

HARRISBURG MEDICAL CENTER

HARRISBURG, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED JUNE 30, 2013

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

WORKSHEET S  
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1.  ELECTRONICALLY FILED COST REPORT DATE: 11/14/2013 TIME: 11:15  
 2.  MANUALLY SUBMITTED COST REPORT  
 3.  IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT  
 4.  MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY HARRISBURG MEDICAL CENTER, INC. (14-0210) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, 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: 11/14/2013 11:15  
 RNxjyDyTxdCW:o.DVReUA1ueY6BFm0  
 q0vjs04U0Vmr1.2.m8CwPWE1Xkx2ZW  
 UOcA1RCM1e0E84YD

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

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

PI Encryption: 11/14/2013 11:15  
 :zhH7p084C2PIFuncBtgXVl0iaqpg0  
 iUcMg0yn9dKrk1zvrXuDdVKJL3C:BN  
 WS9r0nDWvr09WiUK  
 PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		-177,255	-111,852	-150,227	1
2 SUBPROVIDER - IPF		89,377			2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC			145,902		10
10.01 HEALTH CLINIC - RHC II			37,879		10.01
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-87,878	71,929	-150,227	200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 100 DR WARREN TUTTLE DRIVE P.O.BOX: 1  
 2 CITY: HARRISBURG STATE: IL ZIP CODE: 62946 COUNTY: SALINE 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	HARRISBURG MEDICAL CENTER, INC	14-0210	99914	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF	HARRISBURG MEDICAL CENTER, INC	14-S210	99914	4	06/19/1989	N	P	O	4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	HARRISBURG MEDICAL CENTER, INC	14-U210	99914		11/03/1988	N	P	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	HARRISBURG MEDICAL CENTER, INC	14-7419	99914		08/15/1985	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	ELDORADO PRIMARY CARE	14-3473	99914		12/31/2001	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	EQUALITY FAMILY PRACTICE	14-8518	99914		09/27/2011	N	O	N	15.01
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2012			TO: 06/30/2013					20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID UNPAID DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	328					24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.						25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			1			35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING: 07/01/2012	ENDING: 06/30/2013	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:	38
39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)						1 Y Y 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

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

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			N N 71
<b>INPATIENT REHABILITATION FACILITY PPS</b>				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
<b>LONG TERM CARE HOSPITAL PPS</b>				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
<b>TEFRA PROVIDERS</b>				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
<b>TITLE V AND XIX INPATIENT SERVICES</b>				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
<b>RURAL PROVIDERS</b>				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 105
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.		PHYSICAL OCCUPATIONAL RESPIRATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.			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: 300,000 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	Y	Y	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 N	2	140
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.				
141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I (CONT)

MULTICAMPUS

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

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

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

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(m)? ENTER 'Y' FOR YES OR 'N' FOR NO. Y 167  
168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),  
ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168  
169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH  
(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 0.75 169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

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

COMPLETED BY ALL HOSPITALS

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

PS&R REPORT DATA		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1	2	3	4
		N		N	
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)	Y	09/17/2013	Y	09/17/2013
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 RELIEF 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 DEBRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 27

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

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

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I

LINE	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)	30	37	13,505		2,165	303	3,165	1
2	HMO					84			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF					166		166	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		37	13,505		2,331	303	3,331	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)		37	13,505		2,331	303	3,331	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF	40	27	9,854		3,334	2,299	8,505	16
17	SUBPROVIDER - IRF	41							17
18	SUBPROVIDER I	42							18
19	SKILLED NURSING FACILITY	44							19
20	NURSING FACILITY	45							20
21	OTHER LONG TERM CARE	46							21
22	HOME HEALTH AGENCY	101				3,307		4,666	22
23	ASC (DISTINCT PART)	115							23
24	HOSPICE (DISTINCT PART)	116							24
25	CMHC	99							25
26	RHC	88				4,422		16,356	26
26.01	RHC II	88.01				394		1,143	26.01
27	TOTAL (SUM OF LINES 14-26)		64						27
28	OBSERVATION BED DAYS							2,158	28
29	AMBULANCE TRIPS								29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								30
31	EMPLOYEE DISCOUNT DAYS-IRF								31
32	LABOR & DELIVERY DAYS (SEE INSTR.)								32
33	LTCH NON-COVERED DAYS								33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I  
 (CONTINUED)

LINE	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---			----- DISCHARGES -----			TOTAL ALL PATIENTS 15	
			INTERNS & RESIDENTS 9	ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14		
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					701	118	1,064	1
2	HMO						29			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)			356.81			701	118	1,064	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40		61.84			380	408	1,293	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101		14.73						22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88		28.03						26
26.01	RHC II	88.01		2.37						26.01
27	TOTAL (SUM OF LINES 14-26)			463.78						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	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	200	21,534,359		21,534,359	964,683.00	22.32	1
2							2
3		675,020		675,020	6,640.00	101.66	3
4							4
4.01							4.01
5		2,397,002		2,397,002	26,927.00	89.02	5
6		961,139	-152,969	808,170	41,387.00	19.53	6
7	21						7
7.01							7.01
8							8
9	44						9
10		3,439,269	-128,475	3,310,794	172,087.00	19.24	10
OTHER WAGES & RELATED COSTS							
11		1,047,913		1,047,913	9,862.00	106.26	11
12							12
13							13
14							14
15							15
16							16
17		4,844,431		4,844,431			17
18							18
19		1,184,852		1,184,852			19
20							20
21		232,549		232,549			21
22							22
22.01							22.01
23		825,784		825,784			23
24		331,119		331,119			24
25							25
26		55,392		55,392	2,633.00	21.04	26
27		2,662,282	140,808	2,803,090	126,983.00	22.07	27
28		85,110		85,110	2,023.00	42.07	28
29							29
30		541,537		541,537	34,431.00	15.73	30
31		44,454		44,454	4,142.00	10.73	31
32		477,940		477,940	42,975.00	11.12	32
33							33
34		547,822		547,822	43,210.00	12.68	34
35							35
36							36
37							37
38		296,280		296,280	9,414.00	31.47	38
39		192,340		192,340	13,040.00	14.75	39
40		560,572		560,572	13,543.00	41.39	40
41		475,348		475,348	31,401.00	15.14	41
42							42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	17,586,308	152,969	17,739,277	891,752.00	19.89	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	3,439,269	-128,475	3,310,794	172,087.00	19.24	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	14,147,039	281,444	14,428,483	719,665.00	20.05	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	1,047,913		1,047,913	9,862.00	106.26	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	4,844,431		4,844,431		33.58%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	20,039,383	281,444	20,320,827	729,527.00	27.85	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	5,939,077	140,808	6,079,885	323,795.00	18.78	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS		1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	648,311	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)	4,497,987	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	67,915	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	31,576	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	470,380	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	1,297,448	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	303,435	18
19 UNEMPLOYMENT INSURANCE		19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	82,845	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	11,750	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	7,411,647	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	7,088	25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3  
 PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	1,047,913	1
2	HOSPITAL	1,047,913	2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II		14.01
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7419

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: SALINE

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		2,050			2,050	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		180.00			180.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: .00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			
	STAFF 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)		1.03	1.03	4
5 OTHER ADMINISTRATIVE PERSONNEL				5
6 DIRECT NURSING SERVICE		7.54	7.54	6
7 NURSING SUPERVISOR		0.90	0.90	7
8 PHYSICAL THERAPY SERVICE		1.69	1.69	8
9 PHYSICAL THERAPY SUPERVISOR				9
10 OCCUPATIONAL THERAPY SERVICE		0.10	0.10	10
11 OCCUPATIONAL THERAPY SUPERVISOR				11
12 SPEECH PATHOLOGY SERVICE		0.08	0.08	12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE				14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE		0.99	0.99	16
17 HOME HEALTH AIDE SUPERVISOR				17
18 OTHER (SPECIFY)				18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

	FULL EPISODES				TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	1,540		77	27	1,644	21
22 SKILLED NURSING VISIT CHARGES	351,120		17,556	6,156	374,832	22
23 PHYSICAL THERAPY VISITS	1,225		7	41	1,273	23
24 PHYSICAL THERAPY VISIT CHARGES	280,525		1,603	9,389	291,517	24
25 OCCUPATIONAL THERAPY VISITS	54			1	55	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	13,338			247	13,585	26
27 SPEECH PATHOLOGY VISITS	60			1	61	27
28 SPEECH PATHOLOGY VISIT CHARGES	14,820			247	15,067	28
29 MEDICAL SOCIAL SERVICE VISITS						29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES						30
31 HOME HEALTH AIDE VISITS	4				4	31
32 HOME HEALTH AIDE VISIT CHARGES	468				468	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	2,883		84	70	3,037	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	660,271		19,159	16,039	695,469	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	202		34	5	241	36
37 TOTAL NUMBER OF OUTLIER EPISODES						37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	25,650		3,053	313	29,016	38

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		Y/N 1	DATE 2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	11/03/1988	2

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

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1			5	5 72
73	PC2				73
74	PC1			14	14 74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL			166	166 200

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

PROVIDER CCN: 14-0210 HARRISBURG MEDICAL CENTER, INC  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2012.11  
 11/08/2013 16:22

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

RHC I  
 COMPONENT NO: 14-3473

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 1007 US ROUTE 45									1
2	CITY: ELDORADO	STATE: IL	ZIP CODE: 62930	COUNTY: SALINE						2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN									3

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)			4
5	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)			5
6	HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER			9

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

		1	2	
		N		10

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
11	CLINIC	0		1	2	0008	0005	0008	0005	0008	0005	0008	0005	0008	0005	11

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

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

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

14 PROVIDER NAME: CCN NUMBER: 14

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

PROVIDER CCN: 14-0210 HARRISBURG MEDICAL CENTER, INC  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2012.11  
 11/08/2013 16:22

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

RHC II  
 COMPONENT NO: 14-8518

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

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

SOURCE OF FEDERAL FUNDS:		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)			4
5	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)			5
6	HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8

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

FACILITY HOURS OF OPERATIONS(1)

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

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

12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	1	2	
		N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.	N		13

14	PROVIDER NAME:	CCN NUMBER:														14
----	----------------	-------------	--	--	--	--	--	--	--	--	--	--	--	--	--	----

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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.381010	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				2,832,887	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				20,865,197	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				7,949,849	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				5,116,962	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				5,116,962	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	2,179,097	464,741	2,643,838		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	830,258	177,071	1,007,329		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	191,546	225,093	416,639		22
23	COST OF CHARITY CARE	638,712	-48,022	590,690		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			5,121,675		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			630,044		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			4,491,631		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,711,356		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			2,302,046		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			7,419,008		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSIFI-	
		1	2	(COL. 1 + COL. 2)	CATIONS	
				3	4	
GENERAL SERVICE COST CENTERS						
1	00100		1,699,016	1,699,016	-933,700	1
2	00200				968,605	2
3	00300					3
4	00400	55,392	7,407,396	7,462,788		4
5	00500	2,662,282	5,043,459	7,705,741	22,413	5
6	00600					6
7	00700					7
8	00800	541,537	581,895	1,123,432		8
9	00900	44,454	78,398	122,852		9
10	01000	477,940	94,839	572,779		10
11	01100	547,822	349,121	896,943		11
12	01200					12
13	01300	296,280	49,400	345,680		13
14	01400	192,340	115,047	307,387		14
15	01500	560,572	33,501	594,073		15
16	01600	475,348	229,884	705,232		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	2,777,855	801,922	3,579,777		30
40	04000	2,614,061	372,164	2,986,225		40
ANCILLARY SERVICE COST CENTERS						
50	05000	499,542	163,392	662,934	-62,579	50
53	05300	675,020	24,087	699,107		53
54	05400	361,323	144,808	506,131	108,030	54
57	05700	250,631	145,681	396,312		57
60	06000	714,822	1,236,746	1,951,568	39,199	60
62.30	06250					62.30
64	06400	41,296	55,331	96,627		64
65	06500	553,330	107,166	660,496		65
66	06600	763,188	19,044	782,232		66
69	06900	59,035	97,284	156,319		69
71	07100		548,249	548,249		71
72	07200				62,579	72
73	07300					73
75	07500	463,400	94,025	557,425		75
76	03450	124,741	173,110	297,851		76
76.01	03631	200,535	28,940	229,475		76.01
76.02	03441	57,650	61,069	118,719		76.02
76.03	03141	69,017	23,069	92,086		76.03
76.04	03190	122,237	6,961	129,198		76.04
76.06	03950					76.06
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	1,907,450	293,100	2,200,550	-161,601	88
88.01	08801	145,797	49,053	194,850	62,143	88.01
91	09100	2,261,746	496,918	2,758,664		91
92	09200					92
93	04950	192,508	60,070	252,578		93
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	555,940	71,729	627,669	-69,151	101
SPECIAL PURPOSE COST CENTERS						
118		21,265,091	23,206,670	44,471,761	35,938	118
NONREIMBURSABLE COST CENTERS						
190	19000	86,392	646	87,038		190
192	19200	182,876	19,916	202,792	-47,228	192
192.01	19201					192.01
192.03	19202				11,290	192.03
200		21,534,359	23,227,232	44,761,591		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	765,316	-40,962	724,354	1
2	00200	CAP REL COSTS-MVBLE EQUIP	968,605		968,605	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	7,462,788	-750,745	6,712,043	4
5	00500	ADMINISTRATIVE & GENERAL	7,728,154	-2,110,340	5,617,814	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	1,123,432	-7,938	1,115,494	7
8	00800	LAUNDRY & LINEN SERVICE	122,852		122,852	8
9	00900	HOUSEKEEPING	572,779	-28,901	543,878	9
10	01000	DIETARY	896,943	-145,998	750,945	10
11	01100	CAFETERIA				11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	345,680	-30,283	315,397	13
14	01400	CENTRAL SERVICES & SUPPLY	307,387	-7,282	300,105	14
15	01500	PHARMACY	594,073	-27,366	566,707	15
16	01600	MEDICAL RECORDS & LIBRARY	705,232	-427	704,805	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	3,579,777	-637,006	2,942,771	30
40	04000	SUBPROVIDER - IPF	2,986,225	-125,188	2,861,037	40
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	600,355	184	600,539	50
53	05300	ANESTHESIOLOGY	699,107	-675,020	24,087	53
54	05400	RADIOLOGY-DIAGNOSTIC	614,161		614,161	54
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	396,312	34	396,346	57
60	06000	LABORATORY	1,990,767	-900	1,989,867	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	06400	INTRAVENOUS THERAPY	96,627		96,627	64
65	06500	RESPIRATORY THERAPY	660,496	-8,509	651,987	65
66	06600	PHYSICAL THERAPY	782,232	362	782,594	66
69	06900	ELECTROCARDIOLOGY	156,319	-62,641	93,678	69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	548,249		548,249	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	62,579		62,579	72
73	07300	DRUGS CHARGED TO PATIENTS	2,450,796		2,450,796	73
75	07500	ASC (NON-DISTINCT PART)	557,425	-2,251	555,174	75
76	03450	NUCLEAR MEDICINE	297,851		297,851	76
76.01	03631	ULTRASOUND	229,475		229,475	76.01
76.02	03441	MAMMOGRAPHY	118,719		118,719	76.02
76.03	03141	CARDIAC REHABILITATION	92,086		92,086	76.03
76.04	03190	FAITH CENTER CHEMOTHERAPY	129,198	-20,245	108,953	76.04
76.06	03950	ROUTINE ANCILLARY				76.06
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC (RHC)	2,038,949	-94,195	1,944,754	88
88.01	08801	RHC II	256,993	-42,532	214,461	88.01
91	09100	EMERGENCY	2,758,664	-1,676,080	1,082,584	91
92	09200	OBSERVATION BEDS				92
93	04950	DAY PSYCHIATRIC	252,578		252,578	93
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
101	10100	HOME HEALTH AGENCY	558,518	-41	558,477	101
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117)	44,507,699	-6,494,270	38,013,429	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	87,038		87,038	190
192	19200	PHYSICIANS' PRIVATE OFFICES	155,564		155,564	192
192.01	19201	DIALYSIS				192.01
192.03	19202	ORTHO CLINIC	11,290		11,290	192.03
200		TOTAL (SUM OF LINES 118-199)	44,761,591	-6,494,270	38,267,321	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
1	1	2	3		4	5
1 DEPRECIATION	A	CAP REL COSTS-MVBLE EQUIP	2			923,712 1
2		HOME HEALTH AGENCY	101			6,581 2
3		RURAL HEALTH CLINIC (RHC)	88			63,112 3
4		ADMINISTRATIVE & GENERAL	5			6,135 4
5		ORTHO CLINIC	192.03			11,290 5
6		PHYSICIANS' PRIVATE OFFICES	192			5,515 6
500 TOTAL RECLASSIFICATIONS						1,016,345 500
CODE LETTER - A						
1 IMPLANTABLE SUPPLIES	B	IMPL. DEV. CHARGED TO PATIENT	72			62,579 1
500 TOTAL RECLASSIFICATIONS						62,579 500
CODE LETTER - B						
1 HHA BILLER	C	ADMINISTRATIVE & GENERAL	5		75,732	1
500 TOTAL RECLASSIFICATIONS					75,732	500
CODE LETTER - C						
1 INSURANCE	D	CAP REL COSTS-BLDG & FIXT	1			82,645 1
2		CAP REL COSTS-MVBLE EQUIP	2			44,893 2
500 TOTAL RECLASSIFICATIONS						127,538 500
CODE LETTER - D						
1 EPC BILLING & ADMITTING	E	ADMINISTRATIVE & GENERAL	5		65,076	1
500 TOTAL RECLASSIFICATIONS					65,076	500
CODE LETTER - E						
1 EPC LAB	F	LABORATORY	60		37,407	1
2 EPC RADIOLOGY	F	RADIOLOGY-DIAGNOSTIC	54		103,229	2
500 TOTAL RECLASSIFICATIONS					140,636	500
CODE LETTER - F						
1 EPC APT EXPENSE	G	ADMINISTRATIVE & GENERAL	5			3,008 1
500 TOTAL RECLASSIFICATIONS						3,008 500
CODE LETTER - G						
1 RHC EPC BLDG EXPENSE	H	LABORATORY	60			1,792 1
2		RADIOLOGY-DIAGNOSTIC	54			4,801 2
500 TOTAL RECLASSIFICATIONS						6,593 500
CODE LETTER - H						
1 BUSINESS DEVELOPMENT EXPENSE ALLOC.	I	RHC II	88.01		59,408	2,735 1
500 TOTAL RECLASSIFICATIONS					59,408	2,735 500
CODE LETTER - I						
GRAND TOTAL (INCREASES)					340,852	1,218,798

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		SALARY	OTHER	WKST A-7	
			LINE #				REF.	
	1	6	7		8	9	10	
1 DEPRECIATION	A	CAP REL COSTS-BLDG & FIXT	1			923,712		9 1
2		CAP REL COSTS-BLDG & FIXT	1			6,581		9 2
3		CAP REL COSTS-BLDG & FIXT	1			63,112		9 3
4		CAP REL COSTS-BLDG & FIXT	1			6,135		9 4
5		CAP REL COSTS-BLDG & FIXT	1			11,290		9 5
6		CAP REL COSTS-BLDG & FIXT	1			5,515		9 6
500 TOTAL RECLASSIFICATIONS CODE LETTER - A						1,016,345		500
1 IMPLANTABLE SUPPLIES	B	OPERATING ROOM		50		62,579		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B						62,579		500
1 HHA BILLER	C	HOME HEALTH AGENCY		101	75,732			1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					75,732			500
1 INSURANCE	D	ADMINISTRATIVE & GENERAL		5		82,645		12 1
2		ADMINISTRATIVE & GENERAL		5		44,893		12 2
500 TOTAL RECLASSIFICATIONS CODE LETTER - D						127,538		500
1 EPC BILLING & ADMITTING	E	RURAL HEALTH CLINIC (RHC)		88	65,076			1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					65,076			500
1 EPC LAB	F	PHYSICIANS' PRIVATE OFFICES		192	52,743			1
2 EPC RADIOLOGY	F	RURAL HEALTH CLINIC (RHC)		88	87,893			2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					140,636			500
1 EPC APT EXPENSE	G	RURAL HEALTH CLINIC (RHC)		88		3,008		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - G						3,008		500
1 RHC EPC BLDG EXPENSE	H	RURAL HEALTH CLINIC (RHC)		88		1,792		1
2		RURAL HEALTH CLINIC (RHC)		88		4,801		2
500 TOTAL RECLASSIFICATIONS CODE LETTER - H						6,593		500
1 BUSINESS DEVELOPMENT EXPENSE ALLOC.	I	RURAL HEALTH CLINIC (RHC)		88	59,408		2,735	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - I					59,408		2,735	500
GRAND TOTAL (DECREASES)					340,852	1,218,798		

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND RETIREMENTS	BALANCE	DEPRECIATED ASSETS
	1	2	3	4	5	6	7
1 LAND	420,001	100,931		100,931		520,932	1
2 LAND IMPROVEMENTS	661,821	37,912		37,912		699,733	2
3 BUILDINGS AND FIXTURES	19,165,489	1,632,998		1,632,998	61,410	20,737,077	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	11,279,373	539,988		539,988	629,976	11,189,385	6
7 HIT DESIGNATED ASSETS	279,505	364,147		364,147		643,652	7
8 SUBTOTAL (SUM OF LINES 1-7)	31,806,189	2,675,976		2,675,976	691,386	33,790,779	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	31,806,189	2,675,976		2,675,976	691,386	33,790,779	10

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

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (SEE INSTR.)	TAXES (SEE INSTR.)	OTHER	TOTAL(1)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	12	13	14	15
1 CAP REL COSTS-BLDG & FIXT	1,509,096		189,920				1,699,016
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	1,509,096		189,920				1,699,016

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2)	RATIO (SEE INSTR.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (SUM OF COLS. 5-7)
	1	2	3	4	5	6	7	8
1 CAP REL COSTS-BLDG & FIXT	21,957,742		21,957,742	0.649815				1
2 CAP REL COSTS-MVBLE EQUIP	11,833,037		11,833,037	0.350185				2
3 TOTAL (SUM OF LINES 1-2)	33,790,779		33,790,779	1.000000				3

DESCRIPTION	DEPREC- IATION	LEASE	INTEREST	INSURANCE (SEE INSTR.)	TAXES (SEE INSTR.)	OTHER	TOTAL(2)
						CAPITAL- RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	12	13	14	15
1 CAP REL COSTS-BLDG & FIXT	492,751		148,958	82,645			724,354
2 CAP REL COSTS-MVBLE EQUIP	923,712			44,893			968,605
3 TOTAL	1,416,463		148,958	127,538			1,692,959

ADJUSTMENTS TO EXPENSES

1	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8	
				COST CENTER 3	LINE NO. 4	WKST A-7 REF	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-40,962	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-3,259	ADMINISTRATIVE & GENERAL	5		4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,526,840				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-107,684	DIETARY	10		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-427	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						19
20	VENDING MACHINES	B	-2,913	ADMINISTRATIVE & GENERAL	5		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
34	PHYSICIAN RECRUITMENT	A	-285,176	ADMINISTRATIVE & GENERAL	5		34
34.01	PHYSICIAN LOANS	A	-13,489	ADMINISTRATIVE & GENERAL	5		34.01
35	CRNA WAGES	A	-675,020	ANESTHESIOLOGY	53		35
35.01	CRNA BENEFITS	A	-232,544	EMPLOYEE BENEFITS	4		35.01
36	EMERGENCY ROOM PHYS BENEFITS	A	-456,172	EMPLOYEE BENEFITS	4		36
37							37
37.01	PSYCH PHYSICIAN TRAVEL	A	-1,983	ADMINISTRATIVE & GENERAL	5		37.01
38	PSYCH SALARY REIMBURSEMENT	A	-39,185	RURAL HEALTH CLINIC (RHC)	88		38
39	ER MD MISC EXPENSE	A	-5,601	EMERGENCY	91		39
40	ASC PHYSICIAN BENEFITS	A	-860	EMPLOYEE BENEFITS	4		40
41							41
42	HHC SCREENINGS	B	-41	HOME HEALTH AGENCY	101		42
43	OTHER INCOME	B	-63,412	ADMINISTRATIVE & GENERAL	5		43
44	MEDICAID ASSESSMENT	A	-1,569,440	ADMINISTRATIVE & GENERAL	5		44
45	MISSIONS EXPENSE	A	-1,008	ADMINISTRATIVE & GENERAL	5		45
45.02	CAPITALIZED INTEREST	A	83	OPERATION OF PLANT	7		45.02
45.03	CAPITALIZED INTEREST	A	362	PHYSICAL THERAPY	66		45.03
45.04	CAPITALIZED INTEREST	A	245	ASC (NON-DISTINCT PART)	75		45.04
45.05	CAPITALIZED INTEREST	A	215	EMERGENCY	91		45.05
45.06	CAPITALIZED INTEREST	A	34	COMPUTED TOMOGRAPHY (CT) SCAN	57		45.06
45.07	CAPITALIZED INTEREST	A	184	OPERATING ROOM	50		45.07
45.20	PHYSICIAN BILLING WAGES	A	-6,006	ADMINISTRATIVE & GENERAL	5		45.20
45.21	PHYSICIAN BILLING FRINGE BENEFIT	A	-2,069	EMPLOYEE BENEFITS	4		45.21
45.22	DONATED MEALS	A	-38,314	DIETARY	10		45.22
45.24	COMM RELATIONS	A	-24,918	ADMINISTRATIVE & GENERAL	5		45.24
45.25	ALCOHOL	A	-2	ADMINISTRATIVE & GENERAL	5		45.25
45.26	IHA LOBBYING	A	-15,427	ADMINISTRATIVE & GENERAL	5		45.26
45.27	AHA LOBBYING	A	-4,090	ADMINISTRATIVE & GENERAL	5		45.27

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
45.28 ADVERTISING	A	-62,735	ADMINISTRATIVE & GENERAL	5	45.28
45.32 MISC INCOME	A	-839	RESPIRATORY THERAPY	65	45.32
45.34 DUE - ROTARY CLUB	A	-300	EMPLOYEE BENEFITS	4	45.34
45.35 OTHER ADMIN DUES	A	-7,657	ADMINISTRATIVE & GENERAL	5	45.35
45.37 PENALTIES	A	-4,193	ADMINISTRATIVE & GENERAL	5	45.37
45.38 INSURANCE SETTLEMENTS	A	-1,520	ADMINISTRATIVE & GENERAL	5	45.38
45.39 IHREF CONTRIBUTION EXPENSE	A	-6,897	ADMINISTRATIVE & GENERAL	5	45.39
45.40 LLC OVERHEAD FRINGE BENEFIT	A	-58,800	EMPLOYEE BENEFITS	4	45.40
45.41 LLC OVERHEAD A&G	A	-36,215	ADMINISTRATIVE & GENERAL	5	45.41
45.42 LLC OVERHEAD PLANT	A	-8,021	OPERATION OF PLANT	7	45.42
45.43 LLC OVERHEAD HOUSEKEEPING	A	-28,901	HOUSEKEEPING	9	45.43
45.44 LLC OVERHEAD NURSING ADMIN	A	-30,283	NURSING ADMINISTRATION	13	45.44
45.45 LLC OVERHEAD CENTRAL SUPPLY	A	-7,282	CENTRAL SERVICES & SUPPLY	14	45.45
45.46 LLC OVERHEAD PHARMACY	A	-27,366	PHARMACY	15	45.46
45.47 LLC OVERHEAD RHC I	A	-55,010	RURAL HEALTH CLINIC (RHC)	88	45.47
45.48 LLC OVERHEAD RHC II	A	-42,532	RHC II	88.01	45.48
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-6,494,270			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

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

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

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		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	MEDICAL FEES		263,888		263,888	138,700	2,080	138,700	6,935	1
2	40	SUBPROVIDER - IPF	SALARIED-DR					138,700				2
3	91	EMERGENCY	SALARIED-DR	1,324,156	1,270,156	54,000	159,800	495	38,029	1,901		3
4	60	LABORATORY	MEDICAL FEES			9,600	208,000	87	8,700	435		4
5	69	ELECTROCARDIOLOGY	MEDICAL FEES	62,641	62,641							5
6	76.04	FAITH CENTER CHEMOTHERAP	MEDICAL FEES DI	20,245	20,245							6
7	91	EMERGENCY	MEDICAL FEES #4	384,567	384,567							7
8	30	ADULTS & PEDIATRICS	HOSPITALISTS ME	481,006	481,006							8
9	30	ADULTS & PEDIATRICS	HOSPITALISTS PU	156,000	156,000							9
10	65	RESPIRATORY THERAPY	RESP THER MEDIC	7,670	7,670							10
11	75	ASC (NON-DISTINCT PART)	SALARIED-DR	2,496	2,496							11
200		TOTAL		2,712,269	2,384,781	327,488		2,662	185,429	9,271		200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11		12	13	14	15	16	17	18	
1	40	SUBPROVIDER - IPF	MEDICAL FEES				138,700	125,188	125,188	1
2	40	SUBPROVIDER - IPF	SALARIED-DR							2
3	91	EMERGENCY	SALARIED-DR				38,029	15,971	1,286,127	3
4	60	LABORATORY	MEDICAL FEES				8,700	900	900	4
5	69	ELECTROCARDIOLOGY	MEDICAL FEES						62,641	5
6	76.04	FAITH CENTER CHEMOTHERAP	MEDICAL FEES DI						20,245	6
7	91	EMERGENCY	MEDICAL FEES #4						384,567	7
8	30	ADULTS & PEDIATRICS	HOSPITALISTS ME						481,006	8
9	30	ADULTS & PEDIATRICS	HOSPITALISTS PU						156,000	9
10	65	RESPIRATORY THERAPY	RESP THER MEDIC						7,670	10
11	75	ASC (NON-DISTINCT PART)	SALARIED-DR						2,496	11
200		TOTAL					185,429	142,059	2,526,840	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	724,354	724,354				1
2 CAP REL COSTS-MVBLE EQUIP	968,605		968,605			2
4 EMPLOYEE BENEFITS	6,712,043	5,615	5,914	6,723,572		4
5 ADMINISTRATIVE & GENERAL	5,617,814	110,657	440,576	957,026	7,126,073	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,115,494	28,592	15,335	184,932	1,344,353	7
8 LAUNDRY & LINEN SERVICE	122,852	13,965	5,961	15,409	158,187	8
9 HOUSEKEEPING	543,878	3,575	1,637	155,649	704,739	9
10 DIETARY	750,945	16,247	8,239	189,890	965,321	10
11 CAFETERIA		9,306			9,306	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	315,397		5,872	102,699	423,968	13
14 CENTRAL SERVICES & SUPPLY	300,105	6,257	18,208	66,670	391,240	14
15 PHARMACY	566,707	12,251	19,444	194,310	792,712	15
16 MEDICAL RECORDS & LIBRARY	704,805	8,549	40,721	164,769	918,844	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,942,771	100,583	51,073	962,880	4,057,307	30
40 SUBPROVIDER - IPF	2,861,037	98,764	6,313	906,107	3,872,221	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	600,539	65,313	51,349	173,155	890,356	50
53 ANESTHESIOLOGY	24,087		12,456		36,543	53
54 RADIOLOGY-DIAGNOSTIC	614,161	41,853	52,167	161,027	869,208	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	396,346	4,774	1,043	86,876	489,039	57
60 LABORATORY	1,989,867	24,449	34,345	260,744	2,309,405	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						
64 INTRAVENOUS THERAPY	96,627			14,314	110,941	64
65 RESPIRATORY THERAPY	651,987	9,738	14,368	191,800	867,893	65
66 PHYSICAL THERAPY	782,594	49,508	11,924	264,542	1,108,568	66
69 ELECTROCARDIOLOGY	93,678		6,642	20,463	120,783	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	548,249				548,249	71
72 IMPL. DEV. CHARGED TO PATIENT	62,579				62,579	72
73 DRUGS CHARGED TO PATIENTS	2,450,796				2,450,796	73
75 ASC (NON-DISTINCT PART)	555,174	43,598	22,497	159,762	781,031	75
76 NUCLEAR MEDICINE	297,851		57,110	43,239	398,200	76
76.01 ULTRASOUND	229,475	5,289	42,831	69,511	347,106	76.01
76.02 MAMMOGRAPHY	118,719	3,186		19,983	141,888	76.02
76.03 CARDIAC REHABILITATION	92,086		8,132	23,923	124,141	76.03
76.04 FAITH CENTER CHEMOTHERAPY	108,953	9,811	1,846	42,371	162,981	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,944,754			573,977	2,518,731	88
88.01 RHC II	214,461			71,130	285,591	88.01
91 EMERGENCY	1,082,584	20,443	32,032	338,177	1,473,236	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	252,578	25,238	570	66,729	345,115	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	558,477			166,454	724,931	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	38,013,429	717,561	968,605	6,648,518	37,931,582	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	87,038	6,793		29,946	123,777	190
192 PHYSICIANS' PRIVATE OFFICES	155,564			45,108	200,672	192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC	11,290				11,290	192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	38,267,321	724,354	968,605	6,723,572	38,267,321	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	7,126,073					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	307,630	1,651,983				7
8 LAUNDRY & LINEN SERVICE	36,198	39,810	234,195			8
9 HOUSEKEEPING	161,266	10,192		876,197		9
10 DIETARY	220,895	46,316			1,232,532	10
11 CAFETERIA	2,130	26,530			619,936	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	97,017					13
14 CENTRAL SERVICES & SUPPLY	89,528	17,837				14
15 PHARMACY	181,397	34,924		10,123		15
16 MEDICAL RECORDS & LIBRARY	210,260	24,372				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	928,427	286,737	64,169	272,415	298,894	30
40 SUBPROVIDER - IPF	886,084	281,551	29,323	125,639	295,666	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	203,741	186,192	21,755	61,629		50
53 ANESTHESIOLOGY	8,362					53
54 RADIOLOGY-DIAGNOSTIC	198,902	119,311	13,856			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	111,907	13,610				57
60 LABORATORY	528,463	69,698		49,124		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	25,387					64
65 RESPIRATORY THERAPY	198,601	27,759	13,073	12,207		65
66 PHYSICAL THERAPY	253,675	141,135	14,546	16,672		66
69 ELECTROCARDIOLOGY	27,639					69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	125,456					71
72 IMPL. DEV. CHARGED TO PATIENT	14,320					72
73 DRUGS CHARGED TO PATIENTS	560,818					73
75 ASC (NON-DISTINCT PART)	178,724	124,288	31,394	87,233		75
76 NUCLEAR MEDICINE	91,121					76
76.01 ULTRASOUND	79,429	15,079				76.01
76.02 MAMMOGRAPHY	32,468	9,083				76.02
76.03 CARDIAC REHABILITATION	28,407					76.03
76.04 FAITH CENTER CHEMOTHERAPY	37,295	27,969				76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	576,364		13,165	96,760		88
88.01 RHC II	65,352					88.01
91 EMERGENCY	337,122	58,277	23,661	132,486		91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	78,973	71,947				93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	165,887			11,909		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	7,049,245	1,632,617	224,942	876,197	1,214,496	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,324	19,366				190
192 PHYSICIANS' PRIVATE OFFICES	45,920		9,253		18,036	192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC	2,584					192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	7,126,073	1,651,983	234,195	876,197	1,232,532	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	657,902					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	10,284	531,269				13
14 CENTRAL SERVICES & SUPPLY	6,131		504,736			14
15 PHARMACY	14,795		2,803	1,036,754		15
16 MEDICAL RECORDS & LIBRARY	34,304		3,111		1,190,891	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	138,625	139,372	101,200		39,443	30
40 SUBPROVIDER - IPF	140,528	141,286	23,984		124,046	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	43,923	44,159	158,759		22,416	50
53 ANESTHESIOLOGY	7,254		3,215		20,204	53
54 RADIOLOGY-DIAGNOSTIC	17,971		3,217		44,797	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	12,594		3,391		171,693	57
60 LABORATORY	40,700		10,492		231,815	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY			43,226		39,986	64
65 RESPIRATORY THERAPY	28,098		5,178		47,320	65
66 PHYSICAL THERAPY	28,938		3,572		36,846	66
69 ELECTROCARDIOLOGY	3,381		1,160		17,572	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					37,769	71
72 IMPL. DEV. CHARGED TO PATIENT					3,818	72
73 DRUGS CHARGED TO PATIENTS				1,036,754	130,467	73
75 ASC (NON-DISTINCT PART)	38,823	39,032	50,075		39,250	75
76 NUCLEAR MEDICINE	4,446		1,593		24,905	76
76.01 ULTRASOUND	12,569		890		34,323	76.01
76.02 MAMMOGRAPHY	2,775		420		8,282	76.02
76.03 CARDIAC REHABILITATION	3,296	3,314	793		5,055	76.03
76.04 FAITH CENTER CHEMOTHERAPY	4,853	4,879	8,944		3,470	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		71,839	6,238			88
88.01 RHC II			762			88.01
91 EMERGENCY	53,448	53,736	64,733		93,845	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	10,166		623		13,569	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		33,652	5,600			101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	657,902	531,269	503,979	1,036,754	1,190,891	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			66			190
192 PHYSICIANS' PRIVATE OFFICES			691			192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	657,902	531,269	504,736	1,036,754	1,190,891	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	6,326,589		6,326,589	30
40 SUBPROVIDER - IPF	5,920,328		5,920,328	40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1,632,930		1,632,930	50
53 ANESTHESIOLOGY	75,578		75,578	53
54 RADIOLOGY-DIAGNOSTIC	1,267,262		1,267,262	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	802,234		802,234	57
60 LABORATORY	3,239,697		3,239,697	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	219,540		219,540	64
65 RESPIRATORY THERAPY	1,200,129		1,200,129	65
66 PHYSICAL THERAPY	1,603,952		1,603,952	66
69 ELECTROCARDIOLOGY	170,535		170,535	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	711,474		711,474	71
72 IMPL. DEV. CHARGED TO PATIENT	80,717		80,717	72
73 DRUGS CHARGED TO PATIENTS	4,178,835		4,178,835	73
75 ASC (NON-DISTINCT PART)	1,369,850		1,369,850	75
76 NUCLEAR MEDICINE	520,265		520,265	76
76.01 ULTRASOUND	489,396		489,396	76.01
76.02 MAMMOGRAPHY	194,916		194,916	76.02
76.03 CARDIAC REHABILITATION	165,006		165,006	76.03
76.04 FAITH CENTER CHEMOTHERAPY	250,391		250,391	76.04
76.06 ROUTINE ANCILLARY				76.06
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIEPT				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	3,283,097		3,283,097	88
88.01 RHC II	351,705		351,705	88.01
91 EMERGENCY	2,290,544		2,290,544	91
92 OBSERVATION BEDS				92
93 DAY PSYCHIATRIC	520,393		520,393	93
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
101 HOME HEALTH AGENCY	941,979		941,979	101
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	37,807,342		37,807,342	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	171,533		171,533	190
192 PHYSICIANS' PRIVATE OFFICES	274,572		274,572	192
192.01 DIALYSIS				192.01
192.03 ORTHO CLINIC	13,874		13,874	192.03
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	38,267,321		38,267,321	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		5,615	5,914	11,529	11,529	4
5 ADMINISTRATIVE & GENERAL	2,703	110,657	440,576	553,936	1,640	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,181	28,592	15,335	45,108	317	7
8 LAUNDRY & LINEN SERVICE		13,965	5,961	19,926	26	8
9 HOUSEKEEPING		3,575	1,637	5,212	267	9
10 DIETARY		16,247	8,239	24,486	325	10
11 CAFETERIA		9,306		9,306		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			5,872	5,872	176	13
14 CENTRAL SERVICES & SUPPLY		6,257	18,208	24,465	114	14
15 PHARMACY		12,251	19,444	31,695	333	15
16 MEDICAL RECORDS & LIBRARY		8,549	40,721	49,270	282	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		100,583	51,073	151,656	1,657	30
40 SUBPROVIDER - IPF	547	98,764	6,313	105,624	1,553	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	69,273	65,313	51,349	185,935	297	50
53 ANESTHESIOLOGY			12,456	12,456		53
54 RADIOLOGY-DIAGNOSTIC		41,853	52,167	94,020	276	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		4,774	1,043	5,817	149	57
60 LABORATORY	140	24,449	34,345	58,934	447	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					25	64
65 RESPIRATORY THERAPY	22,538	9,738	14,368	46,644	329	65
66 PHYSICAL THERAPY	893	49,508	11,924	62,325	453	66
69 ELECTROCARDIOLOGY	29,375		6,642	36,017	35	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)		43,598	22,497	66,095	274	75
76 NUCLEAR MEDICINE			57,110	57,110	74	76
76.01 ULTRASOUND		5,289	42,831	48,120	119	76.01
76.02 MAMMOGRAPHY		3,186		3,186	34	76.02
76.03 CARDIAC REHABILITATION			8,132	8,132	41	76.03
76.04 FAITH CENTER CHEMOTHERAPY		9,811	1,846	11,657	73	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,141			1,141	984	88
88.01 RHC II					122	88.01
91 EMERGENCY	110	20,443	32,032	52,585	580	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC		25,238	570	25,808	114	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY					285	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	127,901	717,561	968,605	1,814,067	11,401	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,793		6,793	51	190
192 PHYSICIANS' PRIVATE OFFICES					77	192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	127,901	724,354	968,605	1,820,860	11,529	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	555,576					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	23,985	69,410				7
8 LAUNDRY & LINEN SERVICE	2,822	1,673	24,447			8
9 HOUSEKEEPING	12,573	428		18,480		9
10 DIETARY	17,222	1,946			43,979	10
11 CAFETERIA	166	1,115			22,120	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	7,564					13
14 CENTRAL SERVICES & SUPPLY	6,980	749				14
15 PHARMACY	14,143	1,467		213		15
16 MEDICAL RECORDS & LIBRARY	16,393	1,024				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	72,374	12,047	6,699	5,746	10,665	30
40 SUBPROVIDER - IPF	69,084	11,830	3,061	2,650	10,550	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	15,885	7,823	2,271	1,300		50
53 ANESTHESIOLOGY	652					53
54 RADIOLOGY-DIAGNOSTIC	15,508	5,013	1,446			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	8,725	572				57
60 LABORATORY	41,202	2,928		1,036		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	1,979					64
65 RESPIRATORY THERAPY	15,484	1,166	1,365	257		65
66 PHYSICAL THERAPY	19,778	5,930	1,518	352		66
69 ELECTROCARDIOLOGY	2,155					69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	9,781					71
72 IMPL. DEV. CHARGED TO PATIENT	1,116					72
73 DRUGS CHARGED TO PATIENTS	43,725					73
75 ASC (NON-DISTINCT PART)	13,934	5,222	3,277	1,840		75
76 NUCLEAR MEDICINE	7,104					76
76.01 ULTRASOUND	6,193	634				76.01
76.02 MAMMOGRAPHY	2,531	382				76.02
76.03 CARDIAC REHABILITATION	2,215					76.03
76.04 FAITH CENTER CHEMOTHERAPY	2,908	1,175				76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	44,937		1,374	2,041		88
88.01 RHC II	5,095					88.01
91 EMERGENCY	26,284	2,449	2,470	2,794		91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	6,157	3,023				93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	12,933			251		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	549,587	68,596	23,481	18,480	43,335	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,208	814				190
192 PHYSICIANS' PRIVATE OFFICES	3,580		966		644	192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC	201					192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	555,576	69,410	24,447	18,480	43,979	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	32,707					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	511	14,123				13
14 CENTRAL SERVICES & SUPPLY	305		32,613			14
15 PHARMACY	736		181	48,768		15
16 MEDICAL RECORDS & LIBRARY	1,705		201		68,875	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,892	3,705	6,539		2,281	30
40 SUBPROVIDER - IPF	6,986	3,755	1,550		7,172	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,184	1,174	10,257		1,296	50
53 ANESTHESIOLOGY	361		208		1,168	53
54 RADIOLOGY-DIAGNOSTIC	893		208		2,590	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	626		219		9,927	57
60 LABORATORY	2,023		678		13,422	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY			2,793		2,312	64
65 RESPIRATORY THERAPY	1,397		335		2,736	65
66 PHYSICAL THERAPY	1,439		231		2,130	66
69 ELECTROCARDIOLOGY	168		75		1,016	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					2,184	71
72 IMPL. DEV. CHARGED TO PATIENT					221	72
73 DRUGS CHARGED TO PATIENTS				48,768	7,543	73
75 ASC (NON-DISTINCT PART)	1,930	1,038	3,236		2,269	75
76 NUCLEAR MEDICINE	221		103		1,440	76
76.01 ULTRASOUND	625		57		1,985	76.01
76.02 MAMMOGRAPHY	138		27		479	76.02
76.03 CARDIAC REHABILITATION	164	88	51		292	76.03
76.04 FAITH CENTER CHEMOTHERAPY	241	130	578		201	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		1,910	403			88
88.01 RHC II			49			88.01
91 EMERGENCY	2,657	1,428	4,183		5,426	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	505		40		785	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		895	362			101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	32,707	14,123	32,564	48,768	68,875	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			4			190
192 PHYSICIANS' PRIVATE OFFICES			45			192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC						192.03
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	32,707	14,123	32,613	48,768	68,875	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	280,261		280,261	30
40 SUBPROVIDER - IPF	223,815		223,815	40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	228,422		228,422	50
53 ANESTHESIOLOGY	14,845		14,845	53
54 RADIOLOGY-DIAGNOSTIC	119,954		119,954	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	26,035		26,035	57
60 LABORATORY	120,670		120,670	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	7,109		7,109	64
65 RESPIRATORY THERAPY	69,713		69,713	65
66 PHYSICAL THERAPY	94,156		94,156	66
69 ELECTROCARDIOLOGY	39,466		39,466	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	11,965		11,965	71
72 IMPL. DEV. CHARGED TO PATIENT	1,337		1,337	72
73 DRUGS CHARGED TO PATIENTS	100,036		100,036	73
75 ASC (NON-DISTINCT PART)	99,115		99,115	75
76 NUCLEAR MEDICINE	66,052		66,052	76
76.01 ULTRASOUND	57,733		57,733	76.01
76.02 MAMMOGRAPHY	6,777		6,777	76.02
76.03 CARDIAC REHABILITATION	10,983		10,983	76.03
76.04 FAITH CENTER CHEMOTHERAPY	16,963		16,963	76.04
76.06 ROUTINE ANCILLARY				76.06
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	52,790		52,790	88
88.01 RHC II	5,266		5,266	88.01
91 EMERGENCY	100,856		100,856	91
92 OBSERVATION BEDS				92
93 DAY PSYCHIATRIC	36,432		36,432	93
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
101 HOME HEALTH AGENCY	14,726		14,726	101
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	1,805,477		1,805,477	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,870		9,870	190
192 PHYSICIANS' PRIVATE OFFICES	5,312		5,312	192
192.01 DIALYSIS				192.01
192.03 ORTHO CLINIC	201		201	192.03
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	1,820,860		1,820,860	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	68,883					1
2 CAP REL COSTS-MVBLE EQUIP		923,712				2
4 EMPLOYEE BENEFITS	534	5,640	19,397,086			4
5 ADMINISTRATIVE & GENERAL	10,523	420,157	2,760,959	-7,126,073	31,141,248	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,719	14,624	533,516		1,344,353	7
8 LAUNDRY & LINEN SERVICE	1,328	5,685	44,454		158,187	8
9 HOUSEKEEPING	340	1,561	449,039		704,739	9
10 DIETARY	1,545	7,857	547,822		965,321	10
11 CAFETERIA	885				9,306	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		5,600	296,280		423,968	13
14 CENTRAL SERVICES & SUPPLY	595	17,364	192,340		391,240	14
15 PHARMACY	1,165	18,543	560,572		792,712	15
16 MEDICAL RECORDS & LIBRARY	813	38,834	475,348		918,844	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	9,565	48,706	2,777,855		4,057,307	30
40 SUBPROVIDER - IPF	9,392	6,020	2,614,061		3,872,221	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,211	48,969	499,542		890,356	50
53 ANESTHESIOLOGY		11,879			36,543	53
54 RADIOLOGY-DIAGNOSTIC	3,980	49,749	464,552		869,208	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	454	995	250,631		489,039	57
60 LABORATORY	2,325	32,753	752,229		2,309,405	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY			41,296		110,941	64
65 RESPIRATORY THERAPY	926	13,702	553,330		867,893	65
66 PHYSICAL THERAPY	4,708	11,371	763,188		1,108,568	66
69 ELECTROCARDIOLOGY		6,334	59,035		120,783	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					548,249	71
72 IMPL. DEV. CHARGED TO PATIENT					62,579	72
73 DRUGS CHARGED TO PATIENTS					2,450,796	73
75 ASC (NON-DISTINCT PART)	4,146		460,904		781,031	75
76 NUCLEAR MEDICINE		21,454	124,741		398,200	76
76.01 ULTRASOUND	503	40,846	200,535		347,106	76.01
76.02 MAMMOGRAPHY	303		57,650		141,888	76.02
76.03 CARDIAC REHABILITATION		7,755	69,017		124,141	76.03
76.04 FAITH CENTER CHEMOTHERAPY	933	1,760	122,237		162,981	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			1,655,888		2,518,731	88
88.01 RHC II			205,205		285,591	88.01
91 EMERGENCY	1,944	30,547	975,619		1,473,236	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	2,400	544	192,508		345,115	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY			480,208		724,931	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	68,237	923,712	19,180,561	-7,126,073	30,805,509	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	646		86,392		123,777	190
192 PHYSICIANS' PRIVATE OFFICES			130,133		200,672	192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC					11,290	192.03

PROVIDER CCN: 14-0210 HARRISBURG MEDICAL CENTER, INC  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2012.11  
 11/08/2013 16:22

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
		1	2	4	5A	5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	724,354	968,605	6,723,572		7,126,073	202
203	UNIT COST MULT-WS B PT I	10.515715	1.048601	0.346628		0.228831	203
204	COST TO BE ALLOC PER B PT II			11,529		555,576	204
205	UNIT COST MULT-WS B PT II			0.000594		0.017841	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET	POUNDS OF LAUNDRY	HOURS OF SERVICE	MEALS SERVED	MEALS SERVED	
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	55,107					7
8 LAUNDRY & LINEN SERVICE	1,328	25,438				8
9 HOUSEKEEPING	340		2,943			9
10 DIETARY	1,545			146,245		10
11 CAFETERIA	885			73,558	602,218	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					9,414	13
14 CENTRAL SERVICES & SUPPLY	595				5,612	14
15 PHARMACY	1,165		34		13,543	15
16 MEDICAL RECORDS & LIBRARY	813				31,401	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	9,565	6,970	915	35,465	126,892	30
40 SUBPROVIDER - IPF	9,392	3,185	422	35,082	128,633	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,211	2,363	207		40,205	50
53 ANESTHESIOLOGY					6,640	53
54 RADIOLOGY-DIAGNOSTIC	3,980	1,505			16,450	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	454				11,528	57
60 LABORATORY	2,325		165		37,255	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY	926	1,420	41		25,720	65
66 PHYSICAL THERAPY	4,708	1,580	56		26,489	66
69 ELECTROCARDIOLOGY					3,095	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)	4,146	3,410	293		35,537	75
76 NUCLEAR MEDICINE					4,070	76
76.01 ULTRASOUND	503				11,505	76.01
76.02 MAMMOGRAPHY	303				2,540	76.02
76.03 CARDIAC REHABILITATION					3,017	76.03
76.04 FAITH CENTER CHEMOTHERAPY	933				4,442	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		1,430	325			88
88.01 RHC II						88.01
91 EMERGENCY	1,944	2,570	445		48,924	91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC	2,400				9,306	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY			40			101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	54,461	24,433	2,943	144,105	602,218	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	646					190
192 PHYSICIANS' PRIVATE OFFICES		1,005		2,140		192
192.01 DIALYSIS						192.01
192.03 ORTHO CLINIC						192.03

PROVIDER CCN: 14-0210 HARRISBURG MEDICAL CENTER, INC  
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2012.11  
 11/08/2013 16:22

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET 7	POUNDS OF LAUNDRY 8	HOURS OF SERVICE 9	MEALS SERVED 10	MEALS SERVED 11	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,651,983	234,195	876,197	1,232,532	657,902	202
203 UNIT COST MULT-WS B PT I	29.977734	9.206502	297.722392	8.427857	1.092465	203
204 COST TO BE ALLOC PER B PT II	69,410	24,447	18,480	43,979	32,707	204
205 UNIT COST MULT-WS B PT II	1.259550	0.961043	6.279307	0.300721	0.054311	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY  COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	483,695				13
14 CENTRAL SERVICES & SUPPLY		912,714			14
15 PHARMACY		5,068	2,450,796		15
16 MEDICAL RECORDS & LIBRARY		5,625		89,657,508	16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	126,892	182,999		2,969,445	30
40 SUBPROVIDER - IPF	128,633	43,370		9,338,727	40
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	40,205	287,088		1,687,585	50
53 ANESTHESIOLOGY		5,814		1,521,039	53
54 RADIOLOGY-DIAGNOSTIC		5,818		3,372,538	54
57 COMPUTED TOMOGRAPHY (CT) SCAN		6,132		12,925,753	57
60 LABORATORY		18,973		17,454,165	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY		78,165		3,010,338	64
65 RESPIRATORY THERAPY		9,363		3,562,464	65
66 PHYSICAL THERAPY		6,460		2,773,952	66
69 ELECTROCARDIOLOGY		2,098		1,322,866	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				2,843,385	71
72 IMPL. DEV. CHARGED TO PATIENT				287,439	72
73 DRUGS CHARGED TO PATIENTS			2,450,796	9,822,101	73
75 ASC (NON-DISTINCT PART)	35,537	90,550		2,954,895	75
76 NUCLEAR MEDICINE		2,881		1,874,917	76
76.01 ULTRASOUND		1,609		2,584,012	76.01
76.02 MAMMOGRAPHY		759		623,541	76.02
76.03 CARDIAC REHABILITATION	3,017	1,434		380,568	76.03
76.04 FAITH CENTER CHEMOTHERAPY	4,442	16,173		261,209	76.04
76.06 ROUTINE ANCILLARY					76.06
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	65,406	11,280			88
88.01 RHC II		1,378			88.01
91 EMERGENCY	48,924	117,056		7,065,034	91
92 OBSERVATION BEDS					92
93 DAY PSYCHIATRIC		1,126		1,021,535	93
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY	30,639	10,127			101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	483,695	911,346	2,450,796	89,657,508	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		119			190
192 PHYSICIANS' PRIVATE OFFICES		1,249			192
192.01 DIALYSIS					192.01
192.03 ORTHO CLINIC					192.03

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY  COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	531,269	504,736	1,036,754	1,190,891	202
203 UNIT COST MULT-WS B PT I	1.098355	0.553006	0.423027	0.013283	203
204 COST TO BE ALLOC PER B PT II	14,123	32,613	48,768	68,875	204
205 UNIT COST MULT-WS B PT II	0.029198	0.035732	0.019899	0.000768	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,326,589		6,326,589		6,326,589	30
40 SUBPROVIDER - IPF	5,920,328		5,920,328	125,188	6,045,516	40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,632,930		1,632,930		1,632,930	50
53 ANESTHESIOLOGY	75,578		75,578		75,578	53
54 RADIOLOGY-DIAGNOSTIC	1,267,262		1,267,262		1,267,262	54
57 COMPUTED TOMOGRAPHY (CT) SC	802,234		802,234		802,234	57
60 LABORATORY	3,239,697		3,239,697	900	3,240,597	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
64 INTRAVENOUS THERAPY	219,540		219,540		219,540	64
65 RESPIRATORY THERAPY	1,200,129		1,200,129		1,200,129	65
66 PHYSICAL THERAPY	1,603,952		1,603,952		1,603,952	66
69 ELECTROCARDIOLOGY	170,535		170,535		170,535	69
71 MEDICAL SUPPLIES CHRGD TO	711,474		711,474		711,474	71
72 IMPL. DEV. CHARGED TO PATIE	80,717		80,717		80,717	72
73 DRUGS CHARGED TO PATIENTS	4,178,835		4,178,835		4,178,835	73
75 ASC (NON-DISTINCT PART)	1,369,850		1,369,850		1,369,850	75
76 NUCLEAR MEDICINE	520,265		520,265		520,265	76
76.01 ULTRASOUND	489,396		489,396		489,396	76.01
76.02 MAMMOGRAPHY	194,916		194,916		194,916	76.02
76.03 CARDIAC REHABILITATION	165,006		165,006		165,006	76.03
76.04 FAITH CENTER CHEMOTHERAPY	250,391		250,391		250,391	76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	3,283,097		3,283,097		3,283,097	88
88.01 RHC II	351,705		351,705		351,705	88.01
91 EMERGENCY	2,290,544		2,290,544	15,971	2,306,515	91
92 OBSERVATION BEDS	2,551,706		2,551,706		2,551,706	92
93 DAY PSYCHIATRIC	520,393		520,393		520,393	93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	941,979		941,979		941,979	101
200 SUBTOTAL (SEE INSTRUCTIONS)	40,359,048		40,359,048	142,059	40,501,107	200
201 LESS OBSERVATION BEDS	2,551,706		2,551,706		2,551,706	201
202 TOTAL (SEE INSTRUCTIONS)	37,807,342		37,807,342		37,949,401	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,969,444		2,969,444			30
40 SUBPROVIDER - IPF	9,338,727		9,338,727			40
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	191,792	1,495,793	1,687,585	0.967613	0.967613	0.967613 50
53 ANESTHESIOLOGY	244,680	1,276,359	1,521,039	0.049688	0.049688	0.049688 53
54 RADIOLOGY-DIAGNOSTIC	368,817	3,003,721	3,372,538	0.375759	0.375759	0.375759 54
57 COMPUTED TOMOGRAPHY (CT) SC	1,105,425	11,820,329	12,925,754	0.062065	0.062065	0.062065 57
60 LABORATORY	2,503,479	14,950,686	17,454,165	0.185612	0.185612	0.185663 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
64 INTRAVENOUS THERAPY	1,041,571	1,968,767	3,010,338	0.072929	0.072929	0.072929 64
65 RESPIRATORY THERAPY	1,491,259	2,071,205	3,562,464	0.336882	0.336882	0.336882 65
66 PHYSICAL THERAPY	397,797	2,376,155	2,773,952	0.578219	0.578219	0.578219 66
69 ELECTROCARDIOLOGY	172,328	1,150,538	1,322,866	0.128913	0.128913	0.128913 69
71 MEDICAL SUPPLIES CHRGED TO	1,120,934	1,722,451	2,843,385	0.250221	0.250221	0.250221 71
72 IMPL. DEV. CHARGED TO PATIE	8,101	279,338	287,439	0.280814	0.280814	0.280814 72
73 DRUGS CHARGED TO PATIENTS	2,172,018	7,650,083	9,822,101	0.425452	0.425452	0.425452 73
75 ASC (NON-DISTINCT PART)	127,373	2,827,523	2,954,896	0.463587	0.463587	0.463587 75
76 NUCLEAR MEDICINE	29,559	1,845,358	1,874,917	0.277487	0.277487	0.277487 76
76.01 ULTRASOUND	289,296	2,294,717	2,584,013	0.189394	0.189394	0.189394 76.01
76.02 MAMMOGRAPHY	423	623,119	623,542	0.312595	0.312595	0.312595 76.02
76.03 CARDIAC REHABILITATION	2,000	378,568	380,568	0.433578	0.433578	0.433578 76.03
76.04 FAITH CENTER CHEMOTHERAPY	1,368	259,841	261,209	0.958585	0.958585	0.958585 76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		2,049,976	2,049,976			88
88.01 RHC II		113,132	113,132			88.01
91 EMERGENCY	693,297	6,371,737	7,065,034	0.324208	0.324208	0.326469 91
92 OBSERVATION BEDS	797,854	5,564,427	6,362,281	0.401068	0.401068	0.401068 92
93 DAY PSYCHIATRIC	129,066	892,469	1,021,535	0.509423	0.509423	0.509423 93
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		1,046,410	1,046,410			101
200 SUBTOTAL (SEE INSTRUCTIONS)	25,196,608	74,032,702	99,229,310			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	25,196,608	74,032,702	99,229,310			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED ADJUSTMENT	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26) 1	2	(COL.1 MINUS COL.2) 3	4	(COL.3 ÷ COL.4) 5	6	(COL.5 x COL.6) 7	
30 INPAT ROUTINE SERV COST CTRS								30
ADULTS & PEDIATRICS	280,261	1,437	278,824	5,323	52.38	2,165	113,403	31
31 INTENSIVE CARE UNIT								32
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	223,815		223,815	8,505	26.32	3,334	87,751	40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	504,076		502,639	13,828		5,499	201,154	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	[XX] HOSPITAL (14-0210) [ ] IPF [ ] IRF	[ ] SUB (OTHER)	[XX] PPS [ ] TEFRA			
	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	228,422	1,687,585	0.135354	117,396	15,890	50
53	ANESTHESIOLOGY	14,845	1,521,039	0.009760	112,291	1,096	53
54	RADIOLOGY-DIAGNOSTIC	119,954	3,372,538	0.035568	330,506	11,755	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	26,035	12,925,754	0.002014	957,186	1,928	57
60	LABORATORY	120,670	17,454,165	0.006914	2,150,211	14,867	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
64	INTRAVENOUS THERAPY	7,109	3,010,338	0.002362	768,346	1,815	64
65	RESPIRATORY THERAPY	69,713	3,562,464	0.019569	1,051,670	20,580	65
66	PHYSICAL THERAPY	94,156	2,773,952	0.033943	264,651	8,983	66
69	ELECTROCARDIOLOGY	39,466	1,322,866	0.029834	144,365	4,307	69
71	MEDICAL SUPPLIES CHRGD TO PA	11,965	2,843,385	0.004208	892,522	3,756	71
72	IMPL. DEV. CHARGED TO PATIENT	1,337	287,439	0.004651	7,178	33	72
73	DRUGS CHARGED TO PATIENTS	100,036	9,822,101	0.010185	836,384	8,519	73
75	ASC (NON-DISTINCT PART)	99,115	2,954,896	0.033543	107,779	3,615	75
76	NUCLEAR MEDICINE	66,052	1,874,917	0.035229	29,141	1,027	76
76.01	ULTRASOUND	57,733	2,584,013	0.022342	268,871	6,007	76.01
76.02	MAMMOGRAPHY	6,777	623,542	0.010869			76.02
76.03	CARDIAC REHABILITATION	10,983	380,568	0.028859	1,781	51	76.03
76.04	FAITH CENTER CHEMOTHERAPY	16,963	261,209	0.064940			76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	52,790	2,049,976	0.025752			88
88.01	RHC II	5,266	113,132	0.046547			88.01
91	EMERGENCY	100,856	7,065,034	0.014275	435,377	6,215	91
92	OBSERVATION BEDS	113,620	6,362,281	0.017858	784,410	14,008	92
93	DAY PSYCHIATRIC	36,432	1,021,535	0.035664			93
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	1,400,295	85,874,729		9,260,065	124,452	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
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS					31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					33
34 BURN INTENSIVE CARE UNIT					34
35 SURGICAL INTENSIVE CARE UNIT					35
40 OTHER SPECIAL CARE (SPECIFY)					40
41 SUBPROVIDER - IPF					41
42 SUBPROVIDER - IRF					42
43 SUBPROVIDER I					43
44 NURSERY					44
45 SKILLED NURSING FACILITY					45
200 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 + COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
30 INPAT ROUTINE SERV COST CTRS ADULTS & PEDIATRICS	5,323		2,165		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	8,505		3,334		40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	13,828		5,499		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)						75
76 NUCLEAR MEDICINE						76
76.01 ULTRASOUND						76.01
76.02 MAMMOGRAPHY						76.02
76.03 CARDIAC REHABILITATION						76.03
76.04 FAITH CENTER CHEMOTHERAPY						76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC						93
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-0210)	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA		
BOXES	[ ] TITLE XIX	[ ] IRF	[ ] NF				
		TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	
	COST CENTER DESCRIPTION	7	8	9	10	11	12
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,687,585			117,396		208,851
53	ANESTHESIOLOGY	1,521,039			112,291		206,383
54	RADIOLOGY-DIAGNOSTIC	3,372,538			330,506		624,845
57	COMPUTED TOMOGRAPHY (CT) SCA	12,925,754			957,186		2,219,996
60	LABORATORY	17,454,165			2,150,211		196,879
62.30	BLOOD CLOTTING FOR HEMOPHILI						
64	INTRAVENOUS THERAPY	3,010,338			768,346		478,833
65	RESPIRATORY THERAPY	3,562,464			1,051,670		415,155
66	PHYSICAL THERAPY	2,773,952			264,651		395
69	ELECTROCARDIOLOGY	1,322,866			144,365		213,567
71	MEDICAL SUPPLIES CHRGED TO P	2,843,385			892,522		317,667
72	IMPL. DEV. CHARGED TO PATIEN	287,439			7,178		89,891
73	DRUGS CHARGED TO PATIENTS	9,822,101			836,384		2,319,913
75	ASC (NON-DISTINCT PART)	2,954,896			107,779		596,556
76	NUCLEAR MEDICINE	1,874,917			29,141		386,604
76.01	ULTRASOUND	2,584,013			268,871		280,926
76.02	MAMMOGRAPHY	623,542					
76.03	CARDIAC REHABILITATION	380,568			1,781		145,551
76.04	FAITH CENTER CHEMOTHERAPY	261,209					62,591
76.06	ROUTINE ANCILLARY						
76.97	CARDIAC REHABILITATION						
76.98	HYPERBARIC OXYGEN THERAPY						
76.99	LITHOTRIPSY						
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	2,049,976					
88.01	RHC II	113,132					
91	EMERGENCY	7,065,034			435,377		952,647
92	OBSERVATION BEDS	6,362,281			784,410		1,251,567
93	DAY PSYCHIATRIC	1,021,535					102,840
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	85,874,729			9,260,065		11,071,657

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	O/P PGM CHARGES 12.01	O/P PGM CHARGES 12.02	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12.01)	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12.02)	
			13	13.01	13.02	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	208,851					50
53 ANESTHESIOLOGY	206,383					53
54 RADIOLOGY-DIAGNOSTIC	624,845					54
57 COMPUTED TOMOGRAPHY (CT) SCA	2,219,996					57
60 LABORATORY	196,879					60
62.30 BLOOD CLOTTING FOR HEMOPHILI						62.30
64 INTRAVENOUS THERAPY	478,833					64
65 RESPIRATORY THERAPY	415,155					65
66 PHYSICAL THERAPY	395					66
69 ELECTROCARDIOLOGY	213,567					69
71 MEDICAL SUPPLIES CHRGD TO P	317,667					71
72 IMPL. DEV. CHARGED TO PATIEN	89,891					72
73 DRUGS CHARGED TO PATIENTS	2,319,913					73
75 ASC (NON-DISTINCT PART)	596,556					75
76 NUCLEAR MEDICINE	386,604					76
76.01 ULTRASOUND	280,926					76.01
76.02 MAMMOGRAPHY						76.02
76.03 CARDIAC REHABILITATION	145,551					76.03
76.04 FAITH CENTER CHEMOTHERAPY	62,591					76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
91 EMERGENCY	952,647					91
92 OBSERVATION BEDS	1,251,567					92
93 DAY PSYCHIATRIC	102,840					93
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	11,071,657					200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES			COST REIMB. SVCS NOT SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	
		PPS REIMBURSED SERVICES 2	PPS REIMBURSED SERVICES 2.01	PPS REIMBURSED SERVICES 2.02			
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.967613	208,851	208,851				50
53 ANESTHESIOLOGY	0.049688	206,383	206,383				53
54 RADIOLOGY-DIAGNOSTIC	0.375759	624,845	624,845				54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.062065	2,219,996	2,219,996				57
60 LABORATORY	0.185612	196,879	196,879				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64 INTRAVENOUS THERAPY	0.072929	478,833	478,833				64
65 RESPIRATORY THERAPY	0.336882	415,155	415,155				65
66 PHYSICAL THERAPY	0.578219	395	395				66
69 ELECTROCARDIOLOGY	0.128913	213,567	213,567				69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.250221	317,667	317,667				71
72 IMPL. DEV. CHARGED TO PATIENT	0.280814	89,891	89,891				72
73 DRUGS CHARGED TO PATIENTS	0.425452	2,319,913	2,319,913				73
75 ASC (NON-DISTINCT PART)	0.463587	596,556	596,556				75
76 NUCLEAR MEDICINE	0.277487	386,604	386,604				76
76.01 ULTRASOUND	0.189394	280,926	280,926				76.01
76.02 MAMMOGRAPHY	0.312595						76.02
76.03 CARDIAC REHABILITATION	0.433578	145,551	145,551				76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.958585	62,591	62,591				76.04
76.06 ROUTINE ANCILLARY							76.06
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
88.01 RHC II							88.01
91 EMERGENCY	0.324208	952,647	952,647				91
92 OBSERVATION BEDS	0.401068	1,251,567	1,251,567				92
93 DAY PSYCHIATRIC	0.509423	102,840	102,840				93
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)		11,071,657	11,071,657				200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		11,071,657	11,071,657				202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	PROGRAM COST		COST	COST	
	PPS SERVICES	PPS SERVICES	PPS SERVICES	SVCES NOT	
	5	5.01	5.02	SUBJECT TO DED & COINS	6
				SUBJECT TO DED & COINS	7
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	202,087	202,087			50
53 ANESTHESIOLOGY	10,255	10,255			53
54 RADIOLOGY-DIAGNOSTIC	234,791	234,791			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	137,784	137,784			57
60 LABORATORY	36,543	36,543			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY	34,921	34,921			64
65 RESPIRATORY THERAPY	139,858	139,858			65
66 PHYSICAL THERAPY	228	228			66
69 ELECTROCARDIOLOGY	27,532	27,532			69
71 MEDICAL SUPPLIES CHRGD TO PATI	79,487	79,487			71
72 IMPL. DEV. CHARGED TO PATIENT	25,243	25,243			72
73 DRUGS CHARGED TO PATIENTS	987,012	987,012			73
75 ASC (NON-DISTINCT PART)	276,556	276,556			75
76 NUCLEAR MEDICINE	107,278	107,278			76
76.01 ULTRASOUND	53,206	53,206			76.01
76.02 MAMMOGRAPHY					76.02
76.03 CARDIAC REHABILITATION	63,108	63,108			76.03
76.04 FAITH CENTER CHEMOTHERAPY	59,999	59,999			76.04
76.06 ROUTINE ANCILLARY					76.06
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
91 EMERGENCY	308,856	308,856			91
92 OBSERVATION BEDS	501,963	501,963			92
93 DAY PSYCHIATRIC	52,389	52,389			93
OTHER REIMBURSABLE COST CENTERS					
200 SUBTOTAL (SEE INSTRUCTIONS)	3,339,096	3,339,096			200
201 LESS PBP CLINIC LAB SERVICES					201
202 NET CHARGES (LINE 200 - LINE 201)	3,339,096	3,339,096			202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	[ ] HOSPITAL [XX] IPF (14-S210) [ ] IRF	[ ] SUB (OTHER)	[XX] PPS [ ] TEFRA				
		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		
	COST CENTER DESCRIPTION							
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	228,422	1,687,585	0.135354				50
53	ANESTHESIOLOGY	14,845	1,521,039	0.009760	29,529	288		53
54	RADIOLOGY-DIAGNOSTIC	119,954	3,372,538	0.035568	34,997	1,245		54
57	COMPUTED TOMOGRAPHY (CT) SCAN	26,035	12,925,754	0.002014	137,396	277		57
60	LABORATORY	120,670	17,454,165	0.006914	320,609	2,217		60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
64	INTRAVENOUS THERAPY	7,109	3,010,338	0.002362	18,506	44		64
65	RESPIRATORY THERAPY	69,713	3,562,464	0.019569	162,482	3,180		65
66	PHYSICAL THERAPY	94,156	2,773,952	0.033943	46,459	1,577		66
69	ELECTROCARDIOLOGY	39,466	1,322,866	0.029834	22,241	664		69
71	MEDICAL SUPPLIES CHRGD TO PA	11,965	2,843,385	0.004208	84,489	356		71
72	IMPL. DEV. CHARGED TO PATIENT	1,337	287,439	0.004651				72
73	DRUGS CHARGED TO PATIENTS	100,036	9,822,101	0.010185	553,348	5,636		73
75	ASC (NON-DISTINCT PART)	99,115	2,954,896	0.033543	1,080	36		75
76	NUCLEAR MEDICINE	66,052	1,874,917	0.035229				76
76.01	ULTRASOUND	57,733	2,584,013	0.022342	15,378	344		76.01
76.02	MAMMOGRAPHY	6,777	623,542	0.010869				76.02
76.03	CARDIAC REHABILITATION	10,983	380,568	0.028859				76.03
76.04	FAITH CENTER CHEMOTHERAPY	16,963	261,209	0.064940				76.04
76.06	ROUTINE ANCILLARY							76.06
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)	52,790	2,049,976	0.025752				88
88.01	RHC II	5,266	113,132	0.046547				88.01
91	EMERGENCY	100,856	7,065,034	0.014275	108,793	1,553		91
92	OBSERVATION BEDS	113,620	6,362,281	0.017858				92
93	DAY PSYCHIATRIC	36,432	1,021,535	0.035664				93
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	1,400,295	85,874,729		1,535,307	17,417		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)						75
76 NUCLEAR MEDICINE						76
76.01 ULTRASOUND						76.01
76.02 MAMMOGRAPHY						76.02
76.03 CARDIAC REHABILITATION						76.03
76.04 FAITH CENTER CHEMOTHERAPY						76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC						93
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM
	CHARGES (FROM WKST C, PT. I, COL. 8)	COST TO CHARGES (COL. 5 + COL. 7)	OF COST TO CHARGES (COL. 6 ÷ COL. 7)		PASS-THRU COSTS (COL. 8 x COL. 10)	CHARGES (COL. 9 x COL. 12)	CHARGES (COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	1,687,585						50
53 ANESTHESIOLOGY	1,521,039			29,529			53
54 RADIOLOGY-DIAGNOSTIC	3,372,538			34,997			54
57 COMPUTED TOMOGRAPHY (CT) SCA	12,925,754			137,396			57
60 LABORATORY	17,454,165			320,609			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
64 INTRAVENOUS THERAPY	3,010,338			18,506			64
65 RESPIRATORY THERAPY	3,562,464			162,482			65
66 PHYSICAL THERAPY	2,773,952			46,459			66
69 ELECTROCARDIOLOGY	1,322,866			22,241			69
71 MEDICAL SUPPLIES CHRGD TO P	2,843,385			84,489			71
72 IMPL. DEV. CHARGED TO PATIEN	287,439						72
73 DRUGS CHARGED TO PATIENTS	9,822,101			553,348			73
75 ASC (NON-DISTINCT PART)	2,954,896			1,080			75
76 NUCLEAR MEDICINE	1,874,917						76
76.01 ULTRASOUND	2,584,013			15,378			76.01
76.02 MAMMOGRAPHY	623,542						76.02
76.03 CARDIAC REHABILITATION	380,568						76.03
76.04 FAITH CENTER CHEMOTHERAPY	261,209						76.04
76.06 ROUTINE ANCILLARY							76.06
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)	2,049,976						88
88.01 RHC II	113,132						88.01
91 EMERGENCY	7,065,034			108,793			91
92 OBSERVATION BEDS	6,362,281						92
93 DAY PSYCHIATRIC	1,021,535						93
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	85,874,729			1,535,307			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [XX] IPF (14-S210) [ ] SNF [ ] S/B-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				COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	
		PPS REIMBURSED SERVICES 2	PPS REIMBURSED SERVICES 2.01	PPS REIMBURSED SERVICES 2.02				
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.967613							50
53 ANESTHESIOLOGY	0.049688							53
54 RADIOLOGY-DIAGNOSTIC	0.375759							54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.062065							57
60 LABORATORY	0.185612							60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64 INTRAVENOUS THERAPY	0.072929							64
65 RESPIRATORY THERAPY	0.336882							65
66 PHYSICAL THERAPY	0.578219							66
69 ELECTROCARDIOLOGY	0.128913							69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.250221							71
72 IMPL. DEV. CHARGED TO PATIENT	0.280814							72
73 DRUGS CHARGED TO PATIENTS	0.425452							73
75 ASC (NON-DISTINCT PART)	0.463587							75
76 NUCLEAR MEDICINE	0.277487							76
76.01 ULTRASOUND	0.189394							76.01
76.02 MAMMOGRAPHY	0.312595							76.02
76.03 CARDIAC REHABILITATION	0.433578							76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.958585							76.04
76.06 ROUTINE ANCILLARY								76.06
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
88.01 RHC II								88.01
91 EMERGENCY	0.324208							91
92 OBSERVATION BEDS	0.401068							92
93 DAY PSYCHIATRIC	0.509423							93
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)								200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	PROGRAM COST			COST	
	PPS SERVICES	PPS SERVICES	PPS SERVICES	SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS
	5	5.01	5.02	6	7
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY					64
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PATI					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
75 ASC (NON-DISTINCT PART)					75
76 NUCLEAR MEDICINE					76
76.01 ULTRASOUND					76.01
76.02 MAMMOGRAPHY					76.02
76.03 CARDIAC REHABILITATION					76.03
76.04 FAITH CENTER CHEMOTHERAPY					76.04
76.06 ROUTINE ANCILLARY					76.06
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
91 EMERGENCY					91
92 OBSERVATION BEDS					92
93 DAY PSYCHIATRIC					93
OTHER REIMBURSABLE COST CENTERS					
200 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-U210)  
 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		PROGRAM CHARGES				PROGRAM COSTS		
	CHARGE RATIO	PPS	COST REIMB.	COST REIMB.	COST	COST	SVCES NOT	SVCES NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SERVICES DED & COINS	SVCES NOT SUBJECT TO DED & COINS	SERVICES DED & COINS	SERVICES DED & COINS	SVCES NOT SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7		
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.967613								50
53 ANESTHESIOLOGY	0.049688								53
54 RADIOLOGY-DIAGNOSTIC	0.375759								54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.062065								57
60 LABORATORY	0.185612								60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS									62.30
64 INTRAVENOUS THERAPY	0.072929								64
65 RESPIRATORY THERAPY	0.336882								65
66 PHYSICAL THERAPY	0.578219								66
69 ELECTROCARDIOLOGY	0.128913								69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.250221								71
72 IMPL. DEV. CHARGED TO PATIENT	0.280814								72
73 DRUGS CHARGED TO PATIENTS	0.425452								73
75 ASC (NON-DISTINCT PART)	0.463587								75
76 NUCLEAR MEDICINE	0.277487								76
76.01 ULTRASOUND	0.189394								76.01
76.02 MAMMOGRAPHY	0.312595								76.02
76.03 CARDIAC REHABILITATION	0.433578								76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.958585								76.04
76.06 ROUTINE ANCILLARY									76.06
76.97 CARDIAC REHABILITATION									76.97
76.98 HYPERBARIC OXYGEN THERAPY									76.98
76.99 LITHOTRIPSY									76.99
OUTPATIENT SERVICE COST CENTERS									
88 RURAL HEALTH CLINIC (RHC)									88
88.01 RHC II									88.01
91 EMERGENCY	0.324208								91
92 OBSERVATION BEDS	0.401068								92
93 DAY PSYCHIATRIC	0.509423								93
OTHER REIMBURSABLE COST CENTERS									
200 SUBTOTAL (SEE INSTRUCTIONS)									200
201 LESS PBP CLINIC LAB SERVICES									201
202 NET CHARGES (LINE 200 - LINE 201)									202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM								50
53 ANESTHESIOLOGY								53
54 RADIOLOGY-DIAGNOSTIC								54
57 COMPUTED TOMOGRAPHY (CT) SCAN								57
60 LABORATORY								60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64 INTRAVENOUS THERAPY								64
65 RESPIRATORY THERAPY								65
66 PHYSICAL THERAPY								66
69 ELECTROCARDIOLOGY								69
71 MEDICAL SUPPLIES CHRGD TO PATI								71
72 IMPL. DEV. CHARGED TO PATIENT								72
73 DRUGS CHARGED TO PATIENTS								73
75 ASC (NON-DISTINCT PART)								75
76 NUCLEAR MEDICINE								76
76.01 ULTRASOUND								76.01
76.02 MAMMOGRAPHY								76.02
76.03 CARDIAC REHABILITATION								76.03
76.04 FAITH CENTER CHEMOTHERAPY								76.04
76.06 ROUTINE ANCILLARY								76.06
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
88.01 RHC II								88.01
91 EMERGENCY								91
92 OBSERVATION BEDS								92
93 DAY PSYCHIATRIC								93
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)								200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED ADJUSTMENT	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM (COL.3 ÷ COL.4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)		
	(FROM WKST B, PT. II, COL. 26)	1	2	(COL.1 MINUS COL.2)	3	4	5	6	7
30 INPAT ROUTINE SERV COST CTRS									
31 ADULTS & PEDIATRICS	280,261	1,437	278,824	5,323	52.38	303	15,871	30	
32 INTENSIVE CARE UNIT								31	
33 CORONARY CARE UNIT								32	
34 BURN INTENSIVE CARE UNIT								33	
35 SURGICAL INTENSIVE CARE UNIT								34	
40 OTHER SPECIAL CARE (SPECIFY)								35	
41 SUBPROVIDER - IPF	223,815		223,815	8,505	26.32	2,299	60,510	40	
42 SUBPROVIDER - IRF								41	
43 SUBPROVIDER I								42	
44 NURSERY								43	
45 SKILLED NURSING FACILITY								44	
200 NURSING FACILITY								45	
200 TOTAL (LINES 30-199)	504,076		502,639	13,828		2,602	76,381	200	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-0210) [ ] IPF [ ] IRF	[ ] SUB (OTHER)	[ ] PPS [ ] TEFRA [XX] OTHER	
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	228,422	1,687,585	0.135354	50
53	ANESTHESIOLOGY	14,845	1,521,039	0.009760	53
54	RADIOLOGY-DIAGNOSTIC	119,954	3,372,538	0.035568	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	26,035	12,925,754	0.002014	57
60	LABORATORY	120,670	17,454,165	0.006914	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA				62.30
64	INTRAVENOUS THERAPY	7,109	3,010,338	0.002362	64
65	RESPIRATORY THERAPY	69,713	3,562,464	0.019569	65
66	PHYSICAL THERAPY	94,156	2,773,952	0.033943	66
69	ELECTROCARDIOLOGY	39,466	1,322,866	0.029834	69
71	MEDICAL SUPPLIES CHRGED TO PA	11,965	2,843,385	0.004208	71
72	IMPL. DEV. CHARGED TO PATIENT	1,337	287,439	0.004651	72
73	DRUGS CHARGED TO PATIENTS	100,036	9,822,101	0.010185	73
75	ASC (NON-DISTINCT PART)	99,115	2,954,896	0.033543	75
76	NUCLEAR MEDICINE	66,052	1,874,917	0.035229	76
76.01	ULTRASOUND	57,733	2,584,013	0.022342	76.01
76.02	MAMMOGRAPHY	6,777	623,542	0.010869	76.02
76.03	CARDIAC REHABILITATION	10,983	380,568	0.028859	76.03
76.04	FAITH CENTER CHEMOTHERAPY	16,963	261,209	0.064940	76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC (RHC)	52,790	2,049,976	0.025752	88
88.01	RHC II	5,266	113,132	0.046547	88.01
91	EMERGENCY	100,856	7,065,034	0.014275	91
92	OBSERVATION BEDS	113,620	6,362,281	0.017858	92
93	DAY PSYCHIATRIC	36,432	1,021,535	0.035664	93
OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (SUM OF LINES 50-199)	1,400,295	85,874,729		200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS	5,323		303		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	8,505		2,299		41
42 SUBPROVIDER - IRF					42
43 SUBPROVIDER I					43
44 NURSERY					44
45 SKILLED NURSING FACILITY					45
200 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)	13,828		2,602		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)						75
76 NUCLEAR MEDICINE						76
76.01 ULTRASOUND						76.01
76.02 MAMMOGRAPHY						76.02
76.03 CARDIAC REHABILITATION						76.03
76.04 FAITH CENTER CHEMOTHERAPY						76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC						93
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-0210)	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] PPS		
APPLICABLE	[ ] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA		
BOXES	[XX] TITLE XIX	[ ] IRF	[ ] NF		[XX] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,687,585					50
53	ANESTHESIOLOGY	1,521,039					53
54	RADIOLOGY-DIAGNOSTIC	3,372,538					54
57	COMPUTED TOMOGRAPHY (CT) SCA	12,925,754					57
60	LABORATORY	17,454,165					60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
64	INTRAVENOUS THERAPY	3,010,338					64
65	RESPIRATORY THERAPY	3,562,464					65
66	PHYSICAL THERAPY	2,773,952					66
69	ELECTROCARDIOLOGY	1,322,866					69
71	MEDICAL SUPPLIES CHRGD TO P	2,843,385					71
72	IMPL. DEV. CHARGED TO PATIEN	287,439					72
73	DRUGS CHARGED TO PATIENTS	9,822,101					73
75	ASC (NON-DISTINCT PART)	2,954,896					75
76	NUCLEAR MEDICINE	1,874,917					76
76.01	ULTRASOUND	2,584,013					76.01
76.02	MAMMOGRAPHY	623,542					76.02
76.03	CARDIAC REHABILITATION	380,568					76.03
76.04	FAITH CENTER CHEMOTHERAPY	261,209					76.04
76.06	ROUTINE ANCILLARY						76.06
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)	2,049,976					88
88.01	RHC II	113,132					88.01
91	EMERGENCY	7,065,034					91
92	OBSERVATION BEDS	6,362,281					92
93	DAY PSYCHIATRIC	1,021,535					93
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	85,874,729					200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES			COST REIMB. SERVICES DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS
		PPS REIMBURSED SERVICES	PPS REIMBURSED SERVICES	PPS REIMBURSED SERVICES		
		2	2.01	2.02		
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	0.967613					50
53 ANESTHESIOLOGY	0.049688					53
54 RADIOLOGY-DIAGNOSTIC	0.375759					54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.062065					57
60 LABORATORY	0.185612					60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	0.072929					64
65 RESPIRATORY THERAPY	0.336882					65
66 PHYSICAL THERAPY	0.578219					66
69 ELECTROCARDIOLOGY	0.128913					69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.250221					71
72 IMPL. DEV. CHARGED TO PATIENT	0.280814					72
73 DRUGS CHARGED TO PATIENTS	0.425452					73
75 ASC (NON-DISTINCT PART)	0.463587					75
76 NUCLEAR MEDICINE	0.277487					76
76.01 ULTRASOUND	0.189394					76.01
76.02 MAMMOGRAPHY	0.312595					76.02
76.03 CARDIAC REHABILITATION	0.433578					76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.958585					76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
91 EMERGENCY	0.324208					91
92 OBSERVATION BEDS	0.401068					92
93 DAY PSYCHIATRIC	0.509423					93
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)						200
201 LESS PBP CLINIC LAB SERVICES						201
202 NET CHARGES (LINE 200 - LINE 201)						202



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[ ] HOSPITAL [XX] IPF (14-S210) [ ] IRF	[ ] SUB (OTHER)	[ ] PPS [ ] TEFRA [XX] OTHER	
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	228,422	1,687,585	0.135354	50
53	ANESTHESIOLOGY	14,845	1,521,039	0.009760	53
54	RADIOLOGY-DIAGNOSTIC	119,954	3,372,538	0.035568	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	26,035	12,925,754	0.002014	57
60	LABORATORY	120,670	17,454,165	0.006914	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA				62.30
64	INTRAVENOUS THERAPY	7,109	3,010,338	0.002362	64
65	RESPIRATORY THERAPY	69,713	3,562,464	0.019569	65
66	PHYSICAL THERAPY	94,156	2,773,952	0.033943	66
69	ELECTROCARDIOLOGY	39,466	1,322,866	0.029834	69
71	MEDICAL SUPPLIES CHRGED TO PA	11,965	2,843,385	0.004208	71
72	IMPL. DEV. CHARGED TO PATIENT	1,337	287,439	0.004651	72
73	DRUGS CHARGED TO PATIENTS	100,036	9,822,101	0.010185	73
75	ASC (NON-DISTINCT PART)	99,115	2,954,896	0.033543	75
76	NUCLEAR MEDICINE	66,052	1,874,917	0.035229	76
76.01	ULTRASOUND	57,733	2,584,013	0.022342	76.01
76.02	MAMMOGRAPHY	6,777	623,542	0.010869	76.02
76.03	CARDIAC REHABILITATION	10,983	380,568	0.028859	76.03
76.04	FAITH CENTER CHEMOTHERAPY	16,963	261,209	0.064940	76.04
76.06	ROUTINE ANCILLARY				76.06
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC (RHC)	52,790	2,049,976	0.025752	88
88.01	RHC II	5,266	113,132	0.046547	88.01
91	EMERGENCY	100,856	7,065,034	0.014275	91
92	OBSERVATION BEDS	113,620	6,362,281	0.017858	92
93	DAY PSYCHIATRIC	36,432	1,021,535	0.035664	93
OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (SUM OF LINES 50-199)	1,400,295	85,874,729		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
75 ASC (NON-DISTINCT PART)						75
76 NUCLEAR MEDICINE						76
76.01 ULTRASOUND						76.01
76.02 MAMMOGRAPHY						76.02
76.03 CARDIAC REHABILITATION						76.03
76.04 FAITH CENTER CHEMOTHERAPY						76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
93 DAY PSYCHIATRIC						93
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[ ] HOSPITAL [XX] IPF (14-S210) [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] NF	[ ] ICF/MR	[ ] PPS [ ] TEFRA [XX] OTHER	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES PGM COL. 10 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS												
50						OPERATING ROOM	1,687,585					50
53						ANESTHESIOLOGY	1,521,039					53
54						RADIOLOGY-DIAGNOSTIC	3,372,538					54
57						COMPUTED TOMOGRAPHY (CT) SCA	12,925,754					57
60						LABORATORY	17,454,165					60
62.30						BLOOD CLOTTING FOR HEMOPHILI						62.30
64						INTRAVENOUS THERAPY	3,010,338					64
65						RESPIRATORY THERAPY	3,562,464					65
66						PHYSICAL THERAPY	2,773,952					66
69						ELECTROCARDIOLOGY	1,322,866					69
71						MEDICAL SUPPLIES CHRGD TO P	2,843,385					71
72						IMPL. DEV. CHARGED TO PATIEN	287,439					72
73						DRUGS CHARGED TO PATIENTS	9,822,101					73
75						ASC (NON-DISTINCT PART)	2,954,896					75
76						NUCLEAR MEDICINE	1,874,917					76
76.01						ULTRASOUND	2,584,013					76.01
76.02						MAMMOGRAPHY	623,542					76.02
76.03						CARDIAC REHABILITATION	380,568					76.03
76.04						FAITH CENTER CHEMOTHERAPY	261,209					76.04
76.06						ROUTINE ANCILLARY						76.06
76.97						CARDIAC REHABILITATION						76.97
76.98						HYPERBARIC OXYGEN THERAPY						76.98
76.99						LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS												
88						RURAL HEALTH CLINIC (RHC)	2,049,976					88
88.01						RHC II	113,132					88.01
91						EMERGENCY	7,065,034					91
92						OBSERVATION BEDS	6,362,281					92
93						DAY PSYCHIATRIC	1,021,535					93
OTHER REIMBURSABLE COST CENTERS												
200						TOTAL (SUM OF LINES 50-199)	85,874,729					200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		PPS SERVICES 5	COST SUBJECT TO DED & COINS 6	COST SUBJECT TO SVCS NOT SUBJECT TO DED & COINS 7	
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	COST SUBJECT TO SVCS NOT SUBJECT TO DED & COINS 7				
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.967613								50
53 ANESTHESIOLOGY	0.049688								53
54 RADIOLOGY-DIAGNOSTIC	0.375759								54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.062065								57
60 LABORATORY	0.185612								60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS									62.30
64 INTRAVENOUS THERAPY	0.072929								64
65 RESPIRATORY THERAPY	0.336882								65
66 PHYSICAL THERAPY	0.578219								66
69 ELECTROCARDIOLOGY	0.128913								69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.250221								71
72 IMPL. DEV. CHARGED TO PATIENT	0.280814								72
73 DRUGS CHARGED TO PATIENTS	0.425452								73
75 ASC (NON-DISTINCT PART)	0.463587								75
76 NUCLEAR MEDICINE	0.277487								76
76.01 ULTRASOUND	0.189394								76.01
76.02 MAMMOGRAPHY	0.312595								76.02
76.03 CARDIAC REHABILITATION	0.433578								76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.958585								76.04
76.06 ROUTINE ANCILLARY									76.06
76.97 CARDIAC REHABILITATION									76.97
76.98 HYPERBARIC OXYGEN THERAPY									76.98
76.99 LITHOTRIPSY									76.99
OUTPATIENT SERVICE COST CENTERS									
88 RURAL HEALTH CLINIC (RHC)									88
88.01 RHC II									88.01
91 EMERGENCY	0.324208								91
92 OBSERVATION BEDS	0.401068								92
93 DAY PSYCHIATRIC	0.509423								93
OTHER REIMBURSABLE COST CENTERS									
200 SUBTOTAL (SEE INSTRUCTIONS)									200
201 LESS PBP CLINIC LAB SERVICES									201
202 NET CHARGES (LINE 200 - LINE 201)									202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	COST SERVICES DED & COINS 5	COST SVCES NOT SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM							50
53 ANESTHESIOLOGY							53
54 RADIOLOGY-DIAGNOSTIC							54
57 COMPUTED TOMOGRAPHY (CT) SCAN							57
60 LABORATORY							60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64 INTRAVENOUS THERAPY							64
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY							66
69 ELECTROCARDIOLOGY							69
71 MEDICAL SUPPLIES CHRGED TO PATI							71
72 IMPL. DEV. CHARGED TO PATIENT							72
73 DRUGS CHARGED TO PATIENTS							73
75 ASC (NON-DISTINCT PART)							75
76 NUCLEAR MEDICINE							76
76.01 ULTRASOUND							76.01
76.02 MAMMOGRAPHY							76.02
76.03 CARDIAC REHABILITATION							76.03
76.04 FAITH CENTER CHEMOTHERAPY							76.04
76.06 ROUTINE ANCILLARY							76.06
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
88.01 RHC II							88.01
91 EMERGENCY							91
92 OBSERVATION BEDS							92
93 DAY PSYCHIATRIC							93
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-0210) [ ] 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)	5,489	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,323	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	369	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,796	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	83	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)	83	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)	2,165	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)	83	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)	83	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	116.26	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	116.26	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,326,589	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	16,011	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	16,426	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)	32,437	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,294,152	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,878,501	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	271,641	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,606,860	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.186608	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	736.15	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	932.35	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)	6,294,152	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,182.44 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,559,983 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) 2,559,983 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS  
 43 INTENSIVE CARE UNIT 43  
 44 CORONARY CARE UNIT 44  
 45 BURN INTENSIVE CARE UNIT 45  
 46 SURGICAL INTENSIVE CARE UNIT 46  
 47 OTHER SPECIAL CARE (SPECIFY) 47  
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 2,431,619 48  
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 4,991,602 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 113,403 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 124,452 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 237,855 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 4,753,747 53

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

PROGRAM INPATIENT ROUTINE SWING BED COST  
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 16,011 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 16,426 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 32,437 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 2,158 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 1,182.44 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 2,551,706 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST	280,261	6,294,152	0.044527	2,551,706	113,620 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS										
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	8,505	1							
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,505	2							
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3							
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,505	4							
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5							
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6							
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7							
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8							
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,334	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)	6,045,516	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	6,045,516	27							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT										
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	9,338,727	28							
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29							
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	9,338,727	30							
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.647360	31							
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32							
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,098.03	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)	6,045,516	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-S210) [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	710.82 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	2,369,874 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)	2,369,874 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	463,982 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	2,833,856 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	87,751 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	17,417 51
52	TOTAL PROGRAM EXCLUDABLE COST	105,168 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	2,728,688 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 [XX] HOSPITAL (14-0210) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,489	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,323	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	369	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,796	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	83	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)	83	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)	303	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	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	116.26	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	116.26	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,326,589	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	16,011	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	16,426	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)	32,437	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,294,152	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,878,501	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	271,641	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,606,860	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.186608	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	736.15	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	932.35	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)	6,294,152	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,182.44 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 358,279 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) 358,279 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 + COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					358,279	49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 15,871 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 15,871 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 2,158 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	8,505	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,505	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,505	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)	2,299	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)	5,920,328	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	5,920,328	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	9,338,727	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	9,338,727	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.633954	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,098.03	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)	5,920,328	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	696.10 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,600,334 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)	40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	1,600,334 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	1,600,334 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	60,510 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	51
52	TOTAL PROGRAM EXCLUDABLE COST	60,510 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	53
TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES	54
55	TARGET AMOUNT PER DISCHARGE	55
56	TARGET AMOUNT (LINE 54 x LINE 55)	56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58	BONUS PAYMENT (SEE INSTRUCTIONS)	58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)	61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		1,958,062			30
40 SUBPROVIDER - IPF					40
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.967613	117,396	113,594		50
53 ANESTHESIOLOGY	0.049688	112,291	5,580		53
54 RADIOLOGY-DIAGNOSTIC	0.375759	330,506	124,191		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.062065	957,186	59,408		57
60 LABORATORY	0.185663	2,150,211	399,215		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY	0.072929	768,346	56,035		64
65 RESPIRATORY THERAPY	0.336882	1,051,670	354,289		65
66 PHYSICAL THERAPY	0.578219	264,651	153,026		66
69 ELECTROCARDIOLOGY	0.128913	144,365	18,611		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.250221	892,522	223,328		71
72 IMPL. DEV. CHARGED TO PATIENT	0.280814	7,178	2,016		72
73 DRUGS CHARGED TO PATIENTS	0.425452	836,384	355,841		73
75 ASC (NON-DISTINCT PART)	0.463587	107,779	49,965		75
76 NUCLEAR MEDICINE	0.277487	29,141	8,086		76
76.01 ULTRASOUND	0.189394	268,871	50,923		76.01
76.02 MAMMOGRAPHY	0.312595				76.02
76.03 CARDIAC REHABILITATION	0.433578	1,781	772		76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.958585				76.04
76.06 ROUTINE ANCILLARY					76.06
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
91 EMERGENCY	0.326469	435,377	142,137		91
92 OBSERVATION BEDS	0.401068	784,410	314,602		92
93 DAY PSYCHIATRIC	0.509423				93
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		9,260,065	2,431,619		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		9,260,065			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-S210) [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [ ] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
40 SUBPROVIDER - IPF		3,689,982		40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.967613			50
53 ANESTHESIOLOGY	0.049688	29,529	1,467	53
54 RADIOLOGY-DIAGNOSTIC	0.375759	34,997	13,150	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.062065	137,396	8,527	57
60 LABORATORY	0.185663	320,609	59,525	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.072929	18,506	1,350	64
65 RESPIRATORY THERAPY	0.336882	162,482	54,737	65
66 PHYSICAL THERAPY	0.578219	46,459	26,863	66
69 ELECTROCARDIOLOGY	0.128913	22,241	2,867	69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.250221	84,489	21,141	71
72 IMPL. DEV. CHARGED TO PATIENT	0.280814			72
73 DRUGS CHARGED TO PATIENTS	0.425452	553,348	235,423	73
75 ASC (NON-DISTINCT PART)	0.463587	1,080	501	75
76 NUCLEAR MEDICINE	0.277487			76
76.01 ULTRASOUND	0.189394	15,378	2,913	76.01
76.02 MAMMOGRAPHY	0.312595			76.02
76.03 CARDIAC REHABILITATION	0.433578			76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.958585			76.04
76.06 ROUTINE ANCILLARY				76.06
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
91 EMERGENCY	0.326469	108,793	35,518	91
92 OBSERVATION BEDS	0.401068			92
93 DAY PSYCHIATRIC	0.509423			93
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,535,307	463,982	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,535,307		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
40 SUBPROVIDER - IPF					40
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.967613				50
53 ANESTHESIOLOGY	0.049688				53
54 RADIOLOGY-DIAGNOSTIC	0.375759	2,748	1,033		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.062065				57
60 LABORATORY	0.185612	28,276	5,248		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY	0.072929	4,983	363		64
65 RESPIRATORY THERAPY	0.336882	34,225	11,530		65
66 PHYSICAL THERAPY	0.578219	79,370	45,893		66
69 ELECTROCARDIOLOGY	0.128913	912	118		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.250221	23,805	5,957		71
72 IMPL. DEV. CHARGED TO PATIENT	0.280814				72
73 DRUGS CHARGED TO PATIENTS	0.425452	26,873	11,433		73
75 ASC (NON-DISTINCT PART)	0.463587	3,412	1,582		75
76 NUCLEAR MEDICINE	0.277487				76
76.01 ULTRASOUND	0.189394	1,026	194		76.01
76.02 MAMMOGRAPHY	0.312595				76.02
76.03 CARDIAC REHABILITATION	0.433578				76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.958585				76.04
76.06 ROUTINE ANCILLARY					76.06
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
91 EMERGENCY	0.324208				91
92 OBSERVATION BEDS	0.401068				92
93 DAY PSYCHIATRIC	0.509423				93
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		205,630	83,351		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		205,630			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
40 SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.967613			50
53 ANESTHESIOLOGY	0.049688			53
54 RADIOLOGY-DIAGNOSTIC	0.375759			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.062065			57
60 LABORATORY	0.185612			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.072929			64
65 RESPIRATORY THERAPY	0.336882			65
66 PHYSICAL THERAPY	0.578219			66
69 ELECTROCARDIOLOGY	0.128913			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.250221			71
72 IMPL. DEV. CHARGED TO PATIENT	0.280814			72
73 DRUGS CHARGED TO PATIENTS	0.425452			73
75 ASC (NON-DISTINCT PART)	0.463587			75
76 NUCLEAR MEDICINE	0.277487			76
76.01 ULTRASOUND	0.189394			76.01
76.02 MAMMOGRAPHY	0.312595			76.02
76.03 CARDIAC REHABILITATION	0.433578			76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.958585			76.04
76.06 ROUTINE ANCILLARY				76.06
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
91 EMERGENCY	0.324208			91
92 OBSERVATION BEDS	0.401068			92
93 DAY PSYCHIATRIC	0.509423			93
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST 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
40 SUBPROVIDER - IPF					40
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.967613				50
53 ANESTHESIOLOGY	0.049688				53
54 RADIOLOGY-DIAGNOSTIC	0.375759				54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.062065				57
60 LABORATORY	0.185612				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY	0.072929				64
65 RESPIRATORY THERAPY	0.336882				65
66 PHYSICAL THERAPY	0.578219				66
69 ELECTROCARDIOLOGY	0.128913				69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.250221				71
72 IMPL. DEV. CHARGED TO PATIENT	0.280814				72
73 DRUGS CHARGED TO PATIENTS	0.425452				73
75 ASC (NON-DISTINCT PART)	0.463587				75
76 NUCLEAR MEDICINE	0.277487				76
76.01 ULTRASOUND	0.189394				76.01
76.02 MAMMOGRAPHY	0.312595				76.02
76.03 CARDIAC REHABILITATION	0.433578				76.03
76.04 FAITH CENTER CHEMOTHERAPY	0.958585				76.04
76.06 ROUTINE ANCILLARY					76.06
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
91 EMERGENCY	0.324208				91
92 OBSERVATION BEDS	0.401068				92
93 DAY PSYCHIATRIC	0.509423				93
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)					200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)					202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	3,301,153	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	217	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)	30.63	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)	0.0702	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1036	31
32	SUM OF LINES 30 AND 31	0.1738	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0405	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	133,697	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)	3,435,067	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	3,908,605	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	3,908,605	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	259,567	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	4,168,172	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	4,168,172	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	590,713	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES		63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	187,619	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	131,333	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	170,785	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	3,708,792	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
70.96	LOW VOLUME PAYMENT ADJUSTMENT - 1	41,682	70.96
70.97	LOW VOLUME PAYMENT ADJUSTMENT - 2	271,304	70.97
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	4,021,778	71
72	INTERIM PAYMENTS	4,199,033	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-177,255	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96



CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

CHECK APPLICABLE BOX:         HOSPITAL                                 IPF (14-S210)         IRF  
     SUB (OTHER)                                 SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER 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 (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK APPLICABLE BOX:	[XX] HOSPITAL (14-0210) [ ] IPF [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF	INPATIENT PART A		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
DESCRIPTION						
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			4,199,033		4,514,278
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	02/05/2013	75,700
			.02			3.01
			.03			3.02
		PROGRAM	.04			3.03
		TO	.05			3.04
		PROVIDER	.06			3.05
			.07			3.06
			.08			3.07
			.09			3.08
			.50	NONE		3.09
			.51			3.50
		PROVIDER	.52			NONE
		TO	.53			3.51
		PROGRAM	.54			3.52
			.55			3.53
			.56			3.54
			.57			3.55
			.58			3.56
			.59			3.57
			.99			3.58
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					75,700
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			4,199,033		4,589,978
			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
			TO .02			5.01
			PROVIDER .03			5.02
			.04			5.03
			.05			5.04
			.06			5.05
			.07			5.06
			.08			5.07
			.09			5.08
		PROVIDER	.50	NONE		NONE
		TO	.51			5.09
		PROGRAM	.52			5.50
			.53			5.51
			.54			5.52
			.55			5.53
			.56			5.54
			.57			5.55
			.58			5.56
			.59			5.57
			.99			5.58
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					5.59
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT		PROGRAM .01			
			TO .02			6.01
			PROVIDER .03			
			TO .04			
			PROGRAM .05	-177,255		-111,852
			TO .06			6.02
			PROGRAM .07			
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			4,021,778		4,478,126
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:		NPR DATE:

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK APPLICABLE BOX:	[ ] HOSPITAL [XX] IPF (14-S210) [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
DESCRIPTION						
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			2,559,461		1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.			NONE	NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.			NONE	NONE	3.01
		PROGRAM .01				3.02
		TO .02				3.03
		PROVIDER .03				3.04
		TO .04				3.05
		PROVIDER .05				3.06
		TO .06				3.07
		PROGRAM .07				3.08
		TO .08				3.09
		PROVIDER .09				3.50
		TO .50		NONE	NONE	3.51
		PROGRAM .51				3.52
		TO .52				3.53
		PROVIDER .53				3.54
		TO .54				3.55
		PROGRAM .55				3.56
		TO .56				3.57
		PROVIDER .57				3.58
		TO .58				3.59
		PROGRAM .59				3.99
		TO .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)			2,559,461		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.			NONE	NONE	5.01
		PROGRAM .01				5.02
		TO .02				5.03
		PROVIDER .03				5.04
		TO .04				5.05
		PROGRAM .05				5.06
		TO .06				5.07
		PROVIDER .07				5.08
		TO .08				5.09
		PROGRAM .09				5.50
		TO .50		NONE	NONE	5.51
		PROGRAM .51				5.52
		TO .52				5.53
		PROGRAM .53				5.54
		TO .54				5.55
		PROGRAM .55				5.56
		TO .56				5.57
		PROGRAM .57				5.58
		TO .58				5.59
		PROGRAM .59				5.99
		TO .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			89,377		6.01
		PROGRAM .01				6.02
		TO .01				
		PROVIDER .02				
		TO .02				
		PROGRAM .02				
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			2,648,838		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-U210)	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
DESCRIPTION						
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				50,426		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 .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		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)				50,426		4
TO BE COMPLETED BY CONTRACTOR						
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01 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		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				6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				50,426		7
8 NAME OF CONTRACTOR:				CONTRACTOR NUMBER:	NPR DATE:	8

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL (14-0210) [ ] CAH  
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,064 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,165 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	84 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,165 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	99,229,310 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,643,838 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)	1,094,937 8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	1,245,164 30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	-150,227 32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [ ] TITLE V [XX] SWING BED - SNF (14-U210)  
 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)	51,356	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	166	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)	51,356	8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	51,356	10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)	207	11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	51,149	12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	723	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)	50,426	15
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19	TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	50,426	19
20	INTERIM PAYMENTS	50,426	20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)		22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART II

CHECK [ ] HOSPITAL  
 APPLICABLE BOX: [XX] IPF (14-S210)

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS)	2,749,787	1
2	NET IPF PPS OUTLIER PAYMENT	3,052	2
3	NET IPF PPS ECT PAYMENT	19,344	3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER \$412.424 (d) (1) (iii) (F) (1) OR (2) (SEE INSTRUCTIONS)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	23.301370	9
10	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (\text{LINE 8}/\text{LINE 9})) \text{ RAISED TO THE POWER OF } .5150 - 1\}$		10
11	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	2,772,183	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	2,772,183	16
17	PRIMARY PAYER PAYMENTS	1,154	17
18	SUBTOTAL (LINE 16 LESS LINE 17)	2,771,029	18
19	DEDUCTIBLES	280,455	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	2,490,574	20
21	COINSURANCE	1,459	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	2,489,115	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	228,175	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	159,723	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	204,475	25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	2,648,838	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IPF ONLY)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	2,648,838	31
32	INTERIM PAYMENTS	2,559,461	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS THE SUM OF LINES 32 AND 33)	89,377	34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35
TO BE COMPLETED BY CONTRACTOR			
50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (SEE INSTRUCTIONS)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
1			COMPUTATION OF NET COST OF COVERED SERVICES
2			INPATIENT HOSPITAL SNF/NF SERVICES
3	358,279	1	MEDICAL AND OTHER SERVICES
4		2	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)
5		3	SUBTOTAL (SUM OF LINES 1, 2 AND 3)
6	358,279	4	INPATIENT PRIMARY PAYER PAYMENTS
7		5	OUTPATIENT PRIMARY PAYER PAYMENTS
8		6	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)
9	358,279	7	COMPUTATION OF LESSER OF COST OR CHARGES
10			REASONABLE CHARGES
11			ROUTINE SERVICE CHARGES
12		8	ANCILLARY SERVICE CHARGES
13		9	ORGAN ACQUISITION CHARGES, NET OF REVENUE
14		10	INCENTIVE FROM TARGET AMOUNT COMPUTATION
15		11	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)
16		12	CUSTOMARY CHARGES
17			AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
18		13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)
19		14	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)
20	1.000000	15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
21		16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))
22		17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))
23	358,279	18	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)
24		19	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)
25		20	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)
26		21	PROSPECTIVE PAYMENT AMOUNT
27		22	OTHER THAN OUTLIER PAYMENTS
28		23	OUTLIER PAYMENTS
29		24	PROGRAM CAPITAL PAYMENTS
30		25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)
31		26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS
32		27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)
33		28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)
34		29	SUM OF LINES 27 AND 21
35			COMPUTATION OF REIMBURSEMENT SETTLEMENT
36		30	EXCESS OF REASONABLE COST (FROM LINE 18)
37		31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)
38		32	DEDUCTIBLES
39		33	COINSURANCE
40		34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)
41		35	UTILIZATION REVIEW
42		36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)
43		37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)
		38	SUBTOTAL (LINE 36 ± LINE 37)
		39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)
		40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)
		41	INTERIM PAYMENTS
		42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)
		43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	1,600,334		1
2			2
3			3
4	1,600,334		4
5			5
6			6
7	1,600,334		7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16			16
17			17
18	1,600,334		18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1,853,501			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	6,621,034			4
5	OTHER RECEIVABLES	3,163,628			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	522,610			7
8	PREPAID EXPENSES	1,265,408			8
9	OTHER CURRENT ASSETS	71,314			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	13,497,495			11
FIXED ASSETS					
12	LAND	520,932			12
13	LAND IMPROVEMENTS	699,734			13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	20,637,987			15
16	ACCUMULATED DEPRECIATION				16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	11,250,649			19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT				23
24	ACCUMULATED DEPRECIATION				24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS	643,652			27
28	ACCUMULATED DEPRECIATION	-19,326,377			28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	14,426,577			30
OTHER ASSETS					
31	INVESTMENTS	6,586,674			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	461,162			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	7,047,836			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	34,971,908			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,019,954			37
38	SALARIES, WAGES & FEES PAYABLE	1,972,131			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	230,110			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	2,140,094			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	5,362,289			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	4,637,030			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	200,000			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	4,837,030			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	10,199,319			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	24,772,589			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)	24,772,589			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	34,971,908			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		27,821,692							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		-3,049,105							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		24,772,587							3
4 ADDITIONS (CREDIT ADJUSTMENTS)		2							4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		2							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		24,772,589							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)		24,772,589							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	2,847,811		2,847,811	2
3 SUBPROVIDER IPF	12,508,430		12,508,430	3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	258,721		258,721	6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	15,614,962		15,614,962	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	15,614,962		15,614,962	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	8,901,859		8,901,859	18
19 ANCILLARY SERVICES				19
20 OUTPATIENT SERVICES		77,232,443	77,232,443	20
20.01 RHC		2,163,151	2,163,151	20.01
21 RHC II				21
22 FQHC				22
23 HOME HEALTH AGENCY		1,046,410	1,046,410	23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	24,516,821	80,442,004	104,958,825	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		44,761,591	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35 OVER/SHORT			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		44,761,591	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	104,958,825	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	64,039,474	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	40,919,351	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	44,761,591	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-3,842,240	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	40,962	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE	2,913	9
10	PURCHASE DISCOUNTS	3,259	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	107,450	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	427	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	58,758	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (PSYCH REIMBURSEMENT)	39,185	24
24.01	OTHER (MEANINGFUL USE)	908,082	24.01
24.02	OTHER (OTHER MISC INCOME)	64,713	24.02
24.03	OTHER (UNREALIZED GAIN ON INVESTMENT)	347,461	24.03
24.04	OTHER (GRANT RECEIPTS)	29,769	24.04
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,602,979	25
26	TOTAL (LINE 5 PLUS LINE 25)	-2,239,261	26
27	OTHER EXPENSES (UNDISTRIBUTED LOSS OF SUBSIDIARY)	710,701	27
27.01	OTHER EXPENSES (LOSS ON DISPOSAL OF ASSETS)	79,610	27.01
27.02	OTHER EXPENSES (EXTRAORDINARY LOSS)	19,006	27.02
27.03	OTHER EXPENSES (MISC EXPENSE)	527	27.03
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	809,844	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-3,049,105	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7419

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS. 1-5) 6
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)						4
6 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	145,935			2,131	25,458	173,524 5
7 SKILLED NURSING CARE	264,868		25,257			290,125 6
8 PHYSICAL THERAPY	95,347		16,508			111,855 7
9 OCCUPATIONAL THERAPY	6,357		1,381			7,738 8
10 SPEECH PATHOLOGY	8,014		880			8,894 9
11 MEDICAL SOCIAL SERVICES						10
12 HOME HEALTH AIDE	35,419		114			35,533 11
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)	555,940		44,140	2,131	25,458	627,669 24





COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7419

WORKSHEET H-1  
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
1							1
2							2
3							3
4							4
5					-104,332	958,550	5
6					308,892	599,017	6
7					127,927	239,782	7
8					9,257	16,995	8
9					21,394	30,288	9
10							10
11					36,935	72,468	11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
23.50							23.50
24					400,073	958,550	24
25						104,332	25
26						0.108844	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7419

WORKSHEET H-2  
 PART I

HHA COST CENTER	HHA TRIAL BALANCE 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS. 0-4) 4A	ADMINIS-TRATIVE & GENERAL 5	MAIN-TENANCE & REPAIRS 6
1 ADMINISTRATIVE AND GENERAL					24,334	24,334	5,568	1
2 SKILLED NURSING CARE	355,323				91,811	447,134	102,320	2
3 PHYSICAL THERAPY	137,954				33,050	171,004	39,131	3
4 OCCUPATIONAL THERAPY	9,588				2,204	11,792	2,698	4
5 SPEECH PATHOLOGY	12,191				2,778	14,969	3,425	5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE	43,421				12,277	55,698	12,745	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)	558,477				166,454	724,931	165,887	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.: 14-7419

WORKSHEET H-2  
 PART I

HHA COST CENTER	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	
1 ADMINISTRATIVE AND GENERAL			11,909				33,652		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								5,600	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)			11,909				33,652	5,600	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.: 14-7419

WORKSHEET H-2  
 PART I

HHA COST CENTER	PHARMACY 15	MEDICAL RECORDS & LIBRARY 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 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)									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.: 14-7419

WORKSHEET H-2  
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (SUM OF COL. 4A-23) 26	ALLOCATED HHA A&G (SEE PT. 2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	75,463		75,463			1
2 SKILLED NURSING CARE	549,454		549,454	47,850	597,304	2
3 PHYSICAL THERAPY	210,135		210,135	18,300	228,435	3
4 OCCUPATIONAL THERAPY	14,490		14,490	1,262	15,752	4
5 SPEECH PATHOLOGY	18,394		18,394	1,602	19,996	5
6 MEDICAL SOCIAL SERVICES						6
7 HOME HEALTH AIDE	68,443		68,443	5,961	74,404	7
8 SUPPLIES	5,600		5,600	488	6,088	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)	941,979		941,979	75,463	941,979	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.				0.087088		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7419

WORKSHEET H-2  
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET
	1	2	3	4	4A	5	6	7
1 ADMINISTRATIVE AND GENERAL				70,203		24,334		1
2 SKILLED NURSING CARE				264,868		447,134		2
3 PHYSICAL THERAPY				95,347		171,004		3
4 OCCUPATIONAL THERAPY				6,357		11,792		4
5 SPEECH PATHOLOGY				8,014		14,969		5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE				35,419		55,698		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)				480,208		724,931		20
21 TOTAL COST TO BE ALLOCATED				166,454		165,887		21
22 UNIT COST MULTIPLIER								22
22 UNIT COST MULTIPLIER				0.346629		0.228831		22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7419

WORKSHEET H-2  
 PART II

HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS SERVED 11	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS-TRATION DIRECT NRSGING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	
1 ADMINISTRATIVE AND GENERAL		40				30,639			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							10,127		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)		40				30,639	10,127		20
21 TOTAL COST TO BE ALLOCATED		11,909				33,652	5,600		21
22 UNIT COST MULTIPLIER							0.552977		22
22 UNIT COST MULTIPLIER		297.725000				1.098339			22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7419

WORKSHEET H-2  
 PART II

HHA COST CENTER	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	NONPHYSIC. ANESTHET. ASSIGNED TIME 19	NURSING SCHOOL ASSIGNED TIME 20	I&R SALARY & FRINGES ASSIGNED TIME 21	I&R PROGRAM COSTS ASSIGNED TIME 22	PARAMED EDUCATION ASSIGNED TIME 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.: 14-7419

WORKSHEET H-3  
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	AVERAGE	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	COSTS (FROM WKST H-2, PART I)	ANCILLARY COSTS (FROM PART II)	COSTS (COLS. 1+2)	CHARGES VISITS	COST PER VISIT (COL.3 ÷ COL.4)	
1	SKILLED NURSING CARE	2	597,304	2	597,304	2,670	223.71	1
2	PHYSICAL THERAPY	3	228,435		228,435	1,745	130.91	2
3	OCCUPATIONAL THERAPY	4	15,752		15,752	146	107.89	3
4	SPEECH PATHOLOGY	5	19,996		19,996	93	215.01	4
5	MEDICAL SOCIAL SERVICES	6						5
6	HOME HEALTH AIDE	7	74,404		74,404	12	6,200.33	6
7	TOTAL (SUM OF LINES 1-6)		935,891		935,891	4,666		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	SHARED	TOTAL HHA	TOTAL	RATIO	
OTHER PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	COSTS (FROM WKST H-2, PART I)	ANCILLARY COSTS (FROM PART II)	COSTS (COLS. 1+2)	CHARGES (FROM HHA RECORD)	(COL.3 ÷ COL.4)	
15	COST OF MEDICAL SUPPLIES	8	6,088	2	6,088	29,016	0.209815	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7419

WORKSHEET H-3  
 PARTS I & II  
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART 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	1,090	554		243,844	123,935		367,779
2 PHYSICAL THERAPY	762	511		99,753	66,895		166,648
3 OCCUPATIONAL THERAPY	38	17		4,100	1,834		5,934
4 SPEECH PATHOLOGY	43	18		9,245	3,870		13,115
5 MEDICAL SOCIAL SERVICES							
6 HOME HEALTH AIDE	2	2		12,401	12,401		24,802
7 TOTAL (SUM OF LINES 1-6)	1,935	1,102		369,343	208,935		578,278

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		TOTAL
		PART A	SUBJECT TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	1	2	3	8
9 PHYSICAL THERAPY	99914	1,090	554	9
10 OCCUPATIONAL THERAPY	99914	762	511	10
11 SPEECH PATHOLOGY	99914	38	17	11
12 MEDICAL SOCIAL SERVICES	99914	43	18	12
13 HOME HEALTH AIDE	99914	2	2	13
14 TOTAL (SUM OF LINES 8-13)		1,935	1,102	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	
OTHER PATIENT SERVICES							
15 COST OF MEDICAL SUPPLIES							15
16 COST OF DRUGS							16

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

FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
		1	2		
1 PHYSICAL THERAPY	0.578219			COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY				COL 2, LINE 3	2
3 SPEECH PATHOLOGY				COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHRGD TO PAT	0.250221			COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	0.425452			COL 2, LINE 16	5

CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7419

WORKSHEET H-4  
 PARTS I & II

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

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

----- PART B -----  
 NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2  
 SUBJECT TO DEDUCTIBLES & COINSURANCE 3

PART A  
 1

DESCRIPTION	PART A 1	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
1 REASONABLE COST OF PART A & PART B SERVICES				1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)				2
3 TOTAL CHARGES	457,035			2
CUSTOMARY CHARGES				
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)				3
5 AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)				4
6 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				5
7 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	457,035			6
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)	457,035			7
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)				8
PRIMARY PAYER PAYMENTS				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

PART A SERVICES 1  
 PART B SERVICES 2

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	335,191	207,375	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	5,849	3,955	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	1,410	6,482	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	342,450	217,812	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	342,450	217,812	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	342,450	217,812	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)	342,450	217,812	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	-1,558	-1,035	30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	340,892	216,777	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	340,892	216,777	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35



CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK  TITLE V  HOSPITAL ((14-021)  PPS  
 APPLICABLE  TITLE XVIII-PT A  SUB (OTHER)  COST METHOD  
 BOXES  TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT		
2	CAPITAL DRG OTHER THAN OUTLIER	259,567	1
3	CAPITAL DRG OUTLIER PAYMENTS		2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	8.67	3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)		8
10	SUM OF LINES 7 AND 8		9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	259,567	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
40 SUBPROVIDER - IPF					40
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
57 COMPUTED TOMOGRAPHY (CT) SCAN					57
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
64 INTRAVENOUS THERAPY					64
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
75 ASC (NON-DISTINCT PART)					75
76 NUCLEAR MEDICINE					76
76.01 ULTRASOUND					76.01
76.02 MAMMOGRAPHY					76.02
76.03 CARDIAC REHABILITATION					76.03
76.04 FAITH CENTER CHEMOTHERAPY					76.04
76.06 ROUTINE ANCILLARY					76.06
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY					91
92 OBSERVATION BEDS					92
93 DAY PSYCHIATRIC					93
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
192.01 DIALYSIS					192.01
192.03 ORTHO CLINIC					192.03
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

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

RHC I  
 COMPONENT NO: 14-3473

WORKSHEET M-1

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7		
FACILITY HEALTH CARE STAFF COSTS									
1	PHYSICIAN	478,166	478,166		478,166		478,166	1	
2	PHYSICIAN ASSISTANT	2,336	2,336		2,336		2,336	2	
3	NURSE PRACTITIONER	314,218	314,218		314,218		314,218	3	
4	VISITING NURSE							4	
5	OTHER NURSE	238,139	238,139		238,139		238,139	5	
6	CLINICAL PSYCHOLOGIST	205,333	205,333		205,333	-39,185	166,148	6	
7	CLINICAL SOCIAL WORKER	56,780	56,780		56,780		56,780	7	
8	LABORATORY TECHNICIAN	36,193	36,193	-36,193				8	
9	OTHER FACILITY HEALTH CARE STAFF COSTS	50,649	50,649	-50,649				9	
10	SUBTOTAL (SUM OF LINES 1-9)	1,381,814	1,381,814	-86,842	1,294,972	-39,185	1,255,787	10	
COSTS UNDER AGREEMENT									
11	PHYSICIAN SERVICES UNDER AGREEMENT							11	
12	PHYSICIAN SUPERVISION UNDER AGREEMENT							12	
13	OTHER COSTS UNDER AGREEMENT							13	
14	SUBTOTAL (SUM OF LINES 11-13)							14	
OTHER HEALTH CARE COSTS									
15	MEDICAL SUPPLIES		21,865	21,865		21,865	21,865	15	
16	TRANSPORTATION (HEALTH CARE STAFF)		12,340	12,340		12,340	12,340	16	
17	DEPRECIATION-MEDICAL EQUIPMENT				63,112	63,112	63,112	17	
18	PROFESSIONAL LIABILITY INSURANCE							18	
19	OTHER HEALTH CARE COSTS							19	
20	ALLOWABLE GME COSTS							20	
21	SUBTOTAL (SUM OF LINES 15-20)		34,205	34,205	63,112	97,317	97,317	21	
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,381,814	34,205	1,416,019	-23,730	1,392,289	-39,185	1,353,104	22
COSTS OTHER THAN RHC/FQHC SERVICES									
23	PHARMACY							23	
24	DENTAL							24	
25	OPTOMETRY							25	
26	ALL OTHER NONREIMBURSABLE COSTS							26	
27	NONALLOWABLE GME COSTS							27	
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)							28	
FACILITY OVERHEAD									
29	FACILITY COSTS		117,827	117,827	-9,601	108,226	108,226	29	
30	ADMINISTRATIVE COSTS	525,636	141,068	666,704	-128,270	538,434	-55,010	483,424	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	525,636	258,895	784,531	-137,871	646,660	-55,010	591,650	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,907,450	293,100	2,200,550	-161,601	2,038,949	-94,195	1,944,754	32

RHC I  
 COMPONENT NO: 14-3473

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	1.73	7,012	4,200	7,266	1
2	PHYSICIAN ASSISTANTS	0.02		2,100	42	2
3	NURSE PRACTITIONERS	2.53	7,101	2,100	5,313	3
4	SUBTOTAL (SUM OF LINES 1-3)	4.28	14,113		12,621	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST	0.90	1,457		1,457	6
7	CLINICAL SOCIAL WORKER	0.88	786		786	7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	6.06	16,356		16,356	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				1,353,104	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				1,353,104	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				591,650	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				1,338,343	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				1,929,993	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				1,929,993	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				1,929,993	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				3,283,097	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I  
 COMPONENT NO: 14-3473

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	3,283,097	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	61,145	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	3,221,952	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	16,356	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	16,356	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	196.99	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	196.99	196.99	196.99	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	4,184			10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	824,206			11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	182			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	35,852			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	29,130			14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)				15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	853,336			16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)	524,285			16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)	868			16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	1,413			16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	633,763			16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	635,176			16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	59,719			18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	98,807			19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	635,176			20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	15,477			21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	650,653			22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	45,932			23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	45,932			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	696,585			26
27	INTERIM PAYMENTS	550,683			27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	145,902			29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

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

RHC I  
 COMPONENT NO: 14-3473

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

[ ] TITLE XIX

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,255,787	1,255,787	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000066	0.008233	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	83	10,339	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	5,890	8,889	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	5,973	19,228	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,353,104	1,353,104	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,929,993	1,929,993	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.004414	0.014210	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	8,519	27,425	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	14,492	46,653	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	99	765	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	146.38	60.98	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	17	213	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	2,488	12,989	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		61,145	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		15,477	16



RHC II  
 COMPONENT NO: 14-8518

WORKSHEET M-1

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

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1	29,769		29,769		29,769		29,769	1
2	27,151		27,151		27,151		27,151	2
3	34,334		34,334		34,334		34,334	3
4								4
5	31,739		31,739		31,739		31,739	5
6								6
7								7
8								8
9								9
10	122,993		122,993		122,993		122,993	10
COSTS UNDER AGREEMENT								
11								11
12								12
13								13
14								14
OTHER HEALTH CARE COSTS								
15		1,793	1,793		1,793		1,793	15
16		821	821		821		821	16
17								17
18								18
19								19
20								20
21		2,614	2,614		2,614		2,614	21
22	122,993	2,614	125,607		125,607		125,607	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26								26
27								27
28								28
FACILITY OVERHEAD								
29		41,777	41,777		41,777		41,777	29
30	22,804	4,662	27,466	62,143	89,609	-42,532	47,077	30
31	22,804	46,439	69,243	62,143	131,386	-42,532	88,854	31
32	145,797	49,053	194,850	62,143	256,993	-42,532	214,461	32

RHC II  
 COMPONENT NO: 14-8518

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3.	4	5	
1	PHYSICIANS	0.02	192	4,200	84	1
2	PHYSICIAN ASSISTANTS	0.23	335	2,100	483	2
3	NURSE PRACTITIONERS	0.33	616	2,100	693	3
4	SUBTOTAL (SUM OF LINES 1-3)	0.58	1,143		1,260	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.58	1,143		1,260	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				125,607	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				125,607	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				88,854	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				137,244	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				226,098	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				226,098	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				226,098	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				351,705	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC II  
 COMPONENT NO: 14-8518

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	351,705	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	17,708	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	333,997	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	1,260	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	1,260	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	265.08	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	265.08	265.08	265.08	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	394	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	104,442	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)		14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)		15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	104,442	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)	44,590	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)	217	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	508	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	80,632	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	81,140	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	3,144	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	8,369	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	81,140	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	600	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	81,740	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	81,740	26
27	INTERIM PAYMENTS	43,861	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	37,879	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		30

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

RHC II  
 COMPONENT NO: 14-8518

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	122,993	122,993	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		0.000518	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)		64	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	5,593	667	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	5,593	731	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	125,607	125,607	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	226,098	226,098	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.044528	0.005820	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	10,068	1,316	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	15,661	2,047	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	94	58	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	166.61	35.29	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		17	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		600	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		17,708	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		600	16



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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	40.67		5.69				46.36 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	6.96	24.75					31.71 50
53 ANESTHESIOLOGY	7.38	27.14					34.52 53
54 RADIOLOGY-DIAGNOSTIC	9.80	37.05					46.85 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	7.41	34.35					41.76 57
60 LABORATORY	12.32	2.26					14.58 60
64 INTRAVENOUS THERAPY	25.52	31.81					57.33 64
65 RESPIRATORY THERAPY	29.52	23.31					52.83 65
66 PHYSICAL THERAPY	9.54	0.03					9.57 66
69 ELECTROCARDIOLOGY	10.91	32.29					43.20 69
71 MEDICAL SUPPLIES CHRGD TO PATI	31.39	22.34					53.73 71
72 IMPL. DEV. CHARGED TO PATIENT	2.50	62.55					65.05 72
73 DRUGS CHARGED TO PATIENTS	8.52	47.24					55.76 73
75 ASC (NON-DISTINCT PART)	3.65	40.38					44.03 75
76 NUCLEAR MEDICINE	1.55	41.24					42.79 76
76.01 ULTRASOUND	10.41	21.74					32.15 76.01
76.03 CARDIAC REHABILITATION	0.47	76.49					76.96 76.03
76.04 FAITH CENTER CHEMOTHERAPY		47.92					47.92 76.04
91 EMERGENCY	6.16	26.97					33.13 91
92 OBSERVATION BEDS	12.33	39.34					51.67 92
93 DAY PSYCHIATRIC		20.13					20.13 93
200 TOTAL CHARGES	10.78	25.79					36.57 200

\*\*\*\*\* 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	39.20		27.03				66.23 40
UTILIZATION PERCENTAGES BASED ON CHARGES							
53 ANESTHESIOLOGY	1.94						1.94 53
54 RADIOLOGY-DIAGNOSTIC	1.04						1.04 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	1.06						1.06 57
60 LABORATORY	1.84						1.84 60
64 INTRAVENOUS THERAPY	0.61						0.61 64
65 RESPIRATORY THERAPY	4.56						4.56 65
66 PHYSICAL THERAPY	1.67						1.67 66
69 ELECTROCARDIOLOGY	1.68						1.68 69
71 MEDICAL SUPPLIES CHRGED TO PATI	2.97						2.97 71
73 DRUGS CHARGED TO PATIENTS	5.63						5.63 73
75 ASC (NON-DISTINCT PART)	0.04						0.04 75
76.01 ULTRASOUND	0.60						0.60 76.01
91 EMERGENCY	1.54						1.54 91
200 TOTAL CHARGES	1.79						1.79 200

\*\*\*\*\* 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	0.08						0.08 54
60 LABORATORY	0.16						0.16 60
64 INTRAVENOUS THERAPY	0.17						0.17 64
65 RESPIRATORY THERAPY	0.96						0.96 65
66 PHYSICAL THERAPY	2.86						2.86 66
69 ELECTROCARDIOLOGY	0.07						0.07 69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.84						0.84 71
73 DRUGS CHARGED TO PATIENTS	0.27						0.27 73
75 ASC (NON-DISTINCT PART)	0.12						0.12 75
76.01 ULTRASOUND	0.04						0.04 76.01
200 TOTAL CHARGES	0.24						0.24 200

COST CENTER	--- DIRECT COSTS ---	---	--- ALLOCATED OVERHEAD ---	---	--- TOTAL COSTS ---	---	
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
1 GENERAL SERVICE COST CENTERS							1
2 CAP REL COSTS-BLDG & FIXT	724,354	1.89	-724,354	-3.93			2
3 CAP REL COSTS-MVBLE EQUIP	968,605	2.53	-968,605	-5.25			3
4 OTHER CAPITAL RELATED COSTS							4
5 EMPLOYEE BENEFITS	6,712,043	17.54	-6,712,043	-36.39			5
6 ADMINISTRATIVE & GENERAL	5,617,814	14.68	-5,617,814	-30.46			6
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT	1,115,494	2.92	-1,115,494	-6.05			8
9 LAUNDRY & LINEN SERVICE	122,852	0.32	-122,852	-0.67			9
10 HOUSEKEEPING	543,878	1.42	-543,878	-2.95			10
11 DIETARY	750,945	1.96	-750,945	-4.07			11
12 CAFETERIA							12
13 MAINTENANCE OF PERSONNEL							13
14 NURSING ADMINISTRATION	315,397	0.82	-315,397	-1.71			14
15 CENTRAL SERVICES & SUPPLY	300,105	0.78	-300,105	-1.63			15
16 PHARMACY	566,707	1.48	-566,707	-3.07			16
17 MEDICAL RECORDS & LIBRARY	704,805	1.84	-704,805	-3.82			17
18 SOCIAL SERVICE							18
19 NONPHYSICIAN ANESTHETISTS							19
20 NURSING SCHOOL							20
21 I&R SRVCES-SALARY & FRINGES APP							21
22 I&R SRVCES-OTHER PRGM COSTS APP							22
23 PARAMED ED PRGM-(SPECIFY)							23
30 INPATIENT ROUTINE SERV COST CENTERS							
40 ADULTS & PEDIATRICS	2,942,771	7.69	3,383,818	18.35	6,326,589	16.53	30
40 SUBPROVIDER - IPF	2,861,037	7.48	3,059,291	16.59	5,920,328	15.47	40
50 ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	600,539	1.57	1,032,391	5.60	1,632,930	4.27	50
53 ANESTHESIOLOGY	24,087	0.06	51,491	0.28	75,578	0.20	53
54 RADIOLOGY-DIAGNOSTIC	614,161	1.60	653,101	3.54	1,267,262	3.31	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	396,346	1.04	405,888	2.20	802,234	2.10	57
60 LABORATORY	1,989,867	5.20	1,249,830	6.78	3,239,697	8.47	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64 INTRAVENOUS THERAPY	96,627	0.25	122,913	0.67	219,540	0.57	64
65 RESPIRATORY THERAPY	651,987	1.70	548,142	2.97	1,200,129	3.14	65
66 PHYSICAL THERAPY	782,594	2.05	821,358	4.45	1,603,952	4.19	66
69 ELECTROCARDIOLOGY	93,678	0.24	76,857	0.42	170,535	0.45	69
71 MEDICAL SUPPLIES CHRGD TO PATI	548,249	1.43	163,225	0.89	711,474	1.86	71
72 IMPL. DEV. CHARGED TO PATIENT	62,579	0.16	18,138	0.10	80,717	0.21	72
73 DRUGS CHARGED TO PATIENTS	2,450,796	6.40	1,728,039	9.37	4,178,835	10.92	73
75 ASC (NON-DISTINCT PART)	555,174	1.45	814,676	4.42	1,369,850	3.58	75
76 NUCLEAR MEDICINE	297,851	0.78	222,414	1.21	520,265	1.36	76
76.01 ULTRASOUND	229,475	0.60	259,921	1.41	489,396	1.28	76.01
76.02 MAMMOGRAPHY	118,719	0.31	76,197	0.41	194,916	0.51	76.02
76.03 CARDIAC REHABILITATION	92,086	0.24	72,920	0.40	165,006	0.43	76.03
76.04 FAITH CENTER CHEMOTHERAPY	108,953	0.28	141,438	0.77	250,391	0.65	76.04
76.06 ROUTINE ANCILLARY							76.06
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
88 RURAL HEALTH CLINIC (RHC)	1,944,754	5.08	1,338,343	7.26	3,283,097	8.58	88
88.01 RHC II	214,461	0.56	137,244	0.74	351,705	0.92	88.01
91 EMERGENCY	1,082,584	2.83	1,207,960	6.55	2,290,544	5.99	91
92 OBSERVATION BEDS							92
93 DAY PSYCHIATRIC	252,578	0.66	267,815	1.45	520,393	1.36	93
99.10 OTHER REIMBURSABLE COST CENTERS							99.10
99.20 OUTPATIENT SERVICE COST CENTERS							99.20
99.30 CORF							99.30
99.40 OUTPATIENT PHYSICAL THERAPY							99.40
101 OUTPATIENT OCCUPATIONAL THERAPY							101
101 OUTPATIENT SPEECH PATHOLOGY	558,477	1.46	383,502	2.08	941,979	2.46	101
190 HOME HEALTH AGENCY							190
192 SPECIAL PURPOSE COST CENTERS							192
192.01 NONREIMBURSABLE COST CENTERS							192.01
192.03 GIFT, FLOWER, COFFEE SHOP & CAN	87,038	0.23	84,495	0.46	171,533	0.45	192.03
200 PHYSICIANS' PRIVATE OFFICES	155,564	0.41	119,008	0.65	274,572	0.72	200
201 DIALYSIS							201
202 ORTHO CLINIC	11,290	0.03	2,584	0.01	13,874	0.04	202
202 CROSS FOOT ADJUSTMENTS							202
202 NEGATIVE COST CENTER							202
202 TOTAL	38,267,321	100.00			38,267,321	100.00	202

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	TOTAL	RATIO	INPATIENT	MEDICARE	
	RELATED		CAPITAL		PROGRAM	
	COSTS	CHARGES	COST TO	CHARGES	PPS CAPITAL	
	1	2	CHARGES	4	COSTS	5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	228,422	1,687,585	0.135354	117,396	15,890	50
53 ANESTHESIOLOGY	14,845	1,521,039	0.009760	112,291	1,096	53
54 RADIOLOGY-DIAGNOSTIC	119,954	3,372,538	0.035568	330,506	11,755	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	26,035	12,925,754	0.002014	957,186	1,928	57
60 LABORATORY	120,670	17,454,165	0.006914	2,150,211	14,867	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	7,109	3,010,338	0.002362	768,346	1,815	64
65 RESPIRATORY THERAPY	69,713	3,562,464	0.019569	1,051,670	20,580	65
66 PHYSICAL THERAPY	94,156	2,773,952	0.033943	264,651	8,983	66
69 ELECTROCARDIOLOGY	39,466	1,322,866	0.029834	144,365	4,307	69
71 MEDICAL SUPPLIES CHRGED TO PATI	11,965	2,843,385	0.004208	892,522	3,756	71
72 IMPL. DEV. CHARGED TO PATIENT	1,337	287,439	0.004651	7,178	33	72
73 DRUGS CHARGED TO PATIENTS	100,036	9,822,101	0.010185	836,384	8,519	73
75 ASC (NON-DISTINCT PART)	99,115	2,954,896	0.033543	107,779	3,615	75
76 NUCLEAR MEDICINE	66,052	1,874,917	0.035229	29,141	1,027	76
76.01 ULTRASOUND	57,733	2,584,013	0.022342	268,871	6,007	76.01
76.02 MAMMOGRAPHY	6,777	623,542	0.010869			76.02
76.03 CARDIAC REHABILITATION	10,983	380,568	0.028859	1,781	51	76.03
76.04 FAITH CENTER CHEMOTHERAPY	16,963	261,209	0.064940			76.04
76.06 ROUTINE ANCILLARY						76.06
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
88 RURAL HEALTH CLINIC (RHC)	52,790	2,049,976	0.025752			88
88.01 RHC II	5,266	113,132	0.046547			88.01
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	100,856	7,065,034	0.014275	435,377	6,215	91
92 OBSERVATION BEDS	113,620	6,362,281	0.017858	784,410	14,008	92
93 DAY PSYCHIATRIC	36,432	1,021,535	0.035664			93
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL	1,400,295	85,874,729		9,260,065	124,452	200

APPORIONMENT 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	280,261	1,437	278,824	5,323	52.38	2,165	113,403 30
200	TOTAL	280,261	1,437	278,824	5,323		2,165	113,403 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								113,403
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								124,452
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								237,855
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								701
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								2,165
PER DISCHARGE CAPITAL COSTS								339.31
PER DIEM CAPITAL COSTS								109.86

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	4,753,747
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	11,218,127
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.424

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))	2,833,856
2. TOTAL MEDICARE CHARGES (WKST D-3 LINE 40 COLUMN 2 PLUS WKST D-3 LINE 202 COLUMN 2) (SEE CR 5619)	5,225,289
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.542

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)	237,855
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.021

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	6,677,736
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)	22,142,524
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.302

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)	10/01/2011 through 09/30/2012 (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	3,301,153		825,288		2,475,865		3,301,153	1
2	Outlier payments for discharges	217		54		163		217	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	0.0405	0.0405	0.0405	0.0405	0.0405	0.0405		10
11	Disproportionate share adjustment	133,697		33,424		100,273		133,697	11
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES									
12	Total ESRD additional payment								12
13	Subtotal	3,435,067		858,766		2,576,301		3,435,067	13
14	Hospital specific payments	3,908,605		977,151		2,931,454		3,908,605	14
15	Total payment for inpatient operating costs - E Part A Line 49	3,908,605		977,151		2,931,454		3,908,605	15
16	Payment for inpatient program capital	259,567		64,892		194,675		259,567	16
17	Special add-on payments for new technologies								17
18	Capital outlier reconciliation adjustment amount								18
19	SUBTOTAL			1,042,043		3,126,129		4,168,172	19
CAPITAL PAYMENTS									
20	Capital DRG other than outlier	259,567		64,892		194,675		259,567	20
21	Capital DRG outlier payments								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	259,567		64,892		194,675		259,567	26
LOW VOLUME ADJUSTMENT									
27	Low volume adjustment factor			0.040000		0.086786			27
28	Low Volume Adjustment			41,682				41,682	28
29	Low Volume Adjustment					271,304		271,304	29