY						76.98
OUTPATIENT SERVICE COST CENTERS						76.99
91 EMERGENCY		1,004	11,689		45	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES		1,056	12,664		256	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		460			12	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
116 HOSPICE		136				116
118 SUBTOTALS (SUM OF LINES 1-117)	51,026	26,998	134,629	53,593	125,406	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		1,318			1,414	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER						194.01
194.02 ASSISTED LIVING						194.02
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	51,026	28,316	134,629	53,593	126,820	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RE CORDS & LI BRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	28,470				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES APPRVD					21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	8,893	365,010		365,010	30
31 INTENSIVE CARE UNIT	1,742	102,477		102,477	31
40 SUBPROVIDER - IPF	382	78,673		78,673	40
43 NURSERY	143	14,304		14,304	43
44 SKILLED NURSING FACILITY	660	146,034		146,034	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	2,489	363,158		363,158	50
53 ANESTHESIOLOGY		32,969		32,969	53
54 RADIOLOGY-DIAGNOSTIC	8	210,262		210,262	54
56 RADIOISOTOPE		7,198		7,198	56
57 CT SCAN	8	46,977		46,977	57
58 MRI	1	2,007		2,007	58
60 LABORATORY	13	146,694		146,694	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY		2,359		2,359	64
65 RESPIRATORY THERAPY		24,533		24,533	65
66 PHYSICAL THERAPY	52	64,968		64,968	66
68 SPEECH PATHOLOGY		3,943		3,943	68
69 ELECTROCARDIOLOGY		8,987		8,987	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		60,148		60,148	71
72 IMPL. DEV. CHARGED TO PATIENTS		8,863		8,863	72
73 DRUGS CHARGED TO PATIENTS		117,209		117,209	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					
91 EMERGENCY	3,050	125,923		125,923	91
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
95 AMBULANCE SERVICES	26	118,817		118,817	95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY		38,095		38,095	101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE		72,096		72,096	113
116 HOSPICE		72,096		72,096	116
118 SUBTOTALS (SUM OF LINES 1-117)	17,467	2,161,704		2,161,704	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES	11,003	185,073		185,073	192
194 OTHER NONREIMBURSABLE					194
194.01 MEMORY DISORDER		1,229		1,229	194.01
194.02 ASSISTED LIVING					194.02
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	28,470	2,348,006		2,348,006	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET 1	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE -NEW 2	EMPLOYEE B ENEFITS DEPARTMENT GROSS SALARIES 4	RECON- CILIATION 5A	ADMINISTRA TIVE & GEN ERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	174,720					1
2 CAP REL COSTS-MVBLE EQUIP		1,122,240				2
4 EMPLOYEE BENEFITS DEPARTMENT	563	824	19,746,665			4
5 ADMINISTRATIVE & GENERAL	17,078	241,258	1,806,824	-4,489,028	35,113,627	5
6 MAINTENANCE & REPAIRS	2,330	41,838	506,840		1,139,069	6
7 OPERATION OF PLANT	8,104				513,350	7
8 LAUNDRY & LINEN SERVICE	3,342	16,994	215,389		245,176	8
9 HOUSEKEEPING	380	1,373	380,152		660,899	9
10 DIETARY	7,011	4,398	188,947		560,514	10
11 CAFETERIA	1,989	8,536	371,873		782,787	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	6,954	71,194	1,157,746		1,862,826	13
14 CENTRAL SERVICES & SUPPLY	4,926	21,162	80,186		172,034	14
15 PHARMACY	2,664	86,764	414,808		2,311,721	15
16 MEDICAL RECORDS & LIBRARY	2,070	4,498	554,415		1,025,393	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	27,811	80,879	1,887,024		2,899,884	30
31 INTENSIVE CARE UNIT	6,482	31,504	683,251		1,020,935	31
40 SUBPROVIDER - IPF	7,630	818	656,927		985,838	40
43 NURSERY	916	977	214,720		314,848	43
44 SKILLED NURSING FACILITY	9,337	4,573	988,989		1,488,821	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	10,802	100,029	665,593		1,383,064	50
53 ANESTHESIOLOGY	64	25,841			55,269	53
54 RADIOLOGY-DIAGNOSTIC	7,809	147,411	644,357		1,317,717	54
56 RADIOISOTOPE	695	825	20,717		204,668	56
57 CT SCAN	693	38,942	109,459		299,131	57
58 MRI					210,420	58
60 LABORATORY	7,298	22,628	1,009,970		2,747,027	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					22,733	64
65 RESPIRATORY THERAPY	840	3,287	382,787		532,477	65
66 PHYSICAL THERAPY	5,333	11,158	1,369,327		1,957,482	66
68 SPEECH PATHOLOGY	207		172,511		238,473	68
69 ELECTROCARDIOLOGY	360	4,981			185,802	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS					1,418,182	71
72 IMPL. DEV. CHARGED TO PATIENTS					198,810	72
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						
91 EMERGENCY	3,412	75,440	649,465		1,041,836	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES	4,950	65,961	499,153		890,361	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,333	283	700,300		1,113,056	101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	1,333	43	207,078		466,498	116
118 SUBTOTALS (SUM OF LINES 1-117)	154,716	1,114,419	16,538,808	-4,489,028	30,267,101	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	19,856	7,740	3,187,348		4,817,149	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER	148	81	20,509		29,377	194.01
194.02 ASSISTED LIVING						194.02

PROVIDER CCN: 14-0147 RICHLAND MEMORIAL HOSPITAL
 PERIOD FROM 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11
 02/11/2014 09:36

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET 1	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE -NEW 2	EMPLOYEE B ENEFITS DEPARTMENT GROSS SALARIES 4	RECON- CILIATION 5A	ADMINISTRA TIVE & GEN ERAL ACCUM COST 5	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	887,114	1,140,021	6,678,589		4,489,028	202
203 UNIT COST MULT-WS B PT I	5.077347	1.015844	0.338214		0.127843	203
204 COST TO BE ALLOC PER B PT II			3,696		334,816	204
205 UNIT COST MULT-WS B PT II			0.000187		0.009535	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAINTENANCE & REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE ICE LAUNDRY POUNDS 8	HOUSEKEEPING HOURS OF SERVICE 9	DIETARY DIETARY MEALS SERVED 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	154,749					6
7 OPERATION OF PLANT	8,104	146,645				7
8 LAUNDRY & LINEN SERVICE	3,342	3,342	559,359			8
9 HOUSEKEEPING	380	380	36,883	694,750		9
10 DIETARY	7,011	7,011	3,691		85,680	10
11 CAFETERIA	1,989	1,989	7,166			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	6,954	6,954		4,500		13
14 CENTRAL SERVICES & SUPPLY	4,926	4,926	7,974	14,050		14
15 PHARMACY	2,664	2,664		1,600		15
16 MEDICAL RECORDS & LIBRARY	2,070	2,070		800		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	27,811	27,811	164,766	197,800	24,006	30
31 INTENSIVE CARE UNIT	6,482	6,482	41,269	47,100	7,171	31
40 SUBPROVIDER - IPF	7,630	7,630	16,947	57,800	9,489	40
43 NURSERY	916	916	6,508	12,500		43
44 SKILLED NURSING FACILITY	9,337	9,337	160,177	112,400	45,014	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	10,802	10,802	50,311	71,500		50
53 ANESTHESIOLOGY	64	64		4,000		53
54 RADIOLOGY-DIAGNOSTIC	7,809	7,809	10,524	34,600		54
56 RADIOISOTOPE	695	695	1,204	4,150		56
57 CT SCAN	693	693	46	4,400		57
58 MRI						58
60 LABORATORY	7,298	7,298	1,229	17,600		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY	840	840		800		65
66 PHYSICAL THERAPY	5,333	5,333	8,192	19,550		66
68 SPEECH PATHOLOGY	207	207				68
69 ELECTROCARDIOLOGY	360	360		3,000		69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
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						
91 EMERGENCY	3,412	3,412	37,543	50,000		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES	4,950	4,950	4,473	1,200		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,333	1,333		9,300		101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	1,333	1,333		9,300		116
118 SUBTOTALS (SUM OF LINES 1-117)	134,745	126,641	558,903	677,950	85,680	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	19,856	19,856	456	16,800		192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER	148	148				194.01
194.02 ASSISTED LIVING						194.02

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAINTENANC E & REPAIR S SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERV ICE LAUNDRY POUNDS 8	HOUSEKEEPI NG HOURS OF SERVICE 9	DIETARY MEALS SERV 10	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,284,691	646,256	318,993	771,254	723,378	202
203 UNIT COST MULT-WS B PT I	8.301773	4.406942	0.570283	1.110117	8.442787	203
204 COST TO BE ALLOC PER B PT II	65,287	49,461	39,146	12,566	51,026	204
205 UNIT COST MULT-WS B PT II	0.421890	0.337284	0.069984	0.018087	0.595542	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	MEDICAL RE CORDS & LI BRARY	
	CAFE MEALS SERV 11	DIRECT NURSING HO 13	CS COSTED REQUIS 14	PHARM COSTED REQ 15	TIME SPENT 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	2,707					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	350	31,309,800				13
14 CENTRAL SERVICES & SUPPLY	84		100			14
15 PHARMACY	94			136,349,800		15
16 MEDICAL RECORDS & LIBRARY	184				163,825	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	378	9,408,100		69,600	51,175	30
31 INTENSIVE CARE UNIT	93	2,772,700		23,500	10,025	31
40 SUBPROVIDER - IPF	95	3,378,500		800	2,200	40
43 NURSERY	26	890,300			825	43
44 SKILLED NURSING FACILITY	88	5,777,500		3,300	3,800	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	183	2,587,100		40,100	14,325	50
53 ANESTHESIOLOGY	53	832,000		1,735,900		53
54 RADIOLOGY-DIAGNOSTIC	83			15,300	45	54
56 RADIOISOTOPE	18			1,400		56
57 CT SCAN	39			2,600	47	57
58 MRI					8	58
60 LABORATORY	159			2,700	75	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY				2,302,700		64
65 RESPIRATORY THERAPY	112			4,254,700		65
66 PHYSICAL THERAPY	247			24,400	300	66
68 SPEECH PATHOLOGY	41			100		68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			87			71
72 IMPL. DEV. CHARGED TO PATIENTS			13			72
73 DRUGS CHARGED TO PATIENTS				126,015,600		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						
91 EMERGENCY	96	2,718,400		48,600	17,550	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS				275,600	150	94
95 AMBULANCE SERVICES	101	2,945,200				95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	44			12,400		101
SPECIAL PURPOSE COST CENTERS						
116 HOSPICE	13					116
118 SUBTOTALS (SUM OF LINES 1-117)	2,581	31,309,800	100	134,829,300	100,525	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	126			1,520,500	63,300	192
194 OTHER NONREIMBURSABLE						194
194.01 MEMORY DISORDER						194.01
194.02 ASSISTED LIVING						194.02

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	MEDICAL RE CORDS & LI BRARY	
	CAFE MEALS SERV 11	DIRECT NURSING HO 13	CS COSTED REQUIS 14	PHARM COSTED REQ 15	TIME SPENT 16	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	912,225	2,312,294	305,082	2,674,567	1,245,683	202
203 UNIT COST MULT-WS B PT I	336.987440	0.073852	3,050.820000	0.019615	7.603742	203
204 COST TO BE ALLOC PER B PT II	28,316	134,629	53,593	126,820	28,470	204
205 UNIT COST MULT-WS B PT II	10.460288	0.004300	535.930000	0.000930	0.173783	205

COMPUTATION OF RATIO OF COST TO CHARGES

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,352,952		5,352,952		5,352,952	30
31 INTENSIVE CARE UNIT	1,682,995		1,682,995		1,682,995	31
40 SUBPROVIDER - IPF	1,661,049		1,661,049	53,323	1,714,372	40
43 NURSERY	465,112		465,112		465,112	43
44 SKILLED NURSING FACILITY	2,879,278		2,879,278		2,879,278	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,167,667		2,167,667		2,167,667	50
53 ANESTHESIOLOGY	180,943		180,943		180,943	53
54 RADIOLOGY-DIAGNOSTIC	1,658,445		1,658,445		1,658,445	54
56 RADIOISOTOPE	251,053		251,053		251,053	56
57 CT SCAN	364,642		364,642		364,642	57
58 MRI	237,382		237,382		237,382	58
60 LABORATORY	3,265,406		3,265,406		3,265,406	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
64 INTRAVENOUS THERAPY	70,806		70,806		70,806	64
65 RESPIRATORY THERAPY	733,312		733,312		733,312	65
66 PHYSICAL THERAPY	2,387,878		2,387,878		2,387,878	66
68 SPEECH PATHOLOGY	285,408		285,408		285,408	68
69 ELECTROCARDIOLOGY	217,460		217,460		217,460	69
71 MEDICAL SUPPLIES CHARGED TO	1,864,908		1,864,908		1,864,908	71
72 IMPL. DEV. CHARGED TO PATIE	263,887		263,887		263,887	72
73 DRUGS CHARGED TO PATIENTS	2,471,861		2,471,861		2,471,861	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						
91 EMERGENCY	1,662,814		1,662,814		1,662,814	91
92 OBSERVATION BEDS (NON-DISTI OTHER REIMBURSABLE COST CENTERS	835,923		835,923		835,923	92
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES	1,329,070		1,329,070		1,329,070	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	1,297,686		1,297,686		1,297,686	101
113 INTEREST EXPENSE						113
116 HOSPICE	557,782		557,782		557,782	116
200 SUBTOTAL (SEE INSTRUCTIONS)	34,145,719		34,145,719	53,323	34,199,042	200
201 LESS OBSERVATION BEDS	835,923		835,923		835,923	201
202 TOTAL (SEE INSTRUCTIONS)	33,309,796		33,309,796		33,363,119	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,597,335		5,597,335			30
31 INTENSIVE CARE UNIT	1,677,929		1,677,929			31
40 SUBPROVIDER - IPF	2,288,076		2,288,076			40
43 NURSERY	586,354		586,354			43
44 SKILLED NURSING FACILITY	2,156,606		2,156,606			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,666,450	9,908,549	13,574,999	0.159681	0.159681	50
53 ANESTHESIOLOGY	2,448,136	2,937,793	5,385,929	0.033596	0.033596	53
54 RADIOLOGY-DIAGNOSTIC	1,419,800	7,422,295	8,842,095	0.187562	0.187562	54
56 RADIOISOTOPE	178,784	2,104,977	2,283,761	0.109930	0.109930	56
57 CT SCAN	1,479,631	7,628,703	9,108,334	0.040034	0.040034	57
58 MRI	133,909	1,488,416	1,622,325	0.146322	0.146322	58
60 LABORATORY	5,388,514	17,863,914	23,252,428	0.140433	0.140433	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
64 INTRAVENOUS THERAPY	708,063	213,713	921,776	0.076815	0.076815	64
65 RESPIRATORY THERAPY	2,808,720	641,539	3,450,259	0.212538	0.212538	65
66 PHYSICAL THERAPY	2,485,567	5,240,190	7,725,757	0.309080	0.309080	66
68 SPEECH PATHOLOGY	255,384	591,033	846,417	0.337195	0.337195	68
69 ELECTROCARDIOLOGY	370,306	2,017,044	2,387,350	0.091088	0.091088	69
71 MEDICAL SUPPLIES CHARGED TO	2,709,583	2,464,907	5,174,490	0.360404	0.360404	71
72 IMPL. DEV. CHARGED TO PATIE	191,237	468,852	660,089	0.399775	0.399775	72
73 DRUGS CHARGED TO PATIENTS	5,446,260	4,679,761	10,126,021	0.244110	0.244110	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						
91 EMERGENCY	1,354,903	6,488,092	7,842,995	0.212013	0.212013	91
92 OBSERVATION BEDS (NON-DISTI	492,499	1,156,840	1,649,339	0.506823	0.506823	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES	63,772	1,822,867	1,886,639	0.704464	0.704464	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		2,637,014	2,637,014			101
113 INTEREST EXPENSE						113
116 HOSPICE		1,394,196	1,394,196			116
200 SUBTOTAL (SEE INSTRUCTIONS)	43,907,818	79,170,695	123,078,513			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	43,907,818	79,170,695	123,078,513			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)			
	1	2	3	4	5	6	7	
30 INPAT ROUTINE SERV COST CTRS	365,010	3,540	361,470	5,682	63.62	2,840	180,681	30
31 ADULTS & PEDIATRICS	102,477		102,477	1,430	71.66	1,090	78,109	31
32 INTENSIVE CARE UNIT								32
33 CORONARY CARE UNIT								33
34 BURN INTENSIVE CARE UNIT								34
35 SURGICAL INTENSIVE CARE UNIT								35
40 OTHER SPECIAL CARE (SPECIFY)								40
41 SUBPROVIDER - IPF	78,673		78,673	2,165	36.34	543	19,733	41
42 SUBPROVIDER - IRF								42
43 SUBPROVIDER I								43
44 NURSERY	14,304		14,304	633	22.60			44
45 SKILLED NURSING FACILITY	146,034		146,034	10,270	14.22	2,999	42,646	45
200 NURSING FACILITY								200
TOTAL (LINES 30-199)	706,498		702,958	20,180		7,472	321,169	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[XX] HOSPITAL (14-0147) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	363,158	13,574,999	0.026752	1,014,052	27,128	50
53	ANESTHESIOLOGY	32,969	5,385,929	0.006121	293,287	1,795	53
54	RADIOLOGY-DIAGNOSTIC	210,262	8,842,095	0.023780	1,205,367	28,664	54
56	RADIOISOTOPE	7,198	2,283,761	0.003152	149,381	471	56
57	CT SCAN	46,977	9,108,334	0.005158	1,258,353	6,491	57
58	MRI	2,007	1,622,325	0.001237	85,605	106	58
60	LABORATORY	146,694	23,252,428	0.006309	4,208,998	26,555	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
64	INTRAVENOUS THERAPY	2,359	921,776	0.002559	284,089	727	64
65	RESPIRATORY THERAPY	24,533	3,450,259	0.007110	1,704,859	12,122	65
66	PHYSICAL THERAPY	64,968	7,725,757	0.008409	578,225	4,862	66
68	SPEECH PATHOLOGY	3,943	846,417	0.004658	63,339	295	68
69	ELECTROCARDIOLOGY	8,987	2,387,350	0.003764	316,513	1,191	69
71	MEDICAL SUPPLIES CHARGED TO P	60,148	5,174,490	0.011624	884,212	10,278	71
72	IMPL. DEV. CHARGED TO PATIENT	8,863	660,089	0.013427	105,979	1,423	72
73	DRUGS CHARGED TO PATIENTS	117,209	10,126,021	0.011575	3,001,380	34,741	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							
91	EMERGENCY	125,923	7,842,995	0.016055	1,114,495	17,893	91
92	OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	57,558	1,649,339	0.034898	226,972	7,921	92
94	HOME PROGRAM DIALYSIS						94
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	1,283,756	104,854,364		16,495,106	182,663	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	5,682		2,840		30
31 INTENSIVE CARE UNIT	1,430		1,090		31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF	2,165		543		40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	633				43
44 SKILLED NURSING FACILITY	10,270		2,999		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	20,180		7,472		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-0147)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[]	SNF	[]		[]	TEFRA
BOXES	[]	TITLE XIX	[]	IRF	[]	NF	[]			
COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P				
	PHYSICIAN ANESTHETIST COST						SCHOOL	HEALTH	MEDICAL EDUCATION COST	COST (SUM OF COLS.1-4)
	1	2	3	4	5	6				
ANCILLARY SERVICE COST CENTERS										
50 OPERATING ROOM						50				
53 ANESTHESIOLOGY						53				
54 RADIOLOGY-DIAGNOSTIC						54				
56 RADIOISOTOPE						56				
57 CT SCAN						57				
58 MRI						58				
60 LABORATORY						60				
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30				
64 INTRAVENOUS THERAPY						64				
65 RESPIRATORY THERAPY						65				
66 PHYSICAL THERAPY						66				
68 SPEECH PATHOLOGY						68				
69 ELECTROCARDIOLOGY						69				
71 MEDICAL SUPPLIES CHARGED TO P						71				
72 IMPL. DEV. CHARGED TO PATIENT						72				
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										
91 EMERGENCY						91				
92 OBSERVATION BEDS (NON-DISTINC						92				
OTHER REIMBURSABLE COST CENTERS										
94 HOME PROGRAM DIALYSIS						94				
95 AMBULANCE SERVICES						95				
200 TOTAL (SUM OF LINES 50-199)						200				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)	
	7	8	9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	13,574,999			1,014,052		3,059,765		50
53 ANESTHESIOLOGY	5,385,929			293,287		623,875		53
54 RADIOLOGY-DIAGNOSTIC	8,842,095			1,205,367		2,553,784		54
56 RADIOISOTOPE	2,283,761			149,381		1,108,289		56
57 CT SCAN	9,108,334			1,258,353		2,789,169		57
58 MRI	1,622,325			85,605		510,756		58
60 LABORATORY	23,252,428			4,208,998		811,360		60
62.30 BLOOD CLOTTING FOR HEMOPHILI								62.30
64 INTRAVENOUS THERAPY	921,776			284,089		131,319		64
65 RESPIRATORY THERAPY	3,450,259			1,704,859		343,888		65
66 PHYSICAL THERAPY	7,725,757			578,225				66
68 SPEECH PATHOLOGY	846,417			63,339		23,168		68
69 ELECTROCARDIOLOGY	2,387,350			316,513		891,807		69
71 MEDICAL SUPPLIES CHARGED TO	5,174,490			884,212		834,525		71
72 IMPL. DEV. CHARGED TO PATIEN	660,089			105,979		249,686		72
73 DRUGS CHARGED TO PATIENTS	10,126,021			3,001,380		2,374,150		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								
91 EMERGENCY	7,842,995			1,114,495		1,580,366		91
92 OBSERVATION BEDS (NON-DISTIN	1,649,339			226,972		346,125		92
OTHER REIMBURSABLE COST CENTERS								
94 HOME PROGRAM DIALYSIS								94
95 AMBULANCE SERVICES								95
200 TOTAL (SUM OF LINES 50-199)	104,854,364			16,495,106		18,232,032		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.159681	3,059,765			488,586		50	
53 ANESTHESIOLOGY	0.033596	623,875			20,960		53	
54 RADIOLOGY-DIAGNOSTIC	0.187562	2,553,784			478,993		54	
56 RADIOISOTOPE	0.109930	1,108,289			121,834		56	
57 CT SCAN	0.040034	2,789,169			111,662		57	
58 MRI	0.146322	510,756			74,735		58	
60 LABORATORY	0.140433	811,360			113,942		60	
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
64 INTRAVENOUS THERAPY	0.076815	131,319			10,087		64	
65 RESPIRATORY THERAPY	0.212538	343,888			73,089		65	
66 PHYSICAL THERAPY	0.309080						66	
68 SPEECH PATHOLOGY	0.337195	23,168			7,812		68	
69 ELECTROCARDIOLOGY	0.091088	891,807			81,233		69	
71 MEDICAL SUPPLIES CHARGED TO PAT	0.360404	834,525			300,766		71	
72 IMPL. DEV. CHARGED TO PATIENTS	0.399775	249,686			99,818		72	
73 DRUGS CHARGED TO PATIENTS	0.244110	2,374,150		13,707	579,554		73	
74 RENAL DIALYSIS						3,346	74	
76.97 CARDIAC REHABILITATION							76.97	
76.98 HYPERBARIC OXYGEN THERAPY							76.98	
76.99 LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.212013	1,580,366			335,058		91	
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.506823	346,125			175,424		92	
HOME PROGRAM DIALYSIS							94	
94 HOME PROGRAM DIALYSIS							94	
95 AMBULANCE SERVICES	0.704464						95	
200 SUBTOTAL (SEE INSTRUCTIONS)		18,232,032		13,707	3,073,553		3,346 200	
201 LESS PBP CLINIC LAB SERVICES							201	
202 NET CHARGES (LINE 200 - LINE 201)		18,232,032		13,707	3,073,553		3,346 202	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
57 CT SCAN						57
58 MRI						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
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						
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO		PASS-THRU		CHARGES
	(FROM WKST	CHARGES	CHARGES	PGM	(COL. 8 x	(COL. 9 x	(COL. 12)
	C, PT. I,	(COL. 5 ÷	(COL. 6 ÷	CHARGES	COL. 10)	COL. 12)	COL. 12)
	COL. 8)	COL. 7)	COL. 7)	10	11	12	13
	7	8	9				
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	13,574,999						50
53 ANESTHESIOLOGY	5,385,929						53
54 RADIOLOGY-DIAGNOSTIC	8,842,095			5,253			54
56 RADIOISOTOPE	2,283,761						56
57 CT SCAN	9,108,334			6,232			57
58 MRI	1,622,325						58
60 LABORATORY	23,252,428			79,004			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
64 INTRAVENOUS THERAPY	921,776			80			64
65 RESPIRATORY THERAPY	3,450,259			1,733			65
66 PHYSICAL THERAPY	7,725,757			1,165			66
68 SPEECH PATHOLOGY	846,417			1,227			68
69 ELECTROCARDIOLOGY	2,387,350			2,747			69
71 MEDICAL SUPPLIES CHARGED TO	5,174,490			3,853			71
72 IMPL. DEV. CHARGED TO PATIEN	660,089						72
73 DRUGS CHARGED TO PATIENTS	10,126,021			152,628			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							
91 EMERGENCY	7,842,995			57,542			91
92 OBSERVATION BEDS (NON-DISTIN	1,649,339						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
95 AMBULANCE SERVICES							95
200 TOTAL (SUM OF LINES 50-199)	104,854,364			311,464			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.159681						50	
53 ANESTHESIOLOGY	0.033596						53	
54 RADIOLOGY-DIAGNOSTIC	0.187562						54	
56 RADIOISOTOPE	0.109930						56	
57 CT SCAN	0.040034						57	
58 MRI	0.146322						58	
60 LABORATORY	0.140433						60	
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
64 INTRAVENOUS THERAPY	0.076815						64	
65 RESPIRATORY THERAPY	0.212538						65	
66 PHYSICAL THERAPY	0.309080						66	
68 SPEECH PATHOLOGY	0.337195						68	
69 ELECTROCARDIOLOGY	0.091088						69	
71 MEDICAL SUPPLIES CHARGED TO PAT	0.360404						71	
72 IMPL. DEV. CHARGED TO PATIENTS	0.399775						72	
73 DRUGS CHARGED TO PATIENTS	0.244110						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								
91 EMERGENCY	0.212013						91	
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.506823						92	
HOME PROGRAM DIALYSIS							94	
94 HOME PROGRAM DIALYSIS							94	
95 AMBULANCE SERVICES	0.704464						95	
200 SUBTOTAL (SEE INSTRUCTIONS)							200	
201 LESS PBP CLINIC LAB SERVICES							201	
202 NET CHARGES (LINE 200 - LINE 201)							202	

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (14-U147)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.159681							50
53 ANESTHESIOLOGY	0.033596							53
54 RADIOLOGY-DIAGNOSTIC	0.187562							54
56 RADIOISOTOPE	0.109930							56
57 CT SCAN	0.040034							57
58 MRI	0.146322							58
60 LABORATORY	0.140433							60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64 INTRAVENOUS THERAPY	0.076815							64
65 RESPIRATORY THERAPY	0.212538							65
66 PHYSICAL THERAPY	0.309080							66
68 SPEECH PATHOLOGY	0.337195							68
69 ELECTROCARDIOLOGY	0.091088							69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.360404							71
72 IMPL. DEV. CHARGED TO PATIENTS	0.399775							72
73 DRUGS CHARGED TO PATIENTS	0.244110							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								
91 EMERGENCY	0.212013							91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.506823							92
94 HOME PROGRAM DIALYSIS								94
95 AMBULANCE SERVICES	0.704464							95
200 SUBTOTAL (SEE INSTRUCTIONS)								200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
57 CT SCAN						57
58 MRI						58
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
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						
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	13,574,999			1,188			50
53 ANESTHESIOLOGY	5,385,929						53
54 RADIOLOGY-DIAGNOSTIC	8,842,095			82,050			54
56 RADIOISOTOPE	2,283,761						56
57 CT SCAN	9,108,334			51,244			57
58 MRI	1,622,325			7,532			58
60 LABORATORY	23,252,428			313,826			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
64 INTRAVENOUS THERAPY	921,776			44,341			64
65 RESPIRATORY THERAPY	3,450,259			816,449			65
66 PHYSICAL THERAPY	7,725,757			1,583,587			66
68 SPEECH PATHOLOGY	846,417			135,609			68
69 ELECTROCARDIOLOGY	2,387,350			2,747			69
71 MEDICAL SUPPLIES CHARGED TO	5,174,490			153,978			71
72 IMPL. DEV. CHARGED TO PATIEN	660,089						72
73 DRUGS CHARGED TO PATIENTS	10,126,021			890,634			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							
91 EMERGENCY	7,842,995						91
92 OBSERVATION BEDS (NON-DISTIN	1,649,339			5,189			92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
95 AMBULANCE SERVICES							95
200 TOTAL (SUM OF LINES 50-199)	104,854,364			4,088,374			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.159681							50
53 ANESTHESIOLOGY	0.033596							53
54 RADIOLOGY-DIAGNOSTIC	0.187562							54
56 RADIOISOTOPE	0.109930							56
57 CT SCAN	0.040034							57
58 MRI	0.146322							58
60 LABORATORY	0.140433							60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64 INTRAVENOUS THERAPY	0.076815							64
65 RESPIRATORY THERAPY	0.212538							65
66 PHYSICAL THERAPY	0.309080							66
68 SPEECH PATHOLOGY	0.337195							68
69 ELECTROCARDIOLOGY	0.091088							69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.360404							71
72 IMPL. DEV. CHARGED TO PATIENTS	0.399775							72
73 DRUGS CHARGED TO PATIENTS	0.244110							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								
91 EMERGENCY	0.212013							91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.506823							92
94 HOME PROGRAM DIALYSIS								94
95 AMBULANCE SERVICES	0.704464							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 (14-0147) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,946	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,682	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,786	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	66	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)	198	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)	2,840	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)	66	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)	198	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	192.90	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	197.90	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	119.75	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	119.75	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,352,952	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	12,731	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	39,184	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)	51,915	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,301,037	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		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)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,301,037	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

38	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							
39	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)						932.95	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)						2,649,578	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)						2,649,578	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	
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42	NURSERY (TITLES V AND XIX ONLY)							42
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43	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
44	INTENSIVE CARE UNIT	1,682,995	1,430	1,176.92	1,090	1,282,843		43
44	CORONARY CARE UNIT							44
45	BURN INTENSIVE CARE UNIT							45
46	SURGICAL INTENSIVE CARE UNIT							46
47	OTHER SPECIAL CARE (SPECIFY)							47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					3,126,372		48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					7,058,793		49

50	PASS-THROUGH COST ADJUSTMENTS							
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					258,790		50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					182,663		51
52	TOTAL PROGRAM EXCLUDABLE COST					441,453		52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					6,617,340		53

54	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

64	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)					12,731		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					39,184		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					51,915		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)						896	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)						932.95	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)						835,923	89

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
90	CAPITAL-RELATED COST	365,010	5,301,037	0.068856	835,923	57,558	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS											
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)									2,165	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)									2,165	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)									484	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)									1,681	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)									543	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)										10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)										11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD										12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)										13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)										14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)										15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)										16
SWING-BED ADJUSTMENT											
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD										17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD										18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD										19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD										20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)									1,714,372	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)										22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)										23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)										24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)										25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)										26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST									1,714,372	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT											
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)									2,288,076	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)									493,680	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)									1,794,396	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)									0.749264	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)									1,020.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)									1,067.46	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)										34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)										35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)										36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)									1,714,372	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	791.86 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	429,980 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)	429,980 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	64,574 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	494,554 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	19,733 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	3,429 51
52	TOTAL PROGRAM EXCLUDABLE COST	23,162 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	471,392 53
TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES	54
55	TARGET AMOUNT PER DISCHARGE	55
56	TARGET AMOUNT (LINE 54 x LINE 55)	56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58	BONUS PAYMENT (SEE INSTRUCTIONS)	58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)	61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	10,270 1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	10,270 2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,270 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)	2,999 9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	16
SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,879,278 21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,879,278 27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	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)	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,879,278 37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PARTS III & IV

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

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	2,879,278	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	280.36	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	840,800	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	840,800	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	840,800	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	1,050,706	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	1,891,506	86

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0147) [] 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		2,386,419			30
31 INTENSIVE CARE UNIT		1,373,248			31
40 SUBPROVIDER - IPF					40
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.159681	1,014,052	161,925		50
53 ANESTHESIOLOGY	0.033596	293,287	9,853		53
54 RADIOLOGY-DIAGNOSTIC	0.187562	1,205,367	226,081		54
56 RADIOISOTOPE	0.109930	149,381	16,421		56
57 CT SCAN	0.040034	1,258,353	50,377		57
58 MRI	0.146322	85,605	12,526		58
60 LABORATORY	0.140433	4,208,998	591,082		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY	0.076815	284,089	21,822		64
65 RESPIRATORY THERAPY	0.212538	1,704,859	362,347		65
66 PHYSICAL THERAPY	0.309080	578,225	178,718		66
68 SPEECH PATHOLOGY	0.337195	63,339	21,358		68
69 ELECTROCARDIOLOGY	0.091088	316,513	28,831		69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.360404	884,212	318,674		71
72 IMPL. DEV. CHARGED TO PATIENTS	0.399775	105,979	42,368		72
73 DRUGS CHARGED TO PATIENTS	0.244110	3,001,380	732,667		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					
91 EMERGENCY	0.212013	1,114,495	236,287		91
92 OBSERVATION BEDS (NON-DISTINCT)	0.506823	226,972	115,035		92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		16,495,106	3,126,372		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		16,495,106			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
40 SUBPROVIDER - IPF		553,153		40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.159681			50
53 ANESTHESIOLOGY	0.033596			53
54 RADIOLOGY-DIAGNOSTIC	0.187562	5,253	985	54
56 RADIOISOTOPE	0.109930			56
57 CT SCAN	0.040034	6,232	249	57
58 MRI	0.146322			58
60 LABORATORY	0.140433	79,004	11,095	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.076815	80	6	64
65 RESPIRATORY THERAPY	0.212538	1,733	368	65
66 PHYSICAL THERAPY	0.309080	1,165	360	66
68 SPEECH PATHOLOGY	0.337195	1,227	414	68
69 ELECTROCARDIOLOGY	0.091088	2,747	250	69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.360404	3,853	1,389	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.399775			72
73 DRUGS CHARGED TO PATIENTS	0.244110	152,628	37,258	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				
91 EMERGENCY	0.212013	57,542	12,200	91
92 OBSERVATION BEDS (NON-DISTINCT	0.506823			92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		311,464	64,574	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		311,464		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.159681			50
53 ANESTHESIOLOGY	0.033596			53
54 RADIOLOGY-DIAGNOSTIC	0.187562	5,430	1,018	54
56 RADIOISOTOPE	0.109930			56
57 CT SCAN	0.040034	8,257	331	57
58 MRI	0.146322	2,574	377	58
60 LABORATORY	0.140433	56,564	7,943	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.076815	5,998	461	64
65 RESPIRATORY THERAPY	0.212538	117,130	24,895	65
66 PHYSICAL THERAPY	0.309080	96,638	29,869	66
68 SPEECH PATHOLOGY	0.337195	4,517	1,523	68
69 ELECTROCARDIOLOGY	0.091088	549	50	69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.360404	16,825	6,064	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.399775			72
73 DRUGS CHARGED TO PATIENTS	0.244110	129,792	31,684	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				
91 EMERGENCY	0.212013			91
92 OBSERVATION BEDS (NON-DISTINCT	0.506823			92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		444,274	104,215	200
201 LESS PBF CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		444,274		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
40 SUBPROVIDER - IPF					40
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.159681	1,188		190	50
53 ANESTHESIOLOGY	0.033596				53
54 RADIOLOGY-DIAGNOSTIC	0.187562	82,050		15,389	54
56 RADIOISOTOPE	0.109930				56
57 CT SCAN	0.040034	51,244		2,052	57
58 MRI	0.146322	7,532		1,102	58
60 LABORATORY	0.140433	313,826		44,072	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY	0.076815	44,341		3,406	64
65 RESPIRATORY THERAPY	0.212538	816,449		173,526	65
66 PHYSICAL THERAPY	0.309080	1,583,587		489,455	66
68 SPEECH PATHOLOGY	0.337195	135,609		45,727	68
69 ELECTROCARDIOLOGY	0.091088	2,747		250	69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.360404	153,978		55,494	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.399775				72
73 DRUGS CHARGED TO PATIENTS	0.244110	890,634		217,413	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					
91 EMERGENCY	0.212013				91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.506823	5,189		2,630	92
94 HOME PROGRAM DIALYSIS					94
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,088,374		1,050,706	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,088,374			202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	4,953,277	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	18,884	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	43.82	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0410	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.2032	31
32	SUM OF LINES 30 AND 31	0.2442	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0936	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	463,627	34
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	5,435,788	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	5,589,574	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	5,551,128	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	389,787	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	5,940,915	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	5,940,915	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	822,212	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	1,480	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	291,902	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	189,736	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	254,538	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	5,306,959	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.93	HVBP PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	2,934	70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (SEE INSTRUCTIONS)	-49,533	70.94
70.97	LOW VOLUME ADJUSTMENT FOR FISCAL YEAR (2013)	543,172	70.97
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	5,803,532	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	58,035	71.01
72	INTERIM PAYMENTS	5,633,622	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	111,875	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	88,000	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,346	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)	3,073,553	2
3	PPS PAYMENTS	2,891,232	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	1,300	4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)	0.810	5
6	LINE 2 TIMES LINE 5	2,489,578	6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	3,346	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	13,707	12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)	13,707	14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	13,707	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	10,361	19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	3,346	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 \$2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)	2,892,532	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	717,306	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	2,178,572	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	2,178,572	30
31	PRIMARY PAYER PAYMENTS	68	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,178,504	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	208,782	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	135,708	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	186,353	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	2,314,212	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	2,314,212	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	23,142	40.01
41	INTERIM PAYMENTS	2,264,636	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	26,434	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 \$2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)		40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		40.01
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 \$2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)		40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		40.01
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[XX] HOSPITAL (14-0147) [] IPF [] IRF	[] SUB (OTHER) [] SNF [] SWING BED SNF	INPATIENT		PART B		
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			5,574,199		2,288,434	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	03/25/2013	59,423		NONE	3.01
		.02					3.02
	PROGRAM	.03					3.03
	TO	.04					3.04
	PROVIDER	.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE			3.50
		.51					3.51
	PROVIDER	.52	03/25/2013			23,798	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
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99		59,423		-23,798	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			5,633,622		2,264,636	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
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01		169,910		49,576	6.01
		PROVIDER TO .02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)	PROGRAM		5,803,532		2,314,212	7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:		NPR DATE:	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL [XX] IPF (14-S147) [] IRF	[] SUB (OTHER) [] SNF [] SWING BED SNF	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
DESCRIPTION						
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			354,859		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		2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01	NONE		3.01
		PROGRAM	.02			3.02
		TO	.03			3.03
		PROVIDER	.04			3.04
			.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50	NONE		3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
			.99			3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			354,859		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		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		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	11,397		6.01
		TO PROVIDER				
		PROVIDER				
		TO .02				6.02
		PROGRAM				
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			366,256		7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:	NPR DATE:	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL [] IPF [] IRF	[] SUB (OTHER) [] SNF [XX] SWING BED SNF (14-U147)	INPATIENT PART A	MM/DD/YYYY 1	AMOUNT 2	PART B MM/DD/YYYY 3	AMOUNT 4	
DESCRIPTION								
1					73,510			1
2					NONE		NONE	2
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.								
3								
					NONE		NONE	3.01
								3.02
								3.03
								3.04
								3.05
								3.06
								3.07
								3.08
								3.09
								3.50
					NONE		NONE	3.51
								3.52
								3.53
								3.54
								3.55
								3.56
								3.57
								3.58
								3.59
								3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)								
4					73,510			4
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)								
TO BE COMPLETED BY CONTRACTOR								
5								
					NONE		NONE	5.01
								5.02
								5.03
								5.04
								5.05
								5.06
								5.07
								5.08
								5.09
								5.50
					NONE		NONE	5.51
								5.52
								5.53
								5.54
								5.55
								5.56
								5.57
								5.58
								5.59
								5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)								
6								
					6,002			6.01
								6.02
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT								
7					79,512			7
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)								
8								8
8 NAME OF CONTRACTOR:					CONTRACTOR NUMBER:	NPR DATE:		

PROVIDER CCN: 14-0147 RICHLAND MEMORIAL HOSPITAL
 PERIOD FROM 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11
 02/11/2014 09:36

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

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

INPATIENT
 PART A
 PART B
 MM/DD/YYYY AMOUNT MM/DD/YYYY AMOUNT
 1 2 3 4

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		938,058			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		938,058			4

TO BE COMPLETED BY CONTRACTOR

5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM		9,719		6.01 6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			947,777		7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:	NPR DATE:	8

PROVIDER CCN: 14-0147 RICHLAND MEMORIAL HOSPITAL
PERIOD FROM 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11
02/11/2014 09:36

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,966	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	3,930	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	61	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	6,216	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	123,078,513	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	5,261,726	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,088,407	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	21,768	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)	1,066,639	10
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	1,059,223	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	7,416	32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-U147)
 APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
 BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	81,603	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)		3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	264	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	81,603	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	81,603	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	81,603	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	7,633	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	73,970	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	8,526	17
17.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	5,542	17.01
18 ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SEE INSTRUCTIONS)	79,512	19
19.01 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	795	19.01
20 INTERIM PAYMENTS	73,510	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS LINES 19.01, 20 AND 21)	5,207	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

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

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS)	458,200	1
2	NET IPF PPS OUTLIER PAYMENT		2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii) (F)(1) OR (2) (SEE INSTRUCTIONS)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	5.931507	9
10	TEACHING ADJUSTMENT FACTOR $\{(1 + (\text{LINE 8}/\text{LINE 9})) \text{ RAISED TO THE POWER OF } .5150 - 1\}$		10
11	TEACHING ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	458,200	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	458,200	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (LINE 16 LESS LINE 17)	458,200	18
19	DEDUCTIBLES	100,136	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	358,064	20
21	COINSURANCE		21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	358,064	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	12,610	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	8,197	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	366,261	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IPF ONLY)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	-5	30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	366,256	31
31.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	3,663	31.01
32	INTERIM PAYMENTS	354,859	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)	7,734	34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VI

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

PROSPECTIVE PAYMENT AMOUNT			
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	1,072,184	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,072,184	4
COMPUTATION OF NET COST OF COVERED SERVICES			
5	MEDICAL AND OTHER SERVICES		5
6	DEDUCTIBLES		6
7	COINSURANCE	124,407	7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		9
10	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	947,777	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	947,777	15
15.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	9,478	15.01
16	INTERIM PAYMENTS	938,058	16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS 15.01, 16 AND 17)	241	18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
1	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	4,994,255		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)	4,994,255		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	4,994,255		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	4,994,255		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))			18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)			27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (FROM LINE 18)			30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			37
38	SUBTOTAL (LINE 36 ± LINE 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)			42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

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

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

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

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,907,585			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	6,360,612			4
5	OTHER RECEIVABLES	1,820,736			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	777,127			7
8	PREPAID EXPENSES	690,517			8
9	OTHER CURRENT ASSETS	808,571			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	13,365,148			11
FIXED ASSETS					
12	LAND	39,983			12
13	LAND IMPROVEMENTS	510,497			13
14	ACCUMULATED DEPRECIATION	-466,071			14
15	BUILDINGS	24,224,611			15
16	ACCUMULATED DEPRECIATION	-16,458,563			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	2,456,266			19
20	ACCUMULATED DEPRECIATION	-2,223,214			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	16,863,573			23
24	ACCUMULATED DEPRECIATION	-11,569,056			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	13,378,026			30
OTHER ASSETS					
31	INVESTMENTS	7,047,020			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	254,404			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	7,301,424			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	34,044,598			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,677,588			37
38	SALARIES, WAGES & FEES PAYABLE	2,434,454			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	266,513			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	1,527,665			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	5,906,220			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	7,054,986			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	7,054,986			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	12,961,206			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	21,083,392			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)	21,083,392			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	34,044,598			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		19,524,320							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		1,559,072							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		21,083,392							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		21,083,392							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)		21,083,392							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				
2 HOSPITAL	5,838,726		5,838,726	1
3 SUBPROVIDER IPF	2,288,076		2,288,076	2
4 SUBPROVIDER IRF				3
5 SWING BED - SNF	97,125		97,125	5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY	2,156,606		2,156,606	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	10,380,533		10,380,533	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
12 INTENSIVE CARE UNIT	1,723,564		1,723,564	11
13 CORONARY CARE UNIT				12
14 BURN INTENSIVE CARE UNIT				13
15 SURGICAL INTENSIVE CARE UNIT				14
16 OTHER SPECIAL CARE (SPECIFY)				15
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	1,723,564		1,723,564	16
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	12,104,097		12,104,097	17
19 ANCILLARY SERVICES	29,196,873	77,802,329	106,999,202	18
20 OUTPATIENT SERVICES		6,866,614	6,866,614	19
21 RHC				20
22 FQHC				21
23 HOME HEALTH AGENCY		4,030,498	4,030,498	22
24 AMBULANCE	63,772	1,822,867	1,886,639	23
25 ASC				25
26 HOSPICE				26
27 OTHER	1,322,752	910,517	2,233,269	27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	42,687,494	91,432,825	134,120,319	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		46,783,460	29
30 ADD (SPECIFY)	203		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		203	36
37 BAD DEBT EXP. DEDUCTED FROM REVENUE	-2,448,203		37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)		-2,448,203	42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		44,335,460	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	134,120,319	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	91,266,887	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	42,853,432	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	44,335,460	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,482,028	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	316,086	6
7	INCOME FROM INVESTMENTS	117,838	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	6,249	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	173,900	13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	246,802	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	10,582	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	2,061	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	3,353	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	13,721	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (PROPERTY TAX REVENUE)	413,481	24
24.01	OTHER (EHR MEANINGFUL USE)	1,341,053	24.01
24.02	OTHER (GRANTS)	113,932	24.02
24.03	OTHER (OTHER)	239,755	24.03
24.04	OTHER (NET ASSETS RELEASED BY FOUNDATION)	42,287	24.04
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	3,041,100	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,559,072	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	1,559,072	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7187

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6
1 GENERAL SERVICE COST CENTER						1
2 CAPITAL RELATED-BLDGS & FIXTURES						2
3 CAPITAL RELATED-MOVABLE EQUIPMENT						3
4 PLANT OPERATION & MAINTENANCE						4
5 TRANSPORTATION (SEE INSTRUCTIONS)						5
6 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	107,542		4,170		85,449	197,161
7 SKILLED NURSING CARE	520,347		42,518			562,865
8 PHYSICAL THERAPY			19,132			19,132
9 OCCUPATIONAL THERAPY			7,870			7,870
10 SPEECH PATHOLOGY			1,533			1,533
11 MEDICAL SOCIAL SERVICES	3,190					3,190
12 HOME HEALTH AIDE	69,221		9,228			78,449
13 SUPPLIES (SEE INSTRUCTIONS)						12
14 DRUGS						13
15 DME						14
16 HHA NONREIMBURSABLE SERVICES						15
17 HOME DIALYSIS AIDE SERVICES						16
18 RESPIRATORY THERAPY						17
19 PRIVATE DUTY NURSING						18
20 CLINIC						19
21 HEALTH PROMOTION ACTIVITIES						20
22 DAY CARE PROGRAM						21
23 HOME DELIVERED MEALS PROGRAM						22
24 HOMEMAKER SERVICE						23
25 ALL OTHERS						24
26 TOTAL (SUM OF LINES 1-23)	700,300		84,451		85,449	870,200

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7187

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5		197,161	-1,050	196,111	5
6		562,865		562,865	6
7		19,132		19,132	7
8		7,870		7,870	8
9		1,533		1,533	9
10		3,190		3,190	10
11		78,449		78,449	11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24		870,200	-1,050	869,150	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7187

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS & BLDG FIXTURES	CAP REL COSTS MVEL EQUIPMENT	PLANT OPERATN MAINT	& TRANSPORT- ATION	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	0	1	2	3	4	4A	5	6	
1									1
2									2
3									3
4									4
5		196,111				196,111	196,111		5
6		562,865				562,865	164,007	726,872	6
7		19,132				19,132	5,575	24,707	7
8		7,870				7,870	2,293	10,163	8
9		1,533				1,533	447	1,980	9
10		3,190				3,190	930	4,120	10
11		78,449				78,449	22,859	101,308	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24		869,150				869,150		869,150	24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7187

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVEL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
1							1
2							2
3							3
4							4
5					-196,111	673,039	5
6							6
7						562,865	7
8						19,132	8
9						7,870	9
10						1,533	10
11						3,190	11
12						78,449	12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
23.50							23.50
24					-196,111	673,039	24
25						196,111	25
26						0.291381	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA No.: 14-7187

WORKSHEET H-2
 PART I

HHA COST CENTER	HHA TRIAL BALANCE	NEW CAP RE L COSTS-BL DG & FIXT 1	NEW CAP RE L COSTS-MV BLE EQUIP 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	ADMINISTRATIVE & GENERAL SERVICES 5	MAINTENANCE & REPAIR 6	
1 ADMINISTRATIVE AND GENERAL		6,768	287		36,372	43,427	5,552	11,066	1
2 SKILLED NURSING CARE	726,872				175,988	902,860	115,423		2
3 PHYSICAL THERAPY	24,707					24,707	3,159		3
4 OCCUPATIONAL THERAPY	10,163					10,163	1,299		4
5 SPEECH PATHOLOGY	1,980					1,980	253		5
6 MEDICAL SOCIAL SERVICES	4,120				1,079	5,199	665		6
7 HOME HEALTH AIDE	101,308				23,412	124,720	15,945		7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
20 TOTAL (SUM OF LINES 1-19)	869,150	6,768	287		236,851	1,113,056	142,296	11,066	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7187

WORKSHEET H-2
 PART I

HHA COST CENTER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
	7	8	9	10	11	12	13	14	
1 ADMINISTRATIVE AND GENERAL	5,874		10,324		14,827				1
2 SKILLED NURSING CARE									2
3 PHYSICAL THERAPY									3
4 OCCUPATIONAL THERAPY									4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE									7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
20 TOTAL (SUM OF LINES 1-19)	5,874		10,324		14,827				20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7187

WORKSHEET H-2
 PART I

HHA COST CENTER	PHARMACY 15	MEDICAL RE CORDS & LI SERVICE BRARY 16	SOCIAL & LI SERVICE 17	NONPHYSIC. ANESTHET. 19	NURSING SCHOOL 20	I&R SALARY & FRINGES 21	I&R PROGRAM COSTS 22	PARAMED EDUCATION 23	
1 ADMINISTRATIVE AND GENERAL		243							1
2 SKILLED NURSING CARE									2
3 PHYSICAL THERAPY									3
4 OCCUPATIONAL THERAPY									4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE									7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
20 TOTAL (SUM OF LINES 1-19)		243							20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7187

WORKSHEET H-2
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (SUM OF COL. 4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	91,313		91,313			1
2 SKILLED NURSING CARE	1,018,283		1,018,283	77,076	1,095,359	2
3 PHYSICAL THERAPY	27,866		27,866	2,109	29,975	3
4 OCCUPATIONAL THERAPY	11,462		11,462	868	12,330	4
5 SPEECH PATHOLOGY	2,233		2,233	169	2,402	5
6 MEDICAL SOCIAL SERVICES	5,864		5,864	444	6,308	6
7 HOME HEALTH AIDE	140,665		140,665	10,647	151,312	7
8 SUPPLIES						8
9 DRUGS						9
10 DME						10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY						12
13 PRIVATE DUTY NURSING						13
14 CLINIC						14
15 HEALTH PROMOTION ACTIVITIES						15
16 DAY CARE PROGRAM						16
17 HOME DELIVERED MEALS PROGRAM						17
18 HOMEMAKER SERVICE						18
19 ALL OTHERS						19
20 TOTAL (SUM OF LINES 1-19)	1,297,686		1,297,686	91,313	1,297,686	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.075692		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7187

WORKSHEET H-2
 PART II

HHA COST CENTER	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE	OTHER CAP REL COSTS NOT USED	EMPLOYEE B ENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION 4A	ADMINISTRA TIVE & GEN ERAL ACCUM COST	MAINTENANC E & REPAIR S SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4		5	6	7	
1 ADMINISTRATIVE AND GENERAL	1,333	283		107,542		43,427	1,333	1,333	1
2 SKILLED NURSING CARE				520,347		902,860			2
3 PHYSICAL THERAPY						24,707			3
4 OCCUPATIONAL THERAPY						10,163			4
5 SPEECH PATHOLOGY						1,980			5
6 MEDICAL SOCIAL SERVICES				3,190		5,199			6
7 HOME HEALTH AIDE				69,221		124,720			7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)	1,333	283		700,300		1,113,056	1,333	1,333	20
21 TOTAL COST TO BE ALLOCATED	6,768	287		236,851		142,296	11,066	5,874	21
22 UNIT COST MULTIPLIER	5.077269						8.301575		22
22 UNIT COST MULTIPLIER		1.014134		0.338214		0.127843		4.406602	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7187

WORKSHEET H-2
 PART II

HHA COST CENTER	LAUNDRY & LINE SERVICE POUNDS	HOUSEKEEPING HOURS OF SERVICE	DIETARY MEALS	DIETARY MEALS SERV	CAFETERIA CAFE MEALS	CAFETERIA MEALS SERV	MAINTENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINISTRATION DIRECT NURSING HO	CENTRAL SERVICES & SUPPLY CS COSTED	REQUIS	PHARMACY PHARM COSTED REQ	
	8	9	10	11	11	11	12	13	14	14	15	
1 ADMINISTRATIVE AND GENERAL		9,300				44					12,400	1
2 SKILLED NURSING CARE												2
3 PHYSICAL THERAPY												3
4 OCCUPATIONAL THERAPY												4
5 SPEECH PATHOLOGY												5
6 MEDICAL SOCIAL SERVICES												6
7 HOME HEALTH AIDE												7
8 SUPPLIES												8
9 DRUGS												9
10 DME												10
11 HOME DIALYSIS AIDE SERVICES												11
12 RESPIRATORY THERAPY												12
13 PRIVATE DUTY NURSING												13
14 CLINIC												14
15 HEALTH PROMOTION ACTIVITIES												15
16 DAY CARE PROGRAM												16
17 HOME DELIVERED MEALS PROGRAM												17
18 HOMEMAKER SERVICE												18
19 ALL OTHERS												19
19.50 TELEMEDICINE												19.50
20 TOTAL (SUM OF LINES 1-19)		9,300				44					12,400	20
21 TOTAL COST TO BE ALLOCATED		10,324				14,827					243	21
22 UNIT COST MULTIPLIER												22
22 UNIT COST MULTIPLIER		1.110108				336.977273					0.019597	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7187

WORKSHEET H-2
 PART II

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

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7187

WORKSHEET H-3
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)		(COL.3 ÷ COL.4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	1,095,359		1,095,359	6,353	172.42	1
2	PHYSICAL THERAPY	3	29,975	251,479	281,454	2,773	101.50	2
3	OCCUPATIONAL THERAPY	4	12,330		12,330	745	16.55	3
4	SPEECH PATHOLOGY	5	2,402	6,029	8,431	155	54.39	4
5	MEDICAL SOCIAL SERVICES	6	6,308		6,308	47	134.21	5
6	HOME HEALTH AIDE	7	151,312		151,312	1,446	104.64	6
7	TOTAL (SUM OF LINES 1-6)		1,297,686	257,508	1,555,194	11,519		7
PATIENT SERVICES								
8	SKILLED NURSING CARE							8
9	PHYSICAL THERAPY							9
10	OCCUPATIONAL THERAPY							10
11	SPEECH PATHOLOGY							11
12	MEDICAL SOCIAL SERVICES							12
13	HOME HEALTH AIDE							13
14	TOTAL (SUM OF LINES 8-13)							14
SUPPLIES AND DRUGS COST COMPUTATIONS		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	
OTHER PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	(FROM HHA RECORD)	(COL.3 ÷ COL.4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8		30,629	30,629	84,986	0.360401	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7187

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS. 9-10)
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
PATIENT SERVICES							
1 SKILLED NURSING CARE	2,425	2,682	8	418,119	462,430	11	880,549
2 PHYSICAL THERAPY	1,494	963		151,641	97,745		249,386
3 OCCUPATIONAL THERAPY	417	218		6,901	3,608		10,509
4 SPEECH PATHOLOGY	81	48		4,406	2,611		7,017
5 MEDICAL SOCIAL SERVICES	28	17		3,758	2,282		6,040
6 HOME HEALTH AIDE	565	867		59,122	90,723		149,845
7 TOTAL (SUM OF LINES 1-6)	5,010	4,795		643,947	659,399		1,303,346

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		PART A	COST OF SERVICES		TOTAL
		NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR		NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	99914	2,425	2,682	2	418,119	462,430	8
9 PHYSICAL THERAPY	99914	963		2	151,641	97,745	9
10 OCCUPATIONAL THERAPY	99914	218		3	6,901	3,608	10
11 SPEECH PATHOLOGY	99914	48		3	4,406	2,611	11
12 MEDICAL SOCIAL SERVICES	99914	17		3	3,758	2,282	12
13 HOME HEALTH AIDE	99914	867		3	59,122	90,723	13
14 TOTAL (SUM OF LINES 8-13)		4,795		3	643,947	659,399	14

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES			
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
15 COST OF MEDICAL SUPPLIES							15
16 COST OF DRUGS							16

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

FROM WKST C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	TOTAL
1 PHYSICAL THERAPY	0.309080	813,638	251,479	COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY				COL 2, LINE 3	2
3 SPEECH PATHOLOGY	0.337195	17,880	6,029	COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHARGED TO PA	0.360404	84,986	30,629	COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	0.244110			COL 2, LINE 16	5

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7187

WORKSHEET H-4
 PARTS I & II

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

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

----- PART B -----
 NOT SUBJECT TO SUBJECT TO
 DEDUCTIBLES DEDUCTIBLES
 & COINSURANCE & COINSURANCE

PART A
 1

2

3

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

PART A
 SERVICES
 1

PART B
 SERVICES
 2

DESCRIPTION	PART A 1	PART B 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	662,902	490,061	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	12,005	40,601	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	8,396	12,122	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	6,599	5,119	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	4,848	21,236	15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES		645	16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	694,750	569,784	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	694,750	569,784	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	694,750	569,784	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	694,750	569,784	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	694,750	569,784	31
31.01 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	7,413	6,140	31.01
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	687,337	563,644	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2			35

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

HHA NO.: 14-7187

WORKSHEET H-5

DESCRIPTION	PART A		PART B	
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		687,337		563,644
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		NONE
	.02			3.01
	.03			3.02
	.04			3.03
	.05			3.04
	.06			3.05
	.07			3.06
	.08			3.07
	.09			3.08
	.10			3.09
	.11	NONE		NONE
	.12			3.50
	.13			3.51
	.14			3.52
	.15			3.53
	.16			3.54
	.17			3.55
	.18			3.56
	.19			3.57
	.20			3.58
	.21			3.59
	.22			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		687,337		563,644
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE
	TO .02			5.01
	PROVIDER .03			5.02
	TO .04			5.03
	.05			5.04
	.06			5.05
	.07			5.06
	.08			5.07
	.09			5.08
	PROVIDER .10	NONE		NONE
	TO .11			5.09
	PROGRAM .12			5.10
	.13			5.11
	.14			5.12
	.15			5.13
	.16			5.14
	.17			5.15
	.18			5.16
	.19			5.17
	.20			5.18
	.21			5.19
	.22			5.20
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO .01	7,413		6,140
	PROVIDER TO .02			6.01
	PROGRAM			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		694,750		569,784
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE NO.: 14-1542

WORKSHEET K

	SALARIES (FROM WKST K-1) 1	EMPLOYEE BENEFITS (FROM WKST K-2) 2	TRANS- PORTATION (SEE INSTR.) 3	CONTRACTED SERVICES (FROM WKST K-3) 4	OTHER 5	TOTAL (COLS. 1-5) 6
1						1
2						2
3						3
4						4
5						5
6	26,954		1,425		161,575	189,954
7						7
8						8
9						9
10	111,504		12,407			123,911
11						11
12						12
13						13
14						14
15	45,250					45,250
16						16
17						17
18						18
19	23,369		7,165			30,534
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36						36
37						37
38						38
39	207,077		20,997		161,575	389,649

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE NO.: 14-1542

WORKSHEET K
 (CONTINUED)

	RECLASSIFI- CATION 7	SUBTOTAL (COL. 6 ± COL. 7) 8	ADJUST- MENTS 9	TOTAL (COL. 8 ± COL. 9) 10	
1					1
2					2
3					3
4					4
5					5
6		189,954		189,954	6
7					7
8					8
9					9
10		123,911		123,911	10
11					11
12					12
13					13
14					14
15		45,250		45,250	15
16					16
17					17
18					18
19		30,534		30,534	19
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39		389,649		389,649	39

HOSPICE COMPENSATION ANALYSIS - SALARIES AND WAGES

HOSPICE NO.: 14-1542

WORKSHEET K-1

	ADMINI- STRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER- VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9
1	GENERAL SERVICE COST CENTER								1
2	CAP REL COSTS-BLDG AND FIXT.								2
3	CAP REL COSTS-MOVABLE EQUIP.								3
4	PLANT OPERATION & MAINT.								4
5	TRANSPORTATION - STAFF								5
6	VOLUNTEER SERVICE COORD.								6
7	ADMINISTRATIVE AND GENERAL			26,954					26,954
8	INPATIENT CARE SERVICE								7
9	INPATIENT - GENERAL CARE								8
10	INPATIENT - RESPITE CARE								9
11	VISITING SERVICES								10
12	PHYSICIAN SERVICES								11
13	NURSING CARE				111,504				111,504
14	NURSING CARE-CONT.HOME CARE								12
15	PHYSICAL THERAPY								13
16	OCCUPATIONAL THERAPY								14
17	SPEECH/LANGUAGE PATHOLOGY								15
18	MEDICAL SOCIAL SERVICES		45,250						45,250
19	SPIRITUAL COUNSELING								16
20	DIETARY COUNSELING								17
21	COUNSELING - OTHER								18
22	HH AIDE AND HOMEMAKER						23,369		23,369
23	HH AIDE & HMKR-CONT.HME CARE								20
24	OTHER								21
25	OTHER HOSPICE SERVICE COSTS								22
26	DRUGS, BIOL. & INFUS. THER.								23
27	ANALGESICS								24
28	SEDATIVES / HYPNOTICS								25
29	OTHER - SPECIFY								26
30	DURABLE MED. EQUIP./OXYGEN								27
31	PATIENT TRANSPORTATION								28
32	IMAGING SERVICES								29
33	LABS AND DIAGNOSTICS								30
34	MEDICAL SUPPLIES								31
35	OUTPAT.SERV.(INCL.E/R DEPT.)								32
36	RADIATION THERAPY								33
37	CHEMOTHERAPY								34
38	OTHER								35
39	HOSPICE NONREIMBURSABLE SERVICE								36
40	BEREAVEMENT PROGRAM COSTS								37
41	VOLUNTEER PROGRAM COSTS								38
42	FUNDRAISING								39
43	OTHER PROGRAM COSTS								40
44	TOTAL (SUM OF LINES 1-38)		45,250	26,954	111,504		23,369		207,077

HOSPICE COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE NO.: 14-1542

WORKSHEET K-2

	ADMINI- STRATOR	DIRECTOR	SOCIAL SERVICES	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL
	1	2	3	4	5	6	7	8	9
1									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
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36									36
37									37
38									38
39									39

HOSPICE COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE NO.: 14-1542

WORKSHEET K-3

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

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE NO.: 14-1542

WORKSHEET K-4
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS & FIXTURE	CAP REL BLDG COSTS EQUIPMENT	MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPOR- TATION	VOLUNTEER SERV. CO- ORDINATOR	SUBTOTAL (COLS. 0-5) 5A	ADMIN & GENERAL 6	TOTAL (COL. 5 ± COL. 6) 7
1										1
2										2
3										3
4										4
5										5
6	189,954							189,954	189,954	6
7										7
8										8
9										9
10	123,911							123,911	117,866	241,777
11										10
12										11
13										12
14										13
15	45,250							45,250	43,043	88,293
16										14
17										15
18										16
19	30,534							30,534	29,045	59,579
20										17
21										18
22										19
23										20
24										21
25										22
26										23
27										24
28										25
29										26
30										27
31										28
32										29
33										30
34										31
35										32
36										33
37										34
38										35
39	389,649							389,649		389,649

COST ALLOCATION - HOSPICE STATISTICAL BASIS

HOSPICE NO.: 14-1542

WORKSHEET K-4
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVEL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPOR- TATION (MILEAGE) 4	VOLUNTEER SERV. CO- ORDINATOR (HOURS) 5	RECONCIL- IATION 6A	ADMIN & GENERAL (ACCUM COST) 6
1							1
2	GENERAL SERVICE COST CENTER						2
3	CAP REL COSTS-BLDG AND FIXT.						3
4	CAP REL COSTS-MOVABLE EQUIP.						4
5	PLANT OPERATION & MAINT.						5
6	TRANSPORTATION - STAFF						6
7	VOLUNTEER SERVICE COORD.					-189,954	7
8	ADMINISTRATIVE AND GENERAL						8
9	INPATIENT CARE SERVICE						9
10	INPATIENT - GENERAL CARE						10
11	INPATIENT - RESPITE CARE						11
12	VISITING SERVICES						12
13	PHYSICIAN SERVICES						13
14	NURSING CARE						14
15	NURSING CARE-CONTINUOUS HOME						15
16	PHYSICAL THERAPY						16
17	OCCUPATIONAL THERAPY						17
18	SPEECH/LANGUAGE PATHOLOGY						18
19	MEDICAL SOCIAL SERVICES						19
20	SPIRITUAL COUNSELING						20
21	DIETARY COUNSELING						21
22	COUNSELING - OTHER						22
23	HH AIDE AND HOMEMAKER						23
24	HH AIDE & HMKR-CONT. HOME CA						24
25	OTHER						25
26	OTHER HOSPICE SERVICE COSTS						26
27	DRUGS, BIOL. & INFUS. THER.						27
28	ANALGESICS						28
29	SEDATIVES / HYPNOTICS						29
30	OTHER - SPECIFY						30
31	DURABLE MED. EQUIP./OXYGEN						31
32	PATIENT TRANSPORTATION						32
33	IMAGING SERVICES						33
34	LABS AND DIAGNOSTICS						34
35	MEDICAL SUPPLIES						35
36	OUTPAT.SERV.(INCL.E/R DEPT.)						36
37	RADIATION THERAPY						37
38	CHEMOTHERAPY						38
39	OTHER						39
40	HOSPICE NONREIMBURSABLE SERVICE						40
41	BEREAVEMENT PROGRAM COSTS						41
42	VOLUNTEER PROGRAM COSTS						42
43	FUNDRAISING						43
44	OTHER PROGRAM COSTS						44
45	COST TO BE ALLOCATED						45
46	UNIT COST MULTIPLIER						46
						189,954	47
						0.951221	48

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART I

HOSPICE COST CENTER	HOSPICE TRIAL BALANCE 0	NEW CAP RE L COSTS-BL DG & FIXT 1	NEW CAP RE L COSTS-MV BLE EQUIP 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL 4A	ADMINISTRATIVE & GENERAL 5	MAINTENANCE & REPAIR 6	
1 ADMINISTRATIVE AND GENERAL		6,768	44		9,116	15,928	2,036	11,066	1
2 INPATIENT - GENERAL CARE									2
3 INPATIENT - RESPITE CARE									3
4 PHYSICIAN SERVICES									4
5 NURSING CARE	241,777				37,713	279,490	35,732		5
6 NURSING CARE-CONTINUOUS HOME									6
7 PHYSICAL THERAPY									7
8 OCCUPATIONAL THERAPY									8
9 SPEECH/LANGUAGE PATHOLOGY									9
10 MEDICAL SOCIAL SERV. - DIRECT	88,293				7,904	96,197	12,298		10
11 SPIRITUAL COUNSELING									11
12 DIETARY COUNSELING									12
13 COUNSELING - OTHER									13
14 HOME HEALTH AIDE & HOME MAKERS	59,579				15,304	74,883	9,573		14
15 HOME HEALTH AIDE & HOME MAKERS - CONT.									15
16 OTHER									16
17 DRUGS, BIOLOGICALS & INFUSIONS									17
18 ANALGESICS									18
19 SEDATIVES / HYPNOTICS									19
20 OTHER - SPECIFY									20
21 DURABLE MED. EQUIP./OXYGEN									21
22 PATIENT TRANSPORTATION									22
23 IMAGING SERVICES									23
24 LABS AND DIAGNOSTICS									24
25 MEDICAL SUPPLIES									25
26 OUTPAT. SERV. (INCL. E/R DEPT)									26
27 RADIATION THERAPY									27
28 CHEMOTHERAPY									28
29 OTHER									29
30 BEREAVEMENT PROGRAM COSTS									30
31 VOLUNTEER PROGRAM COSTS									31
32 FUNDRAISING									32
33 OTHER PROGRAM COSTS									33
34 TOTALS (SUM OF LINES 1-33)	389,649	6,768	44		70,037	466,498	59,639	11,066	34
35 UNIT COST MULTIPLIER									35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART I

HOSPICE COST CENTER	OPERATION OF PLANT	LAUNDRY & LINEN SERV ICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	
	7	8	9	10	11	12	13	14	
1 ADMINISTRATIVE AND GENERAL	5,874		10,324		4,381				1
2 INPATIENT - GENERAL CARE									2
3 INPATIENT - RESPITE CARE									3
4 PHYSICIAN SERVICES									4
5 NURSING CARE									5
6 NURSING CARE-CONTINUOUS HOM									6
7 PHYSICAL THERAPY									7
8 OCCUPATIONAL THERAPY									8
9 SPEECH/LANGUAGE PATHOLOGY									9
10 MEDICAL SOCIAL SERV. - DIRE									10
11 SPIRITUAL COUNSELING									11
12 DIETARY COUNSELING									12
13 COUNSELING - OTHER									13
14 HOME HLTH AIDE & HOMEMAKERS									14
15 HH AIDE & HMKR-CONT. HOME C									15
16 OTHER									16
17 DRUGS,BIOLOGICALS & INFUSIO									17
18 ANALGESICS									18
19 SEDATIVES / HYPNOTICS									19
20 OTHER - SPECIFY									20
21 DURABLE MED. EQUIP./OXYGEN									21
22 PATIENT TRANSPORTATION									22
23 IMAGING SERVICES									23
24 LABS AND DIAGNOSTICS									24
25 MEDICAL SUPPLIES									25
26 OUTPAT. SERV.(INCL.E/R DEPT									26
27 RADIATION THERAPY									27
28 CHEMOTHERAPY									28
29 OTHER									29
30 BEREAVEMENT PROGRAM COSTS									30
31 VOLUNTEER PROGRAM COSTS									31
32 FUNDRAISING									32
33 OTHER PROGRAM COSTS									33
34 TOTALS (SUM OF LINES 1-33)	5,874		10,324		4,381				34
35 UNIT COST MULTIPLIER									35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART I

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART I

HOSPICE COST CENTER	SUBTOTAL (COLS. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (COLS. 24 ± 25) 26	ALLOC HOSP A&G (SEE PART II) 27	TOTAL HOSP COSTS (COL 26 ± 27) 28	
1 ADMINISTRATIVE AND GENERAL	49,609		49,609			1
2 INPATIENT - GENERAL CARE						2
3 INPATIENT - RESPITE CARE						3
4 PHYSICIAN SERVICES						4
5 NURSING CARE	315,222		315,222	30,773	345,995	5
6 NURSING CARE-CONTINUOUS HOM						6
7 PHYSICAL THERAPY						7
8 OCCUPATIONAL THERAPY						8
9 SPEECH/LANGUAGE PATHOLOGY						9
10 MEDICAL SOCIAL SERV. - DIRE	108,495		108,495	10,591	119,086	10
11 SPIRITUAL COUNSELING						11
12 DIETARY COUNSELING						12
13 COUNSELING - OTHER						13
14 HOME HLTH AIDE & HOMEMAKERS	84,456		84,456	8,245	92,701	14
15 HH AIDE & HMKR-CONT. HOME C						15
16 OTHER						16
17 DRUGS,BIOLOGICALS & INFUSIO						17
18 ANALGESICS						18
19 SEDATIVES / HYPNOTICS						19
20 OTHER - SPECIFY						20
21 DURABLE MED. EQUIP./OXYGEN						21
22 PATIENT TRANSPORTATION						22
23 IMAGING SERVICES						23
24 LABS AND DIAGNOSTICS						24
25 MEDICAL SUPPLIES						25
26 OUTPAT. SERV.(INCL.E/R DEPT						26
27 RADIATION THERAPY						27
28 CHEMOTHERAPY						28
29 OTHER						29
30 BEREAVEMENT PROGRAM COSTS						30
31 VOLUNTEER PROGRAM COSTS						31
32 FUNDRAISING						32
33 OTHER PROGRAM COSTS						33
34 TOTALS (SUM OF LINES 1-33)	557,782		557,782		557,782	34
35 UNIT COST MULTIPLIER				0.097622		35

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE -NEW	OTHER CAP REL COSTS NOT USED	EMPLOYEE B ENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINISTRA TIVE & GEN ERAL ACCUM COST	MAINTENANC E & REPAIR S SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4	4A	5	6	7	
1 ADMINISTRATIVE AND GENERAL	1,333	43		26,954		15,928	1,333	1,333	1
2 INPATIENT - GENERAL CARE									2
3 INPATIENT - RESPITE CARE									3
4 PHYSICIAN SERVICES									4
5 NURSING CARE				111,505		279,490			5
6 NURSING CARE-CONTINUOUS HOM									6
7 PHYSICAL THERAPY									7
8 OCCUPATIONAL THERAPY									8
9 SPEECH/LANGUAGE PATHOLOGY									9
10 MEDICAL SOCIAL SERV. - DIRE				23,369		96,197			10
11 SPIRITUAL COUNSELING									11
12 DIETARY COUNSELING									12
13 COUNSELING - OTHER									13
14 HOME HLTH AIDE & HOMEMAKERS				45,250		74,883			14
15 HH AIDE & HMKR-CONT. HOME C									15
16 OTHER									16
17 DRUGS,BIOLOGICALS & INFUSIO									17
18 ANALGESICS									18
19 SEDATIVES / HYPNOTICS									19
20 OTHER - SPECIFY									20
21 DURABLE MED. EQUIP./OXYGEN									21
22 PATIENT TRANSPORTATION									22
23 IMAGING SERVICES									23
24 LABS AND DIAGNOSTICS									24
25 MEDICAL SUPPLIES									25
26 OUTPAT. SERV.(INCL.E/R DEPT									26
27 RADIATION THERAPY									27
28 CHEMOTHERAPY									28
29 OTHER									29
30 BEREAVEMENT PROGRAM COSTS									30
31 VOLUNTEER PROGRAM COSTS									31
32 FUNDRAISING									32
33 OTHER PROGRAM COSTS									33
34 TOTALS (SUM OF LINES 1-33)	1,333	43		207,078		466,498	1,333	1,333	34
35 TOTAL COST TO BE ALLOCATED	6,768	44		70,037		59,639	11,066	5,874	35
36 UNIT COST MULTIPLIER	5.077269	1.023256		0.338216		0.127844	8.301575	4.406602	36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART II

HOSPICE COST CENTER	LAUNDRY & HOUSEKEEPING LAUNDRY POUNDS 8	HOURS OF SERVICE 9	DIETARY MEALS SERV 10	CAFETERIA CAFE MEALS SERV 11	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINISTRATION DIRECT NURSING HOURS 13	CENTRAL SERVICES & SUPPLY CS COSTED REQUIS 14	SE PHARMACY PHARM COSTED REQ 15	
1 ADMINISTRATIVE AND GENERAL		9,300		13				2,900	1
2 INPATIENT - GENERAL CARE									2
3 INPATIENT - RESPITE CARE									3
4 PHYSICIAN SERVICES									4
5 NURSING CARE									5
6 NURSING CARE-CONTINUOUS HOME									6
7 PHYSICAL THERAPY									7
8 OCCUPATIONAL THERAPY									8
9 SPEECH/LANGUAGE PATHOLOGY									9
10 MEDICAL SOCIAL SERV. - DIRECT									10
11 SPIRITUAL COUNSELING									11
12 DIETARY COUNSELING									12
13 COUNSELING - OTHER									13
14 HOME HEALTH AIDE & HOME MAKERS									14
15 HOME AIDE & HOMEKEEPER-CONT. HOME CARE									15
16 OTHER									16
17 DRUGS, BIOLOGICALS & INFUSIONS									17
18 ANALGESICS									18
19 SEDATIVES / HYPNOTICS									19
20 OTHER - SPECIFY									20
21 DURABLE MED. EQUIP./OXYGEN									21
22 PATIENT TRANSPORTATION									22
23 IMAGING SERVICES									23
24 LABS AND DIAGNOSTICS									24
25 MEDICAL SUPPLIES									25
26 OUTPAT. SERV. (INCL. E/R DEPT)									26
27 RADIATION THERAPY									27
28 CHEMOTHERAPY									28
29 OTHER									29
30 BEREAVEMENT PROGRAM COSTS									30
31 VOLUNTEER PROGRAM COSTS									31
32 FUNDRAISING									32
33 OTHER PROGRAM COSTS									33
34 TOTALS (SUM OF LINES 1-33)		9,300		13				2,900	34
35 TOTAL COST TO BE ALLOCATED		10,324		4,381					35
36 UNIT COST MULTIPLIER		1.110108		337.000000					36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 STATISTICAL BASIS

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART II

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

PROVIDER CCN: 14-0147 RICHLAND MEMORIAL HOSPITAL
 PERIOD FROM 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11
 02/11/2014 09:36

APPORTIONMENT OF HOSPICE SHARED SERVICES

HOSPICE NO.: 14-1542

WORKSHEET K-5
 PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	WKST C, PART I, COL. 9, LINE 0	COST TO CHARGE RATIO 1	TOTAL HOSPICE CHARGES (PROVIDER RECORDS) 2	HOSPICE SHARED ANCILLARY COSTS (COL.1 x 2) 3	
ANCILLARY SERVICE COST CENTERS					
1	PHYSICAL THERAPY	66	0.309080		1
2	OCCUPATIONAL THERAPY	67			2
3	SPEECH/LANGUAGE PATHOLOGY	68	0.337195		3
4	DRUGS, BIOLOGICALS AND INFUSION	73	0.244110		4
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96			5
6	LABS AND DIAGNOSTICS	60	0.140433		6
7	MEDICAL SUPPLIES	71	0.360404		7
8	OUTPATIENT SERVICES (INCL. E/R DEPT)	93			8
9	RADIATION THERAPY	55			9
10	OTHER ANCILLARY (SPECIFY)	76			10
10.97	CARDIAC REHABILITATION	76.97			10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98			10.98
10.99	LITHOTRIPSY	76.99			10.99
11	TOTALS (SUM OF LINES 1-10)				11

CALCULATION OF HOSPICE PER DIEM COST

HOSPICE NO.: 14-1542

WORKSHEET K-6

COMPUTATION OF PER DIEM COST	TITLE XVIII 1	TITLE XIX 2	OTHER 3	TOTAL 4	
1 TOTAL COST (SEE INSTRUCTIONS)				557,782	1
2 TOTAL UNDUPLICATED DAYS (WKST S-9, COL. 6, LINE 5)				4,731	2
3 AVERAGE COST PER DIEM (LINE 1 DIVIDED BY LINE 2)				117.90	3
4 UNDUPLICATED MEDICARE DAYS (WKST S-9, COL. 1, LINE 5)	4,440				4
5 AGGREGATE MEDICARE COST (LINE 3 TIMES LINE 4)	523,476				5
6 UNDUPLICATED MEDICAID DAYS (WKST S-9, COL. 2, LINE 5)		27			6
7 AGGREGATE MEDICAID COST (LINE 3 TIMES LINE 6)		3,183			7
8 UNDUPLICATED SNF DAYS (WKST S-9, COL. 3, LINE 5)					8
9 AGGREGATE SNF COST (LINE 3 TIMES LINE 8)					9
10 UNDUPLICATED NF DAYS (WKST S-9, COL. 4, LINE 5)					10
11 AGGREGATE NF COST (LINE 3 TIMES LINE 10)					11
12 OTHER UNDUPLICATED DAYS (WKST S-9, COL. 5, LINE 5)			264		12
13 AGGREGATE COST FOR OTHER DAYS (LINE 3 TIMES LINE 12)			31,126		13

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT		
2	CAPITAL DRG OTHER THAN OUTLIER	388,153	1
3	CAPITAL DRG OUTLIER PAYMENTS	1,634	2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	17.03	3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)		8
10	SUM OF LINES 7 AND 8		9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	389,787	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES					21
22 I&R SERVICES-OTHER PRGM COSTS					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
40 SUBPROVIDER - IPF					40
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
56 RADIOISOTOPE					56
57 CT SCAN					57
58 MRI					58
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
64 INTRAVENOUS THERAPY					64
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHARGED TO PA					71
72 IMPL. DEV. CHARGED TO PATIENTS					72
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					
91 EMERGENCY					91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS					92
94 HOME PROGRAM DIALYSIS					94
95 AMBULANCE SERVICES					95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
116 HOSPICE					116
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES					192
194 OTHER NONREIMBURSABLE					194
194.01 MEMORY DISORDER					194.01
194.02 ASSISTED LIVING					194.02

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)						202
203 TOTAL STATISTICAL BASIS						203
204 UNIT COST MULTIPLIER						204
204 UNIT COST MULTIPLIER						204

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL	
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6		
UTILIZATION PERCENTAGES BASED ON DAYS								
30 ADULTS & PEDIATRICS	49.98		15.21				65.19	30
31 INTENSIVE CARE UNIT	76.22		1.75				77.97	31
43 NURSERY			55.13				55.13	43
UTILIZATION PERCENTAGES BASED ON CHARGES								
50 OPERATING ROOM	7.47	22.54	14.07				44.08	50
53 ANESTHESIOLOGY	5.45	11.58	5.31				22.34	53
54 RADIOLOGY-DIAGNOSTIC	13.63	28.88	1.25				43.76	54
56 RADIOISOTOPE	6.54	48.53	0.65				55.72	56
57 CT SCAN	13.82	30.62	1.58				46.02	57
58 MRI	5.28	31.48	0.32				37.08	58
60 LABORATORY	18.10	3.49	3.06				24.65	60
64 INTRAVENOUS THERAPY	30.82	14.25	0.06				45.13	64
65 RESPIRATORY THERAPY	49.41	9.97	2.36				61.74	65
66 PHYSICAL THERAPY	7.48		0.17				7.65	66
68 SPEECH PATHOLOGY	7.48	2.74	5.63				15.85	68
69 ELECTROCARDIOLOGY	13.26	37.36	1.97				52.59	69
71 MEDICAL SUPPLIES CHARGED TO PAT	17.09	16.13	12.55				45.77	71
72 IMPL. DEV. CHARGED TO PATIENTS	16.06	37.83	4.86				58.75	72
73 DRUGS CHARGED TO PATIENTS	29.64	23.58	7.17				60.39	73
91 EMERGENCY	14.21	20.15	2.29				36.65	91
92 OBSERVATION BEDS (NON-DISTINCT	13.76	20.99	2.28				37.03	92
200 TOTAL CHARGES	15.45	17.09	4.68				37.22	200

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

SUBPROVIDER-IPF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL	
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6		
UTILIZATION PERCENTAGES BASED ON DAYS								
40 SUBPROVIDER - IPF	25.08		28.68				53.76	40
UTILIZATION PERCENTAGES BASED ON CHARGES								
54 RADIOLOGY-DIAGNOSTIC	0.06						0.06	54
57 CT SCAN	0.07						0.07	57
60 LABORATORY	0.34						0.34	60
64 INTRAVENOUS THERAPY	0.01						0.01	64
65 RESPIRATORY THERAPY	0.05						0.05	65
66 PHYSICAL THERAPY	0.02						0.02	66
68 SPEECH PATHOLOGY	0.14						0.14	68
69 ELECTROCARDIOLOGY	0.12						0.12	69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.07						0.07	71
73 DRUGS CHARGED TO PATIENTS	1.51						1.51	73
91 EMERGENCY	0.73						0.73	91
200 TOTAL CHARGES	0.29						0.29	200

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

SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
44 SKILLED NURSING FACILITY	29.20						29.20 44
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	0.01						0.01 50
54 RADIOLOGY-DIAGNOSTIC	0.93						0.93 54
57 CT SCAN	0.56						0.56 57
58 MRI	0.46						0.46 58
60 LABORATORY	1.35						1.35 60
64 INTRAVENOUS THERAPY	4.81						4.81 64
65 RESPIRATORY THERAPY	23.66						23.66 65
66 PHYSICAL THERAPY	20.50						20.50 66
68 SPEECH PATHOLOGY	16.02						16.02 68
69 ELECTROCARDIOLOGY	0.12						0.12 69
71 MEDICAL SUPPLIES CHARGED TO PAT	2.98						2.98 71
73 DRUGS CHARGED TO PATIENTS	8.80						8.80 73
92 OBSERVATION BEDS (NON-DISTINCT	0.31						0.31 92
200 TOTAL CHARGES	3.83						3.83 200

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

SWING-BED SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	0.06						0.06 54
57 CT SCAN	0.09						0.09 57
58 MRI	0.16						0.16 58
60 LABORATORY	0.24						0.24 60
64 INTRAVENOUS THERAPY	0.65						0.65 64
65 RESPIRATORY THERAPY	3.39						3.39 65
66 PHYSICAL THERAPY	1.25						1.25 66
68 SPEECH PATHOLOGY	0.53						0.53 68
69 ELECTROCARDIOLOGY	0.02						0.02 69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.33						0.33 71
73 DRUGS CHARGED TO PATIENTS	1.28						1.28 73
200 TOTAL CHARGES	0.42						0.42 200

COST CENTER		---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
1	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	887,114	2.24	-887,114	-4.49			1
2	CAP REL COSTS-MVBLE EQUIP	1,140,021	2.88	-1,140,021	-5.77			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	6,674,893	16.85	-6,674,893	-33.80			4
5	ADMINISTRATIVE & GENERAL	3,546,142	8.95	-3,546,142	-17.95			5
6	MAINTENANCE & REPAIRS	913,318	2.31	-913,318	-4.62			6
7	OPERATION OF PLANT	472,203	1.19	-472,203	-2.39			7
8	LAUNDRY & LINEN SERVICE	138,097	0.35	-138,097	-0.70			8
9	HOUSEKEEPING	529,002	1.34	-529,002	-2.68			9
10	DIETARY	456,544	1.15	-456,544	-2.31			10
11	CAFETERIA	638,244	1.61	-638,244	-3.23			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,363,630	3.44	-1,363,630	-6.90			13
14	CENTRAL SERVICES & SUPPLY	98,406	0.25	-98,406	-0.50			14
15	PHARMACY	2,069,762	5.23	-2,069,762	-10.48			15
16	MEDICAL RECORDS & LIBRARY	822,803	2.08	-822,803	-4.17			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES A							21
22	I&R SERVICES-OTHER PRGM COSTS A							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,038,299	5.15	3,314,653	16.78	5,352,952	13.52	30
31	INTENSIVE CARE UNIT	724,936	1.83	958,059	4.85	1,682,995	4.25	31
40	SUBPROVIDER - IPF	724,085	1.83	936,964	4.74	1,661,049	4.19	40
43	NURSERY	236,584	0.60	228,528	1.16	465,112	1.17	43
44	SKILLED NURSING FACILITY	1,102,279	2.78	1,776,999	9.00	2,879,278	7.27	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,001,491	2.53	1,166,176	5.90	2,167,667	5.47	50
53	ANESTHESIOLOGY	28,694	0.07	152,249	0.77	180,943	0.46	53
54	RADIOLOGY-DIAGNOSTIC	910,390	2.30	748,055	3.79	1,658,445	4.19	54
56	RADIOISOTOPE	193,294	0.49	57,759	0.29	251,053	0.63	56
57	CT SCAN	219,032	0.55	145,610	0.74	364,642	0.92	57
58	MRI	210,420	0.53	26,962	0.14	237,382	0.60	58
60	LABORATORY	2,345,400	5.92	920,006	4.66	3,265,406	8.25	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	22,733	0.06	48,073	0.24	70,806	0.18	64
65	RESPIRATORY THERAPY	395,409	1.00	337,903	1.71	733,312	1.85	65
66	PHYSICAL THERAPY	1,455,944	3.68	931,934	4.72	2,387,878	6.03	66
68	SPEECH PATHOLOGY	179,076	0.45	106,332	0.54	285,408	0.72	68
69	ELECTROCARDIOLOGY	178,914	0.45	38,546	0.20	217,460	0.55	69
71	MEDICAL SUPPLIES CHARGED TO PAT	1,418,182	3.58	446,726	2.26	1,864,908	4.71	71
72	IMPL. DEV. CHARGED TO PATIENTS	198,810	0.50	65,077	0.33	263,887	0.67	72
73	DRUGS CHARGED TO PATIENTS			2,471,861	12.52	2,471,861	6.24	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
91	EMERGENCY	728,219	1.84	934,595	4.73	1,662,814	4.20	91
92	OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS							92
94	HOME PROGRAM DIALYSIS							94
95	AMBULANCE SERVICES	629,401	1.59	699,669	3.54	1,329,070	3.36	95
	OUTPATIENT SERVICE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	869,150	2.19	428,536	2.17	1,297,686	3.28	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	389,649	0.98	168,133	0.85	557,782	1.41	116
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	3,630,477	9.17	2,627,368	13.30	6,257,845	15.80	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	21,608	0.05	13,406	0.07	35,014	0.09	194.01
194.02	ASSISTED LIVING							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	39,602,655	100.00			39,602,655	100.00	202

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	363,158	13,574,999	0.026752	1,014,052	27,128	50
53 ANESTHESIOLOGY	32,969	5,385,929	0.006121	293,287	1,795	53
54 RADIOLOGY-DIAGNOSTIC	210,262	8,842,095	0.023780	1,205,367	28,664	54
56 RADIOISOTOPE	7,198	2,283,761	0.003152	149,381	471	56
57 CT SCAN	46,977	9,108,334	0.005158	1,258,353	6,491	57
58 MRI	2,007	1,622,325	0.001237	85,605	106	58
60 LABORATORY	146,694	23,252,428	0.006309	4,208,998	26,555	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	2,359	921,776	0.002559	284,089	727	64
65 RESPIRATORY THERAPY	24,533	3,450,259	0.007110	1,704,859	12,122	65
66 PHYSICAL THERAPY	64,968	7,725,757	0.008409	578,225	4,862	66
68 SPEECH PATHOLOGY	3,943	846,417	0.004658	63,339	295	68
69 ELECTROCARDIOLOGY	8,987	2,387,350	0.003764	316,513	1,191	69
71 MEDICAL SUPPLIES CHARGED TO PAT	60,148	5,174,490	0.011624	884,212	10,278	71
72 IMPL. DEV. CHARGED TO PATIENTS	8,863	660,089	0.013427	105,979	1,423	72
73 DRUGS CHARGED TO PATIENTS	117,209	10,126,021	0.011575	3,001,380	34,741	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						
91 EMERGENCY	125,923	7,842,995	0.016055	1,114,495	17,893	91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	57,558	1,649,339	0.034898	226,972	7,921	92
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES						95
200 TOTAL	1,283,756	104,854,364		16,495,106	182,663	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION		CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	REDUCED CAPITAL RELATED COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7	
INPATIENT ROUTINE SERVICE COST CENTERS									
30	ADULTS & PEDIATRICS	365,010	3,540	361,470	5,682	63.62	2,840	180,681	30
31	INTENSIVE CARE UNIT	102,477		102,477	1,430	71.66	1,090	78,109	31
200	TOTAL	467,487	3,540	463,947	7,112		3,930	258,790	200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								258,790	
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								182,663	
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								441,453	
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								1,009	
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								3,930	
PER DISCHARGE CAPITAL COSTS								437.52	
PER DIEM CAPITAL COSTS								112.33	

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	6,617,340
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	20,254,773
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.327

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 9 LINE 40 + WKST D PART IV COL 11 LINE 200))	494,554
2. TOTAL MEDICARE CHARGES (WKST D-3 LINE 40 COLUMN 2 PLUS WKST D-3 LINE 202 COLUMN 2) (SEE CR 5619)	864,617
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.572

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)	441,453
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.022

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	3,065,741
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	18,208,864
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.168

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

EXHIBIT 3

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

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

EXHIBIT 4

	Amounts From E Part A (1)	Prior to 10/1/2010 or after 9/30/2013 Pre/Post Entitlement (2)	NOT APPLICABLE (3)	(3.01)	10/01/2012 through 09/30/2013 (4)	(4.01)	(Columns 2 through 4) TOTAL (5)	
1	DRG Amounts Other than Outlier Payments	4,953,277			4,953,277		4,953,277	1
2	Outlier payments for discharges	18,884			18,884		18,884	2
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments							4
INDIRECT MEDICAL EDUCATION ADJUSTMENT								
5	Amount from Worksheet E Part A, Line 21							5
6	IME payment adjustment							6
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422								
7	Amount from Worksheet E Part A, Line 27							7
8	IME add-on adjustment							8
9	Total IME payment							9
DISPROPORTIONATE SHARE ADJUSTMENT								
10	Allowable disproportionate share percentage	0.0936	0.0936	0.0936	0.0936	0.0936	0.0936	10
11	Disproportionate share adjustment	463,627			463,627		463,627	11
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES								
12	Total ESRD additional payment							12
13	Subtotal	5,435,788			5,435,788		5,435,788	13
14	Hospital specific payments	5,589,574			5,589,574		5,589,574	14
15	Total payment for inpatient operating costs - E Part A Line 49	5,551,128			5,551,128		5,551,128	15
16	Payment for inpatient program capital	389,787			389,787		389,787	16
17	Special add-on payments for new technologies							17
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL				5,940,915		5,940,915	19
CAPITAL PAYMENTS								
20	Capital DRG other than outlier	388,153			388,153		388,153	20
21	Capital DRG outlier payments	1,634			1,634		1,634	21
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage							24
25	Disproportionate share adjustment							25
26	Total prospective capital payments	389,787			389,787		389,787	26
LOW VOLUME ADJUSTMENT								
27	Low volume adjustment factor				0.091429			27
28	Low Volume Adjustment							28
29	Low Volume Adjustment				543,172		543,172	29