

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

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

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY COMMUNITY HOSPITAL (15-0125) (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.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		-191,639	224,615	-153,687		1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF		26,533	44			3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		-165,106	224,659	-153,687		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: 901 MACARTHUR BOULEVARD
 2 CITY: MUNSTER STATE: IN

P.O.BOX:
 ZIP CODE: 46321 COUNTY: LAKE

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	15-0125	23844	1	10/03/1973	N	P	P	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF	15-T125	23844	5	06/30/1996	N	P	P	5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA	15-7487	23844		01/07/1997	N	P	N	12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC								15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2012			TO: 06/30/2013				20
21	TYPE OF CONTROL								21

INPATIENT PPS INFORMATION

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

		IN-STATE		OUT-OF-STATE		OTHER			
		MEDICAID PAID DAYS	MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID PAID DAYS	MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO PAID DAYS	MEDICAID OTHER PAID DAYS		
		1	2	3	4	5	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.	5,834	1,392	1,123	408	5,892		24	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.		156	62				25	
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1			26	
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				1			27	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:		36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:		38	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)							1 N	2 N 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	1 N	2	3	56	
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57	
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58	
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59	
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60	
		Y/N	IME	DIRECT GME		
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(SEE INSTRUCTIONS)	N			61	
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01	
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY) ADDED AS A RESULT OF SECTION 5503. (SEE INSTRUCTIONS)				61.02	
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03	
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04	
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05	
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06	
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
		PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED IME FTE COUNT 3	UNWEIGHTED DIRECT GME FTE COUNT 4	61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					61.20
	ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62	
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01	
	TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63	

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
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)				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 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
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		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				66

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

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
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INPATIENT PSYCHIATRIC FACILITY PPS					
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				71

INPATIENT REHABILITATION FACILITY PPS					
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			N	76

LONG TERM CARE HOSPITAL PPS					
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	80

TEFRA PROVIDERS					
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N	86

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 Y	2 158054	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: COMMUNITY FOUNDATION OF NW IN, CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 00450		141
142	STREET: 10100 DON POWERS DRIVE P.O. BOX:			142
143	CITY: MUNSTER STATE: IN	ZIP CODE: 46321		143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

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

MULTICAMPUS

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

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

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.	1.00		169
170	IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS)	07/01/2012	09/28/2012	170

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

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

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA					
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 N	2	3 N	4 16
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	10/31/2013	Y	10/31/2013
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	18
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	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

	Y/N	DATE	
36	1	2	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? 36
37			IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 37
38	N		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. 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: CONNIE	LAST NAME: BIEGEL	TITLE: DIRECTOR OF REIMBURS	41
42	EMPLOYER: COMMUNITY HOSPITAL			42
43	PHONE NUMBER: 12198366789	E-MAIL ADDRESS: CBIEGEL@COMHS.ORG		43

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	153,351,667	-12,687	153,338,980	5,394,776.00	28.42
2	NON-PHYSICIAN ANESTHETIST PART A						1
3	NON-PHYSICIAN ANESTHETIST PART B		2,772,042		2,772,042	32,549.00	85.17
4	PHYSICIAN-PART A ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B		6,769,653		6,769,653	37,672.00	179.70
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		8,306,503	45,184	8,351,687	348,868.00	23.94
	OTHER WAGES & RELATED COSTS						10
11	CONTRACT LABOR (SEE INSTRUCTIONS)		1,337,539		1,337,539	12,390.00	107.95
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		851,066		851,066	5,633.00	151.09
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		16,258,194		16,258,194	350,069.00	46.44
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)		46,821,190		46,821,190		17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		3,013,475		3,013,475		19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B		636,583		636,583		21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B		1,239,285		1,239,285		23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS DEPARTMENT		894,218		894,218	32,000.00	27.94
27	ADMINISTRATIVE & GENERAL		14,758,318	-34,001	14,724,317	534,286.00	27.56
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		4,029,431		4,029,431	25,348.00	158.96
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		4,565,883		4,565,883	173,722.00	26.28
31	LAUNDRY & LINEN SERVICE		143,816		143,816	9,351.00	15.38
32	HOUSEKEEPING		3,272,267		3,272,267	217,712.00	15.03
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		3,602,611	-1,293,224	2,309,387	131,306.00	17.59
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA			1,293,224	1,293,224	94,166.00	13.73
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		1,629,043		1,629,043	37,791.00	43.11
39	CENTRAL SERVICES AND SUPPLY			34,001	34,001	2,288.00	14.86
40	PHARMACY		3,988,928		3,988,928	107,699.00	37.04
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		3,137,909		3,137,909	157,130.00	19.97
42	SOCIAL SERVICE		711,965		711,965	26,057.00	27.32
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	147,839,403	-12,687	147,826,716	5,349,903.00	27.63	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	8,306,503	45,184	8,351,687	348,868.00	23.94	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	139,532,900	-57,871	139,475,029	5,001,035.00	27.89	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	18,446,799		18,446,799	368,092.00	50.11	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	46,821,190		46,821,190		33.57%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	204,800,889	-57,871	204,743,018	5,369,127.00	38.13	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	40,734,389		40,734,389	1,548,856.00	26.30	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	2,019,762	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	16,204,761	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	229,372	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	20,247,948	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	1,143,840	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	118,725	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	62,635	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	530,850	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	8,681,568	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	2,122,466	18
19 UNEMPLOYMENT INSURANCE	161,951	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	186,654	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	51,710,532	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
12/02/2013 15:17

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
2	HOSPITAL		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 OLTG		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 15-7487

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: LAKE

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		3,643	208	7	3,858	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		1,144.00		418.00	1,562.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			
	STAFF 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			1.20	4
5 OTHER ADMINISTRATIVE PERSONNEL			12.95	5
6 DIRECT NURSING SERVICE			7.48	6
7 NURSING SUPERVISOR				7
8 PHYSICAL THERAPY SERVICE			6.57	8
9 PHYSICAL THERAPY SUPERVISOR				9
10 OCCUPATIONAL THERAPY SERVICE			1.66	10
11 OCCUPATIONAL THERAPY SUPERVISOR				11
12 SPEECH PATHOLOGY SERVICE				12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE			0.01	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE			3.48	16
17 HOME HEALTH AIDE SUPERVISOR				17
18 PRIVATE DUTY			10.66	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).		23844	20

PPS ACTIVITY

	FULL EPISODES				TOTAL (COLS. 1-4)	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	13,781	1,848	300	253	16,182	21
22 SKILLED NURSING VISIT CHARGES	2,191,179	293,832	47,700	40,227	2,572,938	22
23 PHYSICAL THERAPY VISITS	11,001	521	67	94	11,683	23
24 PHYSICAL THERAPY VISIT CHARGES	2,034,075	96,385	12,395	17,390	2,160,245	24
25 OCCUPATIONAL THERAPY VISITS	2,837	273	11	26	3,147	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	522,625	50,505	2,035	4,810	579,975	26
27 SPEECH PATHOLOGY VISITS						27
28 SPEECH PATHOLOGY VISIT CHARGES						28
29 MEDICAL SOCIAL SERVICE VISITS	16	2		1	19	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	3,376	422		211	4,009	30
31 HOME HEALTH AIDE VISITS	3,052	530	2	41	3,625	31
32 HOME HEALTH AIDE VISIT CHARGES	363,188	63,070	238	4,879	431,375	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	30,687	3,174	380	415	34,656	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	5,114,443	504,214	62,368	67,517	5,748,542	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	1,387		150	26	1,563	36
37 TOTAL NUMBER OF OUTLIER EPISODES		59			59	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	268,683	28,526	7,455	29,270	333,934	38

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)				0.307986	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				15,109,418	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				109,050,198	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				33,585,934	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.				18,476,516	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP				864	9
10	STAND-ALONE SCHIP CHARGES				7,738	10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)				2,383	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.				1,519	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)				11,235	13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)				183,438	14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)				56,496	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.				45,261	16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE				4,260	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)				18,523,297	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	26,557,110			26,557,110	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	8,179,218			8,179,218	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	30,408			30,408	22
23	COST OF CHARITY CARE	8,148,810			8,148,810	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)				18,066,354	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				1,180,675	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				16,885,679	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				5,200,553	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				13,349,363	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				31,872,660	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100				11,517,727	1
2	00200				9,308,579	2
3	00300					3
4	00400	894,218	393,558	1,287,776	47,798,949	4
5	00500	14,758,318	147,269,158	162,027,476	-69,079,715	5
6	00600					6
7	00700	4,565,883	7,236,534	11,802,417	1,125,631	7
8	00800	143,816	1,219,749	1,363,565		8
9	00900	3,272,267	890,107	4,162,374	-28,397	9
10	01000	3,602,611	2,933,044	6,535,655	-2,726,128	10
11	01100				2,714,910	11
12	01200					12
13	01300	1,629,043	143,947	1,772,990	-9,626	13
14	01400		149,952	149,952	34,001	14
15	01500	3,988,928	13,095,234	17,084,162		15
16	01600	3,137,909	1,397,097	4,535,006	-336	16
17	01700	711,965	14,358	726,323		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	33,479,202	4,848,210	38,327,412	-704,258	30
31	03100	8,066,290	1,051,249	9,117,539	-40,826	31
32.01	02060	2,533,359	249,330	2,782,689	16,237	32.01
41	04100	3,720,284	1,773,486	5,493,770	18,017	41
43	04300	1,545,855	246,457	1,792,312	6,906	43
ANCILLARY SERVICE COST CENTERS						
50	05000	23,736,636	39,102,378	62,839,014	-25,269,542	50
52	05200	1,977,527	309,963	2,287,490	-58,527	52
54	05400	7,542,728	7,311,368	14,854,096	-236,394	54
60	06000	5,540,392	5,687,693	11,228,085		60
62	06200	389,958	2,785,946	3,175,904		62
62.30	06250					62.30
65	06500	3,408,877	613,459	4,022,336		65
66	06600	4,490,340	3,922,763	8,413,103	-157,810	66
70	07000	618,760	319,938	938,698	-95	70
71	07100				16,080,954	71
72	07200				26,536,370	72
73	07300					73
74	07400					74
76	03140	6,719,250	21,033,320	27,752,570	-16,460,448	76
76.97	07697	448,324	24,873	473,197	-79,208	76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	1,690,767	527,700	2,218,467	-14,277	90
91	09100	6,151,941	1,613,564	7,765,505	-5,422	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	2,023,583	1,310,128	3,333,711	-34,389	101
SPECIAL PURPOSE COST CENTERS						
118		150,789,031	267,474,563	418,263,594	252,883	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
191	19100	272,833	126,442	399,275	-2,985	191
192	19200	12,687	-40	12,647		192
194	07950				796,696	194
194.01	07951	1,557,343	2,024,315	3,581,658	-1,043,510	194.01
194.02	07952	309,910	103,444	413,354	-3,084	194.02
194.03	07953	409,863	3,735,051	4,144,914		194.03
194.04	07954					194.04
194.05	07955					194.05
200		153,351,667	273,463,775	426,815,442		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	11,517,727	238,869	11,756,596	1
2	00200	CAP REL COSTS-MVBLE EQUIP	9,308,579	5,657,848	14,966,427	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	49,086,725	-4,235,050	44,851,675	4
5	00500	ADMINISTRATIVE & GENERAL	92,947,761	-40,644,129	52,303,632	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	12,928,048	-109,545	12,818,503	7
8	00800	LAUNDRY & LINEN SERVICE	1,363,565		1,363,565	8
9	00900	HOUSEKEEPING	4,133,977		4,133,977	9
10	01000	DIETARY	3,809,527	-9,148	3,800,379	10
11	01100	CAFETERIA	2,714,910	-1,993,224	721,686	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	1,763,364		1,763,364	13
14	01400	CENTRAL SERVICES & SUPPLY	183,953		183,953	14
15	01500	PHARMACY	17,084,162	-95	17,084,067	15
16	01600	MEDICAL RECORDS & LIBRARY	4,534,670	-25,158	4,509,512	16
17	01700	SOCIAL SERVICE	726,323		726,323	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	37,623,154	-56,734	37,566,420	30
31	03100	INTENSIVE CARE UNIT	9,076,713		9,076,713	31
32.01	02060	NEONATAL INTENSIVE CARE	2,798,926	-50,417	2,748,509	32.01
41	04100	SUBPROVIDER - IRF	5,511,787		5,511,787	41
43	04300	NURSERY	1,799,218	-1,911	1,797,307	43
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	37,569,472	-11,437,860	26,131,612	50
52	05200	DELIVERY ROOM & LABOR ROOM	2,228,963		2,228,963	52
54	05400	RADIOLOGY-DIAGNOSTIC	14,617,702	-100,161	14,517,541	54
60	06000	LABORATORY	11,228,085	-9,556	11,218,529	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,175,904		3,175,904	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	4,022,336		4,022,336	65
66	06600	PHYSICAL THERAPY	8,255,293	-450	8,254,843	66
70	07000	ELECTROENCEPHALOGRAPHY	938,603	-28,485	910,118	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,080,954		16,080,954	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS	26,536,370		26,536,370	72
73	07300	DRUGS CHARGED TO PATIENTS				73
74	07400	RENAL DIALYSIS				74
76	03140	CARDIOLOGY	11,292,122	-936,483	10,355,639	76
76.97	07697	CARDIAC REHABILITATION	393,989	-62,705	331,284	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	CLINIC	2,204,190	432	2,204,622	90
91	09100	EMERGENCY	7,760,083	-42,370	7,717,713	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS						
94	09400	HOME PROGRAM DIALYSIS				94
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	3,299,322		3,299,322	101
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117)	418,516,477	-53,846,332	364,670,145	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
191	19100	RESEARCH	396,290		396,290	191
192	19200	PHYSICIANS' PRIVATE OFFICES	12,647	-12,647		192
194	07950	ADVERTISING	796,696		796,696	194
194.01	07951	FITNESS POINTE	2,538,148		2,538,148	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	410,270		410,270	194.02
194.03	07953	RETAIL PHARMACY	4,144,914		4,144,914	194.03
194.04	07954	HOSPICE				194.04
194.05	07955	RUSH RESIDENTS				194.05
200		TOTAL (SUM OF LINES 118-199)	426,815,442	-53,858,979	372,956,463	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		OTHER	
			LINE #	SALARY		
1	2	3	4	5		
1 OPERATING RM SUPPLIES	A	MEDICAL SUPPLIES CHARGED TO P	71		15,325,171	1
2		IMPL. DEV. CHARGED TO PATIENT	72		26,536,370	2
3		MEDICAL SUPPLIES CHARGED TO P	71		755,783	3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
500 TOTAL RECLASSIFICATIONS					42,617,324	500
CODE LETTER - A						
1 NURSING FLOAT SALARIES	B	INTENSIVE CARE UNIT	31	97,695		1
2		NURSERY	43	19,756		2
3		NEONATAL INTENSIVE CARE	32.01	28,010		3
4		DELIVERY ROOM & LABOR ROOM	52	24,609		4
5		EMERGENCY	91	91,325		5
6		SUBPROVIDER - IRF	41	57,871		6
500 TOTAL RECLASSIFICATIONS				319,266		500
CODE LETTER - B						
1 STOREROOM SALARY RECLASS	C	CENTRAL SERVICES & SUPPLY	14	34,001		1
500 TOTAL RECLASSIFICATIONS				34,001		500
CODE LETTER - C						
1 CAFETERIA EXPENSE	D	CAFETERIA	11	1,293,224	1,421,686	1
500 TOTAL RECLASSIFICATIONS				1,293,224	1,421,686	500
CODE LETTER - D						
1 INTEREST EXPENSE	E	CAP REL COSTS-MVBLE EQUIP	2		2,544	1
500 TOTAL RECLASSIFICATIONS					2,544	500
CODE LETTER - E						
1 BUILDING INSURANCE	F	CAP REL COSTS-BLDG & FIXT	1		359,394	1
2		CAP REL COSTS-MVBLE EQUIP	2		8,752	2
500 TOTAL RECLASSIFICATIONS					368,146	500
CODE LETTER - F						
1 UTILITY RECLASS	G	OPERATION OF PLANT	7		1,125,631	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
500 TOTAL RECLASSIFICATIONS					1,125,631	500
CODE LETTER - G						
1 ADVERTISING NON-REIMBURSABLE	H	ADVERTISING	194		796,696	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
500 TOTAL RECLASSIFICATIONS					796,696	500
CODE LETTER - H						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----			
		COST CENTER	LINE #	SALARY	OTHER
1	1	2	3	4	5
1 DEPRECIATION AND BENEFIT RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		11,158,333 1
2		CAP REL COSTS-MVBLE EQUIP	2		9,297,283 2
3		EMPLOYEE BENEFITS DEPARTMENT	4		47,967,138 3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
500 TOTAL RECLASSIFICATIONS					68,422,754 500
CODE LETTER - I					
1 RECLASS POB SALARIES TO NONWAGE FOR	J	PHYSICIANS' PRIVATE OFFICES	192		12,687 1
2 FOR WAGE INDEX PURPOSES	J				2
500 TOTAL RECLASSIFICATIONS					12,687 500
CODE LETTER - J					
GRAND TOTAL (INCREASES)				1,646,491	114,767,468

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 OPERATING RM SUPPLIES	A	OPERATING ROOM	50		25,267,070	1
2		CARDIOLOGY	76		16,424,022	2
3		RADIOLOGY-DIAGNOSTIC	54		170,449	3
4		ADULTS & PEDIATRICS	30		377,197	4
5		INTENSIVE CARE UNIT	31		136,726	5
6		NEONATAL INTENSIVE CARE	32.01		11,773	6
7		SUBPROVIDER - IRF	41		39,854	7
8		NURSERY	43		12,850	8
9		DELIVERY ROOM & LABOR ROOM	52		83,136	9
10		EMERGENCY	91		94,247	10
500 TOTAL RECLASSIFICATIONS					42,617,324	500
CODE LETTER - A						
1 NURSING FLOAT SALARIES	B	ADULTS & PEDIATRICS	30	319,266		1
2						2
3						3
4						4
5						5
6						6
500 TOTAL RECLASSIFICATIONS				319,266		500
CODE LETTER - B						
1 STOREROOM SALARY RECLASS	C	ADMINISTRATIVE & GENERAL	5	34,001		1
500 TOTAL RECLASSIFICATIONS				34,001		500
CODE LETTER - C						
1 CAFETERIA EXPENSE	D	DIETARY	10	1,293,224	1,421,686	1
500 TOTAL RECLASSIFICATIONS				1,293,224	1,421,686	500
CODE LETTER - D						
1 INTEREST EXPENSE	E	ADMINISTRATIVE & GENERAL	5		2,544	11 1
500 TOTAL RECLASSIFICATIONS					2,544	500
CODE LETTER - E						
1 BUILDING INSURANCE	F	ADMINISTRATIVE & GENERAL	5		368,146	12 1
2						12 2
500 TOTAL RECLASSIFICATIONS					368,146	500
CODE LETTER - F						
1 UTILITY RECLASS	G	HOME HEALTH AGENCY	101		27,697	1
2		ADMINISTRATIVE & GENERAL	5		684,896	2
3		FITNESS POINTE	194.01		244,685	3
4		RADIOLOGY-DIAGNOSTIC	54		62,677	4
5		CLINIC	90		11,310	5
6		RESEARCH	191		2,985	6
7		HOUSEKEEPING	9		28,397	7
8		CARDIAC REHABILITATION	76.97		21,166	8
9		PHYSICAL THERAPY	66		41,818	9
500 TOTAL RECLASSIFICATIONS					1,125,631	500
CODE LETTER - G						
1 ADVERTISING NON-REIMBURSABLE	H	CLINIC	90		2,967	1
2		HOME HEALTH AGENCY	101		6,692	2
3		NURSING ADMINISTRATION	13		6,945	3
4		ADMINISTRATIVE & GENERAL	5		716,695	4
5		MEDICAL RECORDS & LIBRARY	16		336	5
6		ADULTS & PEDIATRICS	30		804	6
7		PHYSICAL THERAPY	66		1,314	7
8		ELECTROENCEPHALOGRAPHY	70		95	8
9		RADIOLOGY-DIAGNOSTIC	54		3,268	9
10		DIETARY	10		11,218	10
11		OPERATING ROOM	50		472	11
12		EMPLOYEE BENEFITS DEPARTMENT	4		9,464	12
13		CARDIOLOGY	76		36,426	13
500 TOTAL RECLASSIFICATIONS					796,696	500
CODE LETTER - H						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 DEPRECIATION AND BENEFIT RECLASS	I	ADMINISTRATIVE & GENERAL	5		67,273,433	9 1
2		OPERATING ROOM	50		2,000	9 2
3		EMPLOYEE BENEFITS DEPARTMENT	4		158,725	3
4		NURSING ADMINISTRATION	13		2,681	4
5		ADULTS & PEDIATRICS	30		6,991	5
6		INTENSIVE CARE UNIT	31		1,795	6
7		PHYSICAL THERAPY	66		114,678	7
8		CARDIAC REHABILITATION	76.97		58,042	8
9		FITNESS POINTE	194.01		798,825	9
10		FITNESS POINTE SPA/PRO SHOP/D	194.02		3,084	10
11		EMERGENCY	91		2,500	11
500 TOTAL RECLASSIFICATIONS					68,422,754	500
CODE LETTER - I						
1 RECLASS POB SALARIES TO NONWAGE FOR	J	PHYSICIANS' PRIVATE OFFICES	192	12,687		1
2 FOR WAGE INDEX PURPOSES	J					2
500 TOTAL RECLASSIFICATIONS				12,687		500
CODE LETTER - J						
GRAND TOTAL (DECREASES)				1,659,178	114,754,781	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND	BALANCE	DEPRECIATED
	1	2	3	4	RETIREMENTS	6	ASSETS
					5		7
1 LAND	2,809,397	247,186		247,186		3,056,583	1
2 LAND IMPROVEMENTS	6,430,338	317,516		317,516		6,747,854	2
3 BUILDINGS AND FIXTURES	233,931,137	37,280,595		37,280,595		271,211,732	3
4 BUILDING IMPROVEMENTS	55,361,386	2,438,688		2,438,688	107,775	57,692,299	4
5 FIXED EQUIPMENT	2,379,122					2,379,122	5
6 MOVABLE EQUIPMENT	119,261,870	6,660,878		6,660,878	1,067,585	124,855,163	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	420,173,250	46,944,863		46,944,863	1,175,360	465,942,753	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	420,173,250	46,944,863		46,944,863	1,175,360	465,942,753	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL(1)
						CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	(SEE INSTR.)	(SEE INSTR.)	14	15
1 CAP REL COSTS-BLDG & FIXT							1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)							3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	RATIOS		INSURANCE	TAXES	OTHER	TOTAL
			FOR RATIO (COL. 1 - COL. 2)	(SEE INSTR.)			CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 5-7)
	1	2	3	4	5	6	7	8
1 CAP REL COSTS-BLDG & FIXT	338,708,468		338,708,468	0.726932				1
2 CAP REL COSTS-MVBLE EQUIP	127,234,285		127,234,285	0.273068				2
3 TOTAL (SUM OF LINES 1-2)	465,942,753		465,942,753	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL(2)
						CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	(SEE INSTR.)	(SEE INSTR.)	14	15
1 CAP REL COSTS-BLDG & FIXT	11,397,202			359,394			11,756,596
2 CAP REL COSTS-MVBLE EQUIP	14,957,675			8,752			14,966,427
3 TOTAL	26,354,877			368,146			26,723,023

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-2,544	CAP REL COSTS-MVBLE EQUIP	2	11 2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-1,369	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	-12,532,001			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-12,154,633			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					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	B	-95	PHARMACY	15	17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-25,158	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					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 OFFSET IHA LOBBYING DUES	A	-6,698	ADMINISTRATIVE & GENERAL	5	33
34 BABY PHOTO INCOME	B	-1,911	NURSERY	43	34
35 A&G OTHER INCOME	B	-161,350	ADMINISTRATIVE & GENERAL	5	35
36					36
37 OFFSET MAMMO FEES	A	-16,320	RADIOLOGY-DIAGNOSTIC	54	37
38 PHYSICIAN RENTAL/X RAY SALES-RA	B	-8,268	RADIOLOGY-DIAGNOSTIC	54	38
39 OFFSET PT OTHER INCOME	B	-450	PHYSICAL THERAPY	66	39
40 PHYSICIAN RENTAL-LAB	B	-145	LABORATORY	60	40
41 REMOVE MEDICAID ASSESSMENT FEES	A	-21,726,295	ADMINISTRATIVE & GENERAL	5	41
42 VARIOUS EH&W OFFSETS	B	-8,419	EMPLOYEE BENEFITS DEPARTMENT	4	42
43 OFFSET HEART SCAN COSTS	A	-1,000	RADIOLOGY-DIAGNOSTIC	54	43
43.02 OFFSET RESEARCH COSTS HEART CTR	A	-191,120	CARDIOLOGY	76	43.02
44 OFFSET BIOTERRORISM GRANT	B	-8,707	ADMINISTRATIVE & GENERAL	5	44
45 MEDICAL RESTRICTED	A	-5,581	ADMINISTRATIVE & GENERAL	5	45
45.01 EMPLOYEE CAFETERIA REVENUE	B	-1,993,224	CAFETERIA	11	45.01
45.03 GUEST TRAYS/CANDLELIGHT DINNERS	B	-590	DIETARY	10	45.03
45.04 TELEPHONE SERVICE	A	-83,339	ADMINISTRATIVE & GENERAL	5	45.04
45.05 TELEPHONE SERVICE	A	-248	CAP REL COSTS-BLDG & FIXT	1	9 45.05
45.06 TELEPHONE SERVICE	A	-21,786	CAP REL COSTS-MVBLE EQUIP	2	9 45.06
45.07 TELEPHONE SERVICE	A	-21,870	EMPLOYEE BENEFITS DEPARTMENT	4	45.07
45.08 TELEVISION SERVICE	A	-52,089	OPERATION OF PLANT	7	45.08
45.09 TELEVISION SERVICE	A	-33,123	CAP REL COSTS-MVBLE EQUIP	2	9 45.09
45.10 PENSION CONTRIBTN EXCESS OF EXP	A	-4,204,761	EMPLOYEE BENEFITS DEPARTMENT	4	45.10
45.11 SERVICE CHGS ON CHECKING	A	-89,846	ADMINISTRATIVE & GENERAL	5	45.11
45.18 RENTAL INCOME	B	-296,646	ADMINISTRATIVE & GENERAL	5	45.18
45.19 CAPITALIZED INTEREST	A	1,589	CAP REL COSTS-BLDG & FIXT	1	9 45.19
45.21 PARETN ASSET DEP AJE	A	-2,672	CAP REL COSTS-BLDG & FIXT	1	9 45.21
45.28 1996 ASSET LIFE ADJUSTMENT	A	6,312	CAP REL COSTS-BLDG & FIXT	1	9 45.28
45.30 OFFSET RELEASED TEMP REST OP IN	B	-176	CARDIOLOGY	76	45.30

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 12/02/2013 15:17

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	
45.33 NON-PT CARE RELATED EXPENSES	A	-10,331	ADMINISTRATIVE & GENERAL	5	45.33
45.37 OTHER DIETARY INCOME	B	-8,558	DIETARY	10	45.37
45.40 OFFSET PHYSICIAN RENTAL	B	-10	CLINIC	90	45.40
46 ELIMINATE REMAINING POB COSTS	A	-12,647	PHYSICIANS' PRIVATE OFFICES	192	46
47 OFFSET CARDIAC REHAB CLASS INCOME	B	-62,705	CARDIAC REHABILITATION	76.97	47
47.01 UTILITIES INCOME	B	-52,761	OPERATION OF PLANT	7	47.01
47.02 MAMMOGRAPHY FEES	B	-14,460	RADIOLOGY-DIAGNOSTIC	54	47.02
47.03 CLEANING SERVICES-PHYSICIANS	B	-52,974	ADMINISTRATIVE & GENERAL	5	47.03
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-53,858,979			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	1	CAP REL COSTS-BLDG & FIXT				
		CFNI CORPORATE ALLOCATION	233,888		233,888	9 1
2	2	CAP REL COSTS-MVBLE EQUIP	5,715,301		5,715,301	9 2
3	5	ADMINISTRATIVE & GENERAL	30,476,812	39,044,818	-8,568,006	3
3.02	5	ADMINISTRATIVE & GENERAL		9,489,724	-9,489,724	4.02
		CCN				
3.04	5	ADMINISTRATIVE & GENERAL		75,026	-75,026	4.04
3.05	7	OPERATION OF PLANT		25,344	-25,344	4.05
3.06	54	RADIOLOGY-DIAGNOSTIC		126,552	-126,552	4.06
3.07	60	LABORATORY		11,800	-11,800	4.07
3.08	90	CLINIC		12,851	-12,851	4.08
3.09	76	CARDIOLOGY		10,146	-10,146	4.09
3.10	5	ADMINISTRATIVE & GENERAL	65,999		65,999	4.10
3.11	7	OPERATION OF PLANT	20,649		20,649	4.11
3.12	54	RADIOLOGY-DIAGNOSTIC	100,384		100,384	4.12
3.13	76	CARDIOLOGY	3,054		3,054	4.13
3.14	90	CLINIC	15,959		15,959	4.14
3.15	60	LABORATORY	9,582		9,582	4.15
4						4
5		TOTALS (SUM OF LINES 1-4)	36,641,628	48,796,261	-12,154,633	5
		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	PERCENT OF OWNERSHIP		RELATED ORGANIZATION(S) AND/OR HOME OFFICE		TYPE OF BUSINESS
		3	4	5	6	
6	B	100.00	CFNI		PARENT	6
7						7
8						8
9						9
10						10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE NO.	1	2	3	4	5	6	7	8	9	
1	5	ADMINISTRATIVE & GENERAL	329,863	68,395	261,468	171,400	2,374	195,627	9,781	1
2	32.01	NEONATAL INTENSIVE CARE	50,417	50,417		171,400				2
3	54	RADIOLOGY-DIAGNOSTIC	45,833	22,917	22,916	231,100	107	11,888	594	3
4	50	OPERATING ROOM	11,437,860	11,437,860						4
5	60	LABORATORY	22,917		22,917	219,500	149	15,724	786	5
6	65	RESPIRATORY THERAPY	29,200		29,200	171,400	389	32,055	1,603	6
7	76	CARDIOLOGY	847,280	558,330	288,950	171,400	1,325	109,185	5,459	7
8	54	RADIOLOGY-DIAGNOSTIC								8
9	30	ADULTS & PEDIATRICS								9
10	30	ADULTS & PEDIATRICS								10
11	90	CLINIC	2,666	2,666		171,400				11
12	70	ELECTROENCEPHALOGRAPHY	49,333	5,058	44,275	171,400	253	20,848	1,042	12
13	91	EMERGENCY	98,157		98,157	171,400	677	55,787	2,789	13
14	30	ADULTS & PEDIATRICS	86,317	3,134	83,183	171,400	359	29,583	1,479	14
15	50	OPERATING ROOM								15
200		TOTAL	12,999,843	12,148,777	851,066		5,633	470,697	23,533	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11		12	13	14	15	16	17	18	
1	5	ADMINISTRATIVE & GENERAL	AGGREGATE				195,627	65,841	134,236	1
2	32.01	NEONATAL INTENSIVE CARE	AGGREGATE						50,417	2
3	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE				11,888	11,028	33,945	3
4	50	OPERATING ROOM	ANESTHESIA						11,437,860	4
5	60	LABORATORY	AGGREGATE				15,724	7,193	7,193	5
6	65	RESPIRATORY THERAPY	AGGREGATE				32,055			6
7	76	CARDIOLOGY	AGGREGATE				109,185	179,765	738,095	7
8	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE							8
9	30	ADULTS & PEDIATRICS	AGGREGATE							9
10	30	ADULTS & PEDIATRICS	AGGREGATE							10
11	90	CLINIC	AGGREGATE						2,666	11
12	70	ELECTROENCEPHALOGRAPHY	AGGREGATE				20,848	23,427	28,485	12
13	91	EMERGENCY	AGGREGATE				55,787	42,370	42,370	13
14	30	ADULTS & PEDIATRICS	AGGREGATE				29,583	53,600	56,734	14
15	50	OPERATING ROOM	AGGREGATE							15
200		TOTAL					470,697	383,224	12,532,001	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 DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	11,756,596	11,756,596				1
2 CAP REL COSTS-MVBLE EQUIP	14,966,427		14,966,427			2
4 EMPLOYEE BENEFITS DEPARTMENT	44,851,675	38,633	13,461	44,903,769		4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	52,303,632	2,950,848	718,918	4,337,165	60,310,563	5
7 OPERATION OF PLANT	12,818,503	1,438,903	311,258	1,344,917	15,913,581	7
8 LAUNDRY & LINEN SERVICE	1,363,565	15,056		42,362	1,420,983	8
9 HOUSEKEEPING	4,133,977	45,134	47,282	963,872	5,190,265	9
10 DIETARY	3,800,379	128,122	55,612	680,248	4,664,361	10
11 CAFETERIA	721,686	134,759	52,309	380,929	1,289,683	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,763,364	18,792	476,060	479,848	2,738,064	13
14 CENTRAL SERVICES & SUPPLY	183,953			10,015	193,968	14
15 PHARMACY	17,084,067	51,669	411,623	1,174,971	18,722,330	15
16 MEDICAL RECORDS & LIBRARY	4,509,512	94,410	5,022	924,296	5,533,240	16
17 SOCIAL SERVICE	726,323	21,929	1,836	209,715	959,803	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	37,566,420	1,747,233	820,205	9,767,471	49,901,329	30
31 INTENSIVE CARE UNIT	9,076,713	247,497	649,843	2,404,767	12,378,820	31
32.01 NEONATAL INTENSIVE CARE	2,748,509	67,300	170,493	754,472	3,740,774	32.01
41 SUBPROVIDER - IRF	5,511,787	289,133	41,699	1,112,886	6,955,505	41
43 NURSERY	1,797,307	25,812	6,561	461,163	2,290,843	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	26,131,612	752,345	3,104,615	6,991,816	36,980,388	50
52 DELIVERY ROOM & LABOR ROOM	2,228,963	141,090	193,942	589,745	3,153,740	52
54 RADIOLOGY-DIAGNOSTIC	14,517,541	478,506	4,151,176	2,221,771	21,368,994	54
60 LABORATORY	11,218,529	227,239	525,166	1,631,967	13,602,901	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	3,175,904	17,065	44,377	114,865	3,352,211	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	4,022,336	39,976	221,082	1,004,112	5,287,506	65
66 PHYSICAL THERAPY	8,254,843	408,734	96,400	1,322,666	10,082,643	66
70 ELECTROENCEPHALOGRAPHY	910,118	26,749	166,263	182,261	1,285,391	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,080,954				16,080,954	71
72 IMPL. DEV. CHARGED TO PATIENTS	26,536,370				26,536,370	72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 CARDIOLOGY	10,355,639	424,218	1,751,232	1,979,209	14,510,298	76
76.97 CARDIAC REHABILITATION	331,284	26,918	5,521	132,057	495,780	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,204,622	84,580	14,661	498,029	2,801,892	90
91 EMERGENCY	7,717,713	355,665	665,051	1,839,004	10,577,433	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	3,299,322	40,349	22,912	596,063	3,958,646	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	364,670,145	10,338,664	14,744,580	44,152,662	362,279,259	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		25,507			25,507	190
191 RESEARCH	396,290		341	80,365	476,996	191
192 PHYSICIANS' PRIVATE OFFICES		739,456			739,456	192
194 ADVERTISING	796,696				796,696	194
194.01 FITNESS POINTE	2,538,148	538,041	178,021	458,728	3,712,938	194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY	410,270	18,577	6,216	91,286	526,349	194.02
194.03 RETAIL PHARMACY	4,144,914	16,636	37,269	120,728	4,319,547	194.03
194.04 HOSPICE		79,715			79,715	194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	372,956,463	11,756,596	14,966,427	44,903,769	372,956,463	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	60,310,563					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	3,069,793	18,983,374				7
8 LAUNDRY & LINEN SERVICE	274,113	39,002	1,734,098			8
9 HOUSEKEEPING	1,001,223	116,917		6,308,405		9
10 DIETARY	899,774	331,894	377	8,488	5,904,894	10
11 CAFETERIA	248,785	349,085		29,494		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	528,183	48,679		1,756		13
14 CENTRAL SERVICES & SUPPLY	37,417					14
15 PHARMACY	3,611,612	133,845		16,502		15
16 MEDICAL RECORDS & LIBRARY	1,067,384	244,564		65,659		16
17 SOCIAL SERVICE	185,150	56,807		14,747		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	9,626,086	4,526,125	602,950	1,864,733	4,621,271	30
31 INTENSIVE CARE UNIT	2,387,924	641,130	91,052	339,740	413,246	31
32.01 NEONATAL INTENSIVE CARE	721,610	174,338	5,768	82,029		32.01
41 SUBPROVIDER - IRF	1,341,745	748,984	97,642	295,499	790,977	41
43 NURSERY	441,913	66,864	6,392	74,761		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,133,665	1,948,914	285,514	1,330,344		50
52 DELIVERY ROOM & LABOR ROOM	608,369	365,487	54,567	244,702	79,400	52
54 RADIOLOGY-DIAGNOSTIC	4,122,164	1,239,545	82,639	190,006		54
60 LABORATORY	2,624,054	588,650		118,677		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	646,655	44,206				62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,019,981	103,556	6,217	15,748		65
66 PHYSICAL THERAPY	1,944,982	1,058,805	46,405	83,276		66
70 ELECTROENCEPHALOGRAPHY	247,957	69,291	17,752	13,465		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,102,080					71
72 IMPL. DEV. CHARGED TO PATIENTS	5,118,972					72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 CARDIOLOGY	2,799,095	1,098,917	123,069	394,575		76
76.97 CARDIAC REHABILITATION	95,638	69,729	998			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	540,496	219,099	31,948	26,887		90
91 EMERGENCY	2,040,429	921,334	149,078	816,020		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	763,639	104,521		10,533		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	58,250,888	15,310,288	1,602,368	6,037,641	5,904,894	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,920	66,075				190
191 RESEARCH	92,014					191
192 PHYSICIANS' PRIVATE OFFICES	142,644	1,915,526	2,977	250,118		192
194 ADVERTISING	153,686					194
194.01 FITNESS POINTE	716,241	1,393,769	128,753	20,646		194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY	101,535	48,123				194.02
194.03 RETAIL PHARMACY	833,258	43,095				194.03
194.04 HOSPICE	15,377	206,498				194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	60,310,563	18,983,374	1,734,098	6,308,405	5,904,894	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	1,917,047					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	18,412	3,335,094				13
14 CENTRAL SERVICES & SUPPLY	1,115		232,500			14
15 PHARMACY	52,470			22,536,759		15
16 MEDICAL RECORDS & LIBRARY	76,547				6,987,394	16
17 SOCIAL SERVICE	12,697					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	612,650	1,556,055			623,435	30
31 INTENSIVE CARE UNIT	128,095	325,350			100,607	31
32.01 NEONATAL INTENSIVE CARE	36,723	93,273			47,465	32.01
41 SUBPROVIDER - IRF	75,878	192,722			62,640	41
43 NURSERY	25,901	65,774			18,616	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	262,807	667,495			922,872	50
52 DELIVERY ROOM & LABOR ROOM	32,264	81,937			39,941	52
54 RADIOLOGY-DIAGNOSTIC	85,870				1,303,672	54
60 LABORATORY	97,401				897,480	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	5,391				60,999	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	50,048				178,909	65
66 PHYSICAL THERAPY	42,377				238,988	66
70 ELECTROENCEPHALOGRAPHY	3,820				52,367	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			232,500		270,365	71
72 IMPL. DEV. CHARGED TO PATIENTS					346,544	72
73 DRUGS CHARGED TO PATIENTS				22,536,759	586,575	73
74 RENAL DIALYSIS						74
76 CARDIOLOGY	97,847				688,493	76
76.97 CARDIAC REHABILITATION	7,164				9,506	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	24,958	48,358			33,003	90
91 EMERGENCY	119,745	304,130			466,938	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	36,085				37,979	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,906,265	3,335,094	232,500	22,536,759	6,987,394	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
191 RESEARCH	4,550					191
192 PHYSICIANS' PRIVATE OFFICES						192
194 ADVERTISING						194
194.01 FITNESS POINTE						194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03 RETAIL PHARMACY	6,232					194.03
194.04 HOSPICE						194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,917,047	3,335,094	232,500	22,536,759	6,987,394	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	1,229,204				17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES APPRVD					21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	1,086,352	75,020,986		75,020,986	30
31 INTENSIVE CARE UNIT	95,622	16,901,586		16,901,586	31
32.01 NEONATAL INTENSIVE CARE		4,901,980		4,901,980	32.01
41 SUBPROVIDER - IRF		10,561,592		10,561,592	41
43 NURSERY	469	2,991,533		2,991,533	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1,875	49,533,874		49,533,874	50
52 DELIVERY ROOM & LABOR ROOM	937	4,661,344		4,661,344	52
54 RADIOLOGY-DIAGNOSTIC		28,392,890		28,392,890	54
60 LABORATORY		17,929,163		17,929,163	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		4,109,462		4,109,462	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		6,661,965		6,661,965	65
66 PHYSICAL THERAPY		13,497,476		13,497,476	66
70 ELECTROENCEPHALOGRAPHY		1,690,043		1,690,043	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		19,685,899		19,685,899	71
72 IMPL. DEV. CHARGED TO PATIENTS		32,001,886		32,001,886	72
73 DRUGS CHARGED TO PATIENTS		23,123,334		23,123,334	73
74 RENAL DIALYSIS					74
76 CARDIOLOGY		19,712,294		19,712,294	76
76.97 CARDIAC REHABILITATION		678,815		678,815	76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		3,726,641		3,726,641	90
91 EMERGENCY	43,949	15,439,056		15,439,056	91
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
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		4,911,403		4,911,403	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	1,229,204	356,133,222		356,133,222	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		96,502		96,502	190
191 RESEARCH		573,560		573,560	191
192 PHYSICIANS' PRIVATE OFFICES		3,050,721		3,050,721	192
194 ADVERTISING		950,382		950,382	194
194.01 FITNESS POINTE		5,972,347		5,972,347	194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY		676,007		676,007	194.02
194.03 RETAIL PHARMACY		5,202,132		5,202,132	194.03
194.04 HOSPICE		301,590		301,590	194.04
194.05 RUSH RESIDENTS					194.05
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	1,229,204	372,956,463		372,956,463	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 DEPARTMENT 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT	23,400	38,633	13,461	75,494	75,494	4
5 ADMINISTRATIVE & GENERAL	184,730	2,950,848	718,918	3,854,496	7,289	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	4,294	1,438,903	311,258	1,754,455	2,260	7
8 LAUNDRY & LINEN SERVICE		15,056		15,056	71	8
9 HOUSEKEEPING	6,501	45,134	47,282	98,917	1,620	9
10 DIETARY	5,129	128,122	55,612	188,863	1,143	10
11 CAFETERIA		134,759	52,309	187,068	640	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,353	18,792	476,060	496,205	806	13
14 CENTRAL SERVICES & SUPPLY	131,907			131,907	17	14
15 PHARMACY	17,511	51,669	411,623	480,803	1,975	15
16 MEDICAL RECORDS & LIBRARY	243,696	94,410	5,022	343,128	1,553	16
17 SOCIAL SERVICE	1,037	21,929	1,836	24,802	352	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	146,894	1,747,233	820,205	2,714,332	16,449	30
31 INTENSIVE CARE UNIT	60,867	247,497	649,843	958,207	4,041	31
32.01 NEONATAL INTENSIVE CARE	180	67,300	170,493	237,973	1,268	32.01
41 SUBPROVIDER - IRF	11,238	289,133	41,699	342,070	1,870	41
43 NURSERY	95	25,812	6,561	32,468	775	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,098,889	752,345	3,104,615	4,955,849	11,750	50
52 DELIVERY ROOM & LABOR ROOM	95	141,090	193,942	335,127	991	52
54 RADIOLOGY-DIAGNOSTIC	608,626	478,506	4,151,176	5,238,308	3,734	54
60 LABORATORY		227,239	525,166	752,405	2,742	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		17,065	44,377	61,442	193	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	17,378	39,976	221,082	278,436	1,687	65
66 PHYSICAL THERAPY	13,180	408,734	96,400	518,314	2,223	66
70 ELECTROENCEPHALOGRAPHY	193,901	26,749	166,263	386,913	306	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 CARDIOLOGY	1,532,577	424,218	1,751,232	3,708,027	3,326	76
76.97 CARDIAC REHABILITATION		26,918	5,521	32,439	222	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	51,624	84,580	14,661	150,865	837	90
91 EMERGENCY	2,416	355,665	665,051	1,023,132	3,090	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	423	40,349	22,912	63,684	1,002	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	4,357,941	10,338,664	14,744,580	29,441,185	74,232	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		25,507		25,507		190
191 RESEARCH	942		341	1,283	135	191
192 PHYSICIANS' PRIVATE OFFICES		739,456		739,456		192
194 ADVERTISING						194
194.01 FITNESS POINTE	86	538,041	178,021	716,148	771	194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY		18,577	6,216	24,793	153	194.02
194.03 RETAIL PHARMACY		16,636	37,269	53,905	203	194.03
194.04 HOSPICE		79,715		79,715		194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,358,969	11,756,596	14,966,427	31,081,992	75,494	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	3,861,785					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	196,565	1,953,280				7
8 LAUNDRY & LINEN SERVICE	17,552	4,013	36,692			8
9 HOUSEKEEPING	64,110	12,030		176,677		9
10 DIETARY	57,614	34,150		238	282,016	10
11 CAFETERIA	15,930	35,919		826		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	33,821	5,009		49		13
14 CENTRAL SERVICES & SUPPLY	2,396					14
15 PHARMACY	231,258	13,772		462		15
16 MEDICAL RECORDS & LIBRARY	68,347	25,164		1,839		16
17 SOCIAL SERVICE	11,855	5,845		413		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	616,365	465,710	12,757	52,226	220,710	30
31 INTENSIVE CARE UNIT	152,903	65,969	1,927	9,515	19,737	31
32.01 NEONATAL INTENSIVE CARE	46,206	17,938	122	2,297		32.01
41 SUBPROVIDER - IRF	85,914	77,066	2,066	8,276	37,777	41
43 NURSERY	28,296	6,880	135	2,094		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	456,782	200,532	6,041	37,258		50
52 DELIVERY ROOM & LABOR ROOM	38,955	37,607	1,155	6,853	3,792	52
54 RADIOLOGY-DIAGNOSTIC	263,950	127,542	1,749	5,321		54
60 LABORATORY	168,023	60,569		3,324		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	41,407	4,549				62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	65,311	10,655	132	441		65
66 PHYSICAL THERAPY	124,541	108,945	982	2,332		66
70 ELECTROENCEPHALOGRAPHY	15,877	7,130	376	377		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	198,632					71
72 IMPL. DEV. CHARGED TO PATIENTS	327,777					72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 CARDIOLOGY	179,231	113,072	2,604	11,051		76
76.97 CARDIAC REHABILITATION	6,124	7,175	21			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	34,609	22,544	676	753		90
91 EMERGENCY	130,652	94,800	3,154	22,854		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	48,897	10,755		295		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	3,729,900	1,575,340	33,905	169,094	282,016	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	6,799				190
191 RESEARCH	5,892					191
192 PHYSICIANS' PRIVATE OFFICES	9,134	197,097	63	7,005		192
194 ADVERTISING	9,841					194
194.01 FITNESS POINTE	45,862	143,411	2,724	578		194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY	6,501	4,952				194.02
194.03 RETAIL PHARMACY	53,355	4,434				194.03
194.04 HOSPICE	985	21,247				194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	3,861,785	1,953,280	36,692	176,677	282,016	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	240,383					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,309	538,199				13
14 CENTRAL SERVICES & SUPPLY	140		134,460			14
15 PHARMACY	6,579			734,849		15
16 MEDICAL RECORDS & LIBRARY	9,598				449,629	16
17 SOCIAL SERVICE	1,592					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	76,821	251,107			40,132	30
31 INTENSIVE CARE UNIT	16,062	52,503			6,476	31
32.01 NEONATAL INTENSIVE CARE	4,605	15,052			3,055	32.01
41 SUBPROVIDER - IRF	9,515	31,100			4,032	41
43 NURSERY	3,248	10,614			1,198	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	32,954	107,717			59,407	50
52 DELIVERY ROOM & LABOR ROOM	4,046	13,223			2,571	52
54 RADIOLOGY-DIAGNOSTIC	10,767				83,756	54
60 LABORATORY	12,213				57,773	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	676				3,927	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	6,276				11,517	65
66 PHYSICAL THERAPY	5,314				15,384	66
70 ELECTROENCEPHALOGRAPHY	479				3,371	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			134,460		17,404	71
72 IMPL. DEV. CHARGED TO PATIENTS					22,308	72
73 DRUGS CHARGED TO PATIENTS				734,849	37,759	73
74 RENAL DIALYSIS						74
76 CARDIOLOGY	12,269				44,320	76
76.97 CARDIAC REHABILITATION	898				612	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,130	7,804			2,124	90
91 EMERGENCY	15,015	49,079			30,058	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	4,525				2,445	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	239,031	538,199	134,460	734,849	449,629	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
191 RESEARCH	571					191
192 PHYSICIANS' PRIVATE OFFICES						192
194 ADVERTISING						194
194.01 FITNESS POINTE						194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03 RETAIL PHARMACY	781					194.03
194.04 HOSPICE						194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	240,383	538,199	134,460	734,849	449,629	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	44,859				17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES APPRVD					21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	39,646	4,506,255		4,506,255	30
31 INTENSIVE CARE UNIT	3,490	1,290,830		1,290,830	31
32.01 NEONATAL INTENSIVE CARE		328,516		328,516	32.01
41 SUBPROVIDER - IRF		599,686		599,686	41
43 NURSERY	17	85,725		85,725	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	68	5,868,358		5,868,358	50
52 DELIVERY ROOM & LABOR ROOM	34	444,354		444,354	52
54 RADIOLOGY-DIAGNOSTIC		5,735,127		5,735,127	54
60 LABORATORY		1,057,049		1,057,049	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		112,194		112,194	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		374,455		374,455	65
66 PHYSICAL THERAPY		778,035		778,035	66
70 ELECTROENCEPHALOGRAPHY		414,829		414,829	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		350,496		350,496	71
72 IMPL. DEV. CHARGED TO PATIENTS		350,085		350,085	72
73 DRUGS CHARGED TO PATIENTS		772,608		772,608	73
74 RENAL DIALYSIS					74
76 CARDIOLOGY		4,073,900		4,073,900	76
76.97 CARDIAC REHABILITATION		47,491		47,491	76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		223,342		223,342	90
91 EMERGENCY	1,604	1,373,438		1,373,438	91
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
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		131,603		131,603	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	44,859	28,918,376		28,918,376	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		32,621		32,621	190
191 RESEARCH		7,881		7,881	191
192 PHYSICIANS' PRIVATE OFFICES		952,755		952,755	192
194 ADVERTISING		9,841		9,841	194
194.01 FITNESS POINTE		909,494		909,494	194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY		36,399		36,399	194.02
194.03 RETAIL PHARMACY		112,678		112,678	194.03
194.04 HOSPICE		101,947		101,947	194.04
194.05 RUSH RESIDENTS					194.05
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	44,859	31,081,992		31,081,992	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES NEW- SQ FT 1	CAP MOVABLE EQUIPMENT NEW- \$ VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,041,669					1
2 CAP REL COSTS-MVBLE EQUIP		9,270,441				2
4 EMPLOYEE BENEFITS DEPARTMENT	3,423	8,338	152,444,762			4
5 ADMINISTRATIVE & GENERAL	261,454	445,309	14,724,317	-60,310,563	312,645,900	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	127,491	192,798	4,565,883		15,913,581	7
8 LAUNDRY & LINEN SERVICE	1,334		143,816		1,420,983	8
9 HOUSEKEEPING	3,999	29,287	3,272,267		5,190,265	9
10 DIETARY	11,352	34,447	2,309,387		4,664,361	10
11 CAFETERIA	11,940	32,401	1,293,224		1,289,683	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,665	294,879	1,629,043		2,738,064	13
14 CENTRAL SERVICES & SUPPLY			34,001		193,968	14
15 PHARMACY	4,578	254,966	3,988,928		18,722,330	15
16 MEDICAL RECORDS & LIBRARY	8,365	3,111	3,137,909		5,533,240	16
17 SOCIAL SERVICE	1,943	1,137	711,965		959,803	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	154,810	508,048	33,159,936		49,901,329	30
31 INTENSIVE CARE UNIT	21,929	402,523	8,163,985		12,378,820	31
32.01 NEONATAL INTENSIVE CARE	5,963	105,606	2,561,369		3,740,774	32.01
41 SUBPROVIDER - IRF	25,618	25,829	3,778,155		6,955,505	41
43 NURSERY	2,287	4,064	1,565,611		2,290,843	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	66,660	1,923,048	23,736,636		36,980,388	50
52 DELIVERY ROOM & LABOR ROOM	12,501	120,131	2,002,136		3,153,740	52
54 RADIOLOGY-DIAGNOSTIC	42,397	2,571,303	7,542,728		21,368,994	54
60 LABORATORY	20,134	325,296	5,540,392		13,602,901	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,512	27,488	389,958		3,352,211	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,542	136,942	3,408,877		5,287,506	65
66 PHYSICAL THERAPY	36,215	59,712	4,490,340		10,082,643	66
70 ELECTROENCEPHALOGRAPHY	2,370	102,986	618,760		1,285,391	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS					16,080,954	71
72 IMPL. DEV. CHARGED TO PATIENTS					26,536,370	72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 CARDIOLOGY	37,587	1,084,741	6,719,250		14,510,298	76
76.97 CARDIAC REHABILITATION	2,385	3,420	448,324		495,780	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	7,494	9,081	1,690,767		2,801,892	90
91 EMERGENCY	31,513	411,943	6,243,266		10,577,433	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	3,575	14,192	2,023,583		3,958,646	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	916,036	9,133,026	149,894,813	-60,310,563	301,968,696	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,260				25,507	190
191 RESEARCH		211	272,833		476,996	191
192 PHYSICIANS' PRIVATE OFFICES	65,518				739,456	192
194 ADVERTISING					796,696	194
194.01 FITNESS POINTE	47,672	110,269	1,557,343		3,712,938	194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY	1,646	3,850	309,910		526,349	194.02
194.03 RETAIL PHARMACY	1,474	23,085	409,863		4,319,547	194.03
194.04 HOSPICE	7,063				79,715	194.04
194.05 RUSH RESIDENTS						194.05

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KPMG LLP COMPU-MAX MICRO SYSTEM
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES NEW- SQ FT 1	CAP MOVABLE EQUIPMENT NEW- \$ VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	11,756,596	14,966,427	44,903,769		60,310,563	202
203	UNIT COST MULT-WS B PT I	11.286307	1.614424	0.294558		0.192904	203
204	COST TO BE ALLOC PER B PT II			75,494		3,861,785	204
205	UNIT COST MULT-WS B PT II			0.000495		0.012352	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE POUNDS	HOUSE-KEEPING TIME SPENT	DIETARY PATIENT MEALS	CAFETERIA FTES	
	SQUARE FEET					
	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	649,301					7
8 LAUNDRY & LINEN SERVICE	1,334	3,925,450				8
9 HOUSEKEEPING	3,999		718,669			9
10 DIETARY	11,352	853	967	333,692		10
11 CAFETERIA	11,940		3,360		189,183	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,665		200		1,817	13
14 CENTRAL SERVICES & SUPPLY					110	14
15 PHARMACY	4,578		1,880		5,178	15
16 MEDICAL RECORDS & LIBRARY	8,365		7,480		7,554	16
17 SOCIAL SERVICE	1,943		1,680		1,253	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	154,810	1,364,894	212,435	261,153	60,459	30
31 INTENSIVE CARE UNIT	21,929	206,113	38,704	23,353	12,641	31
32.01 NEONATAL INTENSIVE CARE	5,963	13,056	9,345		3,624	32.01
41 SUBPROVIDER - IRF	25,618	221,030	33,664	44,699	7,488	41
43 NURSERY	2,287	14,469	8,517		2,556	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	66,660	646,314	151,556		25,935	50
52 DELIVERY ROOM & LABOR ROOM	12,501	123,522	27,877	4,487	3,184	52
54 RADIOLOGY-DIAGNOSTIC	42,397	187,068	21,646		8,474	54
60 LABORATORY	20,134		13,520		9,612	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,512				532	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,542	14,074	1,794		4,939	65
66 PHYSICAL THERAPY	36,215	105,047	9,487		4,182	66
70 ELECTROENCEPHALOGRAPHY	2,370	40,184	1,534		377	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 CARDIOLOGY	37,587	278,589	44,951		9,656	76
76.97 CARDIAC REHABILITATION	2,385	2,259			707	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	7,494	72,320	3,063		2,463	90
91 EMERGENCY	31,513	337,465	92,963		11,817	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	3,575		1,200		3,561	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	523,668	3,627,257	687,823	333,692	188,119	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,260					190
191 RESEARCH					449	191
192 PHYSICIANS' PRIVATE OFFICES	65,518	6,738	28,494			192
194 ADVERTISING						194
194.01 FITNESS POINTE	47,672	291,455	2,352			194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY	1,646					194.02
194.03 RETAIL PHARMACY	1,474				615	194.03
194.04 HOSPICE	7,063					194.04
194.05 RUSH RESIDENTS						194.05

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS	TIME SPENT	PATIENT ME ALS	FTES	
		7	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	18,983,374	1,734,098	6,308,405	5,904,894	1,917,047	202
203	UNIT COST MULT-WS B PT I	29.236631	0.441758	8.777901	17.695641	10.133294	203
204	COST TO BE ALLOC PER B PT II	1,953,280	36,692	176,677	282,016	240,383	204
205	UNIT COST MULT-WS B PT II	3.008281	0.009347	0.245839	0.845139	1.270637	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING HO URS	CENTRAL SERVICES & SUPPLY COSTED REQ	PHARMACY COSTED REQ	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	
	13	14	15	16	17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,695,281					13
14 CENTRAL SERVICES & SUPPLY		100				14
15 PHARMACY			10,000			15
16 MEDICAL RECORDS & LIBRARY				1,156,330,508		16
17 SOCIAL SERVICE					131,119	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,257,537			103,166,475	115,881	30
31 INTENSIVE CARE UNIT	262,934			16,648,579	10,200	31
32.01 NEONATAL INTENSIVE CARE	75,379			7,854,473		32.01
41 SUBPROVIDER - IRF	155,750			10,365,728		41
43 NURSERY	53,156			3,080,581	50	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	539,441			152,717,523	200	50
52 DELIVERY ROOM & LABOR ROOM	66,218			6,609,417	100	52
54 RADIOLOGY-DIAGNOSTIC				215,784,352		54
60 LABORATORY				148,515,562		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				10,094,099		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY				29,606,048		65
66 PHYSICAL THERAPY				39,547,837		66
70 ELECTROENCEPHALOGRAPHY				8,665,736		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		100		44,740,152		71
72 IMPL. DEV. CHARGED TO PATIENTS				57,346,413		72
73 DRUGS CHARGED TO PATIENTS			10,000	97,066,870		73
74 RENAL DIALYSIS						74
76 CARDIOLOGY				113,932,350		76
76.97 CARDIAC REHABILITATION				1,573,050		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	39,081			5,461,287		90
91 EMERGENCY	245,785			77,269,217	4,688	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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				6,284,759		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	2,695,281	100	10,000	1,156,330,508	131,119	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
191 RESEARCH						191
192 PHYSICIANS' PRIVATE OFFICES						192
194 ADVERTISING						194
194.01 FITNESS POINTE						194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03 RETAIL PHARMACY						194.03
194.04 HOSPICE						194.04
194.05 RUSH RESIDENTS						194.05

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NURSING ADMINIS- TRATION NURSING HO URS 13	CENTRAL SERVICES & SUPPLY COSTED REQ 14	PHARMACY COSTED REQ 15	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	3,335,094	232,500	22,536,759	6,987,394	1,229,204	202
203	UNIT COST MULT-WS B PT I	1.237383	2,325.000000	2,253.675900	0.006043	9.374721	203
204	COST TO BE ALLOC PER B PT II	538,199	134,460	734,849	449,629	44,859	204
205	UNIT COST MULT-WS B PT II	0.199682	1,344.600000	73.484900	0.000389	0.342124	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT	1
2	CAP REL COSTS-MVBLE EQUIP	2
4	EMPLOYEE BENEFITS DEPARTMENT	4
5	ADMINISTRATIVE & GENERAL	5
6	MAINTENANCE & REPAIRS	6
7	OPERATION OF PLANT	7
8	LAUNDRY & LINEN SERVICE	8
9	HOUSEKEEPING	9
10	DIETARY	10
11	CAFETERIA	11
12	MAINTENANCE OF PERSONNEL	12
13	NURSING ADMINISTRATION	13
14	CENTRAL SERVICES & SUPPLY	14
15	PHARMACY	15
16	MEDICAL RECORDS & LIBRARY	16
17	SOCIAL SERVICE	17
19	NONPHYSICIAN ANESTHETISTS	19
20	NURSING SCHOOL	20
21	I&R SERVICES-SALARY & FRINGES APPRVD	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS	30
31	INTENSIVE CARE UNIT	31
32.01	NEONATAL INTENSIVE CARE	32.01
41	SUBPROVIDER - IRF	41
43	NURSERY	43
ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	50
52	DELIVERY ROOM & LABOR ROOM	52
54	RADIOLOGY-DIAGNOSTIC	54
60	LABORATORY	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65	RESPIRATORY THERAPY	65
66	PHYSICAL THERAPY	66
70	ELECTROENCEPHALOGRAPHY	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	71
72	IMPL. DEV. CHARGED TO PATIENTS	72
73	DRUGS CHARGED TO PATIENTS	73
74	RENAL DIALYSIS	74
76	CARDIOLOGY	76
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS		
90	CLINIC	90
91	EMERGENCY	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	92
OTHER REIMBURSABLE COST CENTERS		
94	HOME PROGRAM DIALYSIS	94
99.10	CORF	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	99.40
101	HOME HEALTH AGENCY	101
SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	118
NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190
191	RESEARCH	191
192	PHYSICIANS' PRIVATE OFFICES	192
194	ADVERTISING	194
194.01	FITNESS POINTE	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	194.02
194.03	RETAIL PHARMACY	194.03
194.04	HOSPICE	194.04
194.05	RUSH RESIDENTS	194.05

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

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

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	75,020,986		75,020,986	53,600	75,074,586	30
31 INTENSIVE CARE UNIT	16,901,586		16,901,586		16,901,586	31
32.01 NEONATAL INTENSIVE CARE	4,901,980		4,901,980		4,901,980	32.01
41 SUBPROVIDER - IRF	10,561,592		10,561,592		10,561,592	41
43 NURSERY	2,991,533		2,991,533		2,991,533	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	49,533,874		49,533,874		49,533,874	50
52 DELIVERY ROOM & LABOR ROOM	4,661,344		4,661,344		4,661,344	52
54 RADIOLOGY-DIAGNOSTIC	28,392,890		28,392,890	11,028	28,403,918	54
60 LABORATORY	17,929,163		17,929,163	7,193	17,936,356	60
62 WHOLE BLOOD & PACKED RED BL	4,109,462		4,109,462		4,109,462	62
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	6,661,965		6,661,965		6,661,965	65
66 PHYSICAL THERAPY	13,497,476		13,497,476		13,497,476	66
70 ELECTROENCEPHALOGRAPHY	1,690,043		1,690,043	23,427	1,713,470	70
71 MEDICAL SUPPLIES CHARGED TO	19,685,899		19,685,899		19,685,899	71
72 IMPL. DEV. CHARGED TO PATIE	32,001,886		32,001,886		32,001,886	72
73 DRUGS CHARGED TO PATIENTS	23,123,334		23,123,334		23,123,334	73
74 RENAL DIALYSIS						74
76 CARDIOLOGY	19,712,294		19,712,294	179,765	19,892,059	76
76.97 CARDIAC REHABILITATION	678,815		678,815		678,815	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,726,641		3,726,641		3,726,641	90
91 EMERGENCY	15,439,056		15,439,056	42,370	15,481,426	91
92 OBSERVATION BEDS (NON-DISTI	8,004,322		8,004,322		8,004,322	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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	4,911,403		4,911,403		4,911,403	101
200 SUBTOTAL (SEE INSTRUCTIONS)	364,137,544		364,137,544	317,383	364,454,927	200
201 LESS OBSERVATION BEDS	8,004,322		8,004,322		8,004,322	201
202 TOTAL (SEE INSTRUCTIONS)	356,133,222		356,133,222		356,450,605	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	85,087,422		85,087,422			30
31 INTENSIVE CARE UNIT	16,648,579		16,648,579			31
32.01 NEONATAL INTENSIVE CARE	7,854,473		7,854,473			32.01
41 SUBPROVIDER - IRF	10,365,728		10,365,728			41
43 NURSERY	3,080,581		3,080,581			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	65,256,494	87,461,029	152,717,523	0.324350	0.324350	0.324350 50
52 DELIVERY ROOM & LABOR ROOM	4,825,302	1,784,115	6,609,417	0.705258	0.705258	0.705258 52
54 RADIOLOGY-DIAGNOSTIC	59,002,702	156,781,650	215,784,352	0.131580	0.131580	0.131631 54
60 LABORATORY	65,603,470	82,912,092	148,515,562	0.120722	0.120722	0.120771 60
62 WHOLE BLOOD & PACKED RED BL	7,476,197	2,617,902	10,094,099	0.407115	0.407115	0.407115 62
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	27,716,934	1,889,114	29,606,048	0.225020	0.225020	0.225020 65
66 PHYSICAL THERAPY	25,385,913	14,161,924	39,547,837	0.341295	0.341295	0.341295 66
70 ELECTROENCEPHALOGRAPHY	2,070,201	6,595,535	8,665,736	0.195026	0.195026	0.197729 70
71 MEDICAL SUPPLIES CHARGED TO	24,777,636	19,962,516	44,740,152	0.440005	0.440005	0.440005 71
72 IMPL. DEV. CHARGED TO PATIE	39,582,560	17,763,853	57,346,413	0.558045	0.558045	0.558045 72
73 DRUGS CHARGED TO PATIENTS	73,832,722	23,234,148	97,066,870	0.238221	0.238221	0.238221 73
74 RENAL DIALYSIS						74
76 CARDIOLOGY	53,132,384	60,799,966	113,932,350	0.173018	0.173018	0.174595 76
76.97 CARDIAC REHABILITATION	342,042	1,231,008	1,573,050	0.431528	0.431528	0.431528 76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	274,633	5,186,654	5,461,287	0.682374	0.682374	0.682374 90
91 EMERGENCY	27,178,332	50,090,885	77,269,217	0.199809	0.199809	0.200357 91
92 OBSERVATION BEDS (NON-DISTI	1,735,265	16,343,788	18,079,053	0.442740	0.442740	0.442740 92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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		6,284,759	6,284,759			101
200 SUBTOTAL (SEE INSTRUCTIONS)	601,229,570	555,100,938	1,156,330,508			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	601,229,570	555,100,938	1,156,330,508			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM (COL.3 ÷ COL.4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)					
	1	2	3					
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	4,506,255		4,506,255	92,958	48.48	49,201	2,385,264	30
31 INTENSIVE CARE UNIT	1,290,830		1,290,830	9,980	129.34	5,514	713,181	31
32 CORONARY CARE UNIT								32
32.01 NEONATAL INTENSIVE CARE	328,516		328,516	4,201	78.20			32.01
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF	599,686		599,686	15,080	39.77	13,460	535,304	41
42 SUBPROVIDER I								42
43 NURSERY	85,725		85,725	3,791	22.61			43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	6,811,012		6,811,012	126,010		68,175	3,633,749	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 (15-0125) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA				
		CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)		
		1	2	3	4	5		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,868,358	152,717,523	0.038426	28,440,615	1,092,859	50	
52	DELIVERY ROOM & LABOR ROOM	444,354	6,609,417	0.067230	16,959	1,140	52	
54	RADIOLOGY-DIAGNOSTIC	5,735,127	215,784,352	0.026578	32,120,064	853,687	54	
60	LABORATORY	1,057,049	148,515,562	0.007117	36,408,087	259,116	60	
62	WHOLE BLOOD & PACKED RED BLOO	112,194	10,094,099	0.011115	3,950,579	43,911	62	
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30	
65	RESPIRATORY THERAPY	374,455	29,606,048	0.012648	16,918,329	213,983	65	
66	PHYSICAL THERAPY	778,035	39,547,837	0.019673	6,828,725	134,342	66	
70	ELECTROENCEPHALOGRAPHY	414,829	8,665,736	0.047870	1,200,685	57,477	70	
71	MEDICAL SUPPLIES CHARGED TO P	350,496	44,740,152	0.007834	14,248,277	111,621	71	
72	IMPL. DEV. CHARGED TO PATIENT	350,085	57,346,413	0.006105	23,305,808	142,282	72	
73	DRUGS CHARGED TO PATIENTS	772,608	97,066,870	0.007960	41,451,484	329,954	73	
74	RENAL DIALYSIS						74	
76	CARDIOLOGY	4,073,900	113,932,350	0.035757	33,959,262	1,214,281	76	
76.97	CARDIAC REHABILITATION	47,491	1,573,050	0.030190	189,107	5,709	76.97	
76.98	HYPERBARIC OXYGEN THERAPY						76.98	
76.99	LITHOTRIPSY						76.99	
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	223,342	5,461,287	0.040895	75,810	3,100	90	
91	EMERGENCY	1,373,438	77,269,217	0.017775	13,988,951	248,654	91	
92	OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	480,451	18,079,053	0.026575			92	
94	HOME PROGRAM DIALYSIS						94	
200	TOTAL (SUM OF LINES 50-199)	22,456,212	1,027,008,966		253,102,742	4,712,116	200	

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					32
32.01 NEONATAL INTENSIVE CARE					32.01
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

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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	PER DIEM	INPATIENT	INPAT PGM
	PATIENT	COL.5 ÷	PROGRAM	PASS THRU
	DAYS	COL.6)	DAYS	COSTS
	6	7	8	(COL.7 x
				COL.8)
				9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	92,958		49,201	30
31 INTENSIVE CARE UNIT	9,980		5,514	31
32 CORONARY CARE UNIT				32
32.01 NEONATAL INTENSIVE CARE	4,201			32.01
33 BURN INTENSIVE CARE UNIT				33
34 SURGICAL INTENSIVE CARE UNIT				34
35 OTHER SPECIAL CARE (SPECIFY)				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF	15,080		13,460	41
42 SUBPROVIDER I				42
43 NURSERY	3,791			43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	126,010		68,175	200

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (15-0125)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[]	TITLE XIX	[]	IRF	[]	NF				

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN					
	ANESTHETIST			EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS. 1-4)	COLS. 2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM					50
52	DELIVERY ROOM & LABOR ROOM					52
54	RADIOLOGY-DIAGNOSTIC					54
60	LABORATORY					60
62	WHOLE BLOOD & PACKED RED BLOO					62
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
70	ELECTROENCEPHALOGRAPHY					70
71	MEDICAL SUPPLIES CHARGED TO P					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
74	RENAL DIALYSIS					74
76	CARDIOLOGY					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC					90
91	EMERGENCY					91
92	OBSERVATION BEDS (NON-DISTINC					92
OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS					94
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 (15-0125)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	152,717,523		28,440,615		25,836,795	50
52	DELIVERY ROOM & LABOR ROOM	6,609,417		16,959			52
54	RADIOLOGY-DIAGNOSTIC	215,784,352		32,120,064		55,437,260	54
60	LABORATORY	148,515,562		36,408,087		4,567,142	60
62	WHOLE BLOOD & PACKED RED BLO	10,094,099		3,950,579		743,184	62
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	29,606,048		16,918,329		633,133	65
66	PHYSICAL THERAPY	39,547,837		6,828,725		190,816	66
70	ELECTROENCEPHALOGRAPHY	8,665,736		1,200,685		2,098,006	70
71	MEDICAL SUPPLIES CHARGED TO	44,740,152		14,248,277		8,963,828	71
72	IMPL. DEV. CHARGED TO PATIEN	57,346,413		23,305,808		9,455,712	72
73	DRUGS CHARGED TO PATIENTS	97,066,870		41,451,484		9,853,485	73
74	RENAL DIALYSIS						74
76	CARDIOLOGY	113,932,350		33,959,262		32,557,404	76
76.97	CARDIAC REHABILITATION	1,573,050		189,107		656,732	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	5,461,287		75,810		2,809,874	90
91	EMERGENCY	77,269,217		13,988,951		9,209,237	91
92	OBSERVATION BEDS (NON-DISTIN	18,079,053				5,120,262	92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	1,027,008,966		253,102,742		168,132,870	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0125) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS				
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.324350	25,836,795			8,380,164		50
52 DELIVERY ROOM & LABOR ROOM	0.705258						52
54 RADIOLOGY-DIAGNOSTIC	0.131580	55,437,260			7,294,435		54
60 LABORATORY	0.120722	4,567,142			551,355		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.407115	743,184			302,561		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.225020	633,133			142,468		65
66 PHYSICAL THERAPY	0.341295	190,816			65,125		66
70 ELECTROENCEPHALOGRAPHY	0.195026	2,098,006			409,166		70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.440005	8,963,828			3,944,129		71
72 IMPL. DEV. CHARGED TO PATIENTS	0.558045	9,455,712			5,276,713		72
73 DRUGS CHARGED TO PATIENTS	0.238221	9,853,485		65,751	2,347,307	15,663	73
74 RENAL DIALYSIS							74
76 CARDIOLOGY	0.173018	32,557,404			5,633,017		76
76.97 CARDIAC REHABILITATION	0.431528	656,732			283,398		76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.682374	2,809,874			1,917,385		90
91 EMERGENCY	0.199809	9,209,237			1,840,088		91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	0.442740	5,120,262			2,266,945		92
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)		168,132,870		65,751	40,654,256	15,663	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		168,132,870		65,751	40,654,256	15,663	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 [] IPF [XX] IRF (15-T125)	[] SUB (OTHER)	[XX] PPS [] TEFRA				
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5			
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	5,868,358	152,717,523	0.038426	240,240	9,231		50
52	DELIVERY ROOM & LABOR ROOM	444,354	6,609,417	0.067230				52
54	RADIOLOGY-DIAGNOSTIC	5,735,127	215,784,352	0.026578	1,102,410	29,300		54
60	LABORATORY	1,057,049	148,515,562	0.007117	2,314,452	16,472		60
62	WHOLE BLOOD & PACKED RED BLOO	112,194	10,094,099	0.011115	211,940	2,356		62
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY	374,455	29,606,048	0.012648	713,626	9,026		65
66	PHYSICAL THERAPY	778,035	39,547,837	0.019673	12,235,974	240,718		66
70	ELECTROENCEPHALOGRAPHY	414,829	8,665,736	0.047870	245,578	11,756		70
71	MEDICAL SUPPLIES CHARGED TO P	350,496	44,740,152	0.007834	1,042,225	8,165		71
72	IMPL. DEV. CHARGED TO PATIENT	350,085	57,346,413	0.006105	33,180	203		72
73	DRUGS CHARGED TO PATIENTS	772,608	97,066,870	0.007960	4,496,135	35,789		73
74	RENAL DIALYSIS							74
76	CARDIOLOGY	4,073,900	113,932,350	0.035757	438,523	15,680		76
76.97	CARDIAC REHABILITATION	47,491	1,573,050	0.030190	326	10		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	223,342	5,461,287	0.040895	6,245	255		90
91	EMERGENCY	1,373,438	77,269,217	0.017775	1,108	20		91
92	OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS		18,079,053	18,079,053				92
94	HOME PROGRAM DIALYSIS							94
200	TOTAL (SUM OF LINES 50-199)	21,975,761	1,027,008,966		23,081,962	378,981		200

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input type="checkbox"/>	HOSPITAL	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	ICF/MR	<input type="checkbox"/>	PPS	<input checked="" type="checkbox"/>
APPLICABLE	<input checked="" type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>			TEFRA	<input type="checkbox"/>
BOXES	<input type="checkbox"/>	TITLE XIX	<input checked="" type="checkbox"/>	IRF (15-T125)	<input type="checkbox"/>	NF	<input type="checkbox"/>				

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN					
	ANESTHETIST			EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS. 1-4)	COLS. 2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50						50
						52
52						54
54						60
60						62
62						62.30
62.30						65
65						66
66						70
70						71
71						72
72						73
73						74
74						76
76						76.97
76.97						76.98
76.98						76.99
76.99						
OUTPATIENT SERVICE COST CENTERS						
90						90
91						91
92						92
OTHER REIMBURSABLE COST CENTERS						
94						94
200						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[XX] IRF (15-T125)	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	152,717,523		240,240			50
52	DELIVERY ROOM & LABOR ROOM	6,609,417					52
54	RADIOLOGY-DIAGNOSTIC	215,784,352		1,102,410			54
60	LABORATORY	148,515,562		2,314,452			60
62	WHOLE BLOOD & PACKED RED BLO	10,094,099		211,940			62
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	29,606,048		713,626			65
66	PHYSICAL THERAPY	39,547,837		12,235,974			66
70	ELECTROENCEPHALOGRAPHY	8,665,736		245,578			70
71	MEDICAL SUPPLIES CHARGED TO	44,740,152		1,042,225			71
72	IMPL. DEV. CHARGED TO PATIEN	57,346,413		33,180			72
73	DRUGS CHARGED TO PATIENTS	97,066,870		4,496,135		2,029	73
74	RENAL DIALYSIS						74
76	CARDIOLOGY	113,932,350		438,523			76
76.97	CARDIAC REHABILITATION	1,573,050		326			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	5,461,287		6,245			90
91	EMERGENCY	77,269,217		1,108			91
92	OBSERVATION BEDS (NON-DISTIN	18,079,053					92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	1,027,008,966		23,081,962		2,029	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [XX] IRF (15-T125) [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	PPS	COST SERVICES	COST SVCS NOT
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.324350						50
52 DELIVERY ROOM & LABOR ROOM	0.705258						52
54 RADIOLOGY-DIAGNOSTIC	0.131580						54
60 LABORATORY	0.120722						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.407115						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.225020						65
66 PHYSICAL THERAPY	0.341295						66
70 ELECTROENCEPHALOGRAPHY	0.195026						70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.440005						71
72 IMPL. DEV. CHARGED TO PATIENTS	0.558045						72
73 DRUGS CHARGED TO PATIENTS	0.238221	2,029		3,015	483		73
74 RENAL DIALYSIS							74
76 CARDIOLOGY	0.173018						76
76.97 CARDIAC REHABILITATION	0.431528						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.682374						90
91 EMERGENCY	0.199809						91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	0.442740						92
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)		2,029		3,015	483		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		2,029		3,015	483		202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	4,506,255		4,506,255	92,958	48.48	5,379	260,774	30
31 INTENSIVE CARE UNIT	1,290,830		1,290,830	9,980	129.34	592	76,569	31
32 CORONARY CARE UNIT								32
32.01 NEONATAL INTENSIVE CARE	328,516		328,516	4,201	78.20	606	47,389	32.01
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF	599,686		599,686	15,080	39.77	78	3,102	41
42 SUBPROVIDER I								42
43 NURSERY	85,725		85,725	3,791	22.61	348	7,868	43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	6,811,012		6,811,012	126,010		7,003	395,702	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 (15-0125) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,868,358	152,717,523	0.038426	2,088,879	80,267	50
52	DELIVERY ROOM & LABOR ROOM	444,354	6,609,417	0.067230	127,275	8,557	52
54	RADIOLOGY-DIAGNOSTIC	5,735,127	215,784,352	0.026578	2,916,048	77,503	54
60	LABORATORY	1,057,049	148,515,562	0.007117	3,311,221	23,566	60
62	WHOLE BLOOD & PACKED RED BLOO	112,194	10,094,099	0.011115	467,235	5,193	62
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	374,455	29,606,048	0.012648	785,976	9,941	65
66	PHYSICAL THERAPY	778,035	39,547,837	0.019673	446,014	8,774	66
70	ELECTROENCEPHALOGRAPHY	414,829	8,665,736	0.047870	81,855	3,918	70
71	MEDICAL SUPPLIES CHARGED TO P	350,496	44,740,152	0.007834	1,199,930	9,400	71
72	IMPL. DEV. CHARGED TO PATIENT	350,085	57,346,413	0.006105	893,009	5,452	72
73	DRUGS CHARGED TO PATIENTS	772,608	97,066,870	0.007960	4,734,664	37,688	73
74	RENAL DIALYSIS						74
76	CARDIOLOGY	4,073,900	113,932,350	0.035757	1,745,267	62,406	76
76.97	CARDIAC REHABILITATION	47,491	1,573,050	0.030190	13,231	399	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	223,342	5,461,287	0.040895	18,923	774	90
91	EMERGENCY	1,373,438	77,269,217	0.017775	1,115,089	19,821	91
92	OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	480,451	18,079,053	0.026575			92
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	22,456,212	1,027,008,966		19,944,616	353,659	200

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

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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
32 CORONARY CARE UNIT					32
32.01 NEONATAL INTENSIVE CARE					32.01
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
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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	PER DIEM	INPATIENT	INPAT PGM
	PATIENT DAYS 6	COL.5 ÷ COL.6) 7	PROGRAM DAYS 8	PASS THRU COSTS (COL.7 x COL.8) 9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	92,958		5,379	30
31 INTENSIVE CARE UNIT	9,980		592	31
32 CORONARY CARE UNIT				32
32.01 NEONATAL INTENSIVE CARE	4,201		606	32.01
33 BURN INTENSIVE CARE UNIT				33
34 SURGICAL INTENSIVE CARE UNIT				34
35 OTHER SPECIAL CARE (SPECIFY)				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF	15,080		78	41
42 SUBPROVIDER I				42
43 NURSERY	3,791		348	43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	126,010		7,003	200

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
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VERSION: 2013.11
 12/02/2013 15:17

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (15-0125)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	IRF	[]	NF			[]	OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN					
	COST	SCHOOL		EDUCATION	(SUM OF	(SUM OF
	1	2	3	COST	COLS. 1-4)	COLS. 2-4)
					5	6
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM					50
52	DELIVERY ROOM & LABOR ROOM					52
54	RADIOLOGY-DIAGNOSTIC					54
60	LABORATORY					60
62	WHOLE BLOOD & PACKED RED BLOO					62
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
70	ELECTROENCEPHALOGRAPHY					70
71	MEDICAL SUPPLIES CHARGED TO P					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
74	RENAL DIALYSIS					74
76	CARDIOLOGY					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC					90
91	EMERGENCY					91
92	OBSERVATION BEDS (NON-DISTINC					92
OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS					94
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 (15-0125)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[XX] TITLE XIX	[] IRF	[] NF		[] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	152,717,523		2,088,879			50
52	DELIVERY ROOM & LABOR ROOM	6,609,417		127,275			52
54	RADIOLOGY-DIAGNOSTIC	215,784,352		2,916,048			54
60	LABORATORY	148,515,562		3,311,221			60
62	WHOLE BLOOD & PACKED RED BLO	10,094,099		467,235			62
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	29,606,048		785,976			65
66	PHYSICAL THERAPY	39,547,837		446,014			66
70	ELECTROENCEPHALOGRAPHY	8,665,736		81,855			70
71	MEDICAL SUPPLIES CHARGED TO	44,740,152		1,199,930			71
72	IMPL. DEV. CHARGED TO PATIEN	57,346,413		893,009			72
73	DRUGS CHARGED TO PATIENTS	97,066,870		4,734,664			73
74	RENAL DIALYSIS						74
76	CARDIOLOGY	113,932,350		1,745,267			76
76.97	CARDIAC REHABILITATION	1,573,050		13,231			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	5,461,287		18,923			90
91	EMERGENCY	77,269,217		1,115,089			91
92	OBSERVATION BEDS (NON-DISTIN	18,079,053					92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	1,027,008,966		19,944,616			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK TITLE V - O/P HOSPITAL (15-0125) SUB (OTHER) S/B-SNF
 APPLICABLE TITLE XVIII-PT B IPF SNF S/B-NF
 BOXES TITLE XIX - O/P IRF NF ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT	COST SERVICES	COST SVCES NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.324350						50
52 DELIVERY ROOM & LABOR ROOM	0.705258						52
54 RADIOLOGY-DIAGNOSTIC	0.131580						54
60 LABORATORY	0.120722						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.407115						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.225020						65
66 PHYSICAL THERAPY	0.341295						66
70 ELECTROENCEPHALOGRAPHY	0.195026						70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.440005						71
72 IMPL. DEV. CHARGED TO PATIENTS	0.558045						72
73 DRUGS CHARGED TO PATIENTS	0.238221						73
74 RENAL DIALYSIS							74
76 CARDIOLOGY	0.173018						76
76.97 CARDIAC REHABILITATION	0.431528						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.682374						90
91 EMERGENCY	0.199809						91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	0.442740						92
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL
 PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input type="checkbox"/>	HOSPITAL	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	ICF/MR	<input type="checkbox"/>	PPS	<input checked="" type="checkbox"/>
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>			TEFRA	<input type="checkbox"/>
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input checked="" type="checkbox"/>	IRF (15-T125)	<input type="checkbox"/>	NF	<input type="checkbox"/>			OTHER	<input type="checkbox"/>
COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P					
	PHYSICIAN ANESTHETIST COST 1	SCHOOL 2	HEALTH 3	MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6					
ANCILLARY SERVICE COST CENTERS											
50	OPERATING ROOM					50					
52	DELIVERY ROOM & LABOR ROOM					52					
54	RADIOLOGY-DIAGNOSTIC					54					
60	LABORATORY					60					
62	WHOLE BLOOD & PACKED RED BLOO					62					
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30					
65	RESPIRATORY THERAPY					65					
66	PHYSICAL THERAPY					66					
70	ELECTROENCEPHALOGRAPHY					70					
71	MEDICAL SUPPLIES CHARGED TO P					71					
72	IMPL. DEV. CHARGED TO PATIENT					72					
73	DRUGS CHARGED TO PATIENTS					73					
74	RENAL DIALYSIS					74					
76	CARDIOLOGY					76					
76.97	CARDIAC REHABILITATION					76.97					
76.98	HYPERBARIC OXYGEN THERAPY					76.98					
76.99	LITHOTRIPSY					76.99					
OUTPATIENT SERVICE COST CENTERS											
90	CLINIC					90					
91	EMERGENCY					91					
92	OBSERVATION BEDS (NON-DISTINC					92					
OTHER REIMBURSABLE COST CENTERS											
94	HOME PROGRAM DIALYSIS					94					
200	TOTAL (SUM OF LINES 50-199)					200					

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[]	HOSPITAL	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[XX]	IRF (15-T125)	[]	NF			[]	OTHER
COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM			
	CHARGES	COST TO	OF COST TO		PGM		PASS-THRU	PASS-THRU		
	(FROM WKST	CHARGES	CHARGES	CHARGES	COSTS	CHARGES	COSTS			
	C, PT. I,	(COL. 5 +	(COL. 6 +	PGM	(COL. 8 x	O/P PGM	(COL. 9 x			
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	CHARGES	COL. 12)			
	7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS										
50	OPERATING ROOM	152,717,523						50		
52	DELIVERY ROOM & LABOR ROOM	6,609,417						52		
54	RADIOLOGY-DIAGNOSTIC	215,784,352		3,902				54		
60	LABORATORY	148,515,562		24,291				60		
62	WHOLE BLOOD & PACKED RED BLO	10,094,099						62		
62.30	BLOOD CLOTTING FOR HEMOPHILI							62.30		
65	RESPIRATORY THERAPY	29,606,048		8,178				65		
66	PHYSICAL THERAPY	39,547,837		122,085				66		
70	ELECTROENCEPHALOGRAPHY	8,665,736						70		
71	MEDICAL SUPPLIES CHARGED TO	44,740,152		9,466				71		
72	IMPL. DEV. CHARGED TO PATIEN	57,346,413						72		
73	DRUGS CHARGED TO PATIENTS	97,066,870		55,316				73		
74	RENAL DIALYSIS							74		
76	CARDIOLOGY	113,932,350		9,950				76		
76.97	CARDIAC REHABILITATION	1,573,050						76.97		
76.98	HYPERBARIC OXYGEN THERAPY							76.98		
76.99	LITHOTRIPSY							76.99		
OUTPATIENT SERVICE COST CENTERS										
90	CLINIC	5,461,287						90		
91	EMERGENCY	77,269,217						91		
92	OBSERVATION BEDS (NON-DISTIN	18,079,053						92		
OTHER REIMBURSABLE COST CENTERS										
94	HOME PROGRAM DIALYSIS							94		
200	TOTAL (SUM OF LINES 50-199)	1,027,008,966		233,188				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 [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [XX] IRF (15-T125) [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT	COST SERVICES	COST SVCES NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.324350						50
52 DELIVERY ROOM & LABOR ROOM	0.705258						52
54 RADIOLOGY-DIAGNOSTIC	0.131580						54
60 LABORATORY	0.120722						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.407115						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.225020						65
66 PHYSICAL THERAPY	0.341295						66
70 ELECTROENCEPHALOGRAPHY	0.195026						70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.440005						71
72 IMPL. DEV. CHARGED TO PATIENTS	0.558045						72
73 DRUGS CHARGED TO PATIENTS	0.238221						73
74 RENAL DIALYSIS							74
76 CARDIOLOGY	0.173018						76
76.97 CARDIAC REHABILITATION	0.431528						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.682374						90
91 EMERGENCY	0.199809						91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	0.442740						92
94 HOME PROGRAM DIALYSIS							94
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 (15-0125) [] 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)	92,958	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	92,958	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	25,218	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	57,829	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)	49,201	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)	75,074,586	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	75,074,586	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	60,375,827	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	20,114,954	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	40,260,873	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.243454	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	797.64	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	696.21	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	101.43	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	126.12	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	3,180,494	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	71,894,092	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0125) [] 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) 807.62 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 39,735,712 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) 39,735,712 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	16,901,586	9,980	1,693.55	5,514	9,338,235	43
44 CORONARY CARE UNIT						44
44.01 NEONATAL INTENSIVE CARE	4,901,980	4,201	1,166.86			44.01
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)					63,859,886	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					112,933,833	49
PASS-THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					3,098,445	50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					4,712,116	51
52 TOTAL PROGRAM EXCLUDABLE COST					7,810,561	52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					105,123,272	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) 9,911 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 807.62 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 8,004,322 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	4,506,255	75,074,586	0.060024	8,004,322	480,451	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [XX] IRF (15-T125) [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	15,080	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	15,080	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,524	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,556	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)	13,460	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)	1,317	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)	10,561,592	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	10,561,592	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,447,659	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	646,362	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,801,297	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.938740	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	424.12	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	354.18	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	69.94	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	135.60	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	206,654	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	10,354,938	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [XX] PPS
APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
BOXES [] TITLE XIX-INPT [XX] IRF (15-T125) [] 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)	700.37 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	9,426,980 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)	40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	9,426,980 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	6,603,413 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	16,030,393 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	535,304 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	378,981 51
52	TOTAL PROGRAM EXCLUDABLE COST	914,285 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	15,116,108 53
TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES	54
55	TARGET AMOUNT PER DISCHARGE	55
56	TARGET AMOUNT (LINE 54 x LINE 55)	56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58	BONUS PAYMENT (SEE INSTRUCTIONS)	58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)	61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0125) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	92,958	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	92,958	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	25,218	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	57,829	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)	5,379	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)	3,791	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	348	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)	75,074,586	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	75,074,586	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	60,375,827	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	20,114,954	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	40,260,873	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.243454	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	797.64	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	696.21	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	101.43	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	126.12	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	3,180,494	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	71,894,092	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0125) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 807.62 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 4,344,188 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) 4,344,188 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	2,991,533	3,791	789.11	348	274,610 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	16,901,586	9,980	1,693.55	592	1,002,582 43
44 CORONARY CARE UNIT					44
44.01 NEONATAL INTENSIVE CARE	4,901,980	4,201	1,166.86	606	707,117 44.01
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)					4,787,480 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					11,115,977 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 392,600 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 353,659 51
 52 TOTAL PROGRAM EXCLUDABLE COST 746,259 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 10,369,718 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) 9,911 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [XX] IRF (15-T125) [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	15,080	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	15,080	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,524	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,556	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)	78	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)	10,561,592	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	10,561,592	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,447,659	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	646,362	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,801,297	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.938740	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	424.12	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	354.18	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	69.94	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	135.60	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	206,654	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	10,354,938	37

WORKSHEET D-1
PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
BOXES [XX] TITLE XIX-INPT [XX] IRF (15-T125) [] 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)	700.37 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	54,629 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)	54,629 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	66,034 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	120,663 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	3,102 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	3,652 51
52	TOTAL PROGRAM EXCLUDABLE COST	6,754 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	113,909 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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (15-0125)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	82,736,123	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	1,890,647	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)	378.85	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)	0.0341	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.1442	31
32	SUM OF LINES 30 AND 31	0.1783	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0434	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	3,590,748	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)	88,217,518	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	88,217,518	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	6,977,376	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK HOSPITAL (15-0125)
APPLICABLE BOX: SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	95,194,894	59
60	PRIMARY PAYER PAYMENTS	45,900	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	95,148,994	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	7,733,820	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	630,809	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	673,429	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	471,400	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	182,065	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	87,255,765	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SEQUESTRATION PER PSR)		70
70.93	HVBP PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	-65,213	70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (SEE INSTRUCTIONS)	-634,022	70.94
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	86,556,530	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	432,783	71.01
72	INTERIM PAYMENTS	86,315,386	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	-191,639	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	12,448,373	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 (15-0125) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	15,663	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	40,654,256	2
3	PPS PAYMENTS	37,883,383	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	141,831	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)	15,663	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	65,751	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)	65,751	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)	65,751	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	50,088	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)	15,663	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)	38,025,214	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	8,310,884	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	29,729,993	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)	29,729,993	30
31	PRIMARY PAYER PAYMENTS	14,505	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	29,715,488	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)	1,008,276	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	705,793	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	581,614	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	30,421,281	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	3,256	38
39	OTHER ADJUSTMENTS (FDO LOSS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	30,418,025	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	152,090	40.01
41	INTERIM PAYMENTS	30,041,320	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	224,615	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL IPF IRF (15-T125)
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	718	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	483	2
3	PPS PAYMENTS	550	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)	718	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	3,015	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)	3,015	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)	3,015	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	2,297	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)	718	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)	550	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)	1,268	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)	1,268	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	1,268	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	1,268	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	1,268	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	6	40.01
41	INTERIM PAYMENTS	1,218	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	44	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 [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [XX] IRF (15-T125) [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		20,137,929		1,218
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		3.01
	.02			3.02
	.03			3.03
	.04			3.04
	.05			3.05
	.06			3.06
	.07			3.07
	.08			3.08
	.09			3.09
	.50	NONE		3.50
	.51			3.51
	.52			3.52
	.53			3.53
	.54			3.54
	.55			3.55
	.56			3.56
	.57			3.57
	.58			3.58
	.59			3.59
	.99			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		20,137,929		1,218

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01	127,862		50	6.01
	TO PROVIDER .02				6.02
	PROVIDER .02				6.02
	TO PROGRAM .02				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		20,265,791		1,268	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
12/02/2013 15:17

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (15-0125) [] 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	19,304	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	54,715	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	4,336	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	97,228	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,156,330,508	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	26,557,110	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)	3,500,230	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)		10
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	3,653,917	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	-153,687	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART III

CHECK [] HOSPITAL
APPLICABLE BOX: [XX] IRF (15-T125)

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	19,925,510	1
2	MEDICARE SSI RATIO (SEE INSTRUCTIONS)	0.019300	2
3	INPATIENT REHABILITATION LIP PAYMENTS (SEE INSTRUCTIONS)	306,853	3
4	OUTLIER PAYMENTS	248,211	4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		5
5.01	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)		5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTES IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		9
10	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	41.315068	10
11	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (\text{LINE 9}/\text{LINE 10})) \text{ RAISED TO THE POWER OF } .6876 - 1\}$		11
12	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 11)		12
13	TOTAL PPS PAYMENT (SUM OF LINES 1, 3, 4 AND 12)	20,480,574	13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (SEE INSTRUCTIONS)		14
15	ORGAN ACQUISITION		15
16	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		16
17	SUBTOTAL (SEE INSTRUCTIONS)	20,480,574	17
18	PRIMARY PAYER PAYMENTS		18
19	SUBTOTAL LINE 17b LESS LINE 18)	20,480,574	19
20	DEDUCTIBLES	181,820	20
21	SUBTOTAL (LINE 19 MINUS LINE 20)	20,298,754	21
22	COINSURANCE	36,445	22
23	SUBTOTAL (LINE 21 MINUS LINE 22)	20,262,309	23
24	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	4,974	24
25	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	3,482	25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	2,090	26
27	SUBTOTAL (SUM OF LINES 23 AND 25)	20,265,791	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IRF ONLY)		28
29	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		29
30	OUTLIER PAYMENTS RECONCILIATION		30
31	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	20,265,791	32
32.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	101,329	32.01
33	INTERIM PAYMENTS	20,137,929	33
34	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		34
35	BALANCE DUE PROVIDER/PROGRAM (LINE 32 MINUS LINES 32.01, 33 AND 34)	26,533	35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (SEE INSTRUCTIONS)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (15-0125) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1		1
2		2
3		3
4		4
5		5
6		6
7		7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	6,037,234	8
9	19,944,616	9
10		10
11		11
12	25,981,850	12
CUSTOMARY CHARGES		
13		13
14		14
15	1.000000	1.000000 15
16	25,981,850	16
17	25,981,850	17
18		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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [] HOSPITAL [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [XX] IRF (15-T125) [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES		1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)		4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)		7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES	99,259	8
9 ANCILLARY SERVICE CHARGES	233,188	9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	332,447	12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000 15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	332,447	16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	332,447	17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)		38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	11,305,828			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	99,975,062			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-43,106,912			6
7	INVENTORY	8,171,911			7
8	PREPAID EXPENSES	5,079,564			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	81,425,453			11
FIXED ASSETS					
12	LAND	3,056,583			12
13	LAND IMPROVEMENTS	6,747,854			13
14	ACCUMULATED DEPRECIATION	-5,288,862			14
15	BUILDINGS	271,211,732			15
16	ACCUMULATED DEPRECIATION	-189,779,682			16
17	LEASEHOLD IMPROVEMENTS	984,452			17
18	ACCUMULATED AMORTIZATION	-945,076			18
19	FIXED EQUIPMENT	56,707,846			19
20	ACCUMULATED DEPRECIATION	-16,906,648			20
21	AUTOMOBILES AND TRUCKS	439,627			21
22	ACCUMULATED DEPRECIATION	-366,908			22
23	MAJOR MOVABLE EQUIPMENT	134,626,667			23
24	ACCUMULATED DEPRECIATION	-93,678,841			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE	7,556,545			29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	174,365,289			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	7,362,817			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	7,362,817			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	263,153,559			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	16,035,059			37
38	SALARIES, WAGES & FEES PAYABLE	18,119,751			38
39	PAYROLL TAXES PAYABLE	4,492,314			39
40	NOTES & LOANS PAYABLE (SHORT TERM)	394,363			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	25,652,263			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	64,693,750			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	97,422,326			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	97,422,326			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	162,116,076			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	101,037,483			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)	101,037,483			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	263,153,559			60

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				
2 HOSPITAL	88,291,428		88,291,428	1
3 SUBPROVIDER IPF				2
5 SUBPROVIDER IRF	10,561,867		10,561,867	3
6 SWING BED - SNF				5
7 SWING BED - NF				6
8 SKILLED NURSING FACILITY				7
9 NURSING FACILITY				8
10 OTHER LONG TERM CARE				9
11 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	98,853,295		98,853,295	10
12 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
13 INTENSIVE CARE UNIT	17,299,840		17,299,840	11
14 CORONARY CARE UNIT				12
12.01 NEONATAL INTENSIVE CARE	7,907,291		7,907,291	12.01
13 BURN INTENSIVE CARE UNIT				13
14 SURGICAL INTENSIVE CARE UNIT				14
15 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	25,207,131		25,207,131	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	124,060,426		124,060,426	17
18 ANCILLARY SERVICES	498,329,803		498,329,803	18
19 OUTPATIENT SERVICES		568,100,116	568,100,116	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY		6,284,759	6,284,759	22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	622,390,229	574,384,875	1,196,775,104	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		426,815,442	29
30 ADD (SPECIFY)			30
31 BAD DEBTS	19,404,417		31
32 CHARITY CARE	26,557,110		32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		45,961,527	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)		472,776,969	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	1,196,775,104	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	720,591,307	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	476,183,797	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	472,776,969	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	3,406,828	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	280,825	6
7	INCOME FROM INVESTMENTS	321,068	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	9,367	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	1,993,813	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	4,629,476	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	26,880	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	13,061	21
22	RENTAL OF HOSPITAL SPACE	1,688,772	22
23	GOVERNMENTAL APPROPRIATIONS	6,468,558	23
24	OTHER (OTHER REVENUE)	328,490	24
24.01	OTHER (REVENUE-CLASSES)	52,405	24.01
24.02	OTHER (ASSETS RELEASED FROM RESTRICTION)		24.02
24.03	OTHER (FITNESS REVENUE)	4,340,417	24.03
24.04	OTHER (SALE OF XRAY SCRAP)	8,264	24.04
24.05	OTHER (OTHER INVESTMENT GAINS)		24.05
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	20,161,396	25
26	TOTAL (LINE 5 PLUS LINE 25)	23,568,224	26
27	OTHER EXPENSES (LOSS ON SALE OF ASSETS)	18,085	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	18,085	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	23,550,139	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 15-7487

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS. 1-5) 6
1 GENERAL SERVICE COST CENTER						1
2 CAPITAL RELATED-BLDGS & FIXTURES						2
3 CAPITAL RELATED-MOVABLE EQUIPMENT						3
4 PLANT OPERATION & MAINTENANCE						4
5 TRANSPORTATION (SEE INSTRUCTIONS)						5
6 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	635,138		26,592	3,511	65,692	730,933
7 SKILLED NURSING CARE	1,042,783					1,042,783
8 PHYSICAL THERAPY				822,294		822,294
9 OCCUPATIONAL THERAPY				207,973		207,973
10 SPEECH PATHOLOGY						9
11 MEDICAL SOCIAL SERVICES	1,445					1,445
12 HOME HEALTH AIDE	121,191					121,191
13 SUPPLIES (SEE INSTRUCTIONS)					174,701	174,701
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	223,026				9,365	232,391
20 CLINIC						18
21 HEALTH PROMOTION ACTIVITIES						19
22 DAY CARE PROGRAM						20
23 HOME DELIVERED MEALS PROGRAM						21
24 HOMEMAKER SERVICE						22
25 ALL OTHERS						23
26 TOTAL (SUM OF LINES 1-23)	2,023,583		26,592	1,033,778	249,758	3,333,711

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 15-7487

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5	-34,389	696,544		696,544	5
6		1,042,783		1,042,783	6
7		822,294		822,294	7
8		207,973		207,973	8
9					9
10		1,445		1,445	10
11		121,191		121,191	11
12		174,701		174,701	12
13					13
14					14
15					15
16					16
17		232,391		232,391	17
18					18
19					19
20					20
21					21
22					22
23					23
24	-34,389	3,299,322		3,299,322	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 15-7487

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL (COLS. 0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS. 4A+5) 6	
	0	1	2	3	4				
1									1
2									2
3									3
4									4
5	696,544					696,544	696,544		5
6		1,042,783				1,042,783	278,953	1,321,736	6
7		822,294				822,294	220,251	1,042,545	7
8		207,973				207,973	55,634	263,607	8
9									9
10		1,445				1,445	387	1,832	10
11		121,191				121,191	32,419	153,610	11
12		174,701				174,701	46,734	221,435	12
13									13
14									14
15									15
16									16
17		232,391				232,391	62,166	294,557	17
18									18
19									19
20									20
21									21
22									22
23									23
24		3,299,322				3,299,322		3,299,322	24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 15-7487

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	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-696,544	2,603,832	5
6 SKILLED NURSING CARE						1,042,783	6
7 PHYSICAL THERAPY					1,054	823,348	7
8 OCCUPATIONAL THERAPY						207,973	8
9 SPEECH PATHOLOGY							9
10 MEDICAL SOCIAL SERVICES						1,445	10
11 HOME HEALTH AIDE						121,191	11
12 SUPPLIES (SEE INSTRUCTIONS)						174,701	12
13 DRUGS							13
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING						232,391	17
18 CLINIC							18
19 HEALTH PROMOTION ACTIVITIES							19
20 DAY CARE PROGRAM							20
21 HOME DELIVERED MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL (SUM OF LINES 1-23)					-695,490	2,603,832	24
25 COST TO BE ALLOC (PER W/S H)						696,544	25
26 UNIT COST MULTIPLIER						0.267507	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 15-7487

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	975,628		975,628			1
2 SKILLED NURSING CARE	1,576,705		1,576,705	390,845	1,967,550	2
3 PHYSICAL THERAPY	1,243,656		1,243,656	308,286	1,551,942	3
4 OCCUPATIONAL THERAPY	314,458		314,458	77,950	392,408	4
5 SPEECH PATHOLOGY						5
6 MEDICAL SOCIAL SERVICES	2,185		2,185	542	2,727	6
7 HOME HEALTH AIDE	183,242		183,242	45,423	228,665	7
8 SUPPLIES	264,151		264,151	65,480	329,631	8
9 DRUGS						9
10 DME						10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY						12
13 PRIVATE DUTY NURSING	351,378		351,378	87,102	438,480	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)	4,911,403		4,911,403	975,628	4,911,403	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.				0.247887		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 15-7487

WORKSHEET H-2
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- \$ VALUE	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4	4A	5	6	7	
1 ADMINISTRATIVE AND GENERAL	3,575	14,192		2,023,583		659,324		3,575	1
2 SKILLED NURSING CARE						1,321,736			2
3 PHYSICAL THERAPY						1,042,545			3
4 OCCUPATIONAL THERAPY						263,607			4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES						1,832			6
7 HOME HEALTH AIDE						153,610			7
8 SUPPLIES						221,435			8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING						294,557			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)	3,575	14,192		2,023,583		3,958,646		3,575	20
21 TOTAL COST TO BE ALLOCATED	40,349	22,912		596,063		763,639		104,521	21
22 UNIT COST MULTIPLIER	11.286434								22
22 UNIT COST MULTIPLIER		1.614431		0.294558		0.192904		29.236643	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 15-7487

WORKSHEET H-2
 PART II

HHA COST CENTER	LAUNDRY + LINEN SERVICE POUNDS	HOUSE- KEEPING TIME SPENT	DIETARY PATIENT MEALS	CAFETERIA ME FTES	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS- TRATION NURSING HO URS	CENTRAL SERVICES & SUPPLY COSTED REQ	PHARMACY COSTED REQ
	8	9	10	11	12	13	14	15
1 ADMINISTRATIVE AND GENERAL		1,200		3,561				
2 SKILLED NURSING CARE								
3 PHYSICAL THERAPY								
4 OCCUPATIONAL THERAPY								
5 SPEECH PATHOLOGY								
6 MEDICAL SOCIAL SERVICES								
7 HOME HEALTH AIDE								
8 SUPPLIES								
9 DRUGS								
10 DME								
11 HOME DIALYSIS AIDE SERVICES								
12 RESPIRATORY THERAPY								
13 PRIVATE DUTY NURSING								
14 CLINIC								
15 HEALTH PROMOTION ACTIVITIES								
16 DAY CARE PROGRAM								
17 HOME DELIVERED MEALS PROGRAM								
18 HOMEMAKER SERVICE								
19 ALL OTHERS								
19.50 TELEMEDICINE								
20 TOTAL (SUM OF LINES 1-19)		1,200		3,561				
21 TOTAL COST TO BE ALLOCATED		10,533		36,085				
22 UNIT COST MULTIPLIER		8.777500		10.133389				

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 15-7487

WORKSHEET H-3
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	4	(COL.3 ÷ COL.4)	
			1	2	3		5	
1	SKILLED NURSING CARE	2	1,967,550		1,967,550	20,644	95.31	1
2	PHYSICAL THERAPY	3	1,551,942		1,551,942	14,083	110.20	2
3	OCCUPATIONAL THERAPY	4	392,408		392,408	3,535	111.01	3
4	SPEECH PATHOLOGY	5						4
5	MEDICAL SOCIAL SERVICES	6	2,727		2,727	24	113.63	5
6	HOME HEALTH AIDE	7	228,665		228,665	3,858	59.27	6
7	TOTAL (SUM OF LINES 1-6)		4,143,292		4,143,292	42,144		7

PATIENT SERVICES

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

SUPPLIES AND DRUGS COST COMPUTATIONS

OTHER PATIENT SERVICES		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	
		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	(FROM HHA RECORD)	(COL.3 ÷ COL.4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	329,631		329,631	387,221	0.851274	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 15-7487

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART B			PART B			
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
	6	7	8	9	10	11	12
1 SKILLED NURSING CARE	9,114	7,068		868,655	673,651		1,542,306
2 PHYSICAL THERAPY	7,404	4,279		815,921	471,546		1,287,467
3 OCCUPATIONAL THERAPY	2,190	957		243,112	106,237		349,349
4 SPEECH PATHOLOGY							
5 MEDICAL SOCIAL SERVICES	10	9		1,136	1,023		2,159
6 HOME HEALTH AIDE	1,388	2,237		82,267	132,587		214,854
7 TOTAL (SUM OF LINES 1-6)	20,106	14,550		2,011,091	1,385,044		3,396,135

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS			TOTAL PROGRAM COST
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
		2	3	4	
8 SKILLED NURSING CARE	23844	9,114	7,068		8
9 PHYSICAL THERAPY	23844	7,404	4,279		9
10 OCCUPATIONAL THERAPY	23844	2,190	957		10
11 SPEECH PATHOLOGY	23844				11
12 MEDICAL SOCIAL SERVICES	23844	10	9		12
13 HOME HEALTH AIDE	23844	1,388	2,237		13
14 TOTAL (SUM OF LINES 8-13)		20,106	14,550		14

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

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

	FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
			2	3		
1 PHYSICAL THERAPY	66	0.341295			COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY	67				COL 2, LINE 3	2
3 SPEECH PATHOLOGY	68				COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHARGED TO PA	71	0.440005			COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	73	0.238221			COL 2, LINE 16	5

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 15-7487

WORKSHEET H-4
 PARTS I & II

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

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

DESCRIPTION	----- PART B -----		
	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
	PART A 1	2	3
1 REASONABLE COST OF PART A & PART B SERVICES			1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)			2
2 TOTAL CHARGES			2
CUSTOMARY CHARGES			
3 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)			3
4 AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)			4
5 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)			5
6 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			6
7 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)			7
8 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)			8
9 PRIMARY PAYER PAYMENTS	1,388	71	9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A		PART B		
	SERVICES	1	SERVICES	2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)		-1,388		-71	10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	2,747,440		1,667,870		11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	93,160		100,004		12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	26,243		22,915		13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	13,625		23,265		14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	14,501		34,182		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)	2,893,581		1,848,165		22
23 EXCESS REASONABLE COST (FROM LINE 8)					23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	2,893,581		1,848,165		24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)					25
26 NET COST (LINE 24 MINUS LINE 25)	2,893,581		1,848,165		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)	2,893,581		1,848,165		29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		-35			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	2,893,546		1,848,165		31
31.01 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		14,574		9,433	31.01
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	2,878,972		1,838,732		32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)					33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)					34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2					35

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

HHA NO.: 15-7487

WORKSHEET H-5

DESCRIPTION	PART A		PART B		
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,878,972		1,838,732	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		NONE	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99				3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		2,878,972		1,838,732	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99				5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO .01	14,574		9,433	6.01
	PROVIDER PROVIDER TO .02				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)	PROGRAM	2,893,546		1,848,165	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES					21
22 I&R SERVICES-OTHER PRGM COSTS					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32.01 NEONATAL INTENSIVE CARE					32.01
41 SUBPROVIDER - IRF					41
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62 WHOLE BLOOD & PACKED RED BLOOD					62
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHARGED TO PA					71
72 IMPL. DEV. CHARGED TO PATIENTS					72
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76 CARDIOLOGY					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS					92
94 HOME PROGRAM DIALYSIS					94
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
191 RESEARCH					191
192 PHYSICIANS' PRIVATE OFFICES					192
194 ADVERTISING					194
194.01 FITNESS POINTE					194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DI					194.02
194.03 RETAIL PHARMACY					194.03
194.04 HOSPICE					194.04
194.05 RUSH RESIDENTS					194.05

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
12/02/2013 15:17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	0	2A	24	25	26	
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