RICHLAND MEMORIAL HOSPITAL

OLNEY, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED SEPTEMBER 30, 2016

February 20, 2016

National Government Services
P.O. Box 9731
Portland, ME 04104

Dear Sir or Madam:

We are submitting this cost report on behalf of Richland Memorial Hospital for the fiscal year ended September 30, 2016, which includes six Level 2000 Errors. The 20050O errors and the explanation for these errors is as follows:

- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 3.
- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 5.
- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 13.
- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 14.
- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 38.
- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 41.

All of these errors are due to an error in the cost report (Win-LASH) software, and are not indicative of an actual error in the cost report.

Sincerely,

Kerber, Eck & Braeckel LLP

National Government Services, Inc.
P.O. Box 9731
Portland, ME 04104

Re: Provider: Richland Memorial Hospital
Provider Numbers: 14-0147, 14-S147, 14-U147, 14-5580, 14-7187, 14-1542, 14-8548
Period ended: 09/30/2016
Protested amounts claimed on submitted cost report.

Dear Sir or Madam:

The Provider contends that its base-year hospital-specific rate, applied to calculate the payments to the Provider during this cost reporting period, is artificially low because of the application of a cumulative budget neutrality factor that encompasses all budget neutrality adjustments made prior to the base year. As reflected in the attached calculation, the Provider estimates that the reimbursement impact of this issue for this cost reporting period is $79,000.

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

- It is contrary to the statutory mandate to use "100 percent of the hospital's target amount." See, e.g., Soc. Sec. Act § 1886(d) (5) (D) (i).

- It is duplicative and removes twice the effect of recalibrating DRGs: once when the hospital-specific rate is divided by the hospital's case mix index and again when the budget neutrality factor is directly applied to the hospital-specific rate.

The Provider is appealing its Hospital Acquired Condition (HAC) penalty. The provider believes there is a flaw in the calculation formula; specifically, when the number of cases in the infection domain does not meet the threshold, that domain is not used. This results in 100% of our HAC score coming from the PSI domain, which for all other hospitals, only accounts for 35% of their total HAC score. This unfairly distorts our overall HAC score.

The Provider estimates, based on their CMS Provider Statistical Report (PSR), the reimbursement impact of this issue for this cost reporting period is $58,000.

The total amount protested on worksheet E, Part A is $79,000 + $58,000 = $137,000.

Sincerely,

Richland Memorial Hospital

Richland Memorial Hospital
Hospital Specific Rate Recalculation
September 30, 2016

The hospital specfic calculation without the cummulative buget nuetrality factor would be:

HSP difference for September 30, 2010	109.74
2011 Update Factor	1.0235
2012 Update Factor	1.0190
2013 Update Factor	1.0180
2014 Update Factor	1.0170
2015 Update Factor	1.0220
2016 Update Factor	1.0110
2011 Budget Neutrality	0.996731
2012 Budget Neutrality	0.997903
2013 Budget Neutrality	0.998431
2014 Budget Neutrality	0.997989
2015 Budget Neutrality	0.998761
2016 Budget Neutrality	0.998404
2012 Rural Floor Add-on	1.009
2014 Document & Coding	0.948
2015 Medicare Part A Offset	0.998
2012 difference	115.51
DRG weight	914.26
	105,603
MDH payment factor	0.75
	79,202
Rounded	80,000

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. [X] Electronically filed cost report Date: 02/24/2017 Time: 09:00 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 WERE 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 certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RICHLAND MEMORIAL HOSPITAL (14-0147) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 10/01/2015 and ending 09/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 02/24/2017 09:00
XsSPJL2FmKFT0tItdrL90BojJmMsq0
MVcoz0Zg7RY2ZQ684gJhq0q1J5Grjw
zhGB1Nf2380y2jyn

PI Encryption: 02/24/2017 09:00
L3faWk2nPBFdbAS1k9AcY4p0H7LVE0
J:ifG0tVzhm11l79j5BBh5UercCBlI
TJLt0LzZPR0Cq8FG

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-8,855	13,296			1
2	SUBPROVIDER - IPF		7,105				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		11,134				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			256,399			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		9,384	269,695			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 resopnd 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.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 800 EAST LOCUST	P.O. Box:		1
2	City: OLNEY	State: IL	ZIP Code: 62450-2958	County: RICHLAND	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	RICHLAND MEMORIAL HOSPITAL	14-0147	99914	1	07 / 01 / 1966	N	P	P	3
4	Subprovider - IPF	RICHLAND MEMORIAL HOSPITAL PSYCH	14-S147	99914	4	07 / 01 / 1966	N	P	P	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	RICHLAND MEMORIAL HOSPITAL SWING BED	14-U147	99914		11 / 13 / 2003	N	P	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF	RICHLAND MEMORIAL HOSPITAL SNF	14-5580	99914		11 / 05 / 1987	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	RICHLAND MEMORIAL HOSPITAL HHA	14-7187	99914		05 / 01 / 1980	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice	RICHLAND MEMORIAL HOSPITAL HOSPICE	14-1542	99914		04 / 23 / 1991				14
15	Hospital-Based Health Clinic - RHC	RICHLAND MEMORIAL HOSPITAL WEST SALE	14-8548	99914		12 / 04 / 2015	N	O	N	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: 10 / 01 / 2015	To: 09 / 30 / 2016	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
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 Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	479	79			93	280	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			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 is in effect in the cost reporting period.	1		37

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning: 10 / 01 / 2015	Ending: 09 / 30 / 2016	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
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)	Y	Y	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. 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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 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, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline 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 osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs 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	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

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.

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 reseived 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider 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 HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 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	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N		71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

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.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX 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/IID 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? (see instructions)					106
107	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. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					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
		Physical	Occupational	Speech	Respiratory	
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	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 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 Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	904,492			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 high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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 cetfified 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 cetfified 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 HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
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 (see instructions)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:		141
142	Street:	P.O. Box:			142
143	City:	State:	ZIP Code:		143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.			N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.			N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	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. (see instructions)						166
	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)			N	0	171

HOSPITAL AND HOSPITAL 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	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
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		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/08/2017	Y	01/08/2017	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)	N		N		17
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 Reoprt 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 HOSPITAL 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 relifed 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 capitalization 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

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: MARK	Last name: DALLAS	Title: PARTNER	41
42	Employer: KERBER, ECK & BRAECKEL, LLP			42
43	Phone number: 618-529-1040	E-mail Address: MARKD@KEBCPA.COM		43

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	39	14,274			2,078	557	3,265	1
2	HMO and other (see instructions)						211	93		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						184		184	5
6	Hospital Adults & Peds. Swing Bed NF								12	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		39	14,274			2,262	557	3,461	7
8	Intensive Care Unit	31	8	2,928			686	1	738	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						280	475	13
14	Total (see instructions)		47	17,202			2,948	838	4,674	14
15	CAH Visits									15
16	Subprovider - IPF	40	10	3,660			315	1,040	1,808	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	34	12,444			2,717		9,166	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					9,781		12,073	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116	1	366						24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					3,410		10,075	26
27	Total (sum of lines 14-26)		92							27
28	Observation Bed Days							165	1,027	28
29	Ambulance Trips						1,022			29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					742	258	1,286	1
2	HMO and other (see instructions)					59			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		398.42			742	258	1,286	14
15	CAH Visits								15
16	Subprovider - IPF		15.86			69	282	456	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		29.73						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		15.17						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)		5.01						24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		16.92						26
27	Total (sum of lines 14-26)		481.11						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	23,787,518		23,787,518	1,000,682.00	23.77	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B		870,572		870,572	9,006.00	96.67	3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		333,892		333,892	2,080.00	160.53	5
6	Non-physician-Part B		606,469		606,469	33,117.00	18.31	6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44	1,094,920		1,094,920	61,831.00	17.71	9
10	Excluded area salaries (see instructions)		6,196,734		6,196,734	212,883.00	29.11	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		307,763		307,763	4,133.00	74.46	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
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)(see instructions)		6,285,850	121,853	6,407,703			17
18	Wage-related costs (other)(see instructions)		123,015		123,015			18
19	Excluded areas		2,265,989		2,265,989			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B		168,239		168,239			21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		14,110		14,110			23
24	Wage-related costs (RHC/FQHC)		78,244		78,244			24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		245,212		245,212	8,637.00	28.39	26
27	Administrative & General		2,221,754		2,221,754	105,020.00	21.16	27
28	Administrative & General under contract (see instructions)		36,000		36,000	425.00	84.71	28
29	Maintenance & Repairs		537,302		537,302	26,552.00	20.24	29
30	Operation of Plant							30
31	Laundry & Linen Service		243,495		243,495	18,882.00	12.90	31
32	Housekeeping		354,907		354,907	35,122.00	10.10	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		541,345	-412,419	128,926	13,017.00	9.90	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			412,419	412,419	41,620.00	9.91	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,258,034		1,258,034	39,995.00	31.45	38
39	Central Services and Supply		75,958		75,958	6,641.00	11.44	39
40	Pharmacy		484,935		484,935	14,549.00	33.33	40
41	Medical Records & Medical Records Library		536,352		536,352	28,814.00	18.61	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		22,012,585		22,012,585	956,904.00	23.00	1
2	Excluded area salaries (see instructions)		7,291,654		7,291,654	274,714.00	26.54	2
3	Subtotal salarles (line 1 minus line 2)		14,720,931		14,720,931	682,190.00	21.58	3
4	Subtotal other wages & related costs (see instructions)		307,763		307,763	4,133.00	74.46	4
5	Subtotal wage-related costs (see instructions)		6,408,865	121,853	6,530,718		44.36%	5
6	Total (sum of lines 3 through 5)		21,437,559	121,853	21,559,412	686,323.00	31.41	6
7	Total overhead cost (see instructions)		6,535,294		6,535,294	339,274.00	19.26	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	709,156	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	193,871	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	1,309,730	17
18	Medicare Taxes - Employers Portion Only	306,308	18
19	Unemployment Insurance	7,499	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	136,931	23
24	Total Wage Related cost (Sum of lines 1-23)	2,663,495	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	175,011	25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	520,162		1
2	Hospital	307,762		2
3	Subprovider - IPF	172,300		3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF	30,000		8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice	10,100		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 CCN: 14-7187** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA County:

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		4,472		423	4,895	1
2	Unduplicated Census Count (see instructions)		305.00	39.00	49.00	393.00	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)	0.98		0.98	4
5	Other Administrative Personnel	1.31		1.31	5
6	Direct Nursing Service	11.92		11.92	6
7	Nursing Supervisor	1.29		1.29	7
8	Physical Therapy Service				8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service				10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.07		0.07	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	2.35		2.35	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	99914	20

PPS ACTIVITY

		Full Episodes Without Outliers 1	With Outliers 2	LUPA Episodes 3	PEP only Episodes 4	Total (columns 1 through 4) 5	
21	Skilled Nursing Visits	4,155	1,399	89	27	5,670	21
22	Skilled Nursing Visit Charges	1,059,402	356,480	22,788	6,917	1,445,587	22
23	Physical Therapy Visits	2,034	213	21	24	2,292	23
24	Physical Therapy Visit Charges	521,686	54,624	5,384	6,167	587,861	24
25	Occupational Therapy Visits	405	72		1	478	25
26	Occupational Therapy Visit Charges	103,594	18,445		256	122,295	26
27	Speech Pathology Visits	157	32			189	27
28	Speech Pathology Visit Charges	40,208	8,198			48,406	28
29	Medical Social Service Visits	37	5			42	29
30	Medical Social Service Visit Charges	13,100	1,779			14,879	30
31	Home Health Aide Visits	929	178	3		1,110	31
32	Home Health Aide Visit Charges	138,061	26,547	447		165,055	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,717	1,899	113	52	9,781	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	1,876,051	466,073	28,619	13,340	2,384,083	35
36	Total Number of Episodes (standard/non-outlier)	435		42	6	483	36
37	Total Number of Ourlier Episodes		41			41	37
38	Total Non-Routine Medical Supply Charges	72,434	39,730	4,373	180	116,717	38

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	11/12/2003	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX	11		11	5
6	RVL				6
7	RHX	31		31	7
8	RHL	28		28	8
9	RMX	11		11	9
10	RML				10
11	RLX				11
12	RUC	81		81	12
13	RUB	16		16	13
14	RUA	132		132	14
15	RVC	278		278	15
16	RVB	386		386	16
17	RVA	1,088		1,088	17
18	RHC	71	9	80	18
19	RHB	18	10	28	19
20	RHA	190	16	206	20
21	RMC	78	6	84	21
22	RMB	19	12	31	22
23	RMA	45	20	65	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	30	34	64	28
29	HE2				29
30	HE1	9	3	12	30
31	HD2	1	12	13	31
32	HD1	29		29	32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1	14	18	32	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1	30	5	35	40
41	LC2				41
42	LC1		6	6	42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1	14	3	17	46
47	CD2				47
48	CD1	29	5	34	48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1	30		30	52
53	CA2				53
54	CA1	34	24	58	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1	4		4	72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	6	1	7	76
77	PA2				77
78	PA1	2		2	78
199	AAA	2		2	199
200	TOTAL	2,717	184	2,901	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).	00014	00014	201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing	1,546,758	65.31%	Y	202
203	Recruitment				203
204	Retention of employees				204
205	Training	3,565	0.15%	Y	205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	2,368,179			207

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-8548** **WORKSHEET S-8**

Check applicable box: [XX] Hospital-Based RHC [ ] Hospital-Based FQHC

Clinic Address and Identification:

1	Street: 100 SOUTH MAIN	1
2	City: WEST SALEM State: IL ZIP Code: 62476 County:	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic															11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	RHC/FQHC name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA **HOSPICE CCN: 14-1542** **WORKSHEET S-9 PARTS I THROUGH IV**

PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5

PART II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care							6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay (line 5/line 6)							8
9	Unduplicated Census Count							9

PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Unduplicated Days				
		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1	2	3	4	
10	Hospice Continuous Home Care	1			1	10
11	Hospice Routine Home Care	4,401	28	296	4,725	11
12	Hospice Inpatient Respite Care					12
13	Hospice General Inpatient Care					13
14	Total Hospice Days	4,402	28	296	4,726	14

PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1	2	3	4	
15	Hospice Inpatient Respite Care					15
16	Hospice General Inpatient Care					16

NOTE: Parts I and II, columns 1 and 2 also include the days reported in column 3 and 4.

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.258932	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,774,690	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	35,021,279	6
7	Medicaid cost (line 1 times line 6)	9,068,130	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.	6,293,440	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care				17
18	Government grants, appropriations of transfers for support of hospital operations				18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			6,293,440	19
		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		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	1,216,191	705,452	1,921,643	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	314,911	182,664	497,575	21
22	Partial payment by patients approved for charity care	2,789	33,268	36,057	22
23	Cost of charity care (line 21 minus line 22)	312,122	149,396	461,518	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)		26
27	Medicare bad debts for the entire hospital complex (see instructions)	305,106	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-305,106	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-79,002	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	382,516	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,675,956	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		589,477	589,477	349,208	938,685	-287,651	651,034	1
2	00200	Cap Rel Costs-Mvble Equip		1,517,428	1,517,428	22,923	1,540,351		1,540,351	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	245,212	9,041,896	9,287,108		9,287,108	-196,025	9,091,083	4
5	00500	Administrative & General	2,221,754	4,517,481	6,739,235	-97,220	6,642,015	-2,129,021	4,512,994	5
6	00600	Maintenance & Repairs	537,302	357,790	895,092		895,092		895,092	6
7	00700	Operation of Plant		479,538	479,538		479,538		479,538	7
8	00800	Laundry & Linen Service	243,495	88,653	332,148		332,148	-196,656	135,492	8
9	00900	Housekeeping	354,907	167,464	522,371		522,371		522,371	9
10	01000	Dietary	541,345	821,062	1,362,407	-1,037,938	324,469		324,469	10
11	01100	Cafeteria				1,037,938	1,037,938	-314,477	723,461	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,258,034	176,734	1,434,768		1,434,768		1,434,768	13
14	01400	Central Services & Supply	75,958	16,771	92,729		92,729	-9,691	83,038	14
15	01500	Pharmacy	484,935	1,681,344	2,166,279		2,166,279		2,166,279	15
16	01600	Medical Records & Library	536,352	98,636	634,988		634,988	-984	634,004	16
17	01700	Social Service								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 SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,683,806	121,174	1,804,980		1,804,980	-30	1,804,950	30
31	03100	Intensive Care Unit	639,936	37,797	677,733		677,733		677,733	31
40	04000	Subprovider - IPF	630,318	195,156	825,474		825,474	-118,565	706,909	40
43	04300	Nursery	240,576	16,701	257,277		257,277		257,277	43
44	04400	Skilled Nursing Facility	1,094,920	114,716	1,209,636		1,209,636		1,209,636	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	668,627	349,696	1,018,323		1,018,323		1,018,323	50
53	05300	Anesthesiology	870,572	27,104	897,676		897,676	-871,483	26,193	53
54	05400	Radiology-Diagnostic	679,871	286,802	966,673		966,673		966,673	54
56	05600	Radioisotope	80,413	37,329	117,742		117,742		117,742	56
57	05700	CT Scan	110,606	179,930	290,536		290,536		290,536	57
58	05800	MRI	74,126	63,500	137,626		137,626		137,626	58
60	06000	Laboratory	1,118,961	1,550,428	2,669,389		2,669,389	-20,324	2,649,065	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy		45,537	45,537		45,537		45,537	64
65	06500	Respiratory Therapy	382,039	9,288	391,327		391,327		391,327	65
66	06600	Physical Therapy	1,633,788	63,376	1,697,164		1,697,164		1,697,164	66
68	06800	Speech Pathology	181,790	6,411	188,201		188,201		188,201	68
69	06900	Electrocardiology		156,758	156,758		156,758		156,758	69
71	07100	Medical Supplies Charged to Patients		2,171,511	2,171,511	-437,704	1,733,807		1,733,807	71
72	07200	Impl. Dev. Charged to Patients				437,704	437,704		437,704	72
73	07300	Drugs Charged to Patients								73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	940,361	156,360	1,096,721	227	1,096,948		1,096,948	88
91	09100	Emergency	691,098	949,192	1,640,290		1,640,290	-441,307	1,198,983	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	571,218	131,290	702,508		702,508		702,508	95
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	731,501	147,091	878,592		878,592		878,592	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		274,911	274,911	-274,911				113
116	11600	Hospice	224,310	152,731	377,041		377,041		377,041	116
118		SUBTOTALS (sum of lines 1-117)	19,748,131	26,799,063	46,547,194	227	46,547,421	-4,586,214	41,961,207	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices	4,018,826	549,294	4,568,120	-227	4,567,893		4,567,893	192
194	07950	OTHER NONREIMBURSABLE								194
194.01	07952	MEMORY DISORDER	20,561	343	20,904		20,904		20,904	194.01
194.02	07953	ASSISTED LIVING								194.02
200		TOTAL (sum of lines 118-199)	23,787,518	27,348,700	51,136,218		51,136,218	-4,586,214	46,550,004	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS CAFETERIA	A	Cafeteria	11	412,419	625,519	1
500	Total reclassifications				412,419	625,519	500
	Code Letter - A						
1	INTEREST EXPENSE	B	Cap Rel Costs-Bldg & Fixt	1		274,911	1
500	Total reclassifications					274,911	500
	Code Letter - B						
1	OTHER CAPITAL RELATED	C	Cap Rel Costs-Bldg & Fixt	1		74,297	1
2			Cap Rel Costs-Mvble Equip	2		22,923	2
500	Total reclassifications					97,220	500
	Code Letter - C						
1	RECLASS MEDICAL SUPPLIES	D	Impl. Dev. Charged to Patient	72		437,704	1
500	Total reclassifications					437,704	500
	Code Letter - D						
1	RECLASS RHC EXPENSES	E	Rural Health Clinic	88		227	1
500	Total reclassifications					227	500
	Code Letter - E						
	GRAND TOTAL (Increases)				412,419	1,435,581	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASS CAFETERIA	A	Dietary	10	412,419	625,519		1
500	Total reclassifications				412,419	625,519		500
	Code letter - A							
1	INTEREST EXPENSE	B	Interest Expense	113		274,911	11	1
500	Total reclassifications					274,911		500
	Code letter - B							
1	OTHER CAPITAL RELATED	C	Administrative & General	5		97,220	12	1
2							12	2
500	Total reclassifications					97,220		500
	Code letter - C							
1	RECLASS MEDICAL SUPPLIES	D	Medical Supplies Charged to P	71		437,704		1
500	Total reclassifications					437,704		500
	Code letter - D							
1	RECLASS RHC EXPENSES	E	Physicians' Private Offices	192		227		1
500	Total reclassifications					227		500
	Code letter - E							
	GRAND TOTAL (Decreases)				412,419	1,435,581		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	39,983	91,332		91,332		131,315		1
2	Land Improvements	385,022					385,022		2
3	Buildings and Fixtures	15,451,676	535,550		535,550		15,987,226		3
4	Building Improvements	9,558,256					9,558,256		4
5	Fixed Equipment	2,355,173					2,355,173		5
6	Movable Equipment	16,128,716	2,074,644		2,074,644		18,203,360		6
7	HIT-designated Assets	895,669	70,879		70,879		966,548		7
8	Subtotal (sum of lines 1-7)	44,814,495	2,772,405		2,772,405		47,586,900		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	44,814,495	2,772,405		2,772,405		47,586,900		10

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

	Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	589,477						589,477	1
2	Cap Rel Costs-Mvble Equip	1,517,428						1,517,428	2
3	Total (sum of lines 1-2)	2,106,905						2,106,905	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	28,416,992		28,416,992	0.597160					1
2	Cap Rel Costs-Mvble Equ	19,169,908		19,169,908	0.402840					2
3	Total (sum of lines 1-2)	47,586,900		47,586,900	1.000000					3

	Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	589,477		-12,740	74,297			651,034	1
2	Cap Rel Costs-Mvble Equip	1,517,428			22,923			1,540,351	2
3	Total (sum of lines 1-2)	2,106,905		-12,740	97,220			2,191,385	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-287,651	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)	B	-3,666	Administrative & General	5		4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-15,627	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-580,196				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service	B	-196,656	Laundry & Linen Service	8		13
14	Cafeteria - employees and guests	B	-252,259	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-9,691	Central Services & Supply	14		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-984	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-10,685	Cafeteria	11		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						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						32
33	SPECIAL FUNCTIONS	B	-51,533	Cafeteria	11		33
34	GUEST ROOM	B	-30	Adults & Pediatrics	30		34
35	MISC INCOME	B	-926	Administrative & General	5		35
36	RETURNED CHECKS	B	230	Administrative & General	5		36
37	DIETARY CONSULTATION	B	-37	Administrative & General	5		37
38	PHYSICIAN RECRUITMENT	A	-99,424	Administrative & General	5		38
39	CRNA SALARIES	A	-870,572	Anesthesiology	53		39
40	CRNA CONTRACT SERVICES	A	-911	Anesthesiology	53		40
41	CRNA BENEFITS	A	-168,239	Employee Benefits Department	4		41
42	LOBBYING DUES	A	-19,412	Administrative & General	5		42
43	FOUNDATION SALARIES	A	-73,120	Administrative & General	5		43
44	FOUNDATION BENEFITS	A	-27,786	Employee Benefits Department	4		44
45	FOUNDATION OTHER	A	-10,679	Administrative & General	5		45
46	ADVERTISING	A	-253,010	Administrative & General	5		46
47	PROVIDER TAX ASSESSMENT	A	-1,614,262	Administrative & General	5		47
48							48
49	HHA VEHICLE REIMBURSEMENT	B	-2,663	Administrative & General	5		49
49.01	MISC PATIENT REVENUE	B	-3,676	Administrative & General	5		49.01
49.03	INTEREST RECEIPTS	B	-32,749	Administrative & General	5		49.03
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-4,586,214				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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 CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	40	Subprovider - IPF AGGREGATE	174,350	78,350	96,000	181,300	640	55,785	2,789	1
2	60	Laboratory AGGREGATE	101,620	20,324	81,296	260,300	1,248	156,180	7,809	2
3	91	Emergency AGGREGATE	441,307	441,307		211,500				3
4	44	Skilled Nursing Faci AGGREGATE				211,500				4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	717,277	539,981	177,296		1,888	211,965	10,598	200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	40	Subprovider - IPF AGGREGATE					55,785	40,215	118,565	1
2	60	Laboratory AGGREGATE					156,180		20,324	2
3	91	Emergency AGGREGATE							441,307	3
4	44	Skilled Nursing Faci AGGREGATE								4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					211,965	40,215	580,196	200

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP REL COSTS-BLDG & FIXT	NEW CAP REL COSTS-MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	651,034	651,034					1
2	Cap Rel Costs-Mvble Equip	1,540,351		1,540,351				2
4	Employee Benefits Department	9,091,083	2,042	154	9,093,279			4
5	Administrative & General	4,512,994	61,948	270,899	860,281	5,706,122	5,706,122	5
6	Maintenance & Repairs	895,092	8,452	122,973	216,313	1,242,830	173,631	6
7	Operation of Plant	479,538	29,396			508,934	71,101	7
8	Laundry & Linen Service	135,492	12,123	20,680	98,029	266,324	37,207	8
9	Housekeeping	522,371	1,378	339	142,883	666,971	93,180	9
10	Dietary	324,469	25,432	2,937	51,905	404,743	56,545	10
11	Cafeteria	723,461	7,215	9,300	166,037	906,013	126,575	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,434,768	25,225	117,637	506,474	2,084,104	291,162	13
14	Central Services & Supply	83,038	17,868	27,271	30,580	158,757	22,179	14
15	Pharmacy	2,166,279	9,663	93,948	195,231	2,465,121	344,392	15
16	Medical Records & Library	634,004	7,509	6,782	215,931	864,226	120,738	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	1,804,950	100,879	58,410	677,887	2,642,126	369,121	30
31	Intensive Care Unit	677,733	23,513	13,756	257,633	972,635	135,883	31
40	Subprovider - IPF	706,909	27,677	310	253,761	988,657	138,121	40
43	Nursery	257,277	3,323	8,723	96,854	366,177	51,157	43
44	Skilled Nursing Facility	1,209,636	33,869	8,604	440,806	1,692,915	236,510	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,018,323	39,183	91,193	269,184	1,417,883	198,087	50
53	Anesthesiology	26,193	232	13,741		40,166	5,611	53
54	Radiology-Diagnostic	966,673	28,326	209,650	273,711	1,478,360	206,536	54
56	Radioisotope	117,742	2,521	23,571	32,374	176,208	24,617	56
57	CT Scan	290,536	2,514	24,417	44,529	361,996	50,573	57
58	MRI	137,626		204,970	29,843	372,439	52,032	58
60	Laboratory	2,649,065	26,473	65,622	450,485	3,191,645	445,892	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	45,537				45,537	6,362	64
65	Respiratory Therapy	391,327	3,047	9,768	153,806	557,948	77,949	65
66	Physical Therapy	1,697,164	19,345	18,910	657,750	2,393,169	334,340	66
68	Speech Pathology	188,201	751	1,632	73,187	263,771	36,850	68
69	Electrocardiology	156,758	1,306	7,189		165,253	23,087	69
71	Medical Supplies Charged to Patients	1,733,807				1,733,807	242,223	71
72	Impl. Dev. Charged to Patients	437,704				437,704	61,150	72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,096,948	10,882	14,284	378,582	1,500,696	209,656	88
91	Emergency	1,198,983	12,377	67,905	278,231	1,557,496	217,592	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	702,508	17,956	12,742	229,968	963,174	134,561	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	878,592	4,835	89	294,496	1,178,012	164,575	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	377,041	4,835	814	90,305	472,995	66,080	116
118	SUBTOTALS (sum of lines 1-117)	41,961,207	572,095	1,529,220	7,467,056	40,244,914	4,825,275	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	4,567,893	78,402	11,078	1,617,945	6,275,318	876,688	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	20,904	537	53	8,278	29,772	4,159	194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	46,550,004	651,034	1,540,351	9,093,279	46,550,004	5,706,122	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6	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	1,416,461						6
7	Operation of Plant	71,965	652,000					7
8	Laundry & Linen Service	29,678	14,392	347,601				8
9	Housekeeping	3,374	1,636	22,248	787,409			9
10	Dietary	62,259	30,192	1,252		554,991		10
11	Cafeteria	17,663	8,565	3,966			1,062,782	11
12	Maintenance of Personnel							12
13	Nursing Administration	61,753	29,947		20,447		178,700	13
14	Central Services & Supply	43,744	21,213	4,867	8,986		30,242	14
15	Pharmacy	23,657	11,472		4,689		35,348	15
16	Medical Records & Library	18,382	8,914				42,810	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	246,972	119,767	89,712	181,942	139,596	126,073	30
31	Intensive Care Unit	57,562	27,914	30,904	38,159	26,173	26,314	31
40	Subprovider - IPF	67,756	32,858	9,989	54,830	64,127	40,453	40
43	Nursery	8,134	3,945	21,206	16,540		2,357	43
44	Skilled Nursing Facility	82,915	40,209	93,485	91,035	325,095	55,771	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	95,924	46,518	32,791	70,067		55,771	50
53	Anesthesiology	568	276				6,284	53
54	Radiology-Diagnostic	69,346	33,629	6,084	30,475		56,949	54
56	Radioisotope	6,172	2,993	692	5,209		7,462	56
57	CT Scan	6,154	2,984		10,028		11,390	57
58	MRI							58
60	Laboratory	64,808	31,428	1,037	26,308		59,698	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	7,459	3,617		3,386		36,133	65
66	Physical Therapy	47,358	22,966	5,387	89,863		73,444	66
68	Speech Pathology	1,838	891				7,855	68
69	Electrocardiology	3,197	1,550		4,949			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	26,641	12,919	335				88
91	Emergency	30,299	14,693	21,556	45,452		42,810	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	43,957	21,317	2,090	8,596		62,447	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	11,837	5,740		16,800		43,595	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	11,837	5,740		16,670		21,601	116
118	SUBTOTALS (sum of lines 1-117)	1,223,209	558,285	347,601	744,431	554,991	1,023,507	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	191,938	93,078		42,978		39,275	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	1,314	637					194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,416,461	652,000	347,601	787,409	554,991	1,062,782	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		13	14	15	16	24	25	
	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	2,666,113						13
14	Central Services & Supply		289,988					14
15	Pharmacy			2,884,679				15
16	Medical Records & Library				1,055,070			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	696,321		1,330	259,785	4,872,745		30
31	Intensive Care Unit	219,070		32	25,733	1,560,379		31
40	Subprovider - IPF	285,688		95	53,918	1,736,492		40
43	Nursery	82,628			27,572	579,716		43
44	Skilled Nursing Facility	535,633		103	25,733	3,179,404		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	223,704		719	122,540	2,264,004		50
53	Anesthesiology	78,019		21,659		152,583		53
54	Radiology-Diagnostic			744	1,225	1,883,348		54
56	Radioisotope			8		223,361		56
57	CT Scan				1,225	444,350		57
58	MRI					424,471		58
60	Laboratory			76	3,676	3,824,568		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			95,999		147,898		64
65	Respiratory Therapy			76,338		762,830		65
66	Physical Therapy			337		2,966,864		66
68	Speech Pathology					311,205		68
69	Electrocardiology					198,036		69
71	Medical Supplies Charged to Patients		231,990			2,208,020		71
72	Impl. Dev. Charged to Patients		57,998			556,852		72
73	Drugs Charged to Patients			2,610,488		2,610,488		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			23,689		1,773,936		88
91	Emergency	249,096		4,655	173,394	2,357,043		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	295,954		13,996	11,641	1,557,733		95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency			866		1,421,425		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice					594,923		116
118	SUBTOTALS (sum of lines 1-117)	2,666,113	289,988	2,851,134	706,442	38,612,674		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			33,545	348,628	7,901,448		192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER					35,882		194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,666,113	289,988	2,884,679	1,055,070	46,550,004		202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes 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	4,872,745						30
31	Intensive Care Unit	1,560,379						31
40	Subprovider - IPF	1,736,492						40
43	Nursery	579,716						43
44	Skilled Nursing Facility	3,179,404						44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,264,004						50
53	Anesthesiology	152,583						53
54	Radiology-Diagnostic	1,883,348						54
56	Radioisotope	223,361						56
57	CT Scan	444,350						57
58	MRI	424,471						58
60	Laboratory	3,824,568						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	147,898						64
65	Respiratory Therapy	762,830						65
66	Physical Therapy	2,966,864						66
68	Speech Pathology	311,205						68
69	Electrocardiology	198,036						69
71	Medical Supplies Charged to Patients	2,208,020						71
72	Impl. Dev. Charged to Patients	556,852						72
73	Drugs Charged to Patients	2,610,488						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,773,936						88
91	Emergency	2,357,043						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,557,733						95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	1,421,425						101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	594,923						116
118	SUBTOTALS (sum of lines 1-117)	38,612,674						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	7,901,448						192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	35,882						194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	46,550,004						202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP REL COSTS-BLDG & FIXT	NEW CAP REL COSTS-MVBLE EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		2,042	154	2,196	2,196		4
5	Administrative & General	5,004	61,948	270,899	337,851	207	338,058	5
6	Maintenance & Repairs		8,452	122,973	131,425	52	10,287	6
7	Operation of Plant		29,396		29,396		4,212	7
8	Laundry & Linen Service		12,123	20,680	32,803	24	2,204	8
9	Housekeeping		1,378	339	1,717	34	5,521	9
10	Dietary		25,432	2,937	28,369	13	3,350	10
11	Cafeteria		7,215	9,300	16,515	40	7,499	11
12	Maintenance of Personnel							12
13	Nursing Administration		25,225	117,637	142,862	122	17,250	13
14	Central Services & Supply		17,868	27,271	45,139	7	1,314	14
15	Pharmacy		9,663	93,948	103,611	47	20,404	15
16	Medical Records & Library		7,509	6,782	14,291	52	7,153	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	3,691	100,879	58,410	162,980	163	21,869	30
31	Intensive Care Unit	116	23,513	13,756	37,385	62	8,050	31
40	Subprovider - IPF		27,677	310	27,987	61	8,183	40
43	Nursery		3,323	8,723	12,046	23	3,031	43
44	Skilled Nursing Facility	5,831	33,869	8,604	48,304	106	14,012	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	161,273	39,183	91,193	291,649	65	11,736	50
53	Anesthesiology		232	13,741	13,973		332	53
54	Radiology-Diagnostic		28,326	209,650	237,976	66	12,236	54
56	Radioisotope		2,521	23,571	26,092	8	1,458	56
57	CT Scan		2,514	24,417	26,931	11	2,996	57
58	MRI			204,970	204,970	7	3,083	58
60	Laboratory	4,409	26,473	65,622	96,504	109	26,417	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy						377	64
65	Respiratory Therapy	2,000	3,047	9,768	14,815	37	4,618	65
66	Physical Therapy		19,345	18,910	38,255	158	19,808	66
68	Speech Pathology		751	1,632	2,383	18	2,183	68
69	Electrocardiology		1,306	7,189	8,495		1,368	69
71	Medical Supplies Charged to Patients						14,351	71
72	Impl. Dev. Charged to Patients						3,623	72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		10,882	14,284	25,166	91	12,421	88
91	Emergency		12,377	67,905	80,282	67	12,891	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,775	17,956	12,742	32,473	55	7,972	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	26,231	4,835	89	31,155	71	9,750	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	50,323	4,835	814	55,972	22	3,915	116
118	SUBTOTALS (sum of lines 1-117)	260,653	572,095	1,529,220	2,361,968	1,798	285,874	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		78,402	11,078	89,480	396	51,938	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER		537	53	590	2	246	194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	260,653	651,034	1,540,351	2,452,038	2,196	338,058	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6	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	141,764						6
7	Operation of Plant	7,203	40,811					7
8	Laundry & Linen Service	2,970	901	38,902				8
9	Housekeeping	338	102	2,490	10,202			9
10	Dietary	6,231	1,890	140		39,993		10
11	Cafeteria	1,768	536	444			26,802	11
12	Maintenance of Personnel							12
13	Nursing Administration	6,180	1,874		265		4,509	13
14	Central Services & Supply	4,378	1,328	545	116		763	14
15	Pharmacy	2,368	718		61		891	15
16	Medical Records & Library	1,840	558				1,080	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	24,717	7,497	10,040	2,359	10,059	3,179	30
31	Intensive Care Unit	5,761	1,747	3,459	494	1,886	664	31
40	Subprovider - IPF	6,781	2,057	1,118	710	4,621	1,020	40
43	Nursery	814	247	2,373	214		59	43
44	Skilled Nursing Facility	8,298	2,517	10,461	1,179	23,427	1,406	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,600	2,912	3,670	908		1,406	50
53	Anesthesiology	57	17				158	53
54	Radiology-Diagnostic	6,940	2,105	681	395		1,436	54
56	Radioisotope	618	187	77	67		188	56
57	CT Scan	616	187		130		287	57
58	MRI							58
60	Laboratory	6,486	1,967	116	341		1,506	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	747	226		44		911	65
66	Physical Therapy	4,740	1,438	603	1,164		1,852	66
68	Speech Pathology	184	56				198	68
69	Electrocardiology	320	97		64			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,666	809	38				88
91	Emergency	3,032	920	2,413	589		1,080	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	4,399	1,334	234	111		1,575	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	1,185	359		218		1,099	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	1,185	359		216		545	116
118	SUBTOTALS (sum of lines 1-117)	122,422	34,945	38,902	9,645	39,993	25,812	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	19,210	5,826		557		990	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	132	40					194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	141,764	40,811	38,902	10,202	39,993	26,802	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	MEDICAL RE CORDS & LI BRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		13	14	15	16	24	25	
	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	173,062						13
14	Central Services & Supply		53,590					14
15	Pharmacy			128,100				15
16	Medical Records & Library				24,974			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	45,199		59	6,149	294,270		30
31	Intensive Care Unit	14,220		1	609	74,338		31
40	Subprovider - IPF	18,545		4	1,276	72,363		40
43	Nursery	5,364			653	24,824		43
44	Skilled Nursing Facility	34,769		5	609	145,093		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,521		32	2,901	339,400		50
53	Anesthesiology	5,064		962		20,563		53
54	Radiology-Diagnostic			33	29	261,897		54
56	Radioisotope					28,695		56
57	CT Scan				29	31,187		57
58	MRI					208,060		58
60	Laboratory			3	87	133,536		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			4,263		4,640		64
65	Respiratory Therapy			3,390		24,788		65
66	Physical Therapy			15		68,033		66
68	Speech Pathology					5,022		68
69	Electrocardiology					10,344		69
71	Medical Supplies Charged to Patients		42,872			57,223		71
72	Impl. Dev. Charged to Patients		10,718			14,341		72
73	Drugs Charged to Patients			115,924		115,924		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			1,052		42,243		88
91	Emergency	16,169		207	4,104	121,754		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	19,211		622	276	68,262		95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency			38		43,875		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice					62,214		116
118	SUBTOTALS (sum of lines 1-117)	173,062	53,590	126,610	16,722	2,272,889		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			1,490	8,252	178,139		192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER					1,010		194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	173,062	53,590	128,100	24,974	2,452,038		202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes 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	294,270						30
31	Intensive Care Unit	74,338						31
40	Subprovider - IPF	72,363						40
43	Nursery	24,824						43
44	Skilled Nursing Facility	145,093						44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	339,400						50
53	Anesthesiology	20,563						53
54	Radiology-Diagnostic	261,897						54
56	Radioisotope	28,695						56
57	CT Scan	31,187						57
58	MRI	208,060						58
60	Laboratory	133,536						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	4,640						64
65	Respiratory Therapy	24,788						65
66	Physical Therapy	68,033						66
68	Speech Pathology	5,022						68
69	Electrocardiology	10,344						69
71	Medical Supplies Charged to Patients	57,223						71
72	Impl. Dev. Charged to Patients	14,341						72
73	Drugs Charged to Patients	115,924						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	42,243						88
91	Emergency	121,754						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	68,262						95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	43,875						101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	62,214						116
118	SUBTOTALS (sum of lines 1-117)	2,272,889						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	178,139						192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	1,010						194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,452,038						202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	NEW CAP REL COSTS-BLDG & FIXT SQUARE FEET	NEW CAP REL COSTS-MVBLE EQUIP DOLLAR VALUE -NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	MAINTENANCE & REPAIRS SQUARE FEET	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	179,478						1
2	Cap Rel Costs-Mvble Equip		1,517,428					2
4	Employee Benefits Department	563	152	22,586,836				4
5	Administrative & General	17,078	266,868	2,136,856	-5,706,122	40,843,882		5
6	Maintenance & Repairs	2,330	121,143	537,302		1,242,830	159,507	6
7	Operation of Plant	8,104				508,934	8,104	7
8	Laundry & Linen Service	3,342	20,372	243,495		266,324	3,342	8
9	Housekeeping	380	334	354,907		666,971	380	9
10	Dietary	7,011	2,893	128,926		404,743	7,011	10
11	Cafeteria	1,989	9,162	412,419		906,013	1,989	11
12	Maintenance of Personnel							12
13	Nursing Administration	6,954	115,886	1,258,034		2,084,104	6,954	13
14	Central Services & Supply	4,926	26,865	75,958		158,757	4,926	14
15	Pharmacy	2,664	92,550	484,935		2,465,121	2,664	15
16	Medical Records & Library	2,070	6,681	536,352		864,226	2,070	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	27,811	57,541	1,683,806		2,642,126	27,811	30
31	Intensive Care Unit	6,482	13,551	639,936		972,635	6,482	31
40	Subprovider - IPF	7,630	305	630,318		988,657	7,630	40
43	Nursery	916	8,593	240,576		366,177	916	43
44	Skilled Nursing Facility	9,337	8,476	1,094,920		1,692,915	9,337	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	10,802	89,836	668,627		1,417,883	10,802	50
53	Anesthesiology	64	13,537			40,166	64	53
54	Radiology-Diagnostic	7,809	206,530	679,871		1,478,360	7,809	54
56	Radioisotope	695	23,220	80,413		176,208	695	56
57	CT Scan	693	24,054	110,606		361,996	693	57
58	MRI		201,920	74,126		372,439		58
60	Laboratory	7,298	64,645	1,118,961		3,191,645	7,298	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					45,537		64
65	Respiratory Therapy	840	9,623	382,039		557,948	840	65
66	Physical Therapy	5,333	18,629	1,633,788		2,393,169	5,333	66
68	Speech Pathology	207	1,608	181,790		263,771	207	68
69	Electrocardiology	360	7,082			165,253	360	69
71	Medical Supplies Charged to Patients					1,733,807		71
72	Impl. Dev. Charged to Patients					437,704		72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,000	14,071	940,361		1,500,696	3,000	88
91	Emergency	3,412	66,894	691,098		1,557,496	3,412	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	4,950	12,552	571,218		963,174	4,950	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	1,333	88	731,501		1,178,012	1,333	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	1,333	802	224,310		472,995	1,333	116
118	SUBTOTALS (sum of lines 1-117)	157,716	1,506,463	18,547,449	-5,706,122	34,538,792	137,745	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	21,614	10,913	4,018,826		6,275,318	21,614	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	148	52	20,561		29,772	148	194.01
194.02	ASSISTED LIVING							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	651,034	1,540,351	9,093,279		5,706,122	1,416,461	202
203	Unit Cost Multiplier (Wkst. B, Part I)	3.627375	1.015106	0.402592		0.139706	8.880244	203
204	Cost to be allocated (Per Wkst. B, Part II)			2,196		338,058	141,764	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000097		0.008277	0.888764	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE LAUNDRY POUNDS	HOUSEKEEPING HOURS OF SERVICE	DIETARY DIETARY MEALS SERV	CAFETERIA CAFE MEALS SERV	NURSING ADMINISTRATION DIRECT NURSING HO	
		7	8	9	10	11	13	
	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	151,403						7
8	Laundry & Linen Service	3,342	466,693					8
9	Housekeeping	380	29,870	6,046				9
10	Dietary	7,011	1,681		78,480			10
11	Cafeteria	1,989	5,325			2,706		11
12	Maintenance of Personnel							12
13	Nursing Administration	6,954		157		455	307,759	13
14	Central Services & Supply	4,926	6,534	69		77		14
15	Pharmacy	2,664		36		90		15
16	Medical Records & Library	2,070				109		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	27,811	120,448	1,397	19,740	321	80,379	30
31	Intensive Care Unit	6,482	41,492	293	3,701	67	25,288	31
40	Subprovider - IPF	7,630	13,412	421	9,068	103	32,978	40
43	Nursery	916	28,471	127		6	9,538	43
44	Skilled Nursing Facility	9,337	125,515	699	45,971	142	61,830	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	10,802	44,025	538		142	25,823	50
53	Anesthesiology	64				16	9,006	53
54	Radiology-Diagnostic	7,809	8,168	234		145		54
56	Radioisotope	695	929	40		19		56
57	CT Scan	693		77		29		57
58	MRI							58
60	Laboratory	7,298	1,392	202		152		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					-		64
65	Respiratory Therapy	840		26		92		65
66	Physical Therapy	5,333	7,233	690		187		66
68	Speech Pathology	207				20		68
69	Electrocardiology	360		38				69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,000	450					88
91	Emergency	3,412	28,942	349		109	28,754	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	4,950	2,806	66		159	34,163	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	1,333		129		111		101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	1,333		128		55		116
118	SUBTOTALS (sum of lines 1-117)	129,641	466,693	5,716	78,480	2,606	307,759	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	21,614		330		100		192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	148						194.01
194.02	ASSISTED LIVING							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	652,000	347,601	787,409	554,991	1,062,782	2,666,113	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.306388	0.744817	130.236355	7.071751	392.750185	8.662990	203
204	Cost to be allocated (Per Wkst. B, Part II)	40,811	38,902	10,202	39,993	26,802	173,062	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.269552	0.083357	1.687397	0.509595	9.904656	0.562330	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY CS COSTED REQUIS	PHARMACY PHARM COSTED REQ	MEDICAL RECORDS & LIBRARY TIME SPENT				
		14	15	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							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	100						14
15	Pharmacy		1,368,351					15
16	Medical Records & Library			1,722				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		631	424				30
31	Intensive Care Unit		15	42				31
40	Subprovider - IPF		45	88				40
43	Nursery			45				43
44	Skilled Nursing Facility		49	42				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		341	200				50
53	Anesthesiology		10,274					53
54	Radiology-Diagnostic		353	2				54
56	Radioisotope		4					56
57	CT Scan			2				57
58	MRI							58
60	Laboratory		36	6				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		45,537					64
65	Respiratory Therapy		36,211					65
66	Physical Therapy		160					66
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	80						71
72	Impl. Dev. Charged to Patients	20						72
73	Drugs Charged to Patients		1,238,288					73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		11,237					88
91	Emergency		2,208	283				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		6,639	19				95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency		411					101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)	100	1,352,439	1,153				118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		15,912	569				192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER							194.01
194.02	ASSISTED LIVING							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	289,988	2,884,679	1,055,070				202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,899.880000	2.108143	612.700348				203
204	Cost to be allocated (Per Wkst. B, Part II)	53,590	128,100	24,974				204

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY CS COSTED REQUIS	PHARMACY PHARM COSTED REQ	MEDICAL RECORDS & LIBRARY TIME SPENT				
		14	15	16				
205	Unit Cost Multiplier (Wkst. B, Part II)	535.900000	0.093616	14.502904				205

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,872,745		4,872,745		4,872,745	30
31	Intensive Care Unit	1,560,379		1,560,379		1,560,379	31
40	Subprovider - IPF	1,736,492		1,736,492	40,215	1,776,707	40
43	Nursery	579,716		579,716		579,716	43
44	Skilled Nursing Facility	3,179,404		3,179,404		3,179,404	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,264,004		2,264,004		2,264,004	50
53	Anesthesiology	152,583		152,583		152,583	53
54	Radiology-Diagnostic	1,883,348		1,883,348		1,883,348	54
56	Radioisotope	223,361		223,361		223,361	56
57	CT Scan	444,350		444,350		444,350	57
58	MRI	424,471		424,471		424,471	58
60	Laboratory	3,824,568		3,824,568		3,824,568	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	147,898		147,898		147,898	64
65	Respiratory Therapy	762,830		762,830		762,830	65
66	Physical Therapy	2,966,864		2,966,864		2,966,864	66
68	Speech Pathology	311,205		311,205		311,205	68
69	Electrocardiology	198,036		198,036		198,036	69
71	Medical Supplies Charged to Patients	2,208,020		2,208,020		2,208,020	71
72	Impl. Dev. Charged to Patients	556,852		556,852		556,852	72
73	Drugs Charged to Patients	2,610,488		2,610,488		2,610,488	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	1,773,936		1,773,936		1,773,936	88
91	Emergency	2,357,043		2,357,043		2,357,043	91
92	Observation Beds (Non-Distinct Part)	1,156,238		1,156,238		1,156,238	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,557,733		1,557,733		1,557,733	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	Home Health Agency	1,421,425		1,421,425		1,421,425	101
113	Interest Expense						113
116	Hospice	594,923		594,923		594,923	116
200	Subtotal (sum of lines 30 thru 199)	39,768,912		39,768,912	40,215	39,809,127	200
201	Less Observation Beds	1,156,238		1,156,238		1,156,238	201
202	Total (line 200 minus line 201)	38,612,674		38,612,674		38,652,889	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

	COST CENTER DESCRIPTIONS	CHARGES Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	4,252,724		4,252,724				30
31	Intensive Care Unit	1,612,913		1,612,913				31
40	Subprovider - IPF	2,299,771		2,299,771				40
43	Nursery	508,981		508,981				43
44	Skilled Nursing Facility	2,368,179		2,368,179				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,329,651	12,298,152	15,627,803	0.144870	0.144870	0.144870	50
53	Anesthesiology	863,264	3,756,784	4,620,048	0.033026	0.033026	0.033026	53
54	Radiology-Diagnostic	1,195,300	10,339,454	11,534,754	0.163276	0.163276	0.163276	54
56	Radioisotope	134,667	2,534,469	2,669,136	0.083683	0.083683	0.083683	56
57	CT Scan	1,384,716	13,455,703	14,840,419	0.029942	0.029942	0.029942	57
58	MRI	94,613	3,250,272	3,344,885	0.126902	0.126902	0.126902	58
60	Laboratory	3,449,916	24,921,806	28,371,722	0.134802	0.134802	0.134802	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	860,444	323,137	1,183,581	0.124958	0.124958	0.124958	64
65	Respiratory Therapy	2,447,416	1,218,305	3,665,721	0.208098	0.208098	0.208098	65
66	Physical Therapy	3,288,578	7,163,309	10,451,887	0.283859	0.283859	0.283859	66
68	Speech Pathology	162,564	760,348	922,912	0.337199	0.337199	0.337199	68
69	Electrocardiology	292,693	2,431,208	2,723,901	0.072703	0.072703	0.072703	69
71	Medical Supplies Charged to Patients	2,015,826	3,377,950	5,393,776	0.409364	0.409364	0.409364	71
72	Impl. Dev. Charged to Patients	308,918	785,343	1,094,261	0.508884	0.508884	0.508884	72
73	Drugs Charged to Patients	3,741,150	7,228,879	10,970,029	0.237965	0.237965	0.237965	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		1,343,386	1,343,386				88
91	Emergency	1,213,437	8,679,129	9,892,566	0.238264	0.238264	0.238264	91
92	Observation Beds (Non-Distinct Part)	596,938	2,114,377	2,711,315	0.426449	0.426449	0.426449	92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	30,941	2,169,420	2,200,361	0.707944	0.707944	0.707944	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency		2,972,725	2,972,725				101
113	Interest Expense							113
116	Hospice		1,545,193	1,545,193				116
200	Subtotal (sum of lines 30 thru 199)	36,453,600	112,669,349	149,122,949				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	36,453,600	112,669,349	149,122,949				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

```
Check        [ ] Title V                [XX] PPS
Applicable   [XX] Title XVIII, Part A   [ ] TEFRA
Boxes:       [ ] Title XIX
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		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	294,270	2,453	291,817	4,292	67.99	2,078	141,283	30
31	Intensive Care Unit	74,338		74,338	738	100.73	686	69,101	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF	72,363		72,363	1,808	40.02	315	12,606	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	24,824		24,824	475	52.26			43
44	Skilled Nursing Facility	145,093		145,093	9,166	15.83	2,717	43,010	44
45	Nursing Facility								45
200	Total (lines 30-199)	610,888		608,435	16,479		5,796	266,000	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0147** **WORKSHEET D PART II**

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Check        [  ] Title V                [XX] Hospital    [  ] SUB (Other)        [XX] PPS
Applicable   [XX] Title XVIII, Part A    [  ] IPF                                 [  ] TEFRA
Boxes:       [  ] Title XIX              [  ] IRF
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		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	339,400	15,627,803	0.021718	1,190,051	25,846	50
53	Anesthesiology	20,563	4,620,048	0.004451	253,384	1,128	53
54	Radiology-Diagnostic	261,897	11,534,754	0.022705	1,110,312	25,210	54
56	Radioisotope	28,695	2,669,136	0.010751	126,596	1,361	56
57	CT Scan	31,187	14,840,419	0.002101	1,329,148	2,793	57
58	MRI	208,060	3,344,885	0.062202	78,920	4,909	58
60	Laboratory	133,536	28,371,722	0.004707	3,140,036	14,780	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	4,640	1,183,581	0.003920	313,356	1,228	64
65	Respiratory Therapy	24,788	3,665,721	0.006762	1,590,684	10,756	65
66	Physical Therapy	68,033	10,451,887	0.006509	471,682	3,070	66
68	Speech Pathology	5,022	922,912	0.005441	44,505	242	68
69	Electrocardiology	10,344	2,723,901	0.003797	276,547	1,050	69
71	Medical Supplies Charged to Pat	57,223	5,393,776	0.010609	688,726	7,307	71
72	Impl. Dev. Charged to Patients	14,341	1,094,261	0.013106	237,421	3,112	72
73	Drugs Charged to Patients	115,924	10,970,029	0.010567	2,188,384	23,125	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	42,243	1,343,386	0.031445			88
91	Emergency	121,754	9,892,566	0.012308	1,079,730	13,289	91
92	Observation Beds (Non-Distinct	69,826	2,711,315	0.025754	269,232	6,934	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,557,476	131,362,102		14,388,714	146,140	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

```
Check          [  ] Title V                  [XX] PPS
Applicable     [XX] Title XVIII, Part A      [  ] TEFRA
Boxes:         [  ] Title XIX                [  ] Other
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		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

```
Check        [ ] Title V                [XX] PPS
Applicable   [XX] Title XVIII, Part A   [ ] TEFRA
Boxes:       [ ] Title XIX              [ ] Other
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		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	4,292		2,078		30
31	Intensive Care Unit	738		686		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF	1,808		315		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	475				43
44	Skilled Nursing Facility	9,166		2,717		44
45	Nursing Facility					45
200	Total (lines 30-199)	16,479		5,796		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0147** **WORKSHEET D PART IV**

Check	[ ] Title V	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
Applicable	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
Boxes:	[ ] Title XIX	[ ] IRF	[ ] NF		[ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/24/2017 Run Time: 08:34 Version: 2017.01 (02/16/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0147** **WORKSHEET D PART IV**

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Check        [ ] Title V                [XX] Hospital    [ ] SUB (Other)        [ ] ICF/IID    [XX] PPS
Applicable   [XX] Title XVIII, Part A   [ ] IPF         [ ] SNF                               [ ] TEFRA
Boxes:       [ ] Title XIX              [ ] IRF         [ ] NF                                [ ] Other
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		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,627,803			1,190,051		3,973,413		50
53	Anesthesiology	4,620,048			253,384		805,336		53
54	Radiology-Diagnostic	11,534,754			1,110,312		3,518,062		54
56	Radioisotope	2,669,136			126,596		1,231,852		56
57	CT Scan	14,840,419			1,329,148		4,537,998		57
58	MRI	3,344,885			78,920		956,790		58
60	Laboratory	28,371,722			3,140,036		3,515,087		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,183,581			313,356		231,120		64
65	Respiratory Therapy	3,665,721			1,590,684		479,955		65
66	Physical Therapy	10,451,887			471,682		29,698		66
68	Speech Pathology	922,912			44,505		27,932		68
69	Electrocardiology	2,723,901			276,547		953,413		69
71	Medical Supplies Charged to Pat	5,393,776			688,726		1,196,720		71
72	Impl. Dev. Charged to Patients	1,094,261			237,421		336,399		72
73	Drugs Charged to Patients	10,970,029			2,188,384		3,026,067		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	1,343,386							88
91	Emergency	9,892,566			1,079,730		2,252,073		91
92	Observation Beds (Non-Distinct	2,711,315			269,232		587,038		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	131,362,102			14,388,714		27,658,953		200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0147** **WORKSHEET D PART V**

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Check        [ ] Title V - O/P          [XX] Hospital     [ ] SUB (Other)        [ ] Swing Bed SNF
Applicable   [XX] Title XVIII, Part B   [ ] IPF           [ ] SNF                [ ] Swing Bed NF
Boxes:       [ ] Title XIX - O/P        [ ] IRF           [ ] NF                 [ ] ICF/IID
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			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.144870	3,973,413			575,628			50
53	Anesthesiology	0.033026	805,336			26,597			53
54	Radiology-Diagnostic	0.163276	3,518,062			574,415			54
56	Radioisotope	0.083683	1,231,852			103,085			56
57	CT Scan	0.029942	4,537,998			135,877			57
58	MRI	0.126902	956,790			121,419			58
60	Laboratory	0.134802	3,515,087			473,841			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.124958	231,120			28,880			64
65	Respiratory Therapy	0.208098	479,955			99,878			65
66	Physical Therapy	0.283859	29,698			8,430			66
68	Speech Pathology	0.337199	27,932			9,419			68
69	Electrocardiology	0.072703	953,413			69,316			69
71	Medical Supplies Charged to Pat	0.409364	1,196,720			489,894			71
72	Impl. Dev. Charged to Patients	0.508884	336,399			171,188			72
73	Drugs Charged to Patients	0.237965	3,026,067		10,865	720,098		2,585	73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.238264	2,252,073			536,588			91
92	Observation Beds (Non-Distinct	0.426449	587,038			250,342			92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.707944							95
200	Subtotal (see instructions)		27,658,953		10,865	4,394,895		2,585	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		27,658,953		10,865	4,394,895		2,585	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S147** **WORKSHEET D PART II**

```
Check        [ ] Title V                [ ] Hospital    [ ] SUB (Other)          [XX] PPS
Applicable   [XX] Title XVIII, Part A   [XX] IPF                                [ ] TEFRA
Boxes:       [ ] Title XIX              [ ] IRF
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		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	339,400	15,627,803	0.021718			50
53	Anesthesiology	20,563	4,620,048	0.004451			53
54	Radiology-Diagnostic	261,897	11,534,754	0.022705	10,358	235	54
56	Radioisotope	28,695	2,669,136	0.010751			56
57	CT Scan	31,187	14,840,419	0.002101	7,083	15	57
58	MRI	208,060	3,344,885	0.062202			58
60	Laboratory	133,536	28,371,722	0.004707	50,863	239	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	4,640	1,183,581	0.003920	42		64
65	Respiratory Therapy	24,788	3,665,721	0.006762	1,841	12	65
66	Physical Therapy	68,033	10,451,887	0.006509	2,588	17	66
68	Speech Pathology	5,022	922,912	0.005441			68
69	Electrocardiology	10,344	2,723,901	0.003797	5,958	23	69
71	Medical Supplies Charged to Pat	57,223	5,393,776	0.010609	2,783	30	71
72	Impl. Dev. Charged to Patients	14,341	1,094,261	0.013106			72
73	Drugs Charged to Patients	115,924	10,970,029	0.010567	104,003	1,099	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	42,243	1,343,386	0.031445			88
91	Emergency	121,754	9,892,566	0.012308	27,291	336	91
92	Observation Beds (Non-Distinct		2,711,315				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,487,650	131,362,102		212,810	2,006	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/24/2017 Run Time: 08:34 Version: 2017.01 (02/16/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S147** **WORKSHEET D PART IV**

Check	[ ] Title V	[ ] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
Applicable	[XX] Title XVIII, Part A	[XX] IPF	[ ] SNF		[ ] TEFRA
Boxes:	[ ] Title XIX	[ ] IRF	[ ] NF		[ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S147** **WORKSHEET D PART IV**

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Check        [ ] Title V                 [ ] Hospital     [ ] SUB (Other)        [ ] ICF/IID     [XX] PPS
Applicable   [XX] Title XVIII, Part A    [XX] IPF         [ ] SNF                                [ ] TEFRA
Boxes:       [ ] Title XIX               [ ] IRF          [ ] NF                                 [ ] Other
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		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,627,803							50
53	Anesthesiology	4,620,048							53
54	Radiology-Diagnostic	11,534,754			10,358				54
56	Radioisotope	2,669,136							56
57	CT Scan	14,840,419			7,083				57
58	MRI	3,344,885							58
60	Laboratory	28,371,722			50,863				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,183,581			42				64
65	Respiratory Therapy	3,665,721			1,841				65
66	Physical Therapy	10,451,887			2,588				66
68	Speech Pathology	922,912							68
69	Electrocardiology	2,723,901			5,958				69
71	Medical Supplies Charged to Pat	5,393,776			2,783				71
72	Impl. Dev. Charged to Patients	1,094,261							72
73	Drugs Charged to Patients	10,970,029			104,003				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	1,343,386							88
91	Emergency	9,892,566			27,291				91
92	Observation Beds (Non-Distinct	2,711,315							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	131,362,102			212,810				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S147** **WORKSHEET D PART V**

```
Check        [ ] Title V - O/P          [ ] Hospital     [ ] SUB (Other)        [ ] Swing Bed SNF
Applicable   [XX] Title XVIII, Part B   [XX] IPF          [ ] SNF                [ ] Swing Bed NF
Boxes:       [ ] Title XIX - O/P        [ ] IRF          [ ] NF                 [ ] ICF/IID
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			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.144870							50
53	Anesthesiology	0.033026							53
54	Radiology-Diagnostic	0.163276							54
56	Radioisotope	0.083683							56
57	CT Scan	0.029942							57
58	MRI	0.126902							58
60	Laboratory	0.134802							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.124958							64
65	Respiratory Therapy	0.208098							65
66	Physical Therapy	0.283859							66
68	Speech Pathology	0.337199							68
69	Electrocardiology	0.072703							69
71	Medical Supplies Charged to Pat	0.409364							71
72	Impl. Dev. Charged to Patients	0.508884							72
73	Drugs Charged to Patients	0.237965							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.238264							91
92	Observation Beds (Non-Distinct	0.426449							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.707944							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-U147** **WORKSHEET D PART V**

```
Check        [ ] Title V - O/P          [ ] Hospital     [ ] SUB (Other)        [XX] Swing Bed SNF
Applicable   [XX] Title XVIII, Part B   [ ] IPF          [ ] SNF                [ ] Swing Bed NF
Boxes:       [ ] Title XIX - O/P        [ ] IRF          [ ] NF                 [ ] ICF/IID
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			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.144870							50
53	Anesthesiology	0.033026							53
54	Radiology-Diagnostic	0.163276							54
56	Radioisotope	0.083683							56
57	CT Scan	0.029942							57
58	MRI	0.126902							58
60	Laboratory	0.134802							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.124958							64
65	Respiratory Therapy	0.208098							65
66	Physical Therapy	0.283859							66
68	Speech Pathology	0.337199							68
69	Electrocardiology	0.072703							69
71	Medical Supplies Charged to Pat	0.409364							71
72	Impl. Dev. Charged to Patients	0.508884							72
73	Drugs Charged to Patients	0.237965							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.238264							91
92	Observation Beds (Non-Distinct	0.426449							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.707944							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5580** **WORKSHEET D PART IV**

```
Check        [ ] Title V                  [ ] Hospital     [ ] SUB (Other)        [ ] ICF/IID      [XX] PPS
Applicable   [XX] Title XVIII, Part A     [ ] IPF          [XX] SNF                                [ ] TEFRA
Boxes:       [ ] Title XIX                [ ] IRF          [ ] NF                                  [ ] Other
```

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/24/2017 Run Time: 08:34 Version: 2017.01 (02/16/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5580** **WORKSHEET D PART IV**

```
Check        [ ] Title V                [ ] Hospital    [ ] SUB (Other)        [ ] ICF/IID    [XX] PPS
Applicable   [XX] Title XVIII, Part A   [ ] IPF         [XX] SNF                              [ ] TEFRA
Boxes:       [ ] Title XIX              [ ] IRF         [ ] NF                                [ ] Other
```

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,627,803							50
53	Anesthesiology	4,620,048							53
54	Radiology-Diagnostic	11,534,754			65,115				54
56	Radioisotope	2,669,136			3,964				56
57	CT Scan	14,840,419			42,233				57
58	MRI	3,344,885			8,088				58
60	Laboratory	28,371,722			228,493				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,183,581			41,393				64
65	Respiratory Therapy	3,665,721			795,899				65
66	Physical Therapy	10,451,887			2,277,472				66
68	Speech Pathology	922,912			76,352				68
69	Electrocardiology	2,723,901			8,914				69
71	Medical Supplies Charged to Pat	5,393,776			145,324				71
72	Impl. Dev. Charged to Patients	1,094,261							72
73	Drugs Charged to Patients	10,970,029			695,513				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	1,343,386							88
91	Emergency	9,892,566							91
92	Observation Beds (Non-Distinct	2,711,315			6,214				92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	131,362,102			4,394,974				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-5580** **WORKSHEET D PART V**

```
Check        [ ] Title V - O/P          [ ] Hospital     [ ] SUB (Other)        [ ] Swing Bed SNF
Applicable   [XX] Title XVIII, Part B   [ ] IPF          [XX] SNF               [ ] Swing Bed NF
Boxes:       [ ] Title XIX - O/P        [ ] IRF          [ ] NF                 [ ] ICF/IID
```

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.144870							50
53	Anesthesiology	0.033026							53
54	Radiology-Diagnostic	0.163276							54
56	Radioisotope	0.083683							56
57	CT Scan	0.029942							57
58	MRI	0.126902							58
60	Laboratory	0.134802							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.124958							64
65	Respiratory Therapy	0.208098							65
66	Physical Therapy	0.283859							66
68	Speech Pathology	0.337199							68
69	Electrocardiology	0.072703							69
71	Medical Supplies Charged to Pat	0.409364							71
72	Impl. Dev. Charged to Patients	0.508884							72
73	Drugs Charged to Patients	0.237965							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.238264							91
92	Observation Beds (Non-Distinct	0.426449							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.707944							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

```
Check        [  ] Title V                [XX] PPS
Applicable   [  ] Title XVIII, Part A    [  ] TEFRA
Boxes:       [XX] Title XIX
```

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	294,270	2,453	291,817	4,292	67.99	557	37,870	30
31	Intensive Care Unit	74,338		74,338	738	100.73	1	101	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF	72,363		72,363	1,808	40.02	1,040	41,621	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	24,824		24,824	475	52.26	280	14,633	43
44	Skilled Nursing Facility	145,093		145,093	9,166	15.83			44
45	Nursing Facility								45
200	Total (lines 30-199)	610,888		608,435	16,479		1,878	94,225	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0147** **WORKSHEET D PART II**

```
Check        [ ] Title V                [XX] Hospital    [ ] SUB (Other)        [XX] PPS
Applicable   [ ] Title XVIII, Part A    [ ] IPF                                 [ ] TEFRA
Boxes:       [XX] Title XIX             [ ] IRF
```

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	339,400	15,627,803	0.021718			50
53	Anesthesiology	20,563	4,620,048	0.004451			53
54	Radiology-Diagnostic	261,897	11,534,754	0.022705			54
56	Radioisotope	28,695	2,669,136	0.010751			56
57	CT Scan	31,187	14,840,419	0.002101			57
58	MRI	208,060	3,344,885	0.062202			58
60	Laboratory	133,536	28,371,722	0.004707			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	4,640	1,183,581	0.003920			64
65	Respiratory Therapy	24,788	3,665,721	0.006762			65
66	Physical Therapy	68,033	10,451,887	0.006509			66
68	Speech Pathology	5,022	922,912	0.005441			68
69	Electrocardiology	10,344	2,723,901	0.003797			69
71	Medical Supplies Charged to Pat	57,223	5,393,776	0.010609			71
72	Impl. Dev. Charged to Patients	14,341	1,094,261	0.013106			72
73	Drugs Charged to Patients	115,924	10,970,029	0.010567			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	42,243	1,343,386	0.031445			88
91	Emergency	121,754	9,892,566	0.012308			91
92	Observation Beds (Non-Distinct	69,826	2,711,315	0.025754			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,557,476	131,362,102				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

```
Check          [  ] Title V                  [XX] PPS
Applicable     [  ] Title XVIII, Part A      [  ] TEFRA
Boxes:         [XX] Title XIX                [  ] Other
```

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

```
Check          [  ] Title V                  [XX] PPS
Applicable     [  ] Title XVIII, Part A      [  ] TEFRA
Boxes:         [XX] Title XIX                [  ] Other
```

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	4,292		557		30
31	Intensive Care Unit	738		1		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF	1,808		1,040		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	475		280		43
44	Skilled Nursing Facility	9,166				44
45	Nursing Facility					45
200	Total (lines 30-199)	16,479		1,878		200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/24/2017 Run Time: 08:34 Version: 2017.01 (02/16/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0147** **WORKSHEET D PART IV**

Check	[ ] Title V	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
Applicable	[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
Boxes:	[XX] Title XIX	[ ] IRF	[ ] NF		[ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0147** **WORKSHEET D PART IV**

```
Check        [ ] Title V              [XX] Hospital    [ ] SUB (Other)        [ ] ICF/IID    [XX] PPS
Applicable   [ ] Title XVIII, Part A  [ ] IPF         [ ] SNF                               [ ] TEFRA
Boxes:       [XX] Title XIX           [ ] IRF         [ ] NF                                [ ] Other
```

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,627,803							50
53	Anesthesiology	4,620,048							53
54	Radiology-Diagnostic	11,534,754							54
56	Radioisotope	2,669,136							56
57	CT Scan	14,840,419							57
58	MRI	3,344,885							58
60	Laboratory	28,371,722							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,183,581							64
65	Respiratory Therapy	3,665,721							65
66	Physical Therapy	10,451,887							66
68	Speech Pathology	922,912							68
69	Electrocardiology	2,723,901							69
71	Medical Supplies Charged to Pat	5,393,776							71
72	Impl. Dev. Charged to Patients	1,094,261							72
73	Drugs Charged to Patients	10,970,029							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	1,343,386							88
91	Emergency	9,892,566							91
92	Observation Beds (Non-Distinct	2,711,315							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	131,362,102							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0147** **WORKSHEET D PART V**

```
Check        [ ] Title V - O/P          [XX] Hospital     [ ] SUB (Other)        [ ] Swing Bed SNF
Applicable   [ ] Title XVIII, Part B    [ ] IPF           [ ] SNF                [ ] Swing Bed NF
Boxes:       [XX] Title XIX - O/P       [ ] IRF           [ ] NF                 [ ] ICF/IID
```

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.144870							50
53	Anesthesiology	0.033026							53
54	Radiology-Diagnostic	0.163276							54
56	Radioisotope	0.083683							56
57	CT Scan	0.029942							57
58	MRI	0.126902							58
60	Laboratory	0.134802							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.124958							64
65	Respiratory Therapy	0.208098							65
66	Physical Therapy	0.283859							66
68	Speech Pathology	0.337199							68
69	Electrocardiology	0.072703							69
71	Medical Supplies Charged to Pat	0.409364							71
72	Impl. Dev. Charged to Patients	0.508884							72
73	Drugs Charged to Patients	0.237965							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.238264							91
92	Observation Beds (Non-Distinct	0.426449							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.707944							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S147** **WORKSHEET D PART II**

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Check        [ ] Title V                [ ] Hospital    [ ] SUB (Other)          [XX] PPS
Applicable   [ ] Title XVIII, Part A    [XX] IPF                                 [ ] TEFRA
Boxes:       [XX] Title XIX             [ ] IRF
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		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	339,400	15,627,803	0.021718			50
53	Anesthesiology	20,563	4,620,048	0.004451			53
54	Radiology-Diagnostic	261,897	11,534,754	0.022705			54
56	Radioisotope	28,695	2,669,136	0.010751			56
57	CT Scan	31,187	14,840,419	0.002101			57
58	MRI	208,060	3,344,885	0.062202			58
60	Laboratory	133,536	28,371,722	0.004707			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	4,640	1,183,581	0.003920			64
65	Respiratory Therapy	24,788	3,665,721	0.006762			65
66	Physical Therapy	68,033	10,451,887	0.006509			66
68	Speech Pathology	5,022	922,912	0.005441			68
69	Electrocardiology	10,344	2,723,901	0.003797			69
71	Medical Supplies Charged to Pat	57,223	5,393,776	0.010609			71
72	Impl. Dev. Charged to Patients	14,341	1,094,261	0.013106			72
73	Drugs Charged to Patients	115,924	10,970,029	0.010567			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	42,243	1,343,386	0.031445			88
91	Emergency	121,754	9,892,566	0.012308			91
92	Observation Beds (Non-Distinct		2,711,315				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,487,650	131,362,102				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S147** **WORKSHEET D PART IV**

```
Check        [ ] Title V                [ ] Hospital    [ ] SUB (Other)        [ ] ICF/IID    [XX] PPS
Applicable   [ ] Title XVIII, Part A    [XX] IPF        [ ] SNF                               [ ] TEFRA
Boxes:       [XX] Title XIX             [ ] IRF        [ ] NF                                [ ] Other
```

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S147** **WORKSHEET D PART IV**

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Check        [ ] Title V              [ ] Hospital    [ ] SUB (Other)        [ ] ICF/IID    [XX] PPS
Applicable   [ ] Title XVIII, Part A  [XX] IPF        [ ] SNF                               [ ] TEFRA
Boxes:       [XX] Title XIX           [ ] IRF        [ ] NF                                [ ] Other
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		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,627,803							50
53	Anesthesiology	4,620,048							53
54	Radiology-Diagnostic	11,534,754							54
56	Radioisotope	2,669,136							56
57	CT Scan	14,840,419							57
58	MRI	3,344,885							58
60	Laboratory	28,371,722							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,183,581							64
65	Respiratory Therapy	3,665,721							65
66	Physical Therapy	10,451,887							66
68	Speech Pathology	922,912							68
69	Electrocardiology	2,723,901							69
71	Medical Supplies Charged to Pat	5,393,776							71
72	Impl. Dev. Charged to Patients	1,094,261							72
73	Drugs Charged to Patients	10,970,029							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	1,343,386							88
91	Emergency	9,892,566							91
92	Observation Beds (Non-Distinct	2,711,315							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	131,362,102							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S147** **WORKSHEET D PART V**

```
Check        [  ] Title V - O/P          [  ] Hospital     [  ] SUB (Other)        [  ] Swing Bed SNF
Applicable   [  ] Title XVIII, Part B    [XX] IPF          [  ] SNF                [  ] Swing Bed NF
Boxes:       [XX] Title XIX - O/P        [  ] IRF          [  ] NF                 [  ] ICF/IID
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			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.144870							50
53	Anesthesiology	0.033026							53
54	Radiology-Diagnostic	0.163276							54
56	Radioisotope	0.083683							56
57	CT Scan	0.029942							57
58	MRI	0.126902							58
60	Laboratory	0.134802							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.124958							64
65	Respiratory Therapy	0.208098							65
66	Physical Therapy	0.283859							66
68	Speech Pathology	0.337199							68
69	Electrocardiology	0.072703							69
71	Medical Supplies Charged to Pat	0.409364							71
72	Impl. Dev. Charged to Patients	0.508884							72
73	Drugs Charged to Patients	0.237965							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.238264							91
92	Observation Beds (Non-Distinct	0.426449							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.707944							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0147** **WORKSHEET D-1 PART I**

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Check        [ ] Title V - I/P          [XX] Hospital     [ ] SUB (Other)        [ ] ICF/IID     [XX] PPS
Applicable   [XX] Title XVIII, Part A   [ ] IPF          [ ] SNF                                [ ] TEFRA
Boxes:       [ ] Title XIX - I/P        [ ] IRF          [ ] NF                                 [ ] Other
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PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,488	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,292	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,265	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	46	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)	138	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	3	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	9	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,078	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)	46	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)	138	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 XIX only)		15
16	Nursery days (title V or 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	207.37	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	212.56	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.98	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20
21	Total general inpatient routine service cost (see instructions)	4,872,745	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	9,539	22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	29,333	23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	420	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,328	25
26	Total swing-bed cost (see instructions)	40,620	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,832,125	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,832,125	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0147** **WORKSHEET D-1 PART II**

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Check        [ ] Title V - I/P          [XX] Hospital     [ ] SUB (Other)        [XX] PPS
Applicable   [XX] Title XVIII, Part A   [ ] IPF                                  [ ] TEFRA
Boxes:       [ ] Title XIX - I/P        [ ] IRF                                  [ ] Other
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PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,125.84	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,339,496	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					2,339,496	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)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	1,560,379	738	2,114.33	686	1,450,430	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,680,519	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					6,470,445	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					210,384	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					146,140	51
52	Total Program excludable cost (sum of lines 50 and 51)					356,524	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					6,113,921	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 (line 56 minus line 53)						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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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)					9,539	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					29,333	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					38,872	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 **COMPONENT CCN: 14-0147** **WORKSHEET D-1 PARTS III & IV**

Check Applicable Boxes:					
	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,027	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,125.84	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,156,238	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	294,270	4,872,745	0.060391	1,156,238	69,826	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S147** **WORKSHEET D-1 PART I**

Check Applicable Boxes:					
	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
	[XX] Title XVIII, Part A	[XX] IPF	[ ] SNF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,808	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,808	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,760	3
4	Semi-private room days (excluding swing-bed private room days)	48	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	315	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 XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	1,776,707	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 (line 21 minus line 26)	1,776,707	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	2,298,708	28
29	Private room charges (excluding swing-bed charges)	2,073,512	29
30	Semi-private room charges (excluding swing-bed charges)	225,196	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.772915	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,178.13	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	4,691.58	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,776,707	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S147** **WORKSHEET D-1 PART II**

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Check        [ ] Title V - I/P          [ ] Hospital     [ ] SUB (Other)        [XX] PPS
Applicable   [XX] Title XVIII, Part A   [XX] IPF                                [ ] TEFRA
Boxes:       [ ] Title XIX - I/P        [ ] IRF                                [ ] Other
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PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	982.69	38
39	Program general inpatient routine service cost (line 9 x line 38)	309,547	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)	309,547	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	42,705	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	352,252	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	12,606	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,006	51
52	Total Program excludable cost (sum of lines 50 and 51)	14,612	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	337,640	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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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 **COMPONENT CCN: 14-5580** **WORKSHEET D-1 PART I**

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Check        [ ] Title V - I/P          [ ] Hospital     [ ] SUB (Other)        [ ] ICF/IID     [XX] PPS
Applicable   [XX] Title XVIII, Part A   [ ] IPF          [XX] SNF                               [ ] TEFRA
Boxes:       [ ] Title XIX - I/P        [ ] IRF          [ ] NF                                 [ ] Other
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PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,166	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,166	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	9,166	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,717	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 XIX only)		15
16	Nursery days (title V or 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)	3,179,404	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 (line 21 minus line 26)	3,179,404	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,179,404	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5580** **WORKSHEET D-1 PARTS III & IV**

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Check        [ ] Title V - I/P          [ ] Hospital     [ ] SUB (Other)        [ ] ICF/IID     [XX] PPS
Applicable   [XX] Title XVIII, Part A   [ ] IPF          [XX] SNF                               [ ] TEFRA
Boxes:       [ ] Title XIX - I/P        [ ] IRF          [ ] NF                                 [ ] Other
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PART III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,179,404	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	346.87	71
72	Program routine service cost (line 9 x line 71)	942,446	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	942,446	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	942,446	83
84	Program inpatient ancillary services (see instructions)	1,115,376	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	2,057,822	86

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0147** **WORKSHEET D-1 PART I**

Check Applicable Boxes:					
	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
	[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[XX] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,488	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,292	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,265	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	46	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)	138	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	3	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	9	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	557	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 XIX only)	475	15
16	Nursery days (title V or XIX only)	280	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	207.37	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	212.56	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.98	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20
21	Total general inpatient routine service cost (see instructions)	4,872,745	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	9,539	22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	29,333	23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	420	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,328	25
26	Total swing-bed cost (see instructions)	40,620	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,832,125	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,832,125	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0147** **WORKSHEET D-1 PART II**

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Check        [  ] Title V - I/P          [XX] Hospital     [  ] SUB (Other)          [XX] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF                                    [  ] TEFRA
Boxes:       [XX] Title XIX - I/P        [  ] IRF                                    [  ] Other
```

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,125.84	38
39	Program general inpatient routine service cost (line 9 x line 38)					627,093	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)					627,093	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)	579,716	475	1,220.45	280	341,726	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	1,560,379	738	2,114.33	1	2,114	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	970,933	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	52,604	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	52,604	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	918,329	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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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 **COMPONENT CCN: 14-0147** **WORKSHEET D-1 PARTS III & IV**

Check Applicable Boxes:					
	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
	[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[XX] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,027	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 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S147** **WORKSHEET D-1 PART I**

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Check        [ ] Title V - I/P        [ ] Hospital     [ ] SUB (Other)     [ ] ICF/IID     [XX] PPS
Applicable   [ ] Title XVIII, Part A  [XX] IPF         [ ] SNF                             [ ] TEFRA
Boxes:       [XX] Title XIX - I/P     [ ] IRF          [ ] NF                              [ ] Other
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PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,808	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,808	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,760	3
4	Semi-private room days (excluding swing-bed private room days)	48	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,040	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 XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	1,776,707	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 (line 21 minus line 26)	1,776,707	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	2,298,708	28
29	Private room charges (excluding swing-bed charges)	2,073,512	29
30	Semi-private room charges (excluding swing-bed charges)	225,196	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.772915	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,178.13	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	4,691.58	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,776,707	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S147** **WORKSHEET D-1 PART II**

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Check        [  ] Title V - I/P          [  ] Hospital     [  ] SUB (Other)          [XX] PPS
Applicable   [  ] Title XVIII, Part A    [XX] IPF                                    [  ] TEFRA
Boxes:       [XX] Title XIX - I/P        [  ] IRF                                    [  ] Other
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PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	982.69	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,021,998	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,021,998	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,021,998	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	41,621	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	41,621	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	980,377	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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0147** **WORKSHEET D-3**

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Check        [ ] Title V                  [XX] Hospital     [ ] SUB (Other)        [ ] Swing Bed SNF      [XX] PPS
Applicable   [XX] Title XVIII, Part A     [ ] IPF           [ ] SNF                [ ] Swing Bed NF       [ ] TEFRA
Boxes:       [ ] Title XIX                [ ] IRF           [ ] NF                 [ ] ICF/IID            [ ] Other
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		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		2,031,232		30
31	Intensive Care Unit		989,124		31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.144870	1,190,051	172,403	50
53	Anesthesiology	0.033026	253,384	8,368	53
54	Radiology-Diagnostic	0.163276	1,110,312	181,287	54
56	Radioisotope	0.083683	126,596	10,594	56
57	CT Scan	0.029942	1,329,148	39,797	57
58	MRI	0.126902	78,920	10,015	58
60	Laboratory	0.134802	3,140,036	423,283	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.124958	313,356	39,156	64
65	Respiratory Therapy	0.208098	1,590,684	331,018	65
66	Physical Therapy	0.283859	471,682	133,891	66
68	Speech Pathology	0.337199	44,505	15,007	68
69	Electrocardiology	0.072703	276,547	20,106	69
71	Medical Supplies Charged to Patients	0.409364	688,726	281,940	71
72	Impl. Dev. Charged to Patients	0.508884	237,421	120,820	72
73	Drugs Charged to Patients	0.237965	2,188,384	520,759	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.238264	1,079,730	257,261	91
92	Observation Beds (Non-Distinct Part)	0.426449	269,232	114,814	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		14,388,714	2,680,519	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		14,388,714		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S147** **WORKSHEET D-3**

Check Applicable Boxes:				
[ ] Title V	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[XX] PPS
[XX] Title XVIII, Part A	[XX] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[ ] Title XIX	[ ] IRF	[ ] NF	[ ] ICF/IID	[ ] Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		368,276		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.144870			50
53	Anesthesiology	0.033026			53
54	Radiology-Diagnostic	0.163276	10,358	1,691	54
56	Radioisotope	0.083683			56
57	CT Scan	0.029942	7,083	212	57
58	MRI	0.126902			58
60	Laboratory	0.134802	50,863	6,856	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.124958	42	5	64
65	Respiratory Therapy	0.208098	1,841	383	65
66	Physical Therapy	0.283859	2,588	735	66
68	Speech Pathology	0.337199			68
69	Electrocardiology	0.072703	5,958	433	69
71	Medical Supplies Charged to Patients	0.409364	2,783	1,139	71
72	Impl. Dev. Charged to Patients	0.508884			72
73	Drugs Charged to Patients	0.237965	104,003	24,749	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.238264	27,291	6,502	91
92	Observation Beds (Non-Distinct Part)	0.426449			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		212,810	42,705	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		212,810		202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/24/2017 Run Time: 08:34 Version: 2017.01 (02/16/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-U147** **WORKSHEET D-3**

Check	[ ] Title V	[ ] Hospital	[ ] SUB (Other)	[XX] Swing Bed SNF	[XX] PPS
Applicable	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
Boxes:	[ ] Title XIX	[ ] IRF	[ ] NF	[ ] ICF/IID	[ ] Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.144870			50
53	Anesthesiology	0.033026			53
54	Radiology-Diagnostic	0.163276	9,515	1,554	54
56	Radioisotope	0.083683			56
57	CT Scan	0.029942	6,252	187	57
58	MRI	0.126902			58
60	Laboratory	0.134802	30,524	4,115	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.124958	14,328	1,790	64
65	Respiratory Therapy	0.208098	58,992	12,276	65
66	Physical Therapy	0.283859	61,253	17,387	66
68	Speech Pathology	0.337199	4,838	1,631	68
69	Electrocardiology	0.072703	1,274	93	69
71	Medical Supplies Charged to Patients	0.409364	16,295	6,671	71
72	Impl. Dev. Charged to Patients	0.508884			72
73	Drugs Charged to Patients	0.237965	80,495	19,155	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.238264			91
92	Observation Beds (Non-Distinct Part)	0.426449	1,975	842	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		285,741	65,701	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		285,741		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-5580** **WORKSHEET D-3**

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Check        [ ] Title V                  [ ] Hospital     [ ] SUB (Other)        [ ] Swing Bed SNF      [XX] PPS
Applicable   [XX] Title XVIII, Part A     [ ] IPF          [XX] SNF               [ ] Swing Bed NF       [ ] TEFRA
Boxes:       [ ] Title XIX                [ ] IRF          [ ] NF                 [ ] ICF/IID            [ ] Other
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		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.144870			50
53	Anesthesiology	0.033026			53
54	Radiology-Diagnostic	0.163276	65,115	10,632	54
56	Radioisotope	0.083683	3,964	332	56
57	CT Scan	0.029942	42,233	1,265	57
58	MRI	0.126902	8,088	1,026	58
60	Laboratory	0.134802	228,493	30,801	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.124958	41,393	5,172	64
65	Respiratory Therapy	0.208098	795,899	165,625	65
66	Physical Therapy	0.283859	2,277,472	646,481	66
68	Speech Pathology	0.337199	76,352	25,746	68
69	Electrocardiology	0.072703	8,914	648	69
71	Medical Supplies Charged to Patients	0.409364	145,324	59,490	71
72	Impl. Dev. Charged to Patients	0.508884			72
73	Drugs Charged to Patients	0.237965	695,513	165,508	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.238264			91
92	Observation Beds (Non-Distinct Part)	0.426449	6,214	2,650	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		4,394,974	1,115,376	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,394,974		202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 02/24/2017 Run Time: 08:34 Version: 2017.01 (02/16/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0147** **WORKSHEET D-3**

Check	[ ] Title V	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[XX] PPS
Applicable	[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
Boxes:	[XX] Title XIX	[ ] IRF	[ ] NF	[ ] ICF/IID	[ ] Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.144870			50
53	Anesthesiology	0.033026			53
54	Radiology-Diagnostic	0.163276			54
56	Radioisotope	0.083683			56
57	CT Scan	0.029942			57
58	MRI	0.126902			58
60	Laboratory	0.134802			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.124958			64
65	Respiratory Therapy	0.208098			65
66	Physical Therapy	0.283859			66
68	Speech Pathology	0.337199			68
69	Electrocardiology	0.072703			69
71	Medical Supplies Charged to Patients	0.409364			71
72	Impl. Dev. Charged to Patients	0.508884			72
73	Drugs Charged to Patients	0.237965			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.238264			91
92	Observation Beds (Non-Distinct Part)	0.426449			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S147** **WORKSHEET D-3**

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Check        [ ] Title V                [ ] Hospital     [ ] SUB (Other)        [ ] Swing Bed SNF      [XX] PPS
Applicable   [ ] Title XVIII, Part A    [XX] IPF         [ ] SNF                [ ] Swing Bed NF       [ ] TEFRA
Boxes:       [XX] Title XIX             [ ] IRF          [ ] NF                 [ ] ICF/IID            [ ] Other
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		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.144870			50
53	Anesthesiology	0.033026			53
54	Radiology-Diagnostic	0.163276			54
56	Radioisotope	0.083683			56
57	CT Scan	0.029942			57
58	MRI	0.126902			58
60	Laboratory	0.134802			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.124958			64
65	Respiratory Therapy	0.208098			65
66	Physical Therapy	0.283859			66
68	Speech Pathology	0.337199			68
69	Electrocardiology	0.072703			69
71	Medical Supplies Charged to Patients	0.409364			71
72	Impl. Dev. Charged to Patients	0.508884			72
73	Drugs Charged to Patients	0.237965			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.238264			91
92	Observation Beds (Non-Distinct Part)	0.426449			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,297,575			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	11,187			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	43.66			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)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 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 line 8 plus lines (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 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
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
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 factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0492			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2079			31
32	Sum of lines 30 and 31	0.2571			32
33	Allowable disproportionate share percentage (see instructions)	0.0971			33
34	Disproportionate share adjustment (see instructions)	104,324			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			296,118	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			296,118	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	296,118			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, 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
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
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 41.01 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 41.01)				46

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	4,709,204			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	5,007,238			48
49	Total payment for inpatient operating costs (see instructions)	4,932,730			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	340,465			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	5,273,195			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	5,273,195			61
62	Deductibles billed to program beneficiaries	665,784			62
63	Coinsurance billed to program beneficiaries	315			63
64	Allowable bad debts (see instructions)	240,296			64
65	Adjusted reimbursable bad debts (see instructions)	156,192			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	201,024			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,763,288			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	567			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-4,426			70.91
70.93	HVBP payment adjustment amount (see instructions)	10,898			70.93
70.94	HRR adjustment amount (see instructions)	-85,092			70.94
70.97	Low volume adjustment for federal fiscal year (2016)	622,427			70.97
70.99	HAC adjustment amount (see instructions)	58,176			70.99
71	Amount due provider (see instructions)	5,249,486			71
71.01	Sequestration adjustment (see instructions)	104,990			71.01
72	Interim payments	5,153,351			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-8,855			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	137,000			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. 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

	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)		223,526		100

	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	1.0025358437		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)		567		102

	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.9802		103
104	HRR adjustment amount for HSP bonus payment (see instructions)		-4,426		104

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97) **EXHIBIT 4**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Pre/Post Entitlement					Total (col. 2 through 4)	
		1	2	3	3.01	4	4.01	5	
1	DRG Amounts Other Than Outlier Payments								1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1								1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	4,297,575				4,297,575		4,297,575	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1								1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1								1.04
2	Outlier payments for discharges	11,187				11,187		11,187	2
2.01	Outlier payment for discharges for Model 4 BPCI								2.01
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments								4
	Indirect Medical Education Adjustment								
5	Amount from Worksheet E Part A, line 21								5
6	IME payment adjustment								6
6.01	IME payment adjustment for managed care								6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7	IME payment adjustment factor								7
8	IME add-on adjustment amount								8
8.01	IME payment adjustment add-on for managed care								8.01
9	Total IME payment (sum of lines 6 and 8)								9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)								9.01
	Disproportionate Share Adjustment								
10	Allowable disproportionate share percentage	0.0971	0.0971	0.0971	0.0971	0.0971	0.0971		10
11	Disproportionate share adjustment	104,324				104,324		104,324	11
11.01	Uncompensated care payments	296,118				296,118		296,118	11.01
	Additional payment for high percentage of ESRD beneficiary discharges								
12	Total ESRD additional payment								12
13	Subtotal	4,709,204				4,709,204		4,709,204	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	5,007,238				5,007,238		5,007,238	14
15	Total payment for inpatient operating costs SCH and MDH only	4,932,730				4,932,730		4,932,730	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	340,465				340,465		340,465	16
17	Special add-on payments for new technologies								17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)								17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG								17.02
18	Capital outlier reconciliation adjustment amount								18
19	**SUBTOTAL**					5,273,195		5,273,195	19
20	Capital DRG other than outlier	339,755				339,755		339,755	20
20.01	Model 4 BPCI Capital DRG other than outlier								20.01
21	Capital DRG outlier payments	710				710		710	21
21.01	Model 4 BPCI Capital DRG outlier payments								21.01
22	Indirect medical education percentage								22
23	Indirect medical education adjustment								23
24	Allowable disproportionate share percentage								24
25	Disproportionate share adjustment								25
26	Total prospective capital payments	340,465				340,465		340,465	26
27	**Low volume adjustment factor**					0.118036			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)								28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)					622,427		622,427	29

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCLUATION **EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1							1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	4,297,575			4,297,575		4,297,575	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	11,187			11,187		11,187	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments							4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21							5
6	IME payment adjustment							6
6.01	IME payment adjustment for managed care							6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)							9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage	0.0971	0.0971	0.0971	0.0971	0.0971		10
11	Disproportionate share adjustment	104,324			104,324		104,324	11
11.01	Uncompensated care payments	296,118			296,118		296,118	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	4,709,204			4,709,204		4,709,204	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	5,007,238			5,007,238		5,007,238	14
15	Total payment for inpatient operating costs SCH and MDH only	4,932,730			4,932,730		4,932,730	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	340,465			340,465		340,465	16
17	Special add-on payments for new technologies							17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	**SUBTOTAL**				5,273,195		5,273,195	19
20	Capital DRG other than outlier	339,755			339,755		339,755	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	710			710		710	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage							24
25	Disproportionate share adjustment							25
26	Total prospective capital payments	340,465			340,465		340,465	26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1	622,427			622,427		622,427	29
30	HVBP payment adjustment	10,898			10,898		10,898	30
30.01	HVBP payment adjustment for HSP bonus payment	567			567		567	30.01
31	HRR adjustment	-85,092			-85,092		-85,092	31
31.01	HRR adjustment for HSP bonus payment	-4,426			-4,426		-4,426	31.01
32	HAC Reduction Program adjustment				58,176		58,176	32

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0147** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	2,585			1
2	Medical and other services reimbursed under OPPS (see instructions)	4,394,895			2
3	PPS payments	3,614,860			3
4	Outlier payment (see instructions)	232			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.810			5
6	Line 2 times line 5	3,559,865			6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	2,585			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	10,865			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	10,865			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)	10,865			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	8,280			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)	2,585			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	3,615,092			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	803,460			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,814,217			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,814,217			30
31	Primary payer payments	540			31
32	Subtotal (line 30 minus line 31)	2,813,677			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)	200,508			34
35	Adjusted reimbursable bad debts (see instructions)	130,330			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	170,936			36
37	Subtotal (see instructions)	2,944,007			37
38	MSP-LCC reconciliation amount from PS&R	-8			38
39	Other adjustments (specify) (see instructions)	5,421			39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,949,436			40
40.01	Sequestration adjustment (see instructions)	58,989			40.01
41	Interim payments	2,877,151			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	13,296			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse 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 **COMPONENT CCN: 14-S147** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [XX] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse 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 **COMPONENT CCN: 14-5580** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [XX] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse 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 **COMPONENT CCN: 14-0147** **WORKSHEET E-1 PART I**

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Check        [XX] Hospital     [  ] SUB (Other)
Applicable   [  ] IPF          [  ] SNF
Boxes:       [  ] IRF          [  ] Swing Bed SNF
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				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				5,177,325		2,875,263	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	04/29/2015		04/29/2015	1,888	3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50		23,974			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		-23,974		1,888	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				5,153,351		2,877,151	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.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	Determined net settlement amount (balance due)		.01				13,296	6.01
	based on the cost report (1)		.02		-8,855			6.02
7	Total Medicare program liability (see instructions)				5,144,496		2,890,447	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-S147** **WORKSHEET E-1 PART I**

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Check        [ ] Hospital     [ ] SUB (Other)
Applicable   [XX] IPF         [ ] SNF
Boxes:       [ ] IRF          [ ] Swing Bed SNF
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				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				209,778			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					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. E or Wkst. E-3, line and column as appropriate)				209,778			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.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	Determined net settlement amount (balance due)		.01		7,105			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				216,883			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-U147** **WORKSHEET E-1 PART I**

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Check        [ ] Hospital     [ ] SUB (Other)
Applicable   [ ] IPF          [ ] SNF
Boxes:       [ ] IRF          [XX] Swing Bed SNF
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				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				58,439			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					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. E or Wkst. E-3, line and column as appropriate)				58,439			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.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	Determined net settlement amount (balance due)		.01		11,134			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				69,573			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-5580** **WORKSHEET E-1 PART I**

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Check        [ ] Hospital     [ ] SUB (Other)
Applicable   [ ] IPF          [XX] SNF
Boxes:       [ ] IRF          [ ] Swing Bed SNF
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				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				965,585			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					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. E or Wkst. E-3, line and column as appropriate)				965,585			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.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	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				965,585			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: [XX] Hospital [ ] CAH

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 (Wkst. S-3, Pt. I, col. 15, line 14)	1,286	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	2,764	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	211	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	4,003	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	149,122,949	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	1,921,643	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-U147** **WORKSHEET E-2**

```
Check        [ ] Title V                [XX] Swing Bed - SNF
Applicable   [XX] Title XVIII           [ ] Swing Bed - NF
Boxes:       [ ] Title XIX
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COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	61,207		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)			3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	184		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	61,207		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	61,207		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	-		11
12	Subtotal (line 10 minus line 11)	61,207		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,575		13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	59,632		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)	17,478		17
17.01	Adjusted reimbursable bad debts (see instructions)	11,361		17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	70,993		19
19.01	Sequestration adjustment (see instructions)	1,420		19.01
20	Interim payments	58,439		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	11,134		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S147** **WORKSHEET E-3 PART II**

Check Applicable Box: [ ] Hospital
[XX] Subprovider IPF

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	279,008	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	4.939891	9
10	Teaching adjustment factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	279,008	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	279,008	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	279,008	18
19	Deductibles	54,940	19
20	Subtotal (line 18 minus line 19)	224,068	20
21	Coinsurance	9,982	21
22	Subtotal (line 20 minus line 21)	214,086	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11,112	23
24	Adjusted reimbursable bad debts (see instructions)	7,223	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)		25
26	Subtotal (sum of lines 22 and 24)	221,309	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	221,309	31
31.01	Sequestration adjustment (see instructions)	4,426	31.01
32	Interim payments	209,778	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	7,105	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

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

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	1,112,583	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	1,112,583	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	127,292	7
8	Allowable bad debts (see instructions)		8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)		10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	985,291	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	985,291	15
15.01	Sequestration adjustment (see instructions)	19,706	15.01
16	Interim payments	965,585	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0147** **WORKSHEET E-3 PART VII**

Check Applicable Boxes:	[ ] Title V	[XX] Hospital	[ ] NF	[XX] PPS
	[XX] Title XIX	[ ] SUB (Other)	[ ] ICF/IID	[ ] TEFRA
		[ ] SNF		[ ] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			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	Titles V or XIX (sum of lines 21 and 27)			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 line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S147** **WORKSHEET E-3 PART VII**

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Check        [ ] Title V          [ ] Hospital          [ ] NF          [XX] PPS
Applicable   [XX] Title XIX       [XX] Subprovider IPF  [ ] ICF/IID     [ ] TEFRA
Boxes:                            [ ] SNF                               [ ] Other
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PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			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	Titles V or XIX (sum of lines 21 and 27)			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 line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	2,014,744				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	7,299,554				4
5	Other receivables	671,106				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	828,234				7
8	Prepaid expenses	509,545				8
9	Other current assets	1,754,156				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	13,077,339				11
	FIXED ASSETS					
12	Land	131,315				12
13	Land improvements	385,022				13
14	Accumulated depreciation	-360,338				14
15	Buildings	25,545,482				15
16	Accumulated depreciation	-17,889,360				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	2,355,173				19
20	Accumulated depreciation	-2,253,804				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	19,169,908				23
24	Accumulated depreciation	-12,855,780				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	14,227,618				30
	OTHER ASSETS					
31	Investments	10,909,025				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	303,861				34
35	Total other assets (sum of lines 31-34)	11,212,886				35
36	Total assets (sum of lines 11, 30 and 35)	38,517,843				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,704,771				37
38	Salaries, wages and fees payable	2,021,744				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	299,836				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,689,288				44
45	Total current liabilities (sum of lines 37 thru 44)	5,715,639				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	6,188,641				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	6,188,641				50
51	Total liabilities (sum of lines 45 and 50)	11,904,280				51
	CAPITAL ACCOUNTS					
52	General fund balance	26,613,563				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					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 thru 58)	26,613,563				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	38,517,843				60

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		25,963,633			1
2	Net income (loss) (from Worksheet G-3, line 29)		649,930			2
3	Total (sum of line 1 and line 2)		26,613,563			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		26,613,563			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		26,613,563			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES **WORKSHEET G-2 PARTS I & II**

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	4,835,057		4,835,057	1
2	Subprovider IPF	2,298,708		2,298,708	2
3	Subprovider IRF				3
5	Swing Bed - SNF	90,688		90,688	5
6	Swing Bed - NF				6
7	Skilled nursing facility	2,368,179		2,368,179	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	9,592,632		9,592,632	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	1,563,693		1,563,693	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,563,693		1,563,693	16
17	Total inpatient routine care services (sum of lines 10 and 16)	11,156,325		11,156,325	17
18	Ancillary services	24,874,844	108,702,403	133,577,247	18
19	Outpatient services		9,533,700	9,533,700	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		4,517,918	4,517,918	22
23	Ambulance	30,940	2,169,420	2,200,360	23
25	ASC				25
26	Hospice				26
27	OTHER	1,171,604	1,233,900	2,405,504	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	37,233,713	126,157,341	163,391,054	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		51,136,218	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	BAD DEBT EXP. DEDUCTED FROM REVENUE			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 Worksheet G-3, line 4)		51,136,218	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	163,391,054	1
2	Less contractual allowances and discounts on patients' accounts	113,872,912	2
3	Net patient revenues (line 1 minus line 2)	49,518,142	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	51,136,218	4
5	Net income from service to patients (line 3 minus line 4)	-1,618,076	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	386,354	6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	3,666	10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service	196,656	13
14	Revenue from meals sold to employees and guests	303,829	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	9,691	16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	984	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	10,685	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (PROPERTY TAX REVENUE)	450,326	24
24.01	Other (EHR MEANINGFUL USE)	11,760	24.01
24.02	Other (GRANTS)	52,484	24.02
24.03	Other (OTHER)	184,316	24.03
24.04	Other (NET ASSETS RELEASED BY FOUNDATION)	49,433	24.04
24.05	Other (INVESTMENT INCOME)	607,822	24.05
25	Total other income (sum of lines 6-24)	2,268,006	25
26	Total (line 5 plus line 25)	649,930	26
27.01	Other expenses (NET ASSETS RELEASED BY FOUNDATION)		27.01
29	Net income (or loss) for the period (line 26 minus line 28)	649,930	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7187** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	50,556		1,131		96,224	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	608,588		19,987			6
7	Physical Therapy			11,101			7
8	Occupational Therapy			5,694			8
9	Speech Pathology			2,532			9
10	Medical Social Services	3,472					10
11	Home Health Aide	68,885		10,422			11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	731,501		50,867		96,224	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7187** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	147,911		147,911		147,911	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	628,575		628,575		628,575	6
7	Physical Therapy	11,101		11,101		11,101	7
8	Occupational Therapy	5,694		5,694		5,694	8
9	Speech Pathology	2,532		2,532		2,532	9
10	Medical Social Services	3,472		3,472		3,472	10
11	Home Health Aide	79,307		79,307		79,307	11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	878,592		878,592		878,592	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7187** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	147,911				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	628,575				6
7	Physical Therapy	11,101				7
8	Occupational Therapy	5,694				8
9	Speech Pathology	2,532				9
10	Medical Social Services	3,472				10
11	Home Health Aide	79,307				11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	878,592				24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7187** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		147,911	147,911		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		628,575	127,241	755,816	6
7	Physical Therapy		11,101	2,247	13,348	7
8	Occupational Therapy		5,694	1,153	6,847	8
9	Speech Pathology		2,532	513	3,045	9
10	Medical Social Services		3,472	703	4,175	10
11	Home Health Aide		79,307	16,054	95,361	11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		878,592		878,592	24

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 14-7187** **WORKSHEET H-1 PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-147,911	730,681	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						628,575	6
7	Physical Therapy						11,101	7
8	Occupational Therapy						5,694	8
9	Speech Pathology						2,532	9
10	Medical Social Services						3,472	10
11	Home Health Aide						79,307	11
12	Supplies (see instructions)							12
13	Drugs							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-147,911	730,681	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						147,911	25
26	Unit Cost Multiplier						0.202429	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7187** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	NEW CAP REL COSTS-BLDG & FIXT	NEW CAP REL COSTS-MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General		4,835	89	20,353	25,277	3,531	1
2	Skilled Nursing Care	755,816			245,013	1,000,829	139,821	2
3	Physical Therapy	13,348				13,348	1,865	3
4	Occupational Therapy	6,847				6,847	957	4
5	Speech Pathology	3,045				3,045	425	5
6	Medical Social Services	4,175			1,398	5,573	779	6
7	Home Health Aide	95,361			27,732	123,093	17,197	7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	878,592	4,835	89	294,496	1,178,012	164,575	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7187** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General	11,837	5,740		16,800		43,595	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	11,837	5,740		16,800		43,595	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7187** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	MAIN-TENANCE OF PERSONNEL	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	MEDICAL RE CORDS & LI BRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	Administrative and General				866			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)				866			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7187** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						107,646	1
2	Skilled Nursing Care						1,140,650	2
3	Physical Therapy						15,213	3
4	Occupational Therapy						7,804	4
5	Speech Pathology						3,470	5
6	Medical Social Services						6,352	6
7	Home Health Aide						140,290	7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)						1,421,425	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7187** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS			
		25	26	27	28			
1	Administrative and General		107,646					1
2	Skilled Nursing Care		1,140,650	93,462	1,234,112			2
3	Physical Therapy		15,213	1,246	16,459			3
4	Occupational Therapy		7,804	639	8,443			4
5	Speech Pathology		3,470	284	3,754			5
6	Medical Social Services		6,352	520	6,872			6
7	Home Health Aide		140,290	11,495	151,785			7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		1,421,425	107,646	1,421,425			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.081936				21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7187** **WORKSHEET H-2 PART II**

	HHA COST CENTER	NEW CAP REL COSTS-BLDG & FIXT SQUARE FEET	NEW CAP REL COSTS-MVBLE EQUIP DOLLAR VALUE -NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	MAINTENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	Administrative and General	1,333	88	50,556		25,277	1,333	1
2	Skilled Nursing Care			608,588		1,000,829		2
3	Physical Therapy					13,348		3
4	Occupational Therapy					6,847		4
5	Speech Pathology					3,045		5
6	Medical Social Services			3,472		5,573		6
7	Home Health Aide			68,885		123,093		7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	1,333	88	731,501		1,178,012	1,333	20
21	Total cost to be allocated	4,835	89	294,496		164,575	11,837	21
22	Unit Cost Multiplier	3.627157		0.402591		0.139706		22
22	Unit Cost Multiplier		1.011364				8.879970	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7187** **WORKSHEET H-2 PART II**

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE LAUNDRY POUNDS	HOUSEKEEPING HOURS OF SERVICE	DIETARY DIETARY MEALS SERV	CAFETERIA CAFE MEALS SERV	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	Administrative and General	1,333		129		111		1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	1,333		129		111		20
21	Total cost to be allocated	5,740		16,800		43,595		21
22	Unit Cost Multiplier	4.306077		130.232558		392.747748		22
22	Unit Cost Multiplier							22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7187** **WORKSHEET H-2 PART II**

	HHA COST CENTER	NURSING AD MINISTRATI ON DIRECT NURSING HO	CENTRAL SE RVICES & S UPPLY CS COSTED REQUIS	PHARMACY PHARM COSTED REQ	MEDICAL RE CORDS & LI BRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General			411				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)			411				20
21	Total cost to be allocated			866				21
22	Unit Cost Multiplier			2.107056				22
22	Unit Cost Multiplier							22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7187** **WORKSHEET H-2 PART II**

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME			
		20	21	22	23			
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7187** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	1,234,112		1,234,112	7,215	171.05	1
2	Physical Therapy	3	16,459	240,319	256,778	2,759	93.07	2
3	Occupational Therapy	4	8,443		8,443	604	13.98	3
4	Speech Pathology	5	3,754	17,363	21,117	231	91.42	4
5	Medical Social Services	6	6,872		6,872	49	140.24	5
6	Home Health Aide	7	151,785		151,785	1,215	124.93	6
7	Total (sum of lines 1-6)		1,421,425	257,682	1,679,107	12,073		7

Limitation Cost Comoputation			Program Visits			
				PART B		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	99914		5,670		8
9	Physical Therapy	99914		2,292		9
10	Occupational Therapy	99914		478		10
11	Speech Pathology	99914		189		11
12	Medical Social Services	99914		42		12
13	Home Health Aide	99914		1,110		13
14	Total (sum of lines 8-13)			9,781		14

Supplies and Drugs Cost Computations								
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8		58,976	58,976	144,068	0.409362	15
16	Cost of Drugs	9						16

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.283859	846,613	240,319	col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68	0.337199	51,492	17,363	col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.409364	144,068	58,976	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.237965			col. 2, line 16	5

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7187** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
			Part B			Part B			
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		5,670			969,854		969,854	1
2	Physical Therapy		2,292			213,316		213,316	2
3	Occupational Therapy		478			6,682		6,682	3
4	Speech Pathology		189			17,278		17,278	4
5	Medical Social Services		42			5,890		5,890	5
6	Home Health Aide		1,110			138,672		138,672	6
7	Total (sum of lines 1-6)		9,781			1,351,692		1,351,692	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6	7	8	9	10	11	
15	Cost of Medical Supplies							15
16	Cost of Drugs							16

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7187** **WORKSHEET H-4 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

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

			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
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 excced 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 amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		1,126,745	11
12	Total PPS Reimbursement - Full Episodes with Outliers		118,210	12
13	Total PPS Reimbursement - LUPA Episodes		15,365	13
14	Total PPS Reimbursement - PEP Episodes		4,429	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		42,647	15
16	Total PPS Outlier Reimbursement - PSP 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 thru 20 minus line 21)		1,307,396	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,307,396	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,307,396	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		1,307,396	29
30	Other adjustments (see instructions) (specify)		-123	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,307,273	31
31.01	Sequestration adjustment (see instructions)		26,145	31.01
32	Interim payments (see instructions)		1,281,128	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, §115-2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7187** **WORKSHEET H-5**

				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider						1,281,128	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.							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	To	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					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)						1,281,128	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		To	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		To	.53					5.53
		Program	.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)		.01					6.01
	based on the cost report (see instructions)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						1,281,128	7
8	Name of Contractor			Contractor Number		NPR Date: Month, Day, Year		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0147** **WORKSHEET L**

```
Check          [  ] Title V                  [XX] Hospital                [XX] PPS
Applicable     [XX] Title XVIII, Part A      [  ] SUB (Other)             [  ] Cost Method
Boxes:         [  ] Title XIX
```

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	339,755	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	710	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	10.94	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)	340,465	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0147** **WORKSHEET L**

```
Check          [  ] Title V                  [XX] Hospital                [XX] PPS
Applicable     [  ] Title XVIII, Part A      [  ] SUB (Other)             [  ] Cost Method
Boxes:         [XX] Title XIX
```

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)		12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES **WORKSHEET L-1 PART I**

	COST CENTER DESCRIPTIONS	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 Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER							194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 14-8548** **WORKSHEET M-1**

Check applicable box: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	333,892		333,892		333,892		333,892	1
2	Physician Assistant								2
3	Nurse Practitioner	186,242		186,242		186,242		186,242	3
4	Visiting Nurse								4
5	Other Nurse	141,005		141,005		141,005		141,005	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian	38,851		38,851		38,851		38,851	8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	699,990		699,990		699,990		699,990	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		47,096	47,096		47,096		47,096	15
16	Transportation (Health Care Staff)		9,973	9,973		9,973		9,973	16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		57,069	57,069		57,069		57,069	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	699,990	57,069	757,059		757,059		757,059	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		25,265	25,265		25,265		25,265	29
30	Administrative Costs	240,371	74,026	314,397	227	314,624		314,624	30
31	Total Facility Overhead (sum of lines 29 and 30)	240,371	99,291	339,662	227	339,889		339,889	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	940,361	156,360	1,096,721	227	1,096,948		1,096,948	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-8548** **WORKSHEET M-2**

Check applicable box: [XX] RHC I [ ] FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	1.00	4,118	4,200	4,200		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	2.00	5,957	2,100	4,200		3
4	Subtotal (sum of lines 1 through 3)	3.00	10,075		8,400	10,075	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	3.00	10,075			10,075	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	757,059	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	757,059	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	339,889	14
15	Parent provider overhead allocated to facility (see instructions)	676,988	15
16	Total overhead (sum of lines 14 and 15)	1,016,877	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,016,877	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,016,877	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	1,773,936	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8548** **WORKSHEET M-3**

Check applicable boxes: [XX] RHC I [ ] FQHC [ ] Title V [XX] Title XVIII [ ] Title XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	1,773,936	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	830	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,773,106	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	10,075	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	10,075	6
7	Adjusted cost per visit (line 3 divided by line 6)	175.99	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	175.99	175.99	175.99	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		3,418		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		601,534		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		601,534		16
16.01	Total program charges (see instructions)(from contractor's records)		422,550		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		409		16.02
16.03	Total program preventive costs (see instructions)		582		16.03
16.04	Total program non-preventive costs (see instructions)		459,790		16.04
16.05	Total program cost (see instructions)		460,372		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		26,215		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		79,273		19
20	Net Medicare cost excluding vaccines (see instructions)		460,372		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		830		21
22	Total reimbursable Program cost (line 20 plus line 21)		461,202		22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		461,202		26
26.01	Sequestration adjustment (see instructions)		9,224		26.01
27	Interim payments		195,579		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		256,399		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8548** **WORKSHEET M-4**

Check applicable boxes: [XX] RHC I [ ] FQHC [ ] Title V [XX] Title XVIII [ ] Title XIX

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	699,990	699,990	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000008	0.000379	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	6	265	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	72	11	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	78	276	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	757,059	757,059	6
7	Total overhead (from Wkst. M-2, line 16)	1,016,877	1,016,877	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000103	0.000365	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	105	371	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	183	647	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	3	145	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	61.00	4.46	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	3	145	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	183	647	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		830	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		830	16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **COMPONENT CCN: 14-8548** **WORKSHEET M-5**

Check applicable box: [XX] RHC I [ ] FQHC

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				195,579	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 zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			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. M-3, line 27)				195,579	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.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)		.01		256,399	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				451,978	
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS **HOSPICE CCN: 14-1542** **WORKSHEET O**

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General	33,993	81,725	115,718		115,718		115,718	4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping								7
8	Dietary		632	632		632		632	8
9	Nursing Administration								9
10	Routine Medical Supplies		48,214	48,214		48,214		48,214	10
11	Medical Records								11
12	Staff Transportation		22,160	22,160		22,160		22,160	12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service								16
17	Patient/Residential Care Services								17
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse	121,388		121,388		121,388		121,388	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services	47,470		47,470		47,470		47,470	33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	21,459		21,459		21,459		21,459	37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
100	TOTAL	224,310	152,731	377,041		377,041		377,041	100

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE CONTINUOUS HOME CARE

HOSPICE CCN: 14-1542

WORKSHEET O-1

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse	26		26		26		26	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services	10		10		10		10	33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	5		5		5		5	37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	41		41		41		41	100

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS **HOSPICE CCN: 14-1542** **WORKSHEET O-2**
HOSPICE ROUTINE HOME CARE

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse	121,362		121,362		121,362		121,362	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services	47,460		47,460		47,460		47,460	33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	21,454		21,454		21,454		21,454	37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	190,276		190,276		190,276		190,276	100

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE INPATIENT RESPITE CARE

HOSPICE CCN: 14-1542

WORKSHEET O-3

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE GENERAL INPATIENT CARE

HOSPICE CCN: 14-1542

WORKSHEET O-4

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION **HOSPICE CCN: 14-1542** **WORKSHEET O-5**

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols 1+2)	
		1	2	3	
	GENERAL SERVICE COST CENTERS				
1	Cap Rel Costs-Bldg & Fixt		4,835	4,835	1
2	Cap Rel Costs-Mvble Equip		814	814	2
3	Employee Benefits Department		90,305	90,305	3
4	Administrative & General	115,718	87,681	203,399	4
5	Plant Operation & Maintenance		17,577	17,577	5
6	Laundry & Linen Service				6
7	Housekeeping		16,670	16,670	7
8	Dietary	632		632	8
9	Nursing Administration				9
10	Routine Medical Supplies	48,214		48,214	10
11	Medical Records				11
12	Staff Transportation	22,160		22,160	12
13	Volunteer Service Coordination				13
14	Pharmacy				14
15	Physician Administrative Services				15
16	Other General Service				16
17	Patient/Residential Care Services				17
	LEVEL OF CARE				
50	Hospice Continuous Home Care	41		41	50
51	Hospice Routine Home Care	190,276		190,276	51
52	Hospice Inpatient Respite Care				52
53	Hospice General Inpatient Care				53
	NONREIMBURSABLE COST CENTERS				
60	Bereavement Program				60
61	Volunteer Program				61
62	Fundraising				62
63	Hospice/Palliative Medicine Fellows				63
64	Palliative care Program				64
65	Other Physician Services				65
66	Residential Care				66
67	Advertising				67
68	Telehealth / Telemonitoring				68
69	Thrift Store				69
70	Nursing Facility Room & Board				70
71	Other Nonreimbursable				71
99	Negative Cost Center				99
100	TOTAL	377,041	217,882	594,923	100

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS **HOSPICE CCN: 14-1542** **WORKSHEET O-6 PART I**

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPART-MENT	SUBTOTAL	ADMINI-STRATIVE & GENERAL	PLANT OP & MAINT	
		0	1	2	3	3A	4	5	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	4,835							1
2	Cap Rel Costs-Mvble Equip	814							2
3	Employee Benefits Department	90,305							3
4	Administrative & General	203,399				203,399	203,399		4
5	Plant Operation & Maintenance	17,577				17,577	12,096		5
6	Laundry & Linen Service								6
7	Housekeeping	16,670				16,670	11,472		7
8	Dietary	632				632	435		8
9	Nursing Administration								9
10	Routine Medical Supplies	48,214				48,214	33,179		10
11	Medical Records								11
12	Staff Transportation	22,160				22,160	15,250		12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service								16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care	41				41	28		50
51	Hospice Routine Home Care	190,276				190,276	130,939		51
52	Hospice Inpatient Respite Care								52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	TOTAL	594,923				594,923	203,399		100

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS **HOSPICE CCN: 14-1542** **WORKSHEET O-6 PART I**

	Descriptions	LAUNDRY & LINEN	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS-PORTATION	
		6	7	8	9	10	11	12	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General								4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies								10
11	Medical Records								11
12	Staff Transportation								12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service								16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care								51
52	Hospice Inpatient Respite Care								52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	TOTAL								100

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS **HOSPICE CCN: 14-1542** **WORKSHEET O-6 PART I**

	Descriptions	VOLUNTEER SVC COOR-DINATION	PHARMACY	PHYSICIAN ADMIN SERVICES	OTHER GENERAL SERVICE	PATIENT/ RES CARE SVCS	TOTAL	
		13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
3	Employee Benefits Department							3
4	Administrative & General							4
5	Plant Operation & Maintenance							5
6	Laundry & Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Routine Medical Supplies							10
11	Medical Records							11
12	Staff Transportation							12
13	Volunteer Service Coordination							13
14	Pharmacy							14
15	Physician Administrative Services							15
16	Other General Service							16
17	Patient/Residential Care Services							17
	LEVEL OF CARE							
50	Hospice Continuous Home Care						69	50
51	Hospice Routine Home Care						321,215	51
52	Hospice Inpatient Respite Care							52
53	Hospice General Inpatient Care							53
	NONREIMBURSABLE COST CENTERS							
60	Bereavement Program							60
61	Volunteer Program							61
62	Fundraising							62
63	Hospice/Palliative Medicine Fellows							63
64	Palliative care Program							64
65	Other Physician Services							65
66	Residential Care							66
67	Advertising							67
68	Telehealth / Telemonitoring							68
69	Thrift Store							69
70	Nursing Facility Room & Board							70
71	Other Nonreimbursable							71
99	Negative Cost Center							99
100	TOTAL						594,923	100

COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS **HOSPICE CCN: 14-1542** **WORKSHEET O-6 PART II**

	Descriptions	CAP REL BLDG & FIX SQUARE FEET	CAP REL MVBLE EQUIP DOLLAR VALUE	EMPLOYEE BENEFITS DEPART-MENT GROSS SALARIES	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL ACCUM. COST	PLANT OP & MAINT SQUARE FEET	LAUNDRY & LINEN IN-FACIL-ITY DAYS	
		1	2	3	4A	4	5	6	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General				-203,399	295,570			4
5	Plant Operation & Maintenance					17,577			5
6	Laundry & Linen Service								6
7	Housekeeping					16,670			7
8	Dietary					632			8
9	Nursing Administration								9
10	Routine Medical Supplies					48,214			10
11	Medical Records								11
12	Staff Transportation					22,160			12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service								16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care					41			50
51	Hospice Routine Home Care					190,276			51
52	Hospice Inpatient Respite Care								52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	Cost to be allocated (per O-6 Pt I)	4,835	814	90,305		203,399	29,673		100
101	Unit cost multiplier					0.688158			101

COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS **HOSPICE CCN: 14-1542** **WORKSHEET O-6 PART II**

	Descriptions	HOUSE-KEEPING SQUARE FEET	DIETARY IN-FACIL-ITY DAYS	NURSING ADMINIS-TRATION DIRECT NURS. HRS.	ROUTINE MEDICAL SUPPLIES PATIENT DAYS	MEDICAL RECORDS PATIENT DAYS	STAFF TRANS-PORTATION MILEAGE	VOLUNTEER SVC COOR-DINATION HOURS OF SERVICE	
		7	8	9	10	11	12	13	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General								4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies								10
11	Medical Records								11
12	Staff Transportation								12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service								16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care								51
52	Hospice Inpatient Respite Care								52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	Cost to be allocated (per O-6 Pt I)	28,142	1,067		81,393		37,410		100
101	Unit cost multiplier								101

COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS **HOSPICE CCN: 14-1542** **WORKSHEET O-6 PART II**

	Descriptions	PHARMACY CHARGES	PHYSICIAN ADMIN SERVICES PATIENT DAYS	OTHER GENERAL SERVICE SPECIFY BASIS	PATIENT/ RESIDENT CARE SVCS IN-FACIL-ITY DAYS	
		14	15	16	17	
	GENERAL SERVICE COST CENTERS					
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
3	Employee Benefits Department					3
4	Administrative & General					4
5	Plant Operation & Maintenance					5
6	Laundry & Linen Service					6
7	Housekeeping					7
8	Dietary					8
9	Nursing Administration					9
10	Routine Medical Supplies					10
11	Medical Records					11
12	Staff Transportation					12
13	Volunteer Service Coordination					13
14	Pharmacy					14
15	Physician Administrative Services					15
16	Other General Service					16
17	Patient/Residential Care Services					17
	LEVEL OF CARE					
50	Hospice Continuous Home Care					50
51	Hospice Routine Home Care					51
52	Hospice Inpatient Respite Care					52
53	Hospice General Inpatient Care					53
	NONREIMBURSABLE COST CENTERS					
60	Bereavement Program					60
61	Volunteer Program					61
62	Fundraising					62
63	Hospice/Palliative Medicine Fellows					63
64	Palliative care Program					64
65	Other Physician Services					65
66	Residential Care					66
67	Advertising					67
68	Telehealth / Telemonitoring					68
69	Thrift Store					69
70	Nursing Facility Room & Board					70
71	Other Nonreimbursable					71
99	Negative Cost Center					99
100	Cost to be allocated (per O-6 Pt I)					100
101	Unit cost multiplier					101

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE **HOSPICE CCN: 14-1542** **WORKSHEET O-7**

			Charges by LOC (from Provider Records)					
		Wkst C Pt I, col. 9, line	Cost to Charge Ratio	HCHC	HRHC	HIRC	HGIP	
	Cost Center Descriptions	0	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS							
1	Physical Therapy	66	0.283859					1
2	Occupational Therapy	67						2
3	Speech Language Pathology	68	0.337199					3
4	Drugs, Biological & Infusion Therapy	73	0.237965					4
5	Durable Medical Equipment/Oxygen	96						5
6	Labs and Diagnostics	60	0.134802					6
7	Medical Supplies	71	0.409364					7
8	Outpatient Services (incl E/R)	93						8
9	Radiation Therapy	55						9
10	Other	76						10
11	Totals (sum of lines 1-10)							11

		Shared Service Costs by LOC				
		HCHC (col 1 x col 2)	HRHC (col 1 x col 3)	HIRC (col 1 x col 4)	HGIP (col 1 x col 5)	
	Cost Center Descriptions	6	7	8	9	
	ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy					1
2	Occupational Therapy					2
3	Speech Language Pathology					3
4	Drugs, Biological & Infusion Therapy					4
5	Durable Medical Equipment/Oxygen					5
6	Labs and Diagnostics					6
7	Medical Supplies					7
8	Outpatient Services (incl E/R)					8
9	Radiation Therapy					9
10	Other					10
11	Totals (sum of lines 1-10)					11

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST **HOSPICE CCN: 14-1542** **WORKSHEET O-8**

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1	2	3	
	HOSPICE CONTINUOUS HOME CARE				
1	Total cost			69	1
2	Total unduplicated days			1	2
3	Total average cost per diem			69.00	3
4	Unduplicated program days	1			4
5	Program cost	69			5
	HOSPICE ROUTINE HOME CARE				
6	Total cost			321,215	6
7	Total unduplicated days			4,725	7
8	Total average cost per diem			67.98	8
9	Unduplicated program days	4,401	28		9
10	Program cost	299,180	1,903		10
	HOSPICE INPATIENT RESPITE CARE				
11	Total cost				11
12	Total unduplicated days				12
13	Total average cost per diem				13
14	Unduplicated program days				14
15	Program cost				15
	HOSPICE GENERAL INPATIENT CARE				
16	Total cost				16
17	Total unduplicated days				17
18	Total average cost per diem				18
19	Unduplicated program days				19
20	Program cost				20
	TOTAL HOSPICE CARE				
21	Total cost			321,284	21
22	Total unduplicated days			4,726	22
23	Average cost per diem			67.98	23

REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	Adults & Pediatrics	48.42		12.98				61.40	30
31	Intensive Care Unit	92.95		0.14				93.09	31
43	Nursery			58.95				58.95	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	7.61	25.43					33.04	50
53	Anesthesiology	5.48	17.43					22.91	53
54	Radiology-Diagnostic	9.63	30.50					40.13	54
56	Radioisotope	4.74	46.15					50.89	56
57	CT Scan	8.96	30.58					39.54	57
58	MRI	2.36	28.60					30.96	58
60	Laboratory	11.07	12.39					23.46	60
64	Intravenous Therapy	26.48	19.53					46.01	64
65	Respiratory Therapy	43.39	13.09					56.48	65
66	Physical Therapy	4.51	0.28					4.79	66
68	Speech Pathology	4.82	3.03					7.85	68
69	Electrocardiology	10.15	35.00					45.15	69
71	Medical Supplies Charged to Pat	12.77	22.19					34.96	71
72	Impl. Dev. Charged to Patients	21.70	30.74					52.44	72
73	Drugs Charged to Patients	19.95	27.68					47.63	73
91	Emergency	10.91	22.77					33.68	91
92	Observation Beds (Non-Distinct	9.93	21.65					31.58	92
200	TOTAL CHARGES	10.77	20.72					31.49	200

REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IPF

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
40	Subprovider - IPF	17.42		57.52				74.94	40
	UTILIZATION PERCENTAGES BASED ON CHARGES								
54	Radiology-Diagnostic	0.09						0.09	54
57	CT Scan	0.05						0.05	57
60	Laboratory	0.18						0.18	60
65	Respiratory Therapy	0.05						0.05	65
66	Physical Therapy	0.02						0.02	66
69	Electrocardiology	0.22						0.22	69
71	Medical Supplies Charged to Pat	0.05						0.05	71
73	Drugs Charged to Patients	0.95						0.95	73
91	Emergency	0.28						0.28	91
200	TOTAL CHARGES	0.16						0.16	200

REPORT 97 - UTILIZATION STATISTICS - SNF / NF

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
44	Skilled Nursing Facility	29.64						29.64	44
	UTILIZATION PERCENTAGES BASED ON CHARGES								
54	Radiology-Diagnostic	0.56						0.56	54
56	Radioisotope	0.15						0.15	56
57	CT Scan	0.28						0.28	57
58	MRI	0.24						0.24	58
60	Laboratory	0.81						0.81	60
64	Intravenous Therapy	3.50						3.50	64
65	Respiratory Therapy	21.71						21.71	65
66	Physical Therapy	21.79						21.79	66
68	Speech Pathology	8.27						8.27	68
69	Electrocardiology	0.33						0.33	69
71	Medical Supplies Charged to Pat	2.69						2.69	71
73	Drugs Charged to Patients	6.34						6.34	73
92	Observation Beds (Non-Distinct	0.23						0.23	92
200	TOTAL CHARGES	3.29						3.29	200

REPORT 97 - UTILIZATION STATISTICS - SWING-BED SNF / NF

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON CHARGES								
54	Radiology-Diagnostic	0.08						0.08	54
57	CT Scan	0.04						0.04	57
60	Laboratory	0.11						0.11	60
64	Intravenous Therapy	1.21						1.21	64
65	Respiratory Therapy	1.61						1.61	65
66	Physical Therapy	0.59						0.59	66
68	Speech Pathology	0.52						0.52	68
69	Electrocardiology	0.05						0.05	69
71	Medical Supplies Charged to Pat	0.30						0.30	71
73	Drugs Charged to Patients	0.73						0.73	73
92	Observation Beds (Non-Distinct	0.07						0.07	92
200	TOTAL CHARGES	0.21						0.21	200

REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	651,034	1.40	-651,034	-2.81			1
2	Cap Rel Costs-Mvble Equip	1,540,351	3.31	-1,540,351	-6.64			2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	9,091,083	19.53	-9,091,083	-39.20			4
5	Administrative & General	4,512,994	9.69	-4,512,994	-19.46			5
6	Maintenance & Repairs	895,092	1.92	-895,092	-3.86			6
7	Operation of Plant	479,538	1.03	-479,538	-2.07			7
8	Laundry & Linen Service	135,492	0.29	-135,492	-0.58			8
9	Housekeeping	522,371	1.12	-522,371	-2.25			9
10	Dietary	324,469	0.70	-324,469	-1.40			10
11	Cafeteria	723,461	1.55	-723,461	-3.12			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,434,768	3.08	-1,434,768	-6.19			13
14	Central Services & Supply	83,038	0.18	-83,038	-0.36			14
15	Pharmacy	2,166,279	4.65	-2,166,279	-9.34			15
16	Medical Records & Library	634,004	1.36	-634,004	-2.73			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 SERVICE COST CENTERS							
30	Adults & Pediatrics	1,804,950	3.88	3,067,795	13.23	4,872,745	10.47	30
31	Intensive Care Unit	677,733	1.46	882,646	3.81	1,560,379	3.35	31
40	Subprovider - IPF	706,909	1.52	1,029,583	4.44	1,736,492	3.73	40
43	Nursery	257,277	0.55	322,439	1.39	579,716	1.25	43
44	Skilled Nursing Facility	1,209,636	2.60	1,969,768	8.49	3,179,404	6.83	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,018,323	2.19	1,245,681	5.37	2,264,004	4.86	50
53	Anesthesiology	26,193	0.06	126,390	0.54	152,583	0.33	53
54	Radiology-Diagnostic	966,673	2.08	916,675	3.95	1,883,348	4.05	54
56	Radioisotope	117,742	0.25	105,619	0.46	223,361	0.48	56
57	CT Scan	290,536	0.62	153,814	0.66	444,350	0.95	57
58	MRI	137,626	0.30	286,845	1.24	424,471	0.91	58
60	Laboratory	2,649,065	5.69	1,175,503	5.07	3,824,568	8.22	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	45,537	0.10	102,361	0.44	147,898	0.32	64
65	Respiratory Therapy	391,327	0.84	371,503	1.60	762,830	1.64	65
66	Physical Therapy	1,697,164	3.65	1,269,700	5.47	2,966,864	6.37	66
68	Speech Pathology	188,201	0.40	123,004	0.53	311,205	0.67	68
69	Electrocardiology	156,758	0.34	41,278	0.18	198,036	0.43	69
71	Medical Supplies Charged to Patients	1,733,807	3.72	474,213	2.04	2,208,020	4.74	71
72	Impl. Dev. Charged to Patients	437,704	0.94	119,148	0.51	556,852	1.20	72
73	Drugs Charged to Patients			2,610,488	11.26	2,610,488	5.61	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,096,948	2.36	676,988	2.92	1,773,936	3.81	88
91	Emergency	1,198,983	2.58	1,158,060	4.99	2,357,043	5.06	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	702,508	1.51	855,225	3.69	1,557,733	3.35	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	878,592	1.89	542,833	2.34	1,421,425	3.05	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	377,041	0.81	217,882	0.94	594,923	1.28	116
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	4,567,893	9.81	3,333,555	14.37	7,901,448	16.97	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	20,904	0.04	14,978	0.06	35,882	0.08	194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	46,550,004	100.00			46,550,004	100.00	202

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	339,400	15,627,803	0.021718	1,190,051	25,846	50
53	Anesthesiology	20,563	4,620,048	0.004451	253,384	1,128	53
54	Radiology-Diagnostic	261,897	11,534,754	0.022705	1,110,312	25,210	54
56	Radioisotope	28,695	2,669,136	0.010751	126,596	1,361	56
57	CT Scan	31,187	14,840,419	0.002101	1,329,148	2,793	57
58	MRI	208,060	3,344,885	0.062202	78,920	4,909	58
60	Laboratory	133,536	28,371,722	0.004707	3,140,036	14,780	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	4,640	1,183,581	0.003920	313,356	1,228	64
65	Respiratory Therapy	24,788	3,665,721	0.006762	1,590,684	10,756	65
66	Physical Therapy	68,033	10,451,887	0.006509	471,682	3,070	66
68	Speech Pathology	5,022	922,912	0.005441	44,505	242	68
69	Electrocardiology	10,344	2,723,901	0.003797	276,547	1,050	69
71	Medical Supplies Charged to Pat	57,223	5,393,776	0.010609	688,726	7,307	71
72	Impl. Dev. Charged to Patients	14,341	1,094,261	0.013106	237,421	3,112	72
73	Drugs Charged to Patients	115,924	10,970,029	0.010567	2,188,384	23,125	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	Rural Health Clinic	42,243	1,343,386	0.031445			88
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	121,754	9,892,566	0.012308	1,079,730	13,289	91
92	Observation Beds (Non-Distinct	69,826	2,711,315	0.025754	269,232	6,934	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	TOTAL	1,557,476	131,362,102		14,388,714	146,140	200

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	294,270	2,453	291,817	4,292	67.99	2,078	141,283	30
31	Intensive Care Unit	74,338		74,338	738	100.73	686	69,101	31
200	TOTAL	368,608	2,453	366,155	5,030		2,764	210,384	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	210,384
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	146,140
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	356,524
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	742
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	2,764
PER DISCHARGE CAPITAL COSTS	480.49

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	6,113,921
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	17,409,070
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.351

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 40 + Worksheet D, Part IV, column 11, line 200))	352,252
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	581,086
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.606

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	356,524
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.020

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	4,377,046
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	27,601,323
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.159