

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 11-25-2013 TIME: 21:28
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. MARY MEDICAL CENTER, INC. (15-0034) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		-512,748	80,225	281,570		1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF		26,545	-69			3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		-486,203	80,156	281,570		200

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1500 SOUTH LAKE AVENUE P.O. BOX: 1
 2 CITY: HOBART STATE: IN ZIP CODE: 46342 COUNTY: LAKE 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	1	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N)			
							2	3	4	5
3	HOSPITAL	ST. MARY MEDICAL CENTER, INC.	15-0034	23844	1	07/01/1966	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF	SMMC REHABILITATION UNIT	15-T034	23844	5	01/01/2001	N	P	P	5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	ANCILLA HOME HEALTH OF SMMC	15-7313	23844		02/08/1996	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY) FROM: 07/01/2012 TO: 06/30/2013									20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

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

		IN-STATE		OUT-OF-STATE		OTHER			
		IN-STATE	IN-STATE	OUT-OF-STATE	OUT-OF-STATE	MEDICAID	MEDICAID		
		MEDICAID PAID	MEDICAID ELIGIBLE UNPAID	MEDICAID PAID	MEDICAID ELIGIBLE UNPAID	MEDICAID HMO	MEDICAID OTHER		
		DAYS	DAYS	DAYS	DAYS	DAYS	DAYS		
1	2	3	4	5	6	7	8	9	10
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	3,418	225	132		1,912	651	24	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.		153				75		25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				1				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:		ENDING:		38

39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)								1	2
									N	N 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
64 ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

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

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

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

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

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ALL PROVIDERS

140 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.

	1	2	
	Y	158054	140

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

141	NAME: COMMUNITY FOUNDATION OF NW IN, CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 00450	141
142	STREET: STREET: STREET: 10010 DONA P.O. BOX: 201		142
143	CITY: MUNSTER STATE: IN	ZIP CODE: 46321	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	149

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

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

MULTICAMPUS

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

	N	165
--	---	-----

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

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE	
PROVIDER ORGANIZATION AND OPERATION				
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N	2	1
		Y/N	DATE	V/I
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N	2	3 2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3
FINANCIAL DATA AND REPORTS				
		Y/N	TYPE	DATE
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	3 4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5
APPROVED EDUCATIONAL ACTIVITIES				
		Y/N	Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	2	6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11
			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					
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	11/01/2013	Y	11/01/2013
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: JANE	LAST NAME: BACHMANN	TITLE: CONSULTANT	41
42	EMPLOYER: BACHMANN ASSOCIATES			42
43	PHONE NUMBER: 3122852828	E-MAIL ADDRESS: JBOPIL@ATT.NET		43

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	61,451,003	-10,708	61,440,295	2,337,826.00	26.28
2	NON-PHYSICIAN ANESTHETIST PART A						1
3	NON-PHYSICIAN ANESTHETIST PART B						2
4	PHYSICIAN-PART A ADMINISTRATIVE						3
4.01	PHYSICIAN-PART A - TEACHING						4
5	PHYSICIAN-PART B						4.01
6	NON-PHYSICIAN-PART B						5
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					6
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7
8	HOME OFFICE PERSONNEL						7.01
9	SNF	44					8
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		2,938,265	-10,708	2,927,557	105,814.00	27.67
	OTHER WAGES & RELATED COSTS						10
11	CONTRACT LABOR (SEE INSTRUCTIONS)		2,163,217		2,163,217	31,256.00	69.21
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						11
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		365,367		365,367	2,659.00	137.41
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		7,565,663		7,565,663	162,903.00	46.44
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						14
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						15
	WAGE-RELATED COSTS						16
17	WAGE-RELATED COSTS (CORE)		14,518,194		14,518,194		17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		703,317		703,317		19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS DEPARTMENT		920,552		920,552	26,051.00	35.34
27	ADMINISTRATIVE & GENERAL		5,734,238		5,734,238	264,896.00	21.65
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		1,900,907		1,900,907	11,823.00	160.78
29	MAINTENANCE & REPAIRS		1,123,420		1,123,420	38,925.00	28.86
30	OPERATION OF PLANT		808,881		808,881	46,157.00	17.52
31	LAUNDRY & LINEN SERVICE		75,579		75,579	6,588.00	11.47
32	HOUSEKEEPING		1,674,914		1,674,914	106,088.00	15.79
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		1,776,186	-1,101,525	674,661	40,115.00	16.82
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA			1,101,525	1,101,525	65,506.00	16.82
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		2,342,030	-1,162	2,340,868	32,586.00	71.84
39	CENTRAL SERVICES AND SUPPLY		373,636	391,764	765,400	25,787.00	29.68
40	PHARMACY		2,171,698	-391,764	1,779,934	48,488.00	36.71
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,842,946		1,842,946	86,511.00	21.30
42	SOCIAL SERVICE		-1,162	1,162			42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	63,351,910	-10,708	63,341,202	2,349,649.00	26.96	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2,938,265	-10,708	2,927,557	105,814.00	27.67	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	60,413,645		60,413,645	2,243,835.00	26.92	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	10,094,247		10,094,247	196,818.00	51.29	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	14,518,194		14,518,194		24.03	5
6	TOTAL (SUM OF LINES 3 THRU 5)	85,026,086		85,026,086	2,440,653.00	34.84	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	20,743,825		20,743,825	799,521.00	25.95	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	381,635	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	2,399,808	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	611,420	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	5,489,969	8
9 PRESCRIPTION DRUG PLAN	1,128,241	9
10 DENTAL, HEARING AND VISION PLAN	57,429	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	49,539	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	378,879	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	232,019	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	3,491,100	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	820,978	18
19 UNEMPLOYMENT INSURANCE	122,762	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	57,732	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	15,221,511	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 21:28

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL	2,163,217	2
3	SUBPROVIDER - IPF	2,163,217	3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTG		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 15-7313

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: LAKE

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		3,196		503	3,699	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		496.00		302.00	798.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			
	STAFF 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)	1.00		1.00	4
5 OTHER ADMINISTRATIVE PERSONNEL	8.95		8.95	5
6 DIRECT NURSING SERVICE	12.96		12.96	6
7 NURSING SUPERVISOR				7
8 PHYSICAL THERAPY SERVICE		3.55	3.55	8
9 PHYSICAL THERAPY SUPERVISOR				9
10 OCCUPATIONAL THERAPY SERVICE		0.78	0.78	10
11 OCCUPATIONAL THERAPY SUPERVISOR				11
12 SPEECH PATHOLOGY SERVICE		0.18	0.18	12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE	0.04		0.04	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE	2.99		2.99	16
17 HOME HEALTH AIDE SUPERVISOR				17
18 OTHER (SPECIFY)				18

HOME HEALTH AGENCY CBSA CODES

19 ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.		1	19
20 LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).		23844	20

PPS ACTIVITY

	FULL EPISODES				TOTAL (COLS. 1-4)	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	8,904	1,824	149	130	11,007	21
22 SKILLED NURSING VISIT CHARGES	1,415,736	290,016	23,691	20,670	1,750,113	22
23 PHYSICAL THERAPY VISITS	5,154	394	22	72	5,642	23
24 PHYSICAL THERAPY VISIT CHARGES	953,490	72,890	4,070	13,320	1,043,770	24
25 OCCUPATIONAL THERAPY VISITS	1,139	131	1	24	1,295	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	210,715	24,235	185	4,440	239,575	26
27 SPEECH PATHOLOGY VISITS	228	51	6	19	304	27
28 SPEECH PATHOLOGY VISIT CHARGES	42,180	9,435	1,110	3,515	56,240	28
29 MEDICAL SOCIAL SERVICE VISITS	23	3		2	28	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	4,853	633		422	5,908	30
31 HOME HEALTH AIDE VISITS	2,554	584	10	48	3,196	31
32 HOME HEALTH AIDE VISIT CHARGES	303,926	69,496	1,190	5,712	380,324	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	18,002	2,987	188	295	21,472	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	2,930,900	466,705	30,246	48,079	3,475,930	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	750		78	17	845	36
37 TOTAL NUMBER OF OUTLIER EPISODES		54			54	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	159,432	33,787	22,412	24,073	239,704	38

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.288782	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				22,161,816	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				59,870,268	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				17,289,456	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.					8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				10,000	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)					19
			UNINSURED PATIENTS	INSURED PATIENTS	TOTAL	
			1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	17,396,441			17,396,441	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	5,023,779			5,023,779	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				0	22
23	COST OF CHARITY CARE	5,023,779			5,023,779	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 IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					24
25	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				10,799,833	26
26	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				633,303	27
27	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				10,166,530	28
28	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				2,935,911	29
29	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				7,959,690	30
30	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				7,959,690	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100				6,856,503	1
2	00200				7,220,661	2
3	00300					3
4	00400	82,232	54,394	136,626	15,150,673	4
4.01	00401	838,320	457,990	1,296,310	-1,141	4.01
5.01	00540	199,543	2,282	201,825	-89	5.01
5.02	00560	345,588	211,423	557,011	-78,989	5.02
5.03	00570					5.03
5.04	00580					5.04
5.05	00590					5.05
6	00600	3,640,440	73,629,266	77,269,706	-31,478,781	6
7	00700	1,123,420	6,290,363	7,413,783	-170,416	7
8	00800	808,881	523,916	1,332,797	513,360	8
9	00900	75,579	626,197	701,776	-40	9
10	01000	1,674,914	386,559	2,061,473	-1,553	10
11	01100	1,776,186	1,538,784	3,314,970	-2,064,770	11
12	01200				2,055,822	12
13	01300					13
14	01400	2,342,030	669,793	3,011,823	-5,657	14
15	01500	373,636	236,015	609,651	511,240	15
16	01600	2,171,698	9,226,064	11,397,762	-8,214,619	16
17	01700	1,842,946	669,978	2,512,924	-355	17
19	01900	-1,162	477	-685	685	19
NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERV COST CENTERS						
30	03000	15,406,198	2,074,786	17,480,984	-1,558,083	30
31	03100	2,455,271	478,176	2,933,447	-416,415	31
41	04100	1,667,338	809,531	2,476,869	-149,478	41
43	04300					43
ANCILLARY SERVICE COST CENTERS						
50	05000	4,073,240	16,898,676	20,971,916	-13,516,645	50
51	05100	1,209,372	115,890	1,325,262	-99,789	51
53	05300	1,012	2,581,227	2,582,239	-519,829	53
54	05400	2,861,239	848,325	3,709,564	-463,359	54
54.01	03630	573,601	94,066	667,667	-67,357	54.01
56	05600	367,781	397,254	765,035	-344,822	56
57	05700	573,622	272,261	845,883	-153,740	57
59	05900	1,063,822	2,924,834	3,988,656	-2,956,307	59
60	06000	3,038,888	2,720,496	5,759,384	-2,057	60
62	06200	201,481	1,114,044	1,315,525		62
62.30	06250					62.30
65	06500	1,788,390	326,855	2,115,245	-270,300	65
66	06600		1,930,728	1,930,728	-38,716	66
67	06700	164,422	825,518	989,940	-23,055	67
68	06800		368,166	368,166	-1,641	68
70	07000	688,124	3,653,567	4,341,691	-3,448,779	70
71	07100				14,367,250	71
72	07200				13,139,871	72
73	07300				8,189,840	73
74	07400		534,676	534,676		74
76.97	07697	579,283	74,953	654,236	-17,453	76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	1,698,212	809,862	2,508,074	-290,806	90
91	09100	2,925,862	787,075	3,712,937	-647,164	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
101	10100	1,259,926	823,226	2,083,152	-148,092	101
SPECIAL PURPOSE COST CENTERS						
118		61,440,002	136,039,120	197,479,122	855,167	118
NONREIMBURSABLE COST CENTERS						
192	19200	10,708	19,172	29,880	-3,206	192
194	07950	293	1,107,962	1,108,255	-851,961	194
194.01	07951					194.01
200		61,451,003	137,166,254	198,617,257		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	6,856,503	56,724	6,913,227	1
2	00200	7,220,661	2,456,357	9,677,018	2
3	00300				3
4	00400	15,287,299	-3,305	15,283,994	4
4.01	00401	1,295,169	-3,907	1,291,262	4.01
5.01	00540	201,736		201,736	5.01
5.02	00560	478,022		478,022	5.02
5.03	00570	1,599,653		1,599,653	5.03
5.04	00580				5.04
5.05	00590	45,790,925	-23,958,501	21,832,424	5.05
6	00600	7,243,367		7,243,367	6
7	00700	1,846,157		1,846,157	7
8	00800	701,736		701,736	8
9	00900	2,059,920		2,059,920	9
10	01000	1,250,200	-8,211	1,241,989	10
11	01100	2,055,822	-737,516	1,318,306	11
12	01200				12
13	01300	3,006,166	-5,451	3,000,715	13
14	01400	1,120,891		1,120,891	14
15	01500	3,183,143	-14,876	3,168,267	15
16	01600	2,512,569	-9,365	2,503,204	16
17	01700				17
19	01900				19
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	15,922,901	-71,790	15,851,111	30
31	03100	2,517,032	-11,272	2,505,760	31
41	04100	2,327,391		2,327,391	41
43	04300				43
ANCILLARY SERVICE COST CENTERS					
50	05000	7,455,271		7,455,271	50
51	05100	1,225,473		1,225,473	51
53	05300	2,062,410	-2,050,287	12,123	53
54	05400	3,246,205	-20,594	3,225,611	54
54.01	03630	600,310		600,310	54.01
56	05600	420,213		420,213	56
57	05700	692,143		692,143	57
59	05900	1,032,349	-11,169	1,021,180	59
60	06000	5,757,327	-24,279	5,733,048	60
62	06200	1,315,525		1,315,525	62
62.30	06250				62.30
65	06500	1,844,945	-10,557	1,834,388	65
66	06600	1,892,012		1,892,012	66
67	06700	966,885		966,885	67
68	06800	366,525		366,525	68
70	07000	892,912	-20,475	872,437	70
71	07100	14,367,250		14,367,250	71
72	07200	13,139,871		13,139,871	72
73	07300	8,189,840	-88	8,189,752	73
74	07400	534,676		534,676	74
76.97	07697	636,783	-80,054	556,729	76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	2,217,268	-112,366	2,104,902	90
91	09100	3,065,773	-134,017	2,931,756	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
94	09400				94
101	10100	1,935,060	-1,404	1,933,656	101
SPECIAL PURPOSE COST CENTERS					
118		198,334,289	-24,776,403	173,557,886	118
NONREIMBURSABLE COST CENTERS					
192	19200	26,674	-26,674		192
194	07950	256,294		256,294	194
194.01	07951				194.01
200		198,617,257	-24,803,077	173,814,180	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER	
			LINE #				
	1	2	3		4	5	
1 MEDICAL SUPPLY RECLASS	A	MEDICAL SUPPLIES CHARGED TO P	71			14,367,250	1
2		IMPL. DEV. CHARGED TO PATIENT	72			13,139,871	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
500 TOTAL RECLASSIFICATIONS						27,507,121	500
CODE LETTER - A							
1 RECLASS DEPRECIATION EXPENSE	B	CAP REL COSTS-BLDG & FIXT	1			4,533,480	1
2		CAP REL COSTS-MVBLE EQUIP	2			5,833,291	2
500 TOTAL RECLASSIFICATIONS						10,366,771	500
CODE LETTER - B							
1 RECLASS MINOR SOC SVC COSTS	C	NURSING ADMINISTRATION	13				219 1
2		SOCIAL SERVICE	17		1,162		2
500 TOTAL RECLASSIFICATIONS					1,162		219 500
CODE LETTER - C							
1 RECLASS POB SALARIES FOR WAGE INDEX	D	PHYSICIANS' PRIVATE OFFICES	192			10,708	1
500 TOTAL RECLASSIFICATIONS						10,708	500
CODE LETTER - D							
1 CAFETERIA EXPENSES RECLASS	F	CAFETERIA	11		1,101,525	954,297	1
500 TOTAL RECLASSIFICATIONS					1,101,525	954,297	500
CODE LETTER - F							
1 UNASSIGNED BENEFITS RECLASS	G	EMPLOYEE BENEFITS DEPARTMENT	4			14,993,973	1
2		EMPLOYEE BENEFITS DEPARTMENT	4			169,988	2
3		EMPLOYEE BENEFITS DEPARTMENT	4			1,000	3
4		EMPLOYEE BENEFITS DEPARTMENT	4			4,460	4
5							5
500 TOTAL RECLASSIFICATIONS						15,169,421	500
CODE LETTER - G							
1 UTILITIES EXPENSE RECLASS	H	OPERATION OF PLANT	7			674,944	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
500 TOTAL RECLASSIFICATIONS						674,944	500
CODE LETTER - H							

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		
			LINE #	SALARY OTHER	
	1	2	3	4	5
1 INTEREST EXPENSE RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		585,675 1
2		CAP REL COSTS-MVBLE EQUIP	2		246,011 2
500 TOTAL RECLASSIFICATIONS					831,686 500
CODE LETTER - I					
1 PHARMACY RECLASS EXPENSE	J	DRUGS CHARGED TO PATIENTS	73		8,189,840 1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24					24
25					25
500 TOTAL RECLASSIFICATIONS					8,189,840 500
CODE LETTER - J					
1 BUILDING RENT EXPENSE RECLASS	L	CAP REL COSTS-BLDG & FIXT	1		1,288,089 1
2					2
3					3
4					4
500 TOTAL RECLASSIFICATIONS					1,288,089 500
CODE LETTER - L					

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER	
		COST CENTER	LINE #			
	1	2	3	4	5	
1 EQUIPMENT RENT EXPENSE RECLASS	M	CAP REL COSTS-MVBLE EQUIP	2		1,141,359	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
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26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36						36
37						37
38						38
39						39
500 TOTAL RECLASSIFICATIONS					1,141,359	500
CODE LETTER - M						
1 RECLASS PROPERTY INSURANCE	O	CAP REL COSTS-BLDG & FIXT	1		449,259	1
500 TOTAL RECLASSIFICATIONS					449,259	500
CODE LETTER - O						
1 RECLASS IV COSTS	P	CENTRAL SERVICES & SUPPLY	14	391,764	160,730	1
500 TOTAL RECLASSIFICATIONS				391,764	160,730	500
CODE LETTER - P						
GRAND TOTAL (INCREASES)				1,494,451	66,744,444	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 MEDICAL SUPPLY RECLASS	A	PHARMACY	15		196,820	1
2 ADMINISTRATIVE & GENERAL			5.05		3,569,263	2
3 CENTRAL SERVICES & SUPPLY			14		41,061	3
4 ADULTS & PEDIATRICS			30		1,549,545	4
5 INTENSIVE CARE UNIT			31		416,082	5
6 SUBPROVIDER - IRF			41		147,104	6
7 OPERATING ROOM			50		13,265,748	7
8 RECOVERY ROOM			51		99,097	8
9 ANESTHESIOLOGY			53		352,049	9
10 RADIOLOGY-DIAGNOSTIC			54		246,460	10
11 RADIOLOGY - ULTRASOUND			54.01		24,646	11
12 CARDIAC CATHETERIZATION			59		2,892,898	12
13 CT SCAN			57		90,698	13
14 RADIOISOTOPE			56		16,745	14
15 CARDIAC REHABILITATION			76.97		5,925	15
16 RESPIRATORY THERAPY			65		139,226	16
17 PHYSICAL THERAPY			66		37,427	17
18 OCCUPATIONAL THERAPY			67		17,849	18
19 SPEECH PATHOLOGY			68		1,535	19
20 ELECTROENCEPHALOGRAPHY			70		3,444,690	20
21 CLINIC			90		203,775	21
22 HOME HEALTH AGENCY			101		110,500	22
23 PHYSICIANS' PRIVATE OFFICES			192		2,820	23
24 OTHER NON-REIMBURSEABLE COST			194		2,077	24
25 EMERGENCY			91		633,081	25
500 TOTAL RECLASSIFICATIONS					27,507,121	500
CODE LETTER - A						
1 RECLASS DEPRECIATION EXPENSE	B	ADMINISTRATIVE & GENERAL	5.05		10,366,771	9 1
2						9 2
500 TOTAL RECLASSIFICATIONS					10,366,771	500
CODE LETTER - B						
1 RECLASS MINOR SOC SVC COSTS	C	SOCIAL SERVICE	17		219	1
2 NURSING ADMINISTRATION			13	1,162		2
500 TOTAL RECLASSIFICATIONS				1,162	219	500
CODE LETTER - C						
1 RECLASS POB SALARIES FOR WAGE INDEX	D	PHYSICIANS' PRIVATE OFFICES	192	10,708		1
500 TOTAL RECLASSIFICATIONS				10,708		500
CODE LETTER - D						
1 CAFETERIA EXPENSES RECLASS	F	DIETARY	10	1,101,525	954,297	1
500 TOTAL RECLASSIFICATIONS				1,101,525	954,297	500
CODE LETTER - F						
1 UNASSIGNED BENEFITS RECLASS	G	ADMINISTRATIVE & GENERAL	5.05		14,989,927	1
2 ADULTS & PEDIATRICS			30		4,460	2
3 NURSING ADMINISTRATION			13		4,046	3
4 ADULTS & PEDIATRICS			30		1,000	4
5 ADMINISTRATIVE & GENERAL			5.05		169,988	5
500 TOTAL RECLASSIFICATIONS					15,169,421	500
CODE LETTER - G						
1 UTILITIES EXPENSE RECLASS	H	ADMINISTRATIVE & GENERAL	5.05		231,049	1
2 RADIOLOGY-DIAGNOSTIC			54		1,812	2
3 CARDIAC REHABILITATION			76.97		7,574	3
4 RESPIRATORY THERAPY			65		10,375	4
5 HOME HEALTH AGENCY			101		1,974	5
6 PHYSICIANS' PRIVATE OFFICES			192		266	6
7 OTHER NON-REIMBURSEABLE COST			194		164,894	7
8 PURCHASING, RECEIVING & STORE			5.02		3,316	8
9 MAINTENANCE & REPAIRS			6		101,542	9
10 OPERATING ROOM			50		29	10
11 OPERATION OF PLANT			7		152,113	11
500 TOTAL RECLASSIFICATIONS					674,944	500
CODE LETTER - H						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 INTEREST EXPENSE RECLASS	I	ADMINISTRATIVE & GENERAL	5.05		831,686	11 1
2						11 2
500 TOTAL RECLASSIFICATIONS					831,686	500
CODE LETTER - I						
1 PHARMACY RECLASS EXPENSE	J	PHARMACY	15		7,464,672	1
2		EMPLOYEE BENEFITS DEPARTMENT	4		18,708	2
3		CENTRAL SERVICES & SUPPLY	14		2	3
4		ADULTS & PEDIATRICS	30		1,441	4
5		INTENSIVE CARE UNIT	31		186	5
6		SUBPROVIDER - IRF	41		25	6
7		OPERATING ROOM	50		46,465	7
8		RECOVERY ROOM	51		418	8
9		ANESTHESIOLOGY	53		167,214	9
10		CARDIAC CATHETERIZATION	59		6,865	10
11		CT SCAN	57		17	11
12		RADIOISOTOPE	56		318,314	12
13		RADIOLOGY-DIAGNOSTIC	54		667	13
14		RESPIRATORY THERAPY	65		65,290	14
15		LABORATORY	60		1,383	15
16		OCCUPATIONAL THERAPY	67		5,081	16
17		ELECTROENCEPHALOGRAPHY	70		237	17
18		CARDIAC REHABILITATION	76.97		2,521	18
19		CLINIC	90		11,062	19
20		EMERGENCY	91		14,006	20
21		ADMINISTRATIVE & GENERAL	5.05		956	21
22		MAINTENANCE & REPAIRS	6		55,363	22
23		NURSING ADMINISTRATION	13		79	23
24		OPERATION OF PLANT	7		8,715	24
25		PURCHASING, RECEIVING & STORE	5.02		153	25
500 TOTAL RECLASSIFICATIONS					8,189,840	500
CODE LETTER - J						
1 BUILDING RENT EXPENSE RECLASS	L	MAINTENANCE OF PERSONNEL	4.01		84	10 1
2		OTHER NON-REIMBURSEABLE COST	194		683,635	2
3		HOME HEALTH AGENCY	101		35,413	3
4		ADMINISTRATIVE & GENERAL	5.05		568,957	4
500 TOTAL RECLASSIFICATIONS					1,288,089	500
CODE LETTER - L						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
1	1	6	7	8	9	10
1 EQUIPMENT RENT EXPENSE RECLASS	M	MAINTENANCE OF PERSONNEL	4.01		1,057	10 1
2		EMPLOYEE BENEFITS DEPARTMENT	4		40	2
3		NON-PATIENT TELEPHONES	5.01		89	3
4		PURCHASING, RECEIVING & STORE	5.02		75,520	4
5		PATIENT REGISTRATION	5.03		441	5
6		ADMINISTRATIVE & GENERAL	5.05		300,925	6
7		MAINTENANCE & REPAIRS	6		13,511	7
8		OPERATION OF PLANT	7		756	8
9		LAUNDRY & LINEN SERVICE	8		40	9
10		HOUSEKEEPING	9		1,553	10
11		DIETARY	10		8,948	11
12		NURSING ADMINISTRATION	13		589	12
13		CENTRAL SERVICES & SUPPLY	14		191	13
14		PHARMACY	15		633	14
15		MEDICAL RECORDS & LIBRARY	16		355	15
16		SOCIAL SERVICE	17		258	16
17		ADULTS & PEDIATRICS	30		1,637	17
18		INTENSIVE CARE UNIT	31		147	18
19		SUBPROVIDER - IRF	41		2,349	19
20		OPERATING ROOM	50		204,403	20
21		RECOVERY ROOM	51		274	21
22		ANESTHESIOLOGY	53		566	22
23		RADIOLOGY-DIAGNOSTIC	54		214,420	23
24		RADIOLOGY - ULTRASOUND	54.01		42,711	24
25		RADIOISOTOPE	56		9,763	25
26		CT SCAN	57		63,025	26
27		CARDIAC CATHETERIZATION	59		56,544	27
28		LABORATORY	60		674	28
29		CARDIAC REHABILITATION	76.97		1,433	29
30		RESPIRATORY THERAPY	65		55,409	30
31		PHYSICAL THERAPY	66		1,289	31
32		OCCUPATIONAL THERAPY	67		125	32
33		SPEECH PATHOLOGY	68		106	33
34		ELECTROENCEPHALOGRAPHY	70		3,852	34
35		CLINIC	90		75,969	35
36		EMERGENCY	91		77	36
37		HOME HEALTH AGENCY	101		205	37
38		PHYSICIANS' PRIVATE OFFICES	192		120	38
39		OTHER NON-REIMBURSEABLE COST	194		1,355	39
500 TOTAL RECLASSIFICATIONS CODE LETTER - M					1,141,359	500
1 RECLASS PROPERTY INSURANCE	O	ADMINISTRATIVE & GENERAL	5.05		449,259	12 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - O					449,259	500
1 RECLASS IV COSTS	P	PHARMACY	15	391,764	160,730	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - P				391,764	160,730	500
GRAND TOTAL (DECREASES)				1,505,159	66,733,736	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND	1,025,911					1,025,911	1
2 LAND IMPROVEMENTS	5,447,058	12,074		12,074	38,582	5,420,550	2
3 BUILDINGS AND FIXTURES	93,298,749				444,948	92,853,801	3
4 BUILDING IMPROVEMENTS	16,368,010	848,597		848,597	317,372	16,899,235	4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	89,497,934	7,524,982		7,524,982	1,238,725	95,784,191	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	205,637,662	8,385,653		8,385,653	2,039,627	211,983,688	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	205,637,662	8,385,653		8,385,653	2,039,627	211,983,688	10

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

SUMMARY OF CAPITAL

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	RATIOS		INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8
			FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4				
1 CAP REL COSTS-BLDG & FIXT	116,199,498		116,199,498	0.548153				1
2 CAP REL COSTS-MVBLE EQUIP	95,784,190		95,784,190	0.451847				2
3 TOTAL (SUM OF LINES 1-2)	211,983,688		211,983,688	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	4,590,204	1,288,089	585,675	449,259			6,913,227 1
2 CAP REL COSTS-MVBLE EQUIP	8,487,764	1,141,359	47,895				9,677,018 2
3 TOTAL	13,077,968	2,429,448	633,570	449,259			16,590,245 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-198,116	CAP REL COSTS-MVBLE EQUIP	2	11 2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-342	ADMINISTRATIVE & GENERAL	5.05	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	-10,794	CAP REL COSTS-MVBLE EQUIP	2	9 7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-9,531	CAP REL COSTS-MVBLE EQUIP	2	9 8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-343,617			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-1,125,667			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-737,516	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-9,365	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES	B	-8,211	DIETARY	10	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES	A	-52,102	CAP REL COSTS-BLDG & FIXT	1	9 26
27 DEPRECIATION--MOVABLE EQUIPMENT	A	11,780	CAP REL COSTS-MVBLE EQUIP	2	9 27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 OFFSET CRNA/ANESTHESIOLOGIST FEES	A	-2,050,287	ANESTHESIOLOGY	53	33
33.07 1990 ASSETS-INSTALLMENTS	A	-2,315	CAP REL COSTS-MVBLE EQUIP	2	9 33.07
33.10 1991 AHA LIFE ADJ	A	5,750	CAP REL COSTS-MVBLE EQUIP	2	9 33.10
33.21 1993 AHA ASSETS < \$500 BLDG	A	-13	CAP REL COSTS-BLDG & FIXT	1	9 33.21
34 PHOTOGRAPHIC FEES	B	-1,258	RADIOLOGY-DIAGNOSTIC	54	34
34.03 OFFSET OTHER OP REV	B	-134,017	EMERGENCY	91	34.03
34.04 OFFSET LAMAZE CLASS REVENUE	B	-2,425	ADULTS & PEDIATRICS	30	34.04
34.06 OFFSET OTHER REV	B	-728	ADMINISTRATIVE & GENERAL	5.05	34.06
35 ADVERTISING OFFSET	A	-1,241,622	ADMINISTRATIVE & GENERAL	5.05	35
36 OFFSET RECRUITING EXPENSE	A	-490,906	ADMINISTRATIVE & GENERAL	5.05	36
37 OTHER OP REV/EP	B	-4,964	ELECTROENCEPHALOGRAPHY	70	37
38 OFFSET LAB INCOME	B	-17,389	LABORATORY	60	38
39 OFFSET HHA PR COSTS	A	-1,404	HOME HEALTH AGENCY	101	39
40					40
41 OTHER REVENUE	B	-536	ADULTS & PEDIATRICS	30	41
41.01 OFFSET PAIN CLINIC INCOME	B	-843	CLINIC	90	41.01
41.03 OFFSET OTHER INCOME	B	-3,305	EMPLOYEE BENEFITS DEPARTMENT	4	41.03
41.04 OFFSET REMAINING POB EXP	A	-26,674	PHYSICIANS' PRIVATE OFFICES	192	41.04
42 OFFSET REV COMMERCE BANK	B	-104,511	ADMINISTRATIVE & GENERAL	5.05	42
42.01 OFFSET PHO REVENUE	B	-52,650	ADMINISTRATIVE & GENERAL	5.05	42.01
42.02 OFFSET MED STAFF REVENUE	B	-10,576	ADMINISTRATIVE & GENERAL	5.05	42.02
42.03 OTHER INCOME	B	-9,659	ADMINISTRATIVE & GENERAL	5.05	42.03
42.06 OFFSET OTHER OP REV	B	-88	DRUGS CHARGED TO PATIENTS	73	42.06
43 OFFSET IHA DUES LOBBYING EXP	A	-2,901	ADMINISTRATIVE & GENERAL	5.05	43
43.03 OFFSET CONTRIBUTION EXPENSE	A	-66,577	ADMINISTRATIVE & GENERAL	5.05	43.03
44 OFFSET CARDIAC REHAB REV	B	-56,742	CARDIAC REHABILITATION	76.97	44
44.01 OFFSET VARIOUS TAXES	A	-416,483	ADMINISTRATIVE & GENERAL	5.05	44.01
45					45
45.08 OFFSET GOLF OUTING EXPENSES	A	-5,925	ADMINISTRATIVE & GENERAL	5.05	45.08

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 PERIOD FROM 07/01/2012 TO 06/30/2013

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
46					46
46.01 OFFSET CARDIAC COSTS	A	-23,312	CARDIAC REHABILITATION	76.97	46.01
47					47
48 OFFSET EKG READINGS	A	-1,000	CARDIAC CATHETERIZATION	59	48
49 PROVIDER TAX	A	-12,678,068	ADMINISTRATIVE & GENERAL	5.05	49
49.01 OFFSET PHYSICIAN CORP ALLOCATIONS	A	-4,918,168	ADMINISTRATIVE & GENERAL	5.05	49.01
50 TOTAL (SUM OF LINES 1 THRU 49)		-24,803,077			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	5.05	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE	14,182,216	18,076,305	-3,894,089	1
2	1	CAP REL COSTS-BLDG & FIXT	DEP INT	108,839		108,839	9 2
3	2	CAP REL COSTS-MVBLE EQUIP	EQ DEPR	2,659,583		2,659,583	9 3
4							4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		16,950,638	18,076,305	-1,125,667	5

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

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

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

		----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6	B	CFNI		100.00	
7					
8					
9					
10					

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	30 ADULTS & PEDIATRICS	74,111	60,176	13,935	177,200	62	5,282	264
2	31 INTENSIVE CARE UNIT	18,173		18,173	177,200	81	6,901	345
3	54 RADIOLOGY-DIAGNOSTIC	27,124	8,185	18,939	200,000	81	7,788	389
4	59 CARDIAC CATHETERIZATION	17,092	1,000	16,092	200,000	72	6,923	346
5	15 PHARMACY	37,963		37,963	177,200	271	23,087	1,154
6	65 RESPIRATORY THERAPY	28,703		28,703	177,200	213	18,146	907
7	60 LABORATORY	20,994		20,994	215,700	136	14,104	705
8	70 ELECTROENCEPHALOGRAPHY	37,150		37,150	177,200	254	21,639	1,082
9	90 CLINIC	136,229	97,751	38,478	177,200	290	24,706	1,235
10	4.01 MAINTENANCE OF PERSONNEL	6,292		6,292	177,200	28	2,385	119
11	13 NURSING ADMINISTRATION	31,349		31,349	177,200	304	25,898	1,295
12	5.05 ADMINISTRATIVE & GENERAL	139,158	41,859	97,299	177,200	867	73,862	3,693
200	TOTAL	574,338	208,971	365,367		2,659	230,721	11,534

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11		12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS					5,282	8,653	68,829	1
2	31	INTENSIVE CARE UNIT					6,901	11,272	11,272	2
3	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE				7,788	11,151	19,336	3
4	59	CARDIAC CATHETERIZATION	AGGREGATE				6,923	9,169	10,169	4
5	15	PHARMACY					23,087	14,876	14,876	5
6	65	RESPIRATORY THERAPY					18,146	10,557	10,557	6
7	60	LABORATORY					14,104	6,890	6,890	7
8	70	ELECTROENCEPHALOGRAPHY					21,639	15,511	15,511	8
9	90	CLINIC	AGGREGATE				24,706	13,772	111,523	9
10	4.01	MAINTENANCE OF PERSONNEL					2,385	3,907	3,907	10
11	13	NURSING ADMINISTRATION					25,898	5,451	5,451	11
12	5.05	ADMINISTRATIVE & GENERAL	AGGREGATE				73,862	23,437	65,296	12
200		TOTAL					230,721	134,646	343,617	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL. 7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	MAINTENANCE OF PERSONNEL 4.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	6,913,227	6,913,227				1
2 CAP REL COSTS-MVBLE EQUIP	9,677,018		9,677,018			2
4 EMPLOYEE BENEFITS DEPARTMENT	15,283,994	3,782	5,295	15,293,071		4
4.01 MAINTENANCE OF PERSONNEL	1,291,262	60,047	84,053	208,945	1,644,307	4.01
5.01 NON-PATIENT TELEPHONES	201,736	28,636	40,085	49,735	10,074	5.01
5.02 PURCHASING, RECEIVING & STORES	478,022	61,984	86,764	86,135	14,595	5.02
5.03 PATIENT REGISTRATION	1,599,653	27,301	38,216	385,994	68,125	5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL	21,832,424	499,655	699,409	907,354	73,934	5.05
6 MAINTENANCE & REPAIRS	7,243,367	12,577	17,606	280,005	28,008	6
7 OPERATION OF PLANT	1,846,157	1,709,222	2,392,539	201,608	33,217	7
8 LAUNDRY & LINEN SERVICE	701,736	13,258	18,558	18,838	4,745	8
9 HOUSEKEEPING	2,059,920	50,310	70,423	417,461	76,344	9
10 DIETARY	1,241,989	150,144	210,169	168,155	76,014	10
11 CAFETERIA	1,318,306			274,547		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,000,715	33,819	47,339	583,445	23,457	13
14 CENTRAL SERVICES & SUPPLY	1,120,891			190,771	12,035	14
15 PHARMACY	3,168,267	48,713	68,188	443,636	41,420	15
16 MEDICAL RECORDS & LIBRARY	2,503,204	44,682	62,545	459,341	62,257	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	15,851,111	1,157,961	1,620,894	3,839,889	451,878	30
31 INTENSIVE CARE UNIT	2,505,760	87,139	121,976	611,959	58,096	31
41 SUBPROVIDER - IRF	2,327,391	149,647	209,473	415,572	51,869	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,455,271	434,661	608,431	1,015,227	101,223	50
51 RECOVERY ROOM	1,225,473	53,529	74,929	301,428	28,023	51
53 ANESTHESIOLOGY	12,123			252		53
54 RADIOLOGY-DIAGNOSTIC	3,225,611	364,732	510,546	713,144	70,506	54
54.01 RADIOLOGY - ULTRASOUND	600,310	18,127	25,373	142,966	9,027	54.01
56 RADIOISOTOPE	420,213	43,190	60,457	91,667	6,242	56
57 CT SCAN	692,143	29,408	41,165	142,971	13,083	57
59 CARDIAC CATHETERIZATION	1,021,180	39,408	55,162	265,150	21,032	59
60 LABORATORY	5,733,048	143,875	201,393	757,422	88,110	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,315,525	11,674	16,342	50,218	4,461	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,834,388	40,075	56,096	445,744	43,157	65
66 PHYSICAL THERAPY	1,892,012	189,669	265,496		1,482	66
67 OCCUPATIONAL THERAPY	966,885	27,655	38,710	40,981	3,263	67
68 SPEECH PATHOLOGY	366,525					68
70 ELECTROENCEPHALOGRAPHY	872,437	45,140	63,186	171,510	16,182	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	14,367,250					71
72 IMPL. DEV. CHARGED TO PATIENTS	13,139,871					72
73 DRUGS CHARGED TO PATIENTS	8,189,752					73
74 RENAL DIALYSIS	534,676					74
76.97 CARDIAC REHABILITATION	556,729	84,325	118,037	144,382	13,068	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,104,902	78,802	110,306	423,267	38,606	90
91 EMERGENCY	2,931,756	195,546	273,721	729,251	73,859	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY	1,933,656	27,484	38,472	314,028	25,418	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	173,557,886	5,966,177	8,351,354	15,292,998	1,642,810	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		354,812	496,659			192
194 OTHER NON-REIMBURSEABLE COST CENTERS	256,294	555,592	777,709	73	1,497	194
194.01 OTHER NONREIMBURSABLE		36,646	51,296			194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	173,814,180	6,913,227	9,677,018	15,293,071	1,644,307	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NONPATIENT TELEPHONES 5.01	PURCHASING RECEIVING & STORES 5.02	PATIENT REGISTRATN 5.03	SUBTOTAL (COLS.0-4) 4A	ADMINI- STRATIVE & GENERAL 5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
4.01 MAINTENANCE OF PERSONNEL						4.01
5.01 NON-PATIENT TELEPHONES	330,266					5.01
5.02 PURCHASING, RECEIVING & STORES	1,990	729,490				5.02
5.03 PATIENT REGISTRATION	7,958	9,425	2,136,672			5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL	28,252	70,274		24,111,302	24,111,302	5.05
6 MAINTENANCE & REPAIRS	3,581	128,657		7,713,801	1,242,393	6
7 OPERATION OF PLANT	10,346	24,455		6,217,544	1,001,404	7
8 LAUNDRY & LINEN SERVICE		6,008		763,143	122,913	8
9 HOUSEKEEPING	1,194	59,460		2,735,112	440,520	9
10 DIETARY	7,560	44,900		1,898,931	305,844	10
11 CAFETERIA				1,592,853	256,546	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	4,775	4,105		3,697,655	595,548	13
14 CENTRAL SERVICES & SUPPLY		51,553		1,375,250	221,499	14
15 PHARMACY	6,367	6,502		3,783,093	609,309	15
16 MEDICAL RECORDS & LIBRARY	13,927	3,143		3,149,099	507,197	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	57,296	42,320	188,091	23,209,440	3,738,143	30
31 INTENSIVE CARE UNIT	5,173	2,851	23,114	3,416,068	550,195	31
41 SUBPROVIDER - IRF	5,571	5,897	16,826	3,182,246	512,536	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	21,885	153,899	234,233	10,024,830	1,614,609	50
51 RECOVERY ROOM	1,990	1,842	22,384	1,709,598	275,350	51
53 ANESTHESIOLOGY		1,226	52,197	65,798	10,597	53
54 RADIOLOGY-DIAGNOSTIC	17,508	9,441	181,300	5,092,788	820,250	54
54.01 RADIOLOGY - ULTRASOUND	1,990	1,553	28,814	828,160	133,384	54.01
56 RADIOISOTOPE	6,367	518	25,612	654,266	105,377	56
57 CT SCAN	3,979	441	161,083	1,084,273	174,634	57
59 CARDIAC CATHETERIZATION	5,571	5,944	105,583	1,519,030	244,656	59
60 LABORATORY	8,754	20,388	287,348	7,240,338	1,166,136	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,990	948	16,050	1,417,208	228,257	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,785	2,123	40,338	2,464,706	396,968	65
66 PHYSICAL THERAPY	15,519	13,327	42,342	2,419,847	389,743	66
67 OCCUPATIONAL THERAPY	2,785	999	17,960	1,099,238	177,044	67
68 SPEECH PATHOLOGY	796	194	3,726	371,241	59,792	68
70 ELECTROENCEPHALOGRAPHY	10,744	25,661	35,291	1,240,151	199,740	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			114,214	14,481,464	2,332,399	71
72 IMPL. DEV. CHARGED TO PATIENTS			118,228	13,258,099	2,135,363	72
73 DRUGS CHARGED TO PATIENTS			223,387	8,413,139	1,355,029	73
74 RENAL DIALYSIS			8,734	543,410	87,522	74
76.97 CARDIAC REHABILITATION		2,206	5,240	923,987	148,818	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	9,550	14,528	18,207	2,798,168	450,676	90
91 EMERGENCY	7,958	7,063	153,563	4,372,717	704,274	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY	6,367	5,427	12,807	2,363,659	380,693	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	280,528	727,278	2,136,672	171,231,652	23,695,358	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	46,953	336		898,760	144,755	192
194 OTHER NON-REIMBURSEABLE COST CENTERS	2,785	1,876		1,595,826	257,025	194
194.01 OTHER NONREIMBURSABLE				87,942	14,164	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	330,266	729,490	2,136,672	173,814,180	24,111,302	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
4.01 MAINTENANCE OF PERSONNEL						4.01
5.01 NON-PATIENT TELEPHONES						5.01
5.02 PURCHASING, RECEIVING & STORES						5.02
5.03 PATIENT REGISTRATION						5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL						5.05
6 MAINTENANCE & REPAIRS	8,956,194					6
7 OPERATION OF PLANT	2,864,135	10,083,083				7
8 LAUNDRY & LINEN SERVICE	24,374	29,641	940,071			8
9 HOUSEKEEPING	92,493	112,478	4,641	3,385,244		9
10 DIETARY	276,036	335,678		156,388	2,972,877	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	62,175	75,609		35,225		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	85,227	108,908		48,285		15
16 MEDICAL RECORDS & LIBRARY	82,147	99,896		46,540		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,128,882	2,588,857	492,198	1,206,118	2,425,399	30
31 INTENSIVE CARE UNIT	160,203	194,817	16,926	90,763	147,956	31
41 SUBPROVIDER - IRF	275,121	334,566	70,724	155,870	290,775	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	605,176	971,774	88,951	342,862		50
51 RECOVERY ROOM	45,188	119,676	28,317	25,601		51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	196,055	815,434	60,541	111,075		54
54.01 RADIOLOGY - ULTRASOUND	25,794	40,526		14,614		54.01
56 RADIOISOTOPE	79,404	96,560	9,684	44,986		56
57 CT SCAN	25,000	65,749		14,164		57
59 CARDIAC CATHETERIZATION	69,947	88,104	18,625	39,629		59
60 LABORATORY	188,716	321,662	1,439	106,917		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	21,463	26,100		12,160		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	73,677	89,596		41,742		65
66 PHYSICAL THERAPY	98,484	424,044	17,060	55,796		66
67 OCCUPATIONAL THERAPY	2,719	61,828	7,236	1,540		67
68 SPEECH PATHOLOGY			1,502			68
70 ELECTROENCEPHALOGRAPHY	82,989	100,920	14,015	47,017		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	3,633	188,526	2,649	2,058		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	106,184	176,178	8,179	60,159		90
91 EMERGENCY	359,506	437,183	96,573	203,678	108,747	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY		61,447				101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	8,034,728	7,965,757	939,260	2,863,187	2,972,877	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		793,255				192
194 OTHER NON-REIMBURSEABLE COST CENTERS	921,466	1,242,141	811	522,057		194
194.01 OTHER NONREIMBURSABLE		81,930				194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	8,956,194	10,083,083	940,071	3,385,244	2,972,877	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
4.01 MAINTENANCE OF PERSONNEL						4.01
5.01 NON-PATIENT TELEPHONES						5.01
5.02 PURCHASING, RECEIVING & STORES						5.02
5.03 PATIENT REGISTRATION						5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL						5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	1,849,399					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	34,491	4,500,703				13
14 CENTRAL SERVICES & SUPPLY	17,697		1,614,446			14
15 PHARMACY	60,904			4,695,726		15
16 MEDICAL RECORDS & LIBRARY	91,543				3,976,422	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	664,443	2,531,316			350,077	30
31 INTENSIVE CARE UNIT	85,424	325,451			43,020	31
41 SUBPROVIDER - IRF	76,268	290,565			31,317	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	148,838	567,044			435,957	50
51 RECOVERY ROOM	41,204	156,982			41,662	51
53 ANESTHESIOLOGY					97,149	53
54 RADIOLOGY-DIAGNOSTIC	103,671				337,437	54
54.01 RADIOLOGY - ULTRASOUND	13,273				53,629	54.01
56 RADIOISOTOPE	9,179				47,670	56
57 CT SCAN	19,238				299,808	57
59 CARDIAC CATHETERIZATION	30,925				196,512	59
60 LABORATORY	129,556				534,441	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	6,559				29,872	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	63,457				75,078	65
66 PHYSICAL THERAPY	2,179				78,808	66
67 OCCUPATIONAL THERAPY	4,798				33,427	67
68 SPEECH PATHOLOGY					6,935	68
70 ELECTROENCEPHALOGRAPHY	23,794				65,684	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			843,241		212,576	71
72 IMPL. DEV. CHARGED TO PATIENTS			771,205		220,046	72
73 DRUGS CHARGED TO PATIENTS				4,695,726	415,769	73
74 RENAL DIALYSIS					16,257	74
76.97 CARDIAC REHABILITATION	19,216	73,206			9,753	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	56,766				33,887	90
91 EMERGENCY	108,602	413,751			285,814	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY	37,374	142,388			23,837	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,849,399	4,500,703	1,614,446	4,695,726	3,976,422	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 OTHER NON-REIMBURSEABLE COST CENTERS						194
194.01 OTHER NONREIMBURSABLE						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,849,399	4,500,703	1,614,446	4,695,726	3,976,422	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS		TOTAL	
	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
4.01 MAINTENANCE OF PERSONNEL				4.01
5.01 NON-PATIENT TELEPHONES				5.01
5.02 PURCHASING, RECEIVING & STORES				5.02
5.03 PATIENT REGISTRATION				5.03
5.04 PATIENT ACCOUNTING				5.04
5.05 ADMINISTRATIVE & GENERAL				5.05
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
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	39,334,873		39,334,873	30
31 INTENSIVE CARE UNIT	5,030,823		5,030,823	31
41 SUBPROVIDER - IRF	5,219,988		5,219,988	41
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	14,800,041		14,800,041	50
51 RECOVERY ROOM	2,443,578		2,443,578	51
53 ANESTHESIOLOGY	173,544		173,544	53
54 RADIOLOGY-DIAGNOSTIC	7,537,251		7,537,251	54
54.01 RADIOLOGY - ULTRASOUND	1,109,380		1,109,380	54.01
56 RADIOISOTOPE	1,047,126		1,047,126	56
57 CT SCAN	1,682,866		1,682,866	57
59 CARDIAC CATHETERIZATION	2,207,428		2,207,428	59
60 LABORATORY	9,689,205		9,689,205	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,741,619		1,741,619	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	3,205,224		3,205,224	65
66 PHYSICAL THERAPY	3,485,961		3,485,961	66
67 OCCUPATIONAL THERAPY	1,387,830		1,387,830	67
68 SPEECH PATHOLOGY	439,470		439,470	68
70 ELECTROENCEPHALOGRAPHY	1,774,310		1,774,310	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,869,680		17,869,680	71
72 IMPL. DEV. CHARGED TO PATIENTS	16,384,713		16,384,713	72
73 DRUGS CHARGED TO PATIENTS	14,879,663		14,879,663	73
74 RENAL DIALYSIS	647,189		647,189	74
76.97 CARDIAC REHABILITATION	1,371,846		1,371,846	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	3,690,197		3,690,197	90
91 EMERGENCY	7,090,845		7,090,845	91
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
101 HOME HEALTH AGENCY	3,009,398		3,009,398	101
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	167,254,048		167,254,048	118
NONREIMBURSABLE COST CENTERS				
192 PHYSICIANS' PRIVATE OFFICES	1,836,770		1,836,770	192
194 OTHER NON-REIMBURSEABLE COST CENTERS	4,539,326		4,539,326	194
194.01 OTHER NONREIMBURSABLE	184,036		184,036	194.01
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	173,814,180		173,814,180	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT		3,782	5,295	9,077	9,077	4
4.01 MAINTENANCE OF PERSONNEL		60,047	84,053	144,100	124	4.01
5.01 NON-PATIENT TELEPHONES		28,636	40,085	68,721	30	5.01
5.02 PURCHASING, RECEIVING & STORES		61,984	86,764	148,748	51	5.02
5.03 PATIENT REGISTRATION		27,301	38,216	65,517	229	5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL		499,655	699,409	1,199,064	539	5.05
6 MAINTENANCE & REPAIRS		12,577	17,606	30,183	166	6
7 OPERATION OF PLANT		1,709,222	2,392,539	4,101,761	120	7
8 LAUNDRY & LINEN SERVICE		13,258	18,558	31,816	11	8
9 HOUSEKEEPING		50,310	70,423	120,733	248	9
10 DIETARY		150,144	210,169	360,313	100	10
11 CAFETERIA					163	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		33,819	47,339	81,158	346	13
14 CENTRAL SERVICES & SUPPLY					113	14
15 PHARMACY		48,713	68,188	116,901	263	15
16 MEDICAL RECORDS & LIBRARY		44,682	62,545	107,227	273	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		1,157,961	1,620,894	2,778,855	2,278	30
31 INTENSIVE CARE UNIT		87,139	121,976	209,115	363	31
41 SUBPROVIDER - IRF		149,647	209,473	359,120	247	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		434,661	608,431	1,043,092	603	50
51 RECOVERY ROOM		53,529	74,929	128,458	179	51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		364,732	510,546	875,278	423	54
54.01 RADIOLOGY - ULTRASOUND		18,127	25,373	43,500	85	54.01
56 RADIOISOTOPE		43,190	60,457	103,647	54	56
57 CT SCAN		29,408	41,165	70,573	85	57
59 CARDIAC CATHETERIZATION		39,408	55,162	94,570	157	59
60 LABORATORY		143,875	201,393	345,268	450	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		11,674	16,342	28,016	30	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		40,075	56,096	96,171	265	65
66 PHYSICAL THERAPY		189,669	265,496	455,165		66
67 OCCUPATIONAL THERAPY		27,655	38,710	66,365	24	67
68 SPEECH PATHOLOGY						68
70 ELECTROENCEPHALOGRAPHY		45,140	63,186	108,326	102	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION		84,325	118,037	202,362	86	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		78,802	110,306	189,108	251	90
91 EMERGENCY		195,546	273,721	469,267	433	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY		27,484	38,472	65,956	186	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)		5,966,177	8,351,354	14,317,531	9,077	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		354,812	496,659	851,471		192
194 OTHER NON-REIMBURSEABLE COST CENTERS		555,592	777,709	1,333,301		194
194.01 OTHER NONREIMBURSABLE		36,646	51,296	87,942		194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		6,913,227	9,677,018	16,590,245	9,077	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MAINTENANCE OF PERSONNEL 4.01	NONPATIENT TELEPHONES 5.01	PURCHASING RECEIVING & STORES 5.02	PATIENT REGISTRATN 5.03	ADMINI-STRATIVE & GENERAL 5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
4.01 MAINTENANCE OF PERSONNEL	144,224					4.01
5.01 NON-PATIENT TELEPHONES	884	69,635				5.01
5.02 PURCHASING, RECEIVING & STORES	1,280	419	150,498			5.02
5.03 PATIENT REGISTRATION	5,975	1,678	1,944	75,343		5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL	6,485	5,957	14,498		1,226,543	5.05
6 MAINTENANCE & REPAIRS	2,457	755	26,543		63,199	6
7 OPERATION OF PLANT	2,913	2,181	5,045		50,940	7
8 LAUNDRY & LINEN SERVICE	416		1,239		6,252	8
9 HOUSEKEEPING	6,696	252	12,267		22,409	9
10 DIETARY	6,667	1,594	9,263		15,558	10
11 CAFETERIA					13,050	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,057	1,007	847		30,295	13
14 CENTRAL SERVICES & SUPPLY	1,056		10,636		11,267	14
15 PHARMACY	3,633	1,342	1,341		30,995	15
16 MEDICAL RECORDS & LIBRARY	5,461	2,936	648		25,801	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	39,637	12,084	8,731	6,628	190,183	30
31 INTENSIVE CARE UNIT	5,096	1,091	588	815	27,988	31
41 SUBPROVIDER - IRF	4,549	1,175	1,217	593	26,072	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,878	4,614	31,752	8,254	82,133	50
51 RECOVERY ROOM	2,458	419	380	789	14,007	51
53 ANESTHESIOLOGY			253	1,839	539	53
54 RADIOLOGY-DIAGNOSTIC	6,184	3,691	1,948	6,389	41,725	54
54.01 RADIOLOGY - ULTRASOUND	792	419	320	1,015	6,785	54.01
56 RADIOISOTOPE	548	1,342	107	903	5,360	56
57 CT SCAN	1,148	839	91	5,677	8,883	57
59 CARDIAC CATHETERIZATION	1,845	1,175	1,226	3,721	12,445	59
60 LABORATORY	7,728	1,846	4,206	10,171	59,320	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	391	419	196	566	11,611	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,785	587	438	1,422	20,193	65
66 PHYSICAL THERAPY	130	3,272	2,749	1,492	19,826	66
67 OCCUPATIONAL THERAPY	286	587	206	633	9,006	67
68 SPEECH PATHOLOGY		168	40	131	3,042	68
70 ELECTROENCEPHALOGRAPHY	1,419	2,265	5,294	1,244	10,161	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS				4,025	118,647	71
72 IMPL. DEV. CHARGED TO PATIENTS				4,166	108,624	72
73 DRUGS CHARGED TO PATIENTS				7,872	68,929	73
74 RENAL DIALYSIS				308	4,452	74
76.97 CARDIAC REHABILITATION	1,146		455	185	7,570	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,386	2,014	2,997	642	22,925	90
91 EMERGENCY	6,478	1,678	1,457	5,412	35,826	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY	2,229	1,342	1,120	451	19,365	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	144,093	59,148	150,042	75,343	1,205,383	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		9,900	69		7,364	192
194 OTHER NON-REIMBURSEABLE COST CENTERS	131	587	387		13,075	194
194.01 OTHER NONREIMBURSABLE					721	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	144,224	69,635	150,498	75,343	1,226,543	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
4.01 MAINTENANCE OF PERSONNEL						4.01
5.01 NON-PATIENT TELEPHONES						5.01
5.02 PURCHASING, RECEIVING & STORES						5.02
5.03 PATIENT REGISTRATION						5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL						5.05
6 MAINTENANCE & REPAIRS	123,303					6
7 OPERATION OF PLANT	39,433	4,202,393				7
8 LAUNDRY & LINEN SERVICE	336	12,354	52,424			8
9 HOUSEKEEPING	1,273	46,878	259	211,015		9
10 DIETARY	3,800	139,903		9,748	546,946	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	856	31,512		2,196		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,173	45,390		3,010		15
16 MEDICAL RECORDS & LIBRARY	1,131	41,634		2,901		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	29,309	1,078,979	27,448	75,180	446,222	30
31 INTENSIVE CARE UNIT	2,206	81,195	944	5,658	27,221	31
41 SUBPROVIDER - IRF	3,788	139,439	3,944	9,716	53,496	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,332	405,012	4,960	21,372		50
51 RECOVERY ROOM	622	49,878	1,579	1,596		51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	2,699	339,854	3,376	6,924		54
54.01 RADIOLOGY - ULTRASOUND	355	16,890		911		54.01
56 RADIOISOTOPE	1,093	40,244	540	2,804		56
57 CT SCAN	344	27,402		883		57
59 CARDIAC CATHETERIZATION	963	36,720	1,039	2,470		59
60 LABORATORY	2,598	134,061	80	6,665		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	295	10,878		758		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,014	37,341		2,602		65
66 PHYSICAL THERAPY	1,356	176,732	951	3,478		66
67 OCCUPATIONAL THERAPY	37	25,768	404	96		67
68 SPEECH PATHOLOGY			84			68
70 ELECTROENCEPHALOGRAPHY	1,143	42,061	782	2,931		70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	50	78,573	148	128		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,462	73,427	456	3,750		90
91 EMERGENCY	4,949	182,207	5,385	12,696	20,007	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY		25,610				101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	110,617	3,319,942	52,379	178,473	546,946	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		330,610				192
194 OTHER NON-REIMBURSEABLE COST CENTERS	12,686	517,695	45	32,542		194
194.01 OTHER NONREIMBURSABLE		34,146				194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	123,303	4,202,393	52,424	211,015	546,946	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
4.01 MAINTENANCE OF PERSONNEL						4.01
5.01 NON-PATIENT TELEPHONES						5.01
5.02 PURCHASING, RECEIVING & STORES						5.02
5.03 PATIENT REGISTRATION						5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL						5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	13,213					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	246	150,520				13
14 CENTRAL SERVICES & SUPPLY	126		23,198			14
15 PHARMACY	435			204,483		15
16 MEDICAL RECORDS & LIBRARY	654				188,666	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,748	84,657			16,622	30
31 INTENSIVE CARE UNIT	610	10,884			2,043	31
41 SUBPROVIDER - IRF	545	9,718			1,487	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,063	18,964			20,699	50
51 RECOVERY ROOM	294	5,250			1,978	51
53 ANESTHESIOLOGY					4,613	53
54 RADIOLOGY-DIAGNOSTIC	741				16,022	54
54.01 RADIOLOGY - ULTRASOUND	95				2,546	54.01
56 RADIOISOTOPE	66				2,263	56
57 CT SCAN	137				14,235	57
59 CARDIAC CATHETERIZATION	221				9,330	59
60 LABORATORY	926				25,239	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	47				1,418	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	453				3,565	65
66 PHYSICAL THERAPY	16				3,742	66
67 OCCUPATIONAL THERAPY	34				1,587	67
68 SPEECH PATHOLOGY					329	68
70 ELECTROENCEPHALOGRAPHY	170				3,119	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			12,121		10,093	71
72 IMPL. DEV. CHARGED TO PATIENTS			11,077		10,448	72
73 DRUGS CHARGED TO PATIENTS				204,483	19,741	73
74 RENAL DIALYSIS					772	74
76.97 CARDIAC REHABILITATION	137	2,448			463	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	406				1,609	90
91 EMERGENCY	776	13,837			13,571	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY	267	4,762			1,132	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	13,213	150,520	23,198	204,483	188,666	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 OTHER NON-REIMBURSEABLE COST CENTERS						194
194.01 OTHER NONREIMBURSABLE						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	13,213	150,520	23,198	204,483	188,666	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS		TOTAL	
	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
4.01 MAINTENANCE OF PERSONNEL				4.01
5.01 NON-PATIENT TELEPHONES				5.01
5.02 PURCHASING, RECEIVING & STORES				5.02
5.03 PATIENT REGISTRATION				5.03
5.04 PATIENT ACCOUNTING				5.04
5.05 ADMINISTRATIVE & GENERAL				5.05
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
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	4,801,561		4,801,561	30
31 INTENSIVE CARE UNIT	375,817		375,817	31
41 SUBPROVIDER - IRF	615,106		615,106	41
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1,659,728		1,659,728	50
51 RECOVERY ROOM	207,887		207,887	51
53 ANESTHESIOLOGY	7,244		7,244	53
54 RADIOLOGY-DIAGNOSTIC	1,305,254		1,305,254	54
54.01 RADIOLOGY - ULTRASOUND	73,713		73,713	54.01
56 RADIOISOTOPE	158,971		158,971	56
57 CT SCAN	130,297		130,297	57
59 CARDIAC CATHETERIZATION	165,882		165,882	59
60 LABORATORY	598,558		598,558	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	54,625		54,625	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	167,836		167,836	65
66 PHYSICAL THERAPY	668,909		668,909	66
67 OCCUPATIONAL THERAPY	105,033		105,033	67
68 SPEECH PATHOLOGY	3,794		3,794	68
70 ELECTROENCEPHALOGRAPHY	179,017		179,017	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	144,886		144,886	71
72 IMPL. DEV. CHARGED TO PATIENTS	134,315		134,315	72
73 DRUGS CHARGED TO PATIENTS	301,025		301,025	73
74 RENAL DIALYSIS	5,532		5,532	74
76.97 CARDIAC REHABILITATION	293,751		293,751	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	302,433		302,433	90
91 EMERGENCY	773,979		773,979	91
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
101 HOME HEALTH AGENCY	122,420		122,420	101
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	13,357,573		13,357,573	118
NONREIMBURSABLE COST CENTERS				
192 PHYSICIANS' PRIVATE OFFICES	1,199,414		1,199,414	192
194 OTHER NON-REIMBURSEABLE COST CENTERS	1,910,449		1,910,449	194
194.01 OTHER NONREIMBURSABLE	122,809		122,809	194.01
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	16,590,245		16,590,245	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINTENANCE OF PERSONNEL NUMBER OF FTES	NONPATIENT TELEPHONES	
	1	2	4	4.01	NUMBER OF PHONES	5.01
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	528,217					1
2 CAP REL COSTS-MVBLE EQUIP		528,217				2
4 EMPLOYEE BENEFITS DEPARTMENT	289	289	61,358,063			4
4.01 MAINTENANCE OF PERSONNEL	4,588	4,588	838,320	109,845		4.01
5.01 NON-PATIENT TELEPHONES	2,188	2,188	199,543	673	830	5.01
5.02 PURCHASING, RECEIVING & STORES	4,736	4,736	345,588	975	5	5.02
5.03 PATIENT REGISTRATION	2,086	2,086	1,548,667	4,551	20	5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL	38,177	38,177	3,640,440	4,939	71	5.05
6 MAINTENANCE & REPAIRS	961	961	1,123,420	1,871	9	6
7 OPERATION OF PLANT	130,596	130,596	808,881	2,219	26	7
8 LAUNDRY & LINEN SERVICE	1,013	1,013	75,579	317		8
9 HOUSEKEEPING	3,844	3,844	1,674,914	5,100	3	9
10 DIETARY	11,472	11,472	674,661	5,078	19	10
11 CAFETERIA			1,101,525			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,584	2,584	2,340,868	1,567	12	13
14 CENTRAL SERVICES & SUPPLY			765,400	804		14
15 PHARMACY	3,722	3,722	1,779,934	2,767	16	15
16 MEDICAL RECORDS & LIBRARY	3,414	3,414	1,842,946	4,159	35	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	88,476	88,476	15,406,198	30,187	144	30
31 INTENSIVE CARE UNIT	6,658	6,658	2,455,271	3,881	13	31
41 SUBPROVIDER - IRF	11,434	11,434	1,667,338	3,465	14	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	33,211	33,211	4,073,240	6,762	55	50
51 RECOVERY ROOM	4,090	4,090	1,209,372	1,872	5	51
53 ANESTHESIOLOGY			1,012			53
54 RADIOLOGY-DIAGNOSTIC	27,868	27,868	2,861,239	4,710	44	54
54.01 RADIOLOGY - ULTRASOUND	1,385	1,385	573,601	603	5	54.01
56 RADIOISOTOPE	3,300	3,300	367,781	417	16	56
57 CT SCAN	2,247	2,247	573,622	874	10	57
59 CARDIAC CATHETERIZATION	3,011	3,011	1,063,822	1,405	14	59
60 LABORATORY	10,993	10,993	3,038,888	5,886	22	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	892	892	201,481	298	5	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,062	3,062	1,788,390	2,883	7	65
66 PHYSICAL THERAPY	14,492	14,492		99	39	66
67 OCCUPATIONAL THERAPY	2,113	2,113	164,422	218	7	67
68 SPEECH PATHOLOGY					2	68
70 ELECTROENCEPHALOGRAPHY	3,449	3,449	688,124	1,081	27	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	6,443	6,443	579,283	873		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	6,021	6,021	1,698,212	2,579	24	90
91 EMERGENCY	14,941	14,941	2,925,862	4,934	20	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY	2,100	2,100	1,259,926	1,698	16	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	455,856	455,856	61,357,770	109,745	705	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	27,110	27,110			118	192
194 OTHER NON-REIMBURSABLE COST CENTERS	42,451	42,451	293	100	7	194
194.01 OTHER NONREIMBURSABLE	2,800	2,800				194.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	MAINTENACE OF PERSONNEL NUMBER OF FTES 4.01	NONPATIENT TELEPHONES NUMBER OF PHONES 5.01	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	6,913,227	9,677,018	15,293,071	1,644,307	330,266	202
203	UNIT COST MULT-WS B PT I	13.087854	18.320156	0.249243	14.969339	397.910843	203
204	COST TO BE ALLOC PER B PT II			9,077	144,224	69,635	204
205	UNIT COST MULT-WS B PT II			0.000148	1.312977	83.897590	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING RECEIVING & STORES SUPPLY EXPENSE 5.02	PATIENT REGISTRATN GROSS REVENUE 5.03	RECON- CILIATION 5A.05	ADMINI- STRATIVE & GENERAL ACCUM COST 5.05	MAIN- TENANCE & REPAIRS SQUARE FEET 6	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
4.01 MAINTENANCE OF PERSONNEL						4.01
5.01 NON-PATIENT TELEPHONES						5.01
5.02 PURCHASING, RECEIVING & STORES	2,611,382					5.02
5.03 PATIENT REGISTRATION	33,738	579,170,998				5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL	251,563		-24,111,302	149,702,878		5.05
6 MAINTENANCE & REPAIRS	460,559			7,713,801	372,218	6
7 OPERATION OF PLANT	87,544			6,217,544	119,033	7
8 LAUNDRY & LINEN SERVICE	21,506			763,143	1,013	8
9 HOUSEKEEPING	212,853			2,735,112	3,844	9
10 DIETARY	160,732			1,898,931	11,472	10
11 CAFETERIA				1,592,853		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	14,696			3,697,655	2,584	13
14 CENTRAL SERVICES & SUPPLY	184,546			1,375,250		14
15 PHARMACY	23,275			3,783,093	3,542	15
16 MEDICAL RECORDS & LIBRARY	11,250			3,149,099	3,414	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	151,496	50,987,072		23,209,440	88,476	30
31 INTENSIVE CARE UNIT	10,207	6,265,602		3,416,068	6,658	31
41 SUBPROVIDER - IRF	21,111	4,561,170		3,182,246	11,434	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	550,906	63,495,047		10,024,830	25,151	50
51 RECOVERY ROOM	6,594	6,067,891		1,709,598	1,878	51
53 ANESTHESIOLOGY	4,388	14,149,230		65,798		53
54 RADIOLOGY-DIAGNOSTIC	33,797	49,146,146		5,092,788	8,148	54
54.01 RADIOLOGY - ULTRASOUND	5,561	7,810,857		828,160	1,072	54.01
56 RADIOISOTOPE	1,855	6,942,895		654,266	3,300	56
57 CT SCAN	1,579	43,665,660		1,084,273	1,039	57
59 CARDIAC CATHETERIZATION	21,279	28,621,021		1,519,030	2,907	59
60 LABORATORY	72,985	77,862,784		7,240,338	7,843	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	3,394	4,350,754		1,417,208	892	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	7,598	10,934,771		2,464,706	3,062	65
66 PHYSICAL THERAPY	47,707	11,477,994		2,419,847	4,093	66
67 OCCUPATIONAL THERAPY	3,577	4,868,543		1,099,238	113	67
68 SPEECH PATHOLOGY	696	1,010,121		371,241		68
70 ELECTROENCEPHALOGRAPHY	91,861	9,566,497		1,240,151	3,449	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		30,960,665		14,481,464		71
72 IMPL. DEV. CHARGED TO PATIENTS		32,048,677		13,258,099		72
73 DRUGS CHARGED TO PATIENTS		60,554,792		8,413,139		73
74 RENAL DIALYSIS		2,367,684		543,410		74
76.97 CARDIAC REHABILITATION	7,896	1,420,479		923,987	151	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	52,005	4,935,514		2,798,168	4,413	90
91 EMERGENCY	25,284	41,627,403		4,372,717	14,941	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY	19,426	3,471,729		2,363,659		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	2,603,464	579,170,998	-24,111,302	147,120,350	333,922	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	1,204			898,760		192
194 OTHER NON-REIMBURSABLE COST CENTERS	6,714			1,595,826	38,296	194
194.01 OTHER NONREIMBURSABLE				87,942		194.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		PURCHASING RECEIVING & STORES SUPPLY EXPENSE 5.02	PATIENT REGISTRATN GROSS REVENUE 5.03	RECON- CILIATION 5A.05	ADMINI- STRATIVE & GENERAL ACCUM COST 5.05	MAIN- TENANCE & REPAIRS SQUARE FEET 6	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	729,490	2,136,672		24,111,302	8,956,194	202
203	UNIT COST MULT-WS B PT I	0.279350	0.003689		0.161061	24.061690	203
204	COST TO BE ALLOC PER B PT II	150,498	75,343		1,226,543	123,303	204
205	UNIT COST MULT-WS B PT II	0.057632	0.000130		0.008193	0.331266	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET	MEALS SERVED	NUMBER OF FTES	
	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
4.01 MAINTENANCE OF PERSONNEL						4.01
5.01 NON-PATIENT TELEPHONES						5.01
5.02 PURCHASING, RECEIVING & STORES						5.02
5.03 PATIENT REGISTRATION						5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL						5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	344,596					7
8 LAUNDRY & LINEN SERVICE	1,013	1,078,020				8
9 HOUSEKEEPING	3,844	5,322	248,328			9
10 DIETARY	11,472		11,472	285,924		10
11 CAFETERIA					84,022	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,584		2,584		1,567	13
14 CENTRAL SERVICES & SUPPLY					804	14
15 PHARMACY	3,722		3,542		2,767	15
16 MEDICAL RECORDS & LIBRARY	3,414		3,414		4,159	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	88,476	564,425	88,476	233,269	30,187	30
31 INTENSIVE CARE UNIT	6,658	19,410	6,658	14,230	3,881	31
41 SUBPROVIDER - IRF	11,434	81,102	11,434	27,966	3,465	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	33,211	102,004	25,151		6,762	50
51 RECOVERY ROOM	4,090	32,472	1,878		1,872	51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	27,868	69,425	8,148		4,710	54
54.01 RADIOLOGY - ULTRASOUND	1,385		1,072		603	54.01
56 RADIOISOTOPE	3,300	11,105	3,300		417	56
57 CT SCAN	2,247		1,039		874	57
59 CARDIAC CATHETERIZATION	3,011	21,358	2,907		1,405	59
60 LABORATORY	10,993	1,650	7,843		5,886	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	892		892		298	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,062		3,062		2,883	65
66 PHYSICAL THERAPY	14,492	19,564	4,093		99	66
67 OCCUPATIONAL THERAPY	2,113	8,298	113		218	67
68 SPEECH PATHOLOGY		1,722				68
70 ELECTROENCEPHALOGRAPHY	3,449	16,072	3,449		1,081	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION	6,443	3,038	151		873	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	6,021	9,379	4,413		2,579	90
91 EMERGENCY	14,941	110,744	14,941	10,459	4,934	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY	2,100				1,698	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	272,235	1,077,090	210,032	285,924	84,022	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	27,110					192
194 OTHER NON-REIMBURSEABLE COST CENTERS	42,451	930	38,296			194
194.01 OTHER NONREIMBURSABLE	2,800					194.01

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COST CENTER DESCRIPTION		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET	MEALS SERVED	NUMBER OF FTES	
		7	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	10,083,083	940,071	3,385,244	2,972,877	1,849,399	202
203	UNIT COST MULT-WS B PT I	29.260592	0.872035	13.632148	10.397438	22.010890	203
204	COST TO BE ALLOC PER B PT II	4,202,393	52,424	211,015	546,946	13,213	204
205	UNIT COST MULT-WS B PT II	12.195130	0.048630	0.849743	1.912907	0.157256	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY SUPPLY EXPENSE 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
4.01 MAINTENANCE OF PERSONNEL					4.01
5.01 NON-PATIENT TELEPHONES					5.01
5.02 PURCHASING, RECEIVING & STORES					5.02
5.03 PATIENT REGISTRATION					5.03
5.04 PATIENT ACCOUNTING					5.04
5.05 ADMINISTRATIVE & GENERAL					5.05
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	1,116,357				13
14 CENTRAL SERVICES & SUPPLY		27,507,121			14
15 PHARMACY			10,000		15
16 MEDICAL RECORDS & LIBRARY				579,170,998	16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	627,869			50,987,072	30
31 INTENSIVE CARE UNIT	80,725			6,265,602	31
41 SUBPROVIDER - IRF	72,072			4,561,170	41
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	140,650			63,495,047	50
51 RECOVERY ROOM	38,938			6,067,891	51
53 ANESTHESIOLOGY				14,149,230	53
54 RADIOLOGY-DIAGNOSTIC				49,146,146	54
54.01 RADIOLOGY - ULTRASOUND				7,810,857	54.01
56 RADIOISOTOPE				6,942,895	56
57 CT SCAN				43,665,660	57
59 CARDIAC CATHETERIZATION				28,621,021	59
60 LABORATORY				77,862,784	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				4,350,754	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY				10,934,771	65
66 PHYSICAL THERAPY				11,477,994	66
67 OCCUPATIONAL THERAPY				4,868,543	67
68 SPEECH PATHOLOGY				1,010,121	68
70 ELECTROENCEPHALOGRAPHY				9,566,497	70
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		14,367,250		30,960,665	71
72 IMPL. DEV. CHARGED TO PATIENTS		13,139,871		32,048,677	72
73 DRUGS CHARGED TO PATIENTS			10,000	60,554,792	73
74 RENAL DIALYSIS				2,367,684	74
76.97 CARDIAC REHABILITATION	18,158			1,420,479	76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC				4,935,514	90
91 EMERGENCY	102,627			41,627,403	91
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
101 HOME HEALTH AGENCY	35,318			3,471,729	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	1,116,357	27,507,121	10,000	579,170,998	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES					192
194 OTHER NON-REIMBURSEABLE COST CENTERS					194
194.01 OTHER NONREIMBURSABLE					194.01

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WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY SUPPLY EXPENSE 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	4,500,703	1,614,446	4,695,726	3,976,422	202
203 UNIT COST MULT-WS B PT I	4.031598	0.058692	469.572600	0.006866	203
204 COST TO BE ALLOC PER B PT II	150,520	23,198	204,483	188,666	204
205 UNIT COST MULT-WS B PT II	0.134831	0.000843	20.448300	0.000326	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT				
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	39,334,873		39,334,873	8,653	39,343,526	30
31 INTENSIVE CARE UNIT	5,030,823		5,030,823	11,272	5,042,095	31
41 SUBPROVIDER - IRF	5,219,988		5,219,988		5,219,988	41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	14,800,041		14,800,041		14,800,041	50
51 RECOVERY ROOM	2,443,578		2,443,578		2,443,578	51
53 ANESTHESIOLOGY	173,544		173,544		173,544	53
54 RADIOLOGY-DIAGNOSTIC	7,537,251		7,537,251	11,151	7,548,402	54
54.01 RADIOLOGY - ULTRASOUND	1,109,380		1,109,380		1,109,380	54.01
56 RADIOISOTOPE	1,047,126		1,047,126		1,047,126	56
57 CT SCAN	1,682,866		1,682,866		1,682,866	57
59 CARDIAC CATHETERIZATION	2,207,428		2,207,428	9,169	2,216,597	59
60 LABORATORY	9,689,205		9,689,205	6,890	9,696,095	60
62 WHOLE BLOOD & PACKED RED BL	1,741,619		1,741,619		1,741,619	62
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	3,205,224		3,205,224	10,557	3,215,781	65
66 PHYSICAL THERAPY	3,485,961		3,485,961		3,485,961	66
67 OCCUPATIONAL THERAPY	1,387,830		1,387,830		1,387,830	67
68 SPEECH PATHOLOGY	439,470		439,470		439,470	68
70 ELECTROENCEPHALOGRAPHY	1,774,310		1,774,310	15,511	1,789,821	70
71 MEDICAL SUPPLIES CHARGED TO	17,869,680		17,869,680		17,869,680	71
72 IMPL. DEV. CHARGED TO PATIE	16,384,713		16,384,713		16,384,713	72
73 DRUGS CHARGED TO PATIENTS	14,879,663		14,879,663		14,879,663	73
74 RENAL DIALYSIS	647,189		647,189		647,189	74
76.97 CARDIAC REHABILITATION	1,371,846		1,371,846		1,371,846	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,690,197		3,690,197	13,772	3,703,969	90
91 EMERGENCY	7,090,845		7,090,845		7,090,845	91
92 OBSERVATION BEDS (NON-DISTI	2,563,524		2,563,524		2,563,524	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY	3,009,398		3,009,398		3,009,398	101
200 SUBTOTAL (SEE INSTRUCTIONS)	169,817,572		169,817,572	86,975	169,904,547	200
201 LESS OBSERVATION BEDS	2,563,524		2,563,524		2,563,524	201
202 TOTAL (SEE INSTRUCTIONS)	167,254,048		167,254,048		167,341,023	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	46,653,729		46,653,729			30
31 INTENSIVE CARE UNIT	6,265,602		6,265,602			31
41 SUBPROVIDER - IRF	4,561,170		4,561,170			41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	25,235,624	38,259,423	63,495,047	0.233090	0.233090	0.233090 50
51 RECOVERY ROOM	2,969,421	3,098,470	6,067,891	0.402706	0.402706	0.402706 51
53 ANESTHESIOLOGY	5,497,495	8,651,735	14,149,230	0.012265	0.012265	0.012265 53
54 RADIOLOGY-DIAGNOSTIC	12,260,443	36,885,703	49,146,146	0.153364	0.153364	0.153591 54
54.01 RADIOLOGY - ULTRASOUND	2,446,446	5,364,411	7,810,857	0.142031	0.142031	0.142031 54.01
56 RADIOISOTOPE	2,819,203	4,123,692	6,942,895	0.150820	0.150820	0.150820 56
57 CT SCAN	16,586,707	27,078,953	43,665,660	0.038540	0.038540	0.038540 57
59 CARDIAC CATHETERIZATION	15,873,795	12,747,226	28,621,021	0.077126	0.077126	0.077446 59
60 LABORATORY	32,387,001	45,475,783	77,862,784	0.124439	0.124439	0.124528 60
62 WHOLE BLOOD & PACKED RED BL	3,191,041	1,159,713	4,350,754	0.400303	0.400303	0.400303 62
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	10,004,148	930,623	10,934,771	0.293122	0.293122	0.294088 65
66 PHYSICAL THERAPY	6,487,700	4,990,294	11,477,994	0.303708	0.303708	0.303708 66
67 OCCUPATIONAL THERAPY	3,856,452	1,012,091	4,868,543	0.285061	0.285061	0.285061 67
68 SPEECH PATHOLOGY	790,948	219,173	1,010,121	0.435067	0.435067	0.435067 68
70 ELECTROENCEPHALOGRAPHY	3,893,730	5,672,767	9,566,497	0.185471	0.185471	0.187093 70
71 MEDICAL SUPPLIES CHARGED TO	19,694,403	11,266,262	30,960,665	0.577174	0.577174	0.577174 71
72 IMPL. DEV. CHARGED TO PATIE	24,568,124	7,480,553	32,048,677	0.511245	0.511245	0.511245 72
73 DRUGS CHARGED TO PATIENTS	37,030,829	23,523,963	60,554,792	0.245722	0.245722	0.245722 73
74 RENAL DIALYSIS	2,302,776	64,908	2,367,684	0.273343	0.273343	0.273343 74
76.97 CARDIAC REHABILITATION	425,025	995,454	1,420,479	0.965763	0.965763	0.965763 76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	327,374	4,608,140	4,935,514	0.747682	0.747682	0.750473 90
91 EMERGENCY	14,913,264	26,714,139	41,627,403	0.170341	0.170341	0.170341 91
92 OBSERVATION BEDS (NON-DISTI	256,743	4,076,600	4,333,343	0.591581	0.591581	0.591581 92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY		3,471,729	3,471,729			101
200 SUBTOTAL (SEE INSTRUCTIONS)	301,299,193	277,871,805	579,170,998			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	301,299,193	277,871,805	579,170,998			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 ÷ COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	4,801,561		4,801,561	94.78	27,681	2,623,605	30
31 INTENSIVE CARE UNIT	375,817		375,817	98.30	1,942	190,899	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	615,106		615,106	94.05	5,203	489,342	41
42 SUBPROVIDER I							42
43 NURSERY							43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	5,792,484		5,792,484		34,826	3,303,846	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[XX] HOSPITAL (15-0034) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA				
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5			
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1,659,728	63,495,047	0.026139	13,309,121	347,887		50
51	RECOVERY ROOM	207,887	6,067,891	0.034260	1,440,027	49,335		51
53	ANESTHESIOLOGY	7,244	14,149,230	0.000512	2,434,883	1,247		53
54	RADIOLOGY-DIAGNOSTIC	1,305,254	49,146,146	0.026559	6,604,816	175,417		54
54.01	RADIOLOGY - ULTRASOUND	73,713	7,810,857	0.009437	559,481	5,280		54.01
56	RADIOISOTOPE	158,971	6,942,895	0.022897	1,445,214	33,091		56
57	CT SCAN	130,297	43,665,660	0.002984	8,429,808	25,155		57
59	CARDIAC CATHETERIZATION	165,882	28,621,021	0.005796	10,063,275	58,327		59
60	LABORATORY	598,558	77,862,784	0.007687	18,662,983	143,462		60
62	WHOLE BLOOD & PACKED RED BLOO	54,625	4,350,754	0.012555	1,993,244	25,025		62
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY	167,836	10,934,771	0.015349	4,840,546	74,298		65
66	PHYSICAL THERAPY	668,909	11,477,994	0.058278	2,182,480	127,191		66
67	OCCUPATIONAL THERAPY	105,033	4,868,543	0.021574	623,970	13,462		67
68	SPEECH PATHOLOGY	3,794	1,010,121	0.003756	257,179	966		68
70	ELECTROENCEPHALOGRAPHY	179,017	9,566,497	0.018713	183,640	3,436		70
71	MEDICAL SUPPLIES CHARGED TO P	144,886	30,960,665	0.004680	10,165,665	47,575		71
72	IMPL. DEV. CHARGED TO PATIENT	134,315	32,048,677	0.004191	11,723,928	49,135		72
73	DRUGS CHARGED TO PATIENTS	301,025	60,554,792	0.004971	20,822,136	103,507		73
74	RENAL DIALYSIS	5,532	2,367,684	0.002336	1,453,637	3,396		74
76.97	CARDIAC REHABILITATION	293,751	1,420,479	0.206797	246,077	50,888		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	302,433	4,935,514	0.061277	3,290	202		90
91	EMERGENCY	773,979	41,627,403	0.018593	7,040,199	130,898		91
92	OBSERVATION BEDS (NON-DISTINC	312,858	4,333,343	0.072198	232,812	16,809		92
OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS							94
200	TOTAL (SUM OF LINES 50-199)	7,755,527	518,218,768		124,718,411	1,485,989		200

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 21:28

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 21:28

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL	PER DIEM	INPATIENT	INPAT PGM
	PATIENT	COL.5 ÷	PROGRAM	PASS THRU
	DAYS	COL.6)	DAYS	COSTS
	6	7	8	(COL.7 x
				COL.8)
				9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	50,662		27,681	30
31 INTENSIVE CARE UNIT	3,823		1,942	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	6,540		5,203	41
42 SUBPROVIDER I				42
43 NURSERY	1,065			43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	62,090		34,826	200

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 21:28

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (15-0034)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[]	SNF	[]		[]	TEFRA
BOXES	[]	TITLE XIX	[]	IRF	[]	NF	[]		[]	
COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P				
	PHYSICIAN						SCHOOL	HEALTH	MEDICAL	COST
	ANESTHETIST			EDUCATION	(SUM OF	(SUM OF				
	COST			COST	COLS.1-4)	COLS.2-4)				
	1	2	3	4	5	6				
ANCILLARY SERVICE COST CENTERS										
50	OPERATING ROOM					50				
51	RECOVERY ROOM					51				
53	ANESTHESIOLOGY					53				
54	RADIOLOGY-DIAGNOSTIC					54				
54.01	RADIOLOGY - ULTRASOUND					54.01				
56	RADIOISOTOPE					56				
57	CT SCAN					57				
59	CARDIAC CATHETERIZATION					59				
60	LABORATORY					60				
62	WHOLE BLOOD & PACKED RED BLOO					62				
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30				
65	RESPIRATORY THERAPY					65				
66	PHYSICAL THERAPY					66				
67	OCCUPATIONAL THERAPY					67				
68	SPEECH PATHOLOGY					68				
70	ELECTROENCEPHALOGRAPHY					70				
71	MEDICAL SUPPLIES CHARGED TO P					71				
72	IMPL. DEV. CHARGED TO PATIENT					72				
73	DRUGS CHARGED TO PATIENTS					73				
74	RENAL DIALYSIS					74				
76.97	CARDIAC REHABILITATION					76.97				
76.98	HYPERBARIC OXYGEN THERAPY					76.98				
76.99	LITHOTRIPSY					76.99				
OUTPATIENT SERVICE COST CENTERS										
90	CLINIC					90				
91	EMERGENCY					91				
92	OBSERVATION BEDS (NON-DISTINC					92				
OTHER REIMBURSABLE COST CENTERS										
94	HOME PROGRAM DIALYSIS					94				
200	TOTAL (SUM OF LINES 50-199)					200				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (15-0034)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	63,495,047		13,309,121		14,359,507	50
51	RECOVERY ROOM	6,067,891		1,440,027		1,093,131	51
53	ANESTHESIOLOGY	14,149,230		2,434,883		3,021,562	53
54	RADIOLOGY-DIAGNOSTIC	49,146,146		6,604,816		11,376,320	54
54.01	RADIOLOGY - ULTRASOUND	7,810,857		559,481		642,087	54.01
56	RADIOISOTOPE	6,942,895		1,445,214		1,677,279	56
57	CT SCAN	43,665,660		8,429,808		9,197,367	57
59	CARDIAC CATHETERIZATION	28,621,021		10,063,275		6,891,143	59
60	LABORATORY	77,862,784		18,662,983		1,857,559	60
62	WHOLE BLOOD & PACKED RED BLO	4,350,754		1,993,244		306,654	62
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	10,934,771		4,840,546		520,718	65
66	PHYSICAL THERAPY	11,477,994		2,182,480			66
67	OCCUPATIONAL THERAPY	4,868,543		623,970			67
68	SPEECH PATHOLOGY	1,010,121		257,179			68
70	ELECTROENCEPHALOGRAPHY	9,566,497		183,640		360,605	70
71	MEDICAL SUPPLIES CHARGED TO	30,960,665		10,165,665		3,862,235	71
72	IMPL. DEV. CHARGED TO PATIEN	32,048,677		11,723,928		3,702,930	72
73	DRUGS CHARGED TO PATIENTS	60,554,792		20,822,136		10,567,202	73
74	RENAL DIALYSIS	2,367,684		1,453,637			74
76.97	CARDIAC REHABILITATION	1,420,479		246,077		354,461	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	4,935,514		3,290		725,257	90
91	EMERGENCY	41,627,403		7,040,199		4,480,088	91
92	OBSERVATION BEDS (NON-DISTIN	4,333,343		232,812		830,068	92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	518,218,768		124,718,411		75,826,173	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0034) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS				
	COST TO	PPS	COST REIMB.	COST REIMB.	COST	COST			
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SERVICES DED & COINS	SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	SERVICES SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS		
	1	2	3	4	5	6	7		
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.233090	14,359,507			3,347,057				50
51 RECOVERY ROOM	0.402706	1,093,131			440,210				51
53 ANESTHESIOLOGY	0.012265	3,021,562			37,059				53
54 RADIOLOGY-DIAGNOSTIC	0.153364	11,376,320			1,744,718				54
54.01 RADIOLOGY - ULTRASOUND	0.142031	642,087			91,196				54.01
56 RADIOISOTOPE	0.150820	1,677,279			252,967				56
57 CT SCAN	0.038540	9,197,367			354,467				57
59 CARDIAC CATHETERIZATION	0.077126	6,891,143			531,486				59
60 LABORATORY	0.124439	1,857,559		20,867	231,153		2,597		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.400303	306,654			122,755				62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65 RESPIRATORY THERAPY	0.293122	520,718			152,634				65
66 PHYSICAL THERAPY	0.303708								66
67 OCCUPATIONAL THERAPY	0.285061								67
68 SPEECH PATHOLOGY	0.435067								68
70 ELECTROENCEPHALOGRAPHY	0.185471	360,605			66,882				70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.577174	3,862,235			2,229,182				71
72 IMPL. DEV. CHARGED TO PATIENTS	0.511245	3,702,930			1,893,104				72
73 DRUGS CHARGED TO PATIENTS	0.245722	10,567,202		96,662	2,596,594		23,752		73
74 RENAL DIALYSIS	0.273343								74
76.97 CARDIAC REHABILITATION	0.965763	354,461			342,325				76.97
76.98 HYPERBARIC OXYGEN THERAPY									76.98
76.99 LITHOTRIPSY									76.99
OUTPATIENT SERVICE COST CENTERS									
90 CLINIC	0.747682	725,257			542,262				90
91 EMERGENCY	0.170341	4,480,088			763,143				91
92 OBSERVATION BEDS (NON-DISTINCT	0.591581	830,068			491,052				92
OTHER REIMBURSABLE COST CENTERS									
94 HOME PROGRAM DIALYSIS									94
200 SUBTOTAL (SEE INSTRUCTIONS)		75,826,173		117,529	16,230,246		26,349		200
201 LESS PBP CLINIC LAB SERVICES									201
202 NET CHARGES (LINE 200 - LINE 201)		75,826,173		117,529	16,230,246		26,349		202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [XX] IRF (15-T034) [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			SCHOOL 2	HEALTH 3	MEDICAL EDUCATION COST 4
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 RADIOLOGY - ULTRASOUND						54.01
56 RADIOISOTOPE						56
57 CT SCAN						57
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62 WHOLE BLOOD & PACKED RED BLOO						62
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS						92
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[XX] IRF (15-T034)	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	63,495,047		108,885			50
51	RECOVERY ROOM	6,067,891		11,020			51
53	ANESTHESIOLOGY	14,149,230		16,560			53
54	RADIOLOGY-DIAGNOSTIC	49,146,146		245,381		588	54
54.01	RADIOLOGY - ULTRASOUND	7,810,857		17,067			54.01
56	RADIOISOTOPE	6,942,895		26,087			56
57	CT SCAN	43,665,660		193,453			57
59	CARDIAC CATHETERIZATION	28,621,021		83,977			59
60	LABORATORY	77,862,784		918,988			60
62	WHOLE BLOOD & PACKED RED BLO	4,350,754		71,537			62
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	10,934,771		398,171			65
66	PHYSICAL THERAPY	11,477,994		2,329,828			66
67	OCCUPATIONAL THERAPY	4,868,543		2,292,795			67
68	SPEECH PATHOLOGY	1,010,121		323,834			68
70	ELECTROENCEPHALOGRAPHY	9,566,497		1,331			70
71	MEDICAL SUPPLIES CHARGED TO	30,960,665		516,703		52	71
72	IMPL. DEV. CHARGED TO PATIEN	32,048,677		2,964			72
73	DRUGS CHARGED TO PATIENTS	60,554,792		2,038,426		2,683	73
74	RENAL DIALYSIS	2,367,684		278,319			74
76.97	CARDIAC REHABILITATION	1,420,479					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	4,935,514					90
91	EMERGENCY	41,627,403					91
92	OBSERVATION BEDS (NON-DISTIN	4,333,343					92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	518,218,768		9,875,326		3,323	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [XX] IRF (15-T034) [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	PPS	COST SERVICES	COST SVCS NOT
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.233090						50
51 RECOVERY ROOM	0.402706						51
53 ANESTHESIOLOGY	0.012265						53
54 RADIOLOGY-DIAGNOSTIC	0.153364	588			90		54
54.01 RADIOLOGY - ULTRASOUND	0.142031						54.01
56 RADIOISOTOPE	0.150820						56
57 CT SCAN	0.038540						57
59 CARDIAC CATHETERIZATION	0.077126						59
60 LABORATORY	0.124439						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.400303						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.293122						65
66 PHYSICAL THERAPY	0.303708						66
67 OCCUPATIONAL THERAPY	0.285061						67
68 SPEECH PATHOLOGY	0.435067						68
70 ELECTROENCEPHALOGRAPHY	0.185471						70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.577174	52			30		71
72 IMPL. DEV. CHARGED TO PATIENTS	0.511245						72
73 DRUGS CHARGED TO PATIENTS	0.245722	2,683		4,084	659	1,004	73
74 RENAL DIALYSIS	0.273343						74
76.97 CARDIAC REHABILITATION	0.965763						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.747682						90
91 EMERGENCY	0.170341						91
92 OBSERVATION BEDS (NON-DISTINCT	0.591581						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)		3,323		4,084	779	1,004	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		3,323		4,084	779	1,004	202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 ÷ COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	4,801,561		4,801,561	94.78	4,049	383,764	30
31 INTENSIVE CARE UNIT	375,817		375,817	98.30	83	8,159	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	615,106		615,106	94.05	228	21,443	41
42 SUBPROVIDER I							42
43 NURSERY					78		43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	5,792,484		5,792,484		4,438	413,366	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (15-0034) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,659,728	63,495,047	0.026139	1,389,574	36,322	50
51	RECOVERY ROOM	207,887	6,067,891	0.034260	134,889	4,621	51
53	ANESTHESIOLOGY	7,244	14,149,230	0.000512	268,421	137	53
54	RADIOLOGY-DIAGNOSTIC	1,305,254	49,146,146	0.026559	1,048,071	27,836	54
54.01	RADIOLOGY - ULTRASOUND	73,713	7,810,857	0.009437	90,021	850	54.01
56	RADIOISOTOPE	158,971	6,942,895	0.022897	215,454	4,933	56
57	CT SCAN	130,297	43,665,660	0.002984	1,085,084	3,238	57
59	CARDIAC CATHETERIZATION	165,882	28,621,021	0.005796	978,173	5,669	59
60	LABORATORY	598,558	77,862,784	0.007687	2,640,687	20,299	60
62	WHOLE BLOOD & PACKED RED BLOO	54,625	4,350,754	0.012555	257,447	3,232	62
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	167,836	10,934,771	0.015349	836,003	12,832	65
66	PHYSICAL THERAPY	668,909	11,477,994	0.058278	306,845	17,882	66
67	OCCUPATIONAL THERAPY	105,033	4,868,543	0.021574	122,206	2,636	67
68	SPEECH PATHOLOGY	3,794	1,010,121	0.003756	38,995	146	68
70	ELECTROENCEPHALOGRAPHY	179,017	9,566,497	0.018713	25,085	469	70
71	MEDICAL SUPPLIES CHARGED TO P	144,886	30,960,665	0.004680	1,120,517	5,244	71
72	IMPL. DEV. CHARGED TO PATIENT	134,315	32,048,677	0.004191	520,851	2,183	72
73	DRUGS CHARGED TO PATIENTS	301,025	60,554,792	0.004971	3,817,826	18,978	73
74	RENAL DIALYSIS	5,532	2,367,684	0.002336	275,569	644	74
76.97	CARDIAC REHABILITATION	293,751	1,420,479	0.206797	44,023	9,104	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	302,433	4,935,514	0.061277	1,572	96	90
91	EMERGENCY	773,979	41,627,403	0.018593	973,969	18,109	91
92	OBSERVATION BEDS (NON-DISTINC	312,858	4,333,343	0.072198	11,868	857	92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	7,755,527	518,218,768		16,203,150	196,317	200

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 21:28

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
 PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
 11/25/2013 21:28

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL	PER DIEM	INPATIENT	INPAT PGM
	PATIENT	COL.5 ÷	PROGRAM	PASS THRU
	DAYS	COL.6)	DAYS	COSTS
	6	7	8	(COL.7 x
				COL.8)
				9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	50,662		4,049	30
31 INTENSIVE CARE UNIT	3,823		83	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	6,540		228	41
42 SUBPROVIDER I				42
43 NURSERY	1,065		78	43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	62,090		4,438	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0034) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 RADIOLOGY - ULTRASOUND						54.01
56 RADIOISOTOPE						56
57 CT SCAN						57
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62 WHOLE BLOOD & PACKED RED BLOO						62
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS						92
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0034) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM PASS-THRU COSTS	O/P PGM PASS-THRU COSTS
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 + COL. 7)	(COL. 6 + COL. 7)	INPAT PGM CHARGES (COL. 10)	(COL. 8 x COL. 10) O/P PGM CHARGES (COL. 9 x COL. 12)
	7	8	9	10	11 12 13
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	63,495,047			1,389,574	50
51 RECOVERY ROOM	6,067,891			134,889	51
53 ANESTHESIOLOGY	14,149,230			268,421	53
54 RADIOLOGY-DIAGNOSTIC	49,146,146			1,048,071	54
54.01 RADIOLOGY - ULTRASOUND	7,810,857			90,021	54.01
56 RADIOISOTOPE	6,942,895			215,454	56
57 CT SCAN	43,665,660			1,085,084	57
59 CARDIAC CATHETERIZATION	28,621,021			978,173	59
60 LABORATORY	77,862,784			2,640,687	60
62 WHOLE BLOOD & PACKED RED BLO	4,350,754			257,447	62
62.30 BLOOD CLOTTING FOR HEMOPHILI					62.30
65 RESPIRATORY THERAPY	10,934,771			836,003	65
66 PHYSICAL THERAPY	11,477,994			306,845	66
67 OCCUPATIONAL THERAPY	4,868,543			122,206	67
68 SPEECH PATHOLOGY	1,010,121			38,995	68
70 ELECTROENCEPHALOGRAPHY	9,566,497			25,085	70
71 MEDICAL SUPPLIES CHARGED TO	30,960,665			1,120,517	71
72 IMPL. DEV. CHARGED TO PATIEN	32,048,677			520,851	72
73 DRUGS CHARGED TO PATIENTS	60,554,792			3,817,826	73
74 RENAL DIALYSIS	2,367,684			275,569	74
76.97 CARDIAC REHABILITATION	1,420,479			44,023	76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	4,935,514			1,572	90
91 EMERGENCY	41,627,403			973,969	91
92 OBSERVATION BEDS (NON-DISTIN	4,333,343			11,868	92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-199)	518,218,768			16,203,150	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0034) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.233090						50
51 RECOVERY ROOM	0.402706						51
53 ANESTHESIOLOGY	0.012265						53
54 RADIOLOGY-DIAGNOSTIC	0.153364						54
54.01 RADIOLOGY - ULTRASOUND	0.142031						54.01
56 RADIOISOTOPE	0.150820						56
57 CT SCAN	0.038540						57
59 CARDIAC CATHETERIZATION	0.077126						59
60 LABORATORY	0.124439						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.400303						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.293122						65
66 PHYSICAL THERAPY	0.303708						66
67 OCCUPATIONAL THERAPY	0.285061						67
68 SPEECH PATHOLOGY	0.435067						68
70 ELECTROENCEPHALOGRAPHY	0.185471						70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.577174						71
72 IMPL. DEV. CHARGED TO PATIENTS	0.511245						72
73 DRUGS CHARGED TO PATIENTS	0.245722						73
74 RENAL DIALYSIS	0.273343						74
76.97 CARDIAC REHABILITATION	0.965763						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.747682						90
91 EMERGENCY	0.170341						91
92 OBSERVATION BEDS (NON-DISTINCT	0.591581						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[] HOSPITAL [] IPF [XX] IRF (15-T034)	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS										
50					1,659,728	63,495,047	0.026139	3,504	92	50
51					207,887	6,067,891	0.034260	891	31	51
53					7,244	14,149,230	0.000512	1,114	1	53
54					1,305,254	49,146,146	0.026559	4,827	128	54
54.01					73,713	7,810,857	0.009437	539	5	54.01
56					158,971	6,942,895	0.022897	1,649	38	56
57					130,297	43,665,660	0.002984	8,542	25	57
59					165,882	28,621,021	0.005796	2,868	17	59
60					598,558	77,862,784	0.007687	24,557	189	60
62					54,625	4,350,754	0.012555	1,688	21	62
62.30										62.30
65					167,836	10,934,771	0.015349	5,299	81	65
66					668,909	11,477,994	0.058278	72,172	4,206	66
67					105,033	4,868,543	0.021574	68,817	1,485	67
68					3,794	1,010,121	0.003756	14,374	54	68
70					179,017	9,566,497	0.018713			70
71					144,886	30,960,665	0.004680	9,080	42	71
72					134,315	32,048,677	0.004191	324	1	72
73					301,025	60,554,792	0.004971	51,718	257	73
74					5,532	2,367,684	0.002336			74
76.97					293,751	1,420,479	0.206797			76.97
76.98										76.98
76.99										76.99
OUTPATIENT SERVICE COST CENTERS										
90					302,433	4,935,514	0.061277			90
91					773,979	41,627,403	0.018593			91
92						4,333,343	4,333,343			92
OTHER REIMBURSABLE COST CENTERS										
94										94
200					7,442,669	518,218,768		271,963	6,673	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[]	HOSPITAL	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[XX]	IRF (15-T034)	[]	NF			[]	OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN					
	ANESTHETIST			EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM					50
51	RECOVERY ROOM					51
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC					54
54.01	RADIOLOGY - ULTRASOUND					54.01
56	RADIOISOTOPE					56
57	CT SCAN					57
59	CARDIAC CATHETERIZATION					59
60	LABORATORY					60
62	WHOLE BLOOD & PACKED RED BLOO					62
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
67	OCCUPATIONAL THERAPY					67
68	SPEECH PATHOLOGY					68
70	ELECTROENCEPHALOGRAPHY					70
71	MEDICAL SUPPLIES CHARGED TO P					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
74	RENAL DIALYSIS					74
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC					90
91	EMERGENCY					91
92	OBSERVATION BEDS (NON-DISTINC					92
OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS					94
200	TOTAL (SUM OF LINES 50-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [XX] IRF (15-T034) [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO		PASS-THRU		PASS-THRU
	(FROM WKST	CHARGES	CHARGES	CHARGES	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 +	(COL. 6 +	PGM	(COL. 8 x	O/P PGM	(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	CHARGES	COL. 10)	CHARGES	COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	63,495,047			3,504			50
51 RECOVERY ROOM	6,067,891			891			51
53 ANESTHESIOLOGY	14,149,230			1,114			53
54 RADIOLOGY-DIAGNOSTIC	49,146,146			4,827			54
54.01 RADIOLOGY - ULTRASOUND	7,810,857			539			54.01
56 RADIOISOTOPE	6,942,895			1,649			56
57 CT SCAN	43,665,660			8,542			57
59 CARDIAC CATHETERIZATION	28,621,021			2,868			59
60 LABORATORY	77,862,784			24,557			60
62 WHOLE BLOOD & PACKED RED BLO	4,350,754			1,688			62
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	10,934,771			5,299			65
66 PHYSICAL THERAPY	11,477,994			72,172			66
67 OCCUPATIONAL THERAPY	4,868,543			68,817			67
68 SPEECH PATHOLOGY	1,010,121			14,374			68
70 ELECTROENCEPHALOGRAPHY	9,566,497						70
71 MEDICAL SUPPLIES CHARGED TO	30,960,665			9,080			71
72 IMPL. DEV. CHARGED TO PATIEN	32,048,677			324			72
73 DRUGS CHARGED TO PATIENTS	60,554,792			51,718			73
74 RENAL DIALYSIS	2,367,684						74
76.97 CARDIAC REHABILITATION	1,420,479						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	4,935,514						90
91 EMERGENCY	41,627,403						91
92 OBSERVATION BEDS (NON-DISTIN	4,333,343						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	518,218,768			271,963			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [XX] IRF (15-T034) [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.233090						50
51 RECOVERY ROOM	0.402706						51
53 ANESTHESIOLOGY	0.012265						53
54 RADIOLOGY-DIAGNOSTIC	0.153364						54
54.01 RADIOLOGY - ULTRASOUND	0.142031						54.01
56 RADIOISOTOPE	0.150820						56
57 CT SCAN	0.038540						57
59 CARDIAC CATHETERIZATION	0.077126						59
60 LABORATORY	0.124439						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.400303						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.293122						65
66 PHYSICAL THERAPY	0.303708						66
67 OCCUPATIONAL THERAPY	0.285061						67
68 SPEECH PATHOLOGY	0.435067						68
70 ELECTROENCEPHALOGRAPHY	0.185471						70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.577174						71
72 IMPL. DEV. CHARGED TO PATIENTS	0.511245						72
73 DRUGS CHARGED TO PATIENTS	0.245722						73
74 RENAL DIALYSIS	0.273343						74
76.97 CARDIAC REHABILITATION	0.965763						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.747682						90
91 EMERGENCY	0.170341						91
92 OBSERVATION BEDS (NON-DISTINCT	0.591581						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0034) [] SUB (OTHER) [] ICF/MR [XX] PPS
APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	50,662	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	50,662	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	47,361	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	27,681	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	39,343,526	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	39,343,526	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	39,343,526	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0034) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 776.59 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 21,496,788 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) 21,496,788 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	5,042,095	3,823	1,318.88	1,942	2,561,265	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					30,612,617	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					54,670,670	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 2,814,504 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 1,485,989 51
 52 TOTAL PROGRAM EXCLUDABLE COST 4,300,493 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 50,370,177 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 3,301 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 776.59 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 2,563,524 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	4,801,561	39,343,526	0.122042	2,563,524	312,858	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
BOXES [] TITLE XIX-INPT [XX] IRF (15-T034) [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	6,540	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,540	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,540	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	5,203	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,219,988	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,219,988	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,219,988	37

WORKSHEET D-1
PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [XX] PPS
APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
BOXES [] TITLE XIX-INPT [XX] IRF (15-T034) [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	798.16 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	4,152,826 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)	40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	4,152,826 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	2,727,217 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	6,880,043 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	489,342 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	225,342 51
52	TOTAL PROGRAM EXCLUDABLE COST	714,684 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	6,165,359 53
TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES	54
55	TARGET AMOUNT PER DISCHARGE	55
56	TARGET AMOUNT (LINE 54 x LINE 55)	56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58	BONUS PAYMENT (SEE INSTRUCTIONS)	58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)	61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0034) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	50,662	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	50,662	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	47,361	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	4,049	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	1,065	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	78	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)	39,343,526	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	39,343,526	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	39,343,526	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0034) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS			
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)		776.59 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)		3,144,413 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)		3,144,413 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)		1,065	78		42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	5,042,095	3,823	1,318.88	83	109,467 43
44	CORONARY CARE UNIT					44
45	BURN INTENSIVE CARE UNIT					45
46	SURGICAL INTENSIVE CARE UNIT					46
47	OTHER SPECIAL CARE (SPECIFY)					47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					3,675,866 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					6,929,746 49

PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					391,923 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					196,317 51
52	TOTAL PROGRAM EXCLUDABLE COST					588,240 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					6,341,506 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)					3,301 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

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

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX-INPT IRF (15-T034) NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	6,540	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,540	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,540	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	228	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,219,988	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,219,988	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,219,988	37

WORKSHEET D-1
PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [] HOSPITAL [] SUB (OTHER) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
BOXES [XX] TITLE XIX-INPT [XX] IRF (15-T034) [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 798.16 38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 181,980 39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 181,980 41
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 74,005 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 255,985 49

PASS-THROUGH COST ADJUSTMENTS
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 21,443 50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 6,673 51
52 TOTAL PROGRAM EXCLUDABLE COST 28,116 52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 227,869 53

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

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-0034) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		25,249,768		30
31 INTENSIVE CARE UNIT		2,941,088		31
41 SUBPROVIDER - IRF				41
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.233090	13,309,121	3,102,223	50
51 RECOVERY ROOM	0.402706	1,440,027	579,908	51
53 ANESTHESIOLOGY	0.012265	2,434,883	29,864	53
54 RADIOLOGY-DIAGNOSTIC	0.153591	6,604,816	1,014,440	54
54.01 RADIOLOGY - ULTRASOUND	0.142031	559,481	79,464	54.01
56 RADIOISOTOPE	0.150820	1,445,214	217,967	56
57 CT SCAN	0.038540	8,429,808	324,885	57
59 CARDIAC CATHETERIZATION	0.077446	10,063,275	779,360	59
60 LABORATORY	0.124528	18,662,983	2,324,064	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.400303	1,993,244	797,902	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.294088	4,840,546	1,423,546	65
66 PHYSICAL THERAPY	0.303708	2,182,480	662,837	66
67 OCCUPATIONAL THERAPY	0.285061	623,970	177,870	67
68 SPEECH PATHOLOGY	0.435067	257,179	111,890	68
70 ELECTROENCEPHALOGRAPHY	0.187093	183,640	34,358	70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.577174	10,165,665	5,867,358	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.511245	11,723,928	5,993,800	72
73 DRUGS CHARGED TO PATIENTS	0.245722	20,822,136	5,116,457	73
74 RENAL DIALYSIS	0.273343	1,453,637	397,341	74
76.97 CARDIAC REHABILITATION	0.965763	246,077	237,652	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.750473	3,290	2,469	90
91 EMERGENCY	0.170341	7,040,199	1,199,235	91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.591581	232,812	137,727	92
HOME PROGRAM DIALYSIS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		124,718,411	30,612,617	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		124,718,411		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [XX] IRF (15-T034) [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
41 SUBPROVIDER - IRF		3,509,311		41
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.233090	108,885	25,380	50
51 RECOVERY ROOM	0.402706	11,020	4,438	51
53 ANESTHESIOLOGY	0.012265	16,560	203	53
54 RADIOLOGY-DIAGNOSTIC	0.153591	245,381	37,688	54
54.01 RADIOLOGY - ULTRASOUND	0.142031	17,067	2,424	54.01
56 RADIOISOTOPE	0.150820	26,087	3,934	56
57 CT SCAN	0.038540	193,453	7,456	57
59 CARDIAC CATHETERIZATION	0.077446	83,977	6,504	59
60 LABORATORY	0.124528	918,988	114,440	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.400303	71,537	28,636	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.294088	398,171	117,097	65
66 PHYSICAL THERAPY	0.303708	2,329,828	707,587	66
67 OCCUPATIONAL THERAPY	0.285061	2,292,795	653,586	67
68 SPEECH PATHOLOGY	0.435067	323,834	140,889	68
70 ELECTROENCEPHALOGRAPHY	0.187093	1,331	249	70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.577174	516,703	298,228	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.511245	2,964	1,515	72
73 DRUGS CHARGED TO PATIENTS	0.245722	2,038,426	500,886	73
74 RENAL DIALYSIS	0.273343	278,319	76,077	74
76.97 CARDIAC REHABILITATION	0.965763			76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.750473			90
91 EMERGENCY	0.170341			91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.591581			92
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		9,875,326	2,727,217	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		9,875,326		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-0034) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		3,360,943		30
31 INTENSIVE CARE UNIT		614,904		31
41 SUBPROVIDER - IRF				41
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.233090	1,389,574	323,896	50
51 RECOVERY ROOM	0.402706	134,889	54,321	51
53 ANESTHESIOLOGY	0.012265	268,421	3,292	53
54 RADIOLOGY-DIAGNOSTIC	0.153591	1,048,071	160,974	54
54.01 RADIOLOGY - ULTRASOUND	0.142031	90,021	12,786	54.01
56 RADIOISOTOPE	0.150820	215,454	32,495	56
57 CT SCAN	0.038540	1,085,084	41,819	57
59 CARDIAC CATHETERIZATION	0.077446	978,173	75,756	59
60 LABORATORY	0.124528	2,640,687	328,839	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.400303	257,447	103,057	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.294088	836,003	245,858	65
66 PHYSICAL THERAPY	0.303708	306,845	93,191	66
67 OCCUPATIONAL THERAPY	0.285061	122,206	34,836	67
68 SPEECH PATHOLOGY	0.435067	38,995	16,965	68
70 ELECTROENCEPHALOGRAPHY	0.187093	25,085	4,693	70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.577174	1,120,517	646,733	71
72 IMPL. DEV. CHARGED TO PATIENTS	0.511245	520,851	266,282	72
73 DRUGS CHARGED TO PATIENTS	0.245722	3,817,826	938,124	73
74 RENAL DIALYSIS	0.273343	275,569	75,325	74
76.97 CARDIAC REHABILITATION	0.965763	44,023	42,516	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.750473	1,572	1,180	90
91 EMERGENCY	0.170341	973,969	165,907	91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	0.591581	11,868	7,021	92
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		16,203,150	3,675,866	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		16,203,150		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	<input type="checkbox"/>	TITLE V	<input type="checkbox"/>	HOSPITAL	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	S/B SNF	<input checked="" type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>	S/B NF	<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input checked="" type="checkbox"/>	IRF (15-T034)	<input type="checkbox"/>	NF	<input type="checkbox"/>	ICF/MR	<input type="checkbox"/>	OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
41 SUBPROVIDER - IRF		106,285			41
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.233090	3,504	817		50
51 RECOVERY ROOM	0.402706	891	359		51
53 ANESTHESIOLOGY	0.012265	1,114	14		53
54 RADIOLOGY-DIAGNOSTIC	0.153591	4,827	741		54
54.01 RADIOLOGY - ULTRASOUND	0.142031	539	77		54.01
56 RADIOISOTOPE	0.150820	1,649	249		56
57 CT SCAN	0.038540	8,542	329		57
59 CARDIAC CATHETERIZATION	0.077446	2,868	222		59
60 LABORATORY	0.124528	24,557	3,058		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.400303	1,688	676		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.294088	5,299	1,558		65
66 PHYSICAL THERAPY	0.303708	72,172	21,919		66
67 OCCUPATIONAL THERAPY	0.285061	68,817	19,617		67
68 SPEECH PATHOLOGY	0.435067	14,374	6,254		68
70 ELECTROENCEPHALOGRAPHY	0.187093				70
71 MEDICAL SUPPLIES CHARGED TO PAT	0.577174	9,080	5,241		71
72 IMPL. DEV. CHARGED TO PATIENTS	0.511245	324	166		72
73 DRUGS CHARGED TO PATIENTS	0.245722	51,718	12,708		73
74 RENAL DIALYSIS	0.273343				74
76.97 CARDIAC REHABILITATION	0.965763				76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	0.750473				90
91 EMERGENCY	0.170341				91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.591581				92
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		271,963	74,005		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		271,963			202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (15-0034)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	44,035,276	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	870,699	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	165.96	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0466	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.1207	31
32	SUM OF LINES 30 AND 31	0.1673	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0362	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	1,594,077	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	46,500,052	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	46,500,052	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	3,760,925	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (15-0034)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	50,260,977	59
60	PRIMARY PAYER PAYMENTS	50,499	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	50,210,478	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	4,180,392	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	296,832	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	377,373	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	264,161	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	31,804	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	45,997,415	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (ADD BACK GME REIMBURSEMENT)		70
70.01	OTHER ADJ (NO DESC ENTERED)	8,172	70.01
70.02	OTHER ADJUSTMENTS PER PSR	3,331	70.02
70.93	HVBP PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	103,264	70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (SEE INSTRUCTIONS)	-256,546	70.94
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	45,855,636	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	229,278	71.01
72	INTERIM PAYMENTS	46,139,106	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	-512,748	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	40,000	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL (15-0034) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	26,349	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	16,230,246	2
3	PPS PAYMENTS	17,021,993	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	13,536	4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	26,349	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	117,529	12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)	117,529	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)	117,529	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	91,180	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)	26,349	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)	17,035,529	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	3,812,742	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	13,249,136	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)	13,249,136	30
31	PRIMARY PAYER PAYMENTS	2,491	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	13,246,645	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)	509,416	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	356,591	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	185,707	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	13,603,236	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	1,095	38
39	OTHER ADJUSTMENTS (FDO LOSS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	13,602,141	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	68,011	40.01
41	INTERIM PAYMENTS	13,453,905	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	80,225	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL IPF IRF (15-T034)
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	1,004	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)	779	2
3	PPS PAYMENTS	629	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	1,004	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	4,084	12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)	4,084	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)	4,084	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	3,080	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)	1,004	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)	629	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	18	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	1,615	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	1,615	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	1,615	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	1,615	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	1,615	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	8	40.01
41	INTERIM PAYMENTS	1,676	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	-69	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (15-0034) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		45,725,211		13,174,279
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.		413,895		279,626
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		NONE
	.02			3.01
	.03			3.02
	.04			3.03
	.05			3.04
	.06			3.05
	.07			3.06
	.08			3.07
	.09			3.08
	.50	NONE		NONE
	.51			3.09
	.52			3.50
	.53			3.51
	.54			3.52
	.55			3.53
	.56			3.54
	.57			3.55
	.58			3.56
	.59			3.57
	.99			3.58
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				3.59
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		46,139,106		13,453,905

TO BE COMPLETED BY CONTRACTOR

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [XX] IRF (15-T034) [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		7,485,462		1,676	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		NONE	3.01
	.02				3.02
	.03				3.03
	.04				3.04
	.05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	.52				3.52
	.53				3.53
	.54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		7,485,462		1,676	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50				5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01				6.01
	TO .02				6.02
	PROVIDER .03				6.03
	PROVIDER .04				6.04
	TO .05				6.05
	PROGRAM .06				6.06
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ NPR DATE: _____ 8

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 21:28

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (15-0034) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	10,792	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	29,623	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	4,408	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	51,184	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	579,170,998	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	17,396,441	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	2,693,055	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)		10
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	2,411,485	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	281,570	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART III

CHECK [] HOSPITAL
APPLICABLE BOX: [XX] IRF (15-T034)

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	7,328,651	1
2	MEDICARE SSI RATIO (SEE INSTRUCTIONS)	0.022600	2
3	INPATIENT REHABILITATION LIP PAYMENTS (SEE INSTRUCTIONS)	191,278	3
4	OUTLIER PAYMENTS	160,523	4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		5
5.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)		5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTES IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		9
10	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	17.917808	10
11	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (\text{LINE 9}/\text{LINE 10})) \text{ RAISED TO THE POWER OF } .6876 - 1\}$		11
12	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 11)		12
13	TOTAL PPS PAYMENT (SUM OF LINES 1, 3, 4 AND 12)	7,680,452	13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (SEE INSTRUCTIONS)		14
15	ORGAN ACQUISITION		15
16	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		16
17	SUBTOTAL (SEE INSTRUCTIONS)	7,680,452	17
18	PRIMARY PAYER PAYMENTS		18
19	SUBTOTAL LINE 17b LESS LINE 18)	7,680,452	19
20	DEDUCTIBLES	72,772	20
21	SUBTOTAL (LINE 19 MINUS LINE 20)	7,607,680	21
22	COINSURANCE	70,475	22
23	SUBTOTAL (LINE 21 MINUS LINE 22)	7,537,205	23
24	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	17,930	24
25	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	12,551	25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	9,490	26
27	SUBTOTAL (SUM OF LINES 23 AND 25)	7,549,756	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IRF ONLY)		28
29	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		29
30	OUTLIER PAYMENTS RECONCILIATION		30
31	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	7,549,756	32
32.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	37,749	32.01
33	INTERIM PAYMENTS	7,485,462	33
34	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		34
35	BALANCE DUE PROVIDER/PROGRAM (LINE 32 MINUS LINES 32.01, 33 AND 34)	26,545	35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		36

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (15-0034) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 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	3,975,847	8
9 ANCILLARY SERVICE CHARGES	16,203,150	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)	20,178,997	12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000 15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	20,178,997	16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	20,178,997	17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37 OTHER ADJUSTMENTS (TO ZERO OUT SETTLEMENT, SINCE NO ADD)		37
38 SUBTOTAL (LINE 36 ± LINE 37)		38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [] HOSPITAL [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [XX] IRF (15-T034) [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES		1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)		4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)		7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES	106,285	8
9 ANCILLARY SERVICE CHARGES	271,963	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)	378,248	12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000 15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	378,248	16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	378,248	17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)		38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	4,449,000			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	26,551,000			4
5	OTHER RECEIVABLES	67,000			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	5,305,000			7
8	PREPAID EXPENSES	3,099,000			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS	374,000			10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	39,845,000			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	110,544,000			15
16	ACCUMULATED DEPRECIATION				16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT				23
24	ACCUMULATED DEPRECIATION				24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	110,544,000			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	3,903,000			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	3,903,000			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	154,292,000			36
LIABILITIES AND FUND BALANCES		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	6,542,000			37
38	SALARIES, WAGES & FEES PAYABLE	7,654,000			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	778,000			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	8,834,000			43
44	OTHER CURRENT LIABILITIES	5,914,000			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	29,722,000			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	1,182,000			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	16,324,000			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	17,506,000			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	47,228,000			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	107,064,000			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	107,064,000			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	154,292,000			60

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	48,049,012		48,049,012	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF	4,687,592		4,687,592	5
6 SWING BED - SNF				6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY				8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	52,736,604		52,736,604	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	6,742,338		6,742,338	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	6,742,338		6,742,338	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	59,478,942		59,478,942	17
18 ANCILLARY SERVICES	241,820,252		241,820,252	18
19 OUTPATIENT SERVICES		274,408,866	274,408,866	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY		3,471,729	3,471,729	22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	301,299,194	277,880,595	579,179,789	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		198,617,257	29
30 ADD (SPECIFY)			30
31 BAD DEBTS			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		198,617,257	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	579,179,789	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	369,775,304	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	209,404,485	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	198,617,257	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	10,787,228	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	60,292	6
7	INCOME FROM INVESTMENTS	198,116	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	104,853	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	737,516	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	9,365	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	8,211	21
22	RENTAL OF HOSPITAL SPACE	989,945	22
23	GOVERNMENTAL APPROPRIATIONS	4,374,897	23
24	OTHER (OTHER OPERATING INCOME)	90,502	24
24.01	OTHER (CARDIO INCOME)	56,742	24.01
24.02	OTHER (RELEASED TEMP ASSETS)	10,576	24.02
24.03	OTHER (POB REVENUES)		24.03
24.04	OTHER (THERAPY INCOME)	50	24.04
24.05	OTHER (LAMAZE CLASSES)	136,442	24.05
24.06	OTHER (PHOTOGRAPHIC FEES)	2,101	24.06
24.07	OTHER (GAIN ON SALE OF ASSETS)		24.07
24.08	OTHER (ROUNDING)		24.08
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	6,779,608	25
26	TOTAL (LINE 5 PLUS LINE 25)	17,566,836	26
27	OTHER EXPENSES (ROUNDING)		27
27.01	OTHER EXPENSES (LOSS ON SALE OF ASSETS)	19,191	27.01
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	19,191	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	17,547,645	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 15-7313

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6
1 GENERAL SERVICE COST CENTER						1
2 CAPITAL RELATED-BLDGS & FIXTURES						2
3 CAPITAL RELATED-MOVABLE EQUIPMENT						3
4 PLANT OPERATION & MAINTENANCE						4
5 ADMINISTRATIVE AND GENERAL	483,928				83,864	567,792
6 HHA REIMBURSABLE SERVICES						
7 SKILLED NURSING CARE	698,849		52,095			750,944
8 PHYSICAL THERAPY				443,636		443,636
9 OCCUPATIONAL THERAPY				97,044		97,044
10 SPEECH PATHOLOGY				22,826		22,826
11 MEDICAL SOCIAL SERVICES	1,961					1,961
12 HOME HEALTH AIDE	75,188		13,261			88,449
13 SUPPLIES (SEE INSTRUCTIONS)					110,500	110,500
14 DRUGS						13
15 DME						14
16 HHA NONREIMBURSABLE SERVICES						15
17 HOME DIALYSIS AIDE SERVICES						16
18 RESPIRATORY THERAPY						17
19 PRIVATE DUTY NURSING						18
20 CLINIC						19
21 HEALTH PROMOTION ACTIVITIES						20
22 DAY CARE PROGRAM						21
23 HOME DELIVERED MEALS PROGRAM						22
24 HOMEMAKER SERVICE						23
25 ALL OTHERS						24
26 TOTAL (SUM OF LINES 1-23)	1,259,926		65,356	563,506	194,364	2,083,152

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 15-7313

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5	-37,592	530,200	-1,404	528,796	5
6					6
7		750,944		750,944	7
8		443,636		443,636	8
9		97,044		97,044	9
10		22,826		22,826	10
11		1,961		1,961	11
12	-110,500	88,449		88,449	12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24	-148,092	1,935,060	-1,404	1,933,656	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 15-7313

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL (COLS. 0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS. 4A+5) 6	
	0	1	2	3	4				
1									1
2									2
3									3
4									4
5	528,796					528,796	528,796		5
6									
7	750,944					750,944	280,267	1,031,211	6
8	443,636					443,636	165,573	609,209	7
9	97,044					97,044	36,219	133,263	8
10	22,826					22,826	8,519	31,345	9
11	1,961					1,961	732	2,693	10
12	88,449					88,449	33,011	121,460	11
13							4,475	4,475	12
14									13
									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	1,933,656					1,933,656		1,933,656	24

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COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 15-7313

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET)	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE)	PLANT OPERATN & MAINT (SQUARE FEET)	TRANSPORT- ATION (MILEAGE)	RECONCIL- IATION	ADMIN & GENERAL (ACCUM COST)	
	1	2	3	4	5A	5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-528,796	1,416,851	5
6 SKILLED NURSING CARE						750,944	6
7 PHYSICAL THERAPY						443,636	7
8 OCCUPATIONAL THERAPY						97,044	8
9 SPEECH PATHOLOGY						22,826	9
10 MEDICAL SOCIAL SERVICES						1,961	10
11 HOME HEALTH AIDE						88,449	11
12 SUPPLIES (SEE INSTRUCTIONS)					11,991	11,991	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)					-516,805	1,416,851	24
25 COST TO BE ALLOC (PER W/S H)						528,796	25
26 UNIT COST MULTIPLIER						0.373219	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 15-7313

WORKSHEET H-2
 PART I

HHA COST CENTER	NONPHYSIC. ANESTHET.	SUBTOTAL (SUM OF COL.4A-23)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (SUM OF COL.4A-23)	ALLOCATED HHA A&G (SEE PT.2)	TOTAL HHA COSTS	
	19	24	25	26	27	28	
1 ADMINISTRATIVE AND GENERAL		764,306		764,306			1
2 SKILLED NURSING CARE		1,197,299		1,197,299	407,601	1,604,900	2
3 PHYSICAL THERAPY		707,329		707,329	240,799	948,128	3
4 OCCUPATIONAL THERAPY		154,726		154,726	52,674	207,400	4
5 SPEECH PATHOLOGY		36,393		36,393	12,389	48,782	5
6 MEDICAL SOCIAL SERVICES		3,127		3,127	1,065	4,192	6
7 HOME HEALTH AIDE		141,022		141,022	48,009	189,031	7
8 SUPPLIES		5,196		5,196	1,769	6,965	8
9 DRUGS							9
10 DME							10
11 HOME DIALYSIS AIDE SERVICES							11
12 RESPIRATORY THERAPY							12
13 PRIVATE DUTY NURSING							13
14 CLINIC							14
15 HEALTH PROMOTION ACTIVITIES							15
16 DAY CARE PROGRAM							16
17 HOME DELIVERED MEALS PROGRAM							17
18 HOMEMAKER SERVICE							18
19 ALL OTHERS							19
20 TOTAL (SUM OF LINES 1-19)		3,009,398		3,009,398	764,306	3,009,398	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.					0.340434		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 15-7313

WORKSHEET H-2
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	MAINTENACE OF PERSONNEL NUMBER OF FTES	NONPATIENT TELEPHONES NUMBER OF PHONES	PURCHASING RECEIVING & STORES SUPPLY EXPENSE	PATIENT REGISTRATN GROSS REVENUE	
	1	2	3	4	4.01	5.01	5.02	5.03	
1 ADMINISTRATIVE AND GENERAL	2,100	2,100		1,259,926	1,698	16	19,426	3,471,729	1
2 SKILLED NURSING CARE									2
3 PHYSICAL THERAPY									3
4 OCCUPATIONAL THERAPY									4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE									7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)	2,100	2,100		1,259,926	1,698	16	19,426	3,471,729	20
21 TOTAL COST TO BE ALLOCATED	27,484	38,472		314,028	25,418	6,367	5,427	12,807	21
22 UNIT COST MULTIPLIER	13.087619				14.969376		0.279368		22
22 UNIT COST MULTIPLIER		18.320000		0.249243		397.937500		0.003689	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 15-7313

WORKSHEET H-2
 PART II

HHA COST CENTER	CAFETERIA NUMBER OF FTES 11	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS- TRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY EXPENSE 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	NONPHYSIC. ANESTHET. ASSIGNED TIME 19
1 ADMINISTRATIVE AND GENERAL	1,698		35,318			3,471,729		1
2 SKILLED NURSING CARE								2
3 PHYSICAL THERAPY								3
4 OCCUPATIONAL THERAPY								4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE								7
8 SUPPLIES								8
9 DRUGS								9
10 DME								10
11 HOME DIALYSIS AIDE SERVICES								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIES								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGRAM								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTAL (SUM OF LINES 1-19)	1,698		35,318			3,471,729		20
21 TOTAL COST TO BE ALLOCATED	37,374		142,388			23,837		21
22 UNIT COST MULTIPLIER	22.010601		4.031599					22
22 UNIT COST MULTIPLIER						0.006866		22

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
STATISTICAL BASIS

HHA NO.: 15-7313

WORKSHEET H-2
PART II

HHA COST CENTER

1	ADMINISTRATIVE AND GENERAL	1
2	SKILLED NURSING CARE	2
3	PHYSICAL THERAPY	3
4	OCCUPATIONAL THERAPY	4
5	SPEECH PATHOLOGY	5
6	MEDICAL SOCIAL SERVICES	6
7	HOME HEALTH AIDE	7
8	SUPPLIES	8
9	DRUGS	9
10	DME	10
11	HOME DIALYSIS AIDE SERVICES	11
12	RESPIRATORY THERAPY	12
13	PRIVATE DUTY NURSING	13
14	CLINIC	14
15	HEALTH PROMOTION ACTIVITIES	15
16	DAY CARE PROGRAM	16
17	HOME DELIVERED MEALS PROGRAM	17
18	HOMEMAKER SERVICE	18
19	ALL OTHERS	19
19.50	TELEMEDICINE	19.50
20	TOTAL (SUM OF LINES 1-19)	20
21	TOTAL COST TO BE ALLOCATED	21
22	UNIT COST MULTIPLIER	22
22	UNIT COST MULTIPLIER	22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 15-7313

WORKSHEET H-3
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	4	(COL.3 ÷ COL.4)	
		2	1	2	3	4	5	
1	SKILLED NURSING CARE		1,604,900		1,604,900	14,536	110.41	1
2	PHYSICAL THERAPY	3	948,128		948,128	7,495	126.50	2
3	OCCUPATIONAL THERAPY	4	207,400		207,400	1,609	128.90	3
4	SPEECH PATHOLOGY	5	48,782		48,782	378	129.05	4
5	MEDICAL SOCIAL SERVICES	6	4,192		4,192	33	127.03	5
6	HOME HEALTH AIDE	7	189,031		189,031	3,699	51.10	6
7	TOTAL (SUM OF LINES 1-6)		3,002,433		3,002,433	27,750		7

PATIENT SERVICES

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

SUPPLIES AND DRUGS COST COMPUTATIONS

OTHER PATIENT SERVICES		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES (FROM HHA RECORD)	RATIO (COL.3 ÷ COL.4)	
		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	4	5	
		8	1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES		6,965	129,440	136,405	224,265	0.608231	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 15-7313

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART B			PART B			
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
	6	7	8	9	10	11	12
1 SKILLED NURSING CARE	5,917	5,090		653,296	561,987		1,215,283
2 PHYSICAL THERAPY	3,228	2,414		408,342	305,371		713,713
3 OCCUPATIONAL THERAPY	842	453		108,534	58,392		166,926
4 SPEECH PATHOLOGY	119	185		15,357	23,874		39,231
5 MEDICAL SOCIAL SERVICES	13	15		1,651	1,905		3,556
6 HOME HEALTH AIDE	1,359	1,837		69,445	93,871		163,316
7 TOTAL (SUM OF LINES 1-6)	11,478	9,994		1,256,625	1,045,400		2,302,025

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		PART A	COST OF SERVICES		TOTAL PROGRAM COST
		NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR		NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
		3	4		5	6	
8 SKILLED NURSING CARE	1	23844	5,917	23844	5,917	5,090	8
9 PHYSICAL THERAPY	2	23844	3,228	23844	3,228	2,414	9
10 OCCUPATIONAL THERAPY	3	23844	842	23844	842	453	10
11 SPEECH PATHOLOGY	4	23844	119	23844	119	185	11
12 MEDICAL SOCIAL SERVICES	5	23844	13	23844	13	15	12
13 HOME HEALTH AIDE	6	23844	1,359	23844	1,359	1,837	13
14 TOTAL (SUM OF LINES 8-13)			11,478		11,478	9,994	14

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

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

	FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
			2	3		
1 PHYSICAL THERAPY	66	0.303708			COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY	67	0.285061			COL 2, LINE 3	2
3 SPEECH PATHOLOGY	68	0.435067			COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHARGED TO PA	71	0.577174	224,265	129,440	COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	73	0.245722			COL 2, LINE 16	5

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 15-7313

WORKSHEET H-4
 PARTS I & II

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

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

DESCRIPTION	----- PART B -----		
	PART A 1	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3
1 REASONABLE COST OF PART A & PART B SERVICES			1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)			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 EXCEED 1.000000)			5
6 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			6
7 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)			7
8 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)			8
9 PRIMARY PAYER PAYMENTS		1,630	9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES		PART B SERVICES	
	1	2	3	4
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			-1,630	10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	1,310,629		1,013,720	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	77,015		96,683	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	12,872		9,539	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	14,292		9,781	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	13,615		34,160	15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES				16
17 TOTAL OTHER PAYMENTS				17
18 DME PAYMENTS				18
19 OXYGEN PAYMENTS				19
20 PROSTHETIC AND ORTHOTIC PAYMENTS				20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)				21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	1,428,423		1,162,253	22
23 EXCESS REASONABLE COST (FROM LINE 8)				23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	1,428,423		1,162,253	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)				25
26 NET COST (LINE 24 MINUS LINE 25)	1,428,423		1,162,253	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)				27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	1,428,423		1,162,253	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	1,428,423		1,162,253	31
31.01 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	7,378		5,240	31.01
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	1,421,045		1,157,013	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)				34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2				35

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

COMPONENT NO: -

WORKSHEET I-1

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	TOTAL COSTS	BASIS	STATISTICS	FTE PER 2080 HOURS
	1	2	3	4
1 REGISTERED NURSES		HOURS OF SERVICE		1
2 LICENSED PRACTICAL NURSES		HOURS OF SERVICE		2
3 NURSES AIDES		HOURS OF SERVICE		3
4 TECHNICIANS		HOURS OF SERVICE		4
5 SOCIAL WORKERS		HOURS OF SERVICE		5
6 DIETICIANS		HOURS OF SERVICE		6
7 PHYSICIANS		ACCUMULATED COST		7
8 NON-PATIENT CARE SALARY		ACCUMULATED COST		8
9 SUBTOTAL (SUM OF LINES 1-8)				9
10 EMPLOYEE BENEFITS		SALARY		10
11 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET		11
12 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME		12
13 MACHINES COSTS & REPAIRS		PERCENTAGE OF TIME		13
14 SUPPLIES		REQUISITIONS		14
15 DRUGS		REQUISITIONS		15
16 OTHER		ACCUMULATED COST		16
17 SUBTOTAL (SUM OF LINES 9-16)				17
18 CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET		18
19 CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME		19
20 EMPLOYEE BENEFITS DEPARTMENT		SALARY		20
21 ADMINISTRATIVE AND GENERAL		ACCUMULATED COST		21
22 MAINT./REPAIRS-OPERATION-HOUSEKEEPING		SQUARE FEET		22
23 MEDICAL EDUCATION PROGRAM COSTS				23
24 CENTRAL SERVICES & SUPPLIES		REQUISITIONS		24
25 PHARMACY		REQUISITIONS		25
26 OTHER ALLOCATED COSTS		ACCUMULATED COST		26
27 SUBTOTAL (SUM OF LINES 17-26)				27
28 LABORATORY		CHARGES		28
29 RESPIRATORY THERAPY		CHARGES		29
30 OTHER ANCILLARY (SPECIFY)		CHARGES		30
30.97 CARDIAC REHABILITATION		CHARGES		30.97
30.98 HYPERBARIC OXYGEN THERAPY		CHARGES		30.98
30.99 LITHOTRIPSY		CHARGES		30.99
31 TOTAL COSTS (SUM OF LINES 27-30)				31

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
PERIOD FROM 07/01/2012 TO 06/30/2013

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

VERSION: 2013.11
11/25/2013 21:28

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2

CHECK APPLICABLE BOX:

[XX] RENAL DIALYSIS DEPARTMENT

[] HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE	SALARY	EMPLOYEE BENEFITS	DRUGS	
	BUILDING	EQUIPMENT	RNs	OTHER	DEPARTMENT		
	1	2	3	4	5	6	
1	TOTAL RENAL DEPT COSTS						1
	MAINTENANCE						
2	HEMODIALYSIS						2
3	INTERMITTENT PERITONEAL TRAINING						3
4	HEMODIALYSIS						4
5	INTERMITTENT PERITONEAL						5
6	CAPD						6
7	CCPD						7
	HOME						
8	HEMODIALYSIS						8
9	INTERMITTENT PERITONEAL						9
10	CAPD						10
11	CCPD						11
	OTHER BILLABLE SERVICES						
12	INPATIENT DIALYSIS						12
13	METHOD II HOME PATIENT						13
14	EPO (INCL IN RENAL DEPT)						14
15	ARANESP (INCL IN RENAL DEPT)						15
16	OTHER						16
17	TOTAL (SUM OF LINES 2-16)						17
18	MEDICAL EDUC PGM COSTS						18
19	TOTAL RENAL COSTS (LINES 17+18)						19

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
PERIOD FROM 07/01/2012 TO 06/30/2013

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VERSION: 2013.11
11/25/2013 21:28

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES

COMPONENT NO: -

WORKSHEET I-2
(CONTINUED)

CHECK APPLICABLE BOX:

[XX] RENAL DIALYSIS DEPARTMENT

[] HOME PROGRAM DIALYSIS

	MEDICAL SUPPLIES 7	ROUTINE ANCILLARY SERVICES 8	SUBTOTAL (SUM OF COLS.1-8) 9	OVERHEAD 10	TOTAL (COL.9 + COL.10) 11	
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
 PERIOD FROM 07/01/2012 TO 06/30/2013

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 IN LIEU OF FORM CMS-2552-10 (08/2011)

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DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -
 STATISTICAL BASIS

COMPONENT NO: -

WORKSHEET I-3

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY	EMPLOYEE BENEFITS DEPARTMENT (SALARY)	
	BUILDING (SQUARE FEET)	EQUIPMENT (% OF TIME)	RNs (HOURS)	OTHER (HOURS)	
	1	2	3	4	
1	TOTAL RENAL DEPT COSTS				1
	MAINTENANCE				
2	HEMODIALYSIS				2
3	INTERMITTENT PERITONEAL TRAINING				3
4	HEMODIALYSIS				4
5	INTERMITTENT PERITONEAL				5
6	CAPD				6
7	CCPD				7
	HOME				
8	HEMODIALYSIS				8
9	INTERMITTENT PERITONEAL				9
10	CAPD				10
11	CCPD				11
	OTHER BILLABLE SERVICES				
12	INPT DIAL TRTMNTS				
13	METHOD II HOME PATIENT				13
14	EPO				14
15	ARANESP				15
16	OTHER				16
17	TOTAL STATISTICAL BASIS				17
18	UNIT COST MULTIPLIER				18
	(LINE 1 ÷ LINE 17)				

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PERIOD FROM 07/01/2012 TO 06/30/2013

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IN LIEU OF FORM CMS-2552-10 (08/2011)

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11/25/2013 21:28

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -
STATISTICAL BASIS

COMPONENT NO: -

WORKSHEET I-3
(CONTINUED)

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	DRUGS (REQUIST.) 6	MEDICAL SUPPLIES (REQUIST.) 7	ROUTINE ANCILLARY SERVICES (CHARGES) 8	SUBTOTAL 9	OVERHEAD (ACCUM. COST) 10	
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						
13						13
14						14
15						15
16						16
17						17
18						18

PROVIDER CCN: 15-0034 ST. MARY MEDICAL CENTER, INC.
PERIOD FROM 07/01/2012 TO 06/30/2013

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VERSION: 2013.11
11/25/2013 21:28

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

COMPONENT NO: -

WORKSHEET I-4
(CONTINUED)

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [] HOME PROGRAM DIALYSIS

	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	AVERAGE PAYMENT RATE (COL. 6 ÷ COL. 4)	AVERAGE PAYMENT RATE (COL. 6.01 ÷ COL. 4.01)	AVERAGE PAYMENT RATE (COL. 6.02 ÷ COL. 4.02)	
1 MAINTENANCE - HEMODIALYSIS							1
2 MAINTENANCE - PERITONEAL DIALYSIS							2
3 TRAINING - HEMODIALYSIS							3
4 TRAINING - PERITONEAL DIALYSIS							4
5 TRAINING - CAPD							5
6 TRAINING - CCPD							6
7 HOME PROGRAM - HEMODIALYSIS							7
8 HOME PROGRAM - PERITONEAL DIALYSIS							8
9 HOME PROGRAM - CAPD							9
10 HOME PROGRAM - CCPD							10
11 TOTALS (SUM OF LINES 1-8, COLS. 1 & 4) (SUM OF LINES 1-10, COLS. 2, 5 & 6)	6	6.01	6.02	7	7.01	7.02	11
12 TOTAL TREATMENTS (SUM OF LINES 1-8 PLUS (SUM OF LINES 9 AND 10 TIMES 3))							12

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

COMPONENT NO: -

WORKSHEET I-5

DESCRIPTION

1	TOTAL EXPENSES RELATED TO CARE OF PROGRAM BENEFICIARIES (SEE INSTRUCTIONS)			1
2	TOTAL PAYMENT DUE (FROM I-4, COL. 6, LINE 11)(SEE INSTRUCTIONS)	1	2	2
2.01	TOTAL PAYMENT DUE (FROM I-4, COL. 6.01, LINE 11)(SEE INSTRUCTIONS)			2.01
2.02	TOTAL PAYMENT DUE (FROM I-4, COL. 6.02, LINE 11)(SEE INSTRUCTIONS)			2.02
2.03	TOTAL PAYMENT DUE (SEE INSTRUCTIONS)			2.03
2.04	OUTLIER PAYMENTS			2.04
3	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3
3.01	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.01
3.02	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.02
3.03	TOTAL DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.03
4	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4
4.01	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.01
4.02	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.02
4.03	TOTAL COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.03
5	BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE, NET OF BAD DEBT RECOVERIES			5
5.01	TRANSITION PERIOD 1 (75-25%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2011 BUT BEFORE 1/1/2012			5.01
5.02	TRANSITION PERIOD 2 (50-50%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2012 BUT BEFORE 1/1/2013			5.02
5.03	TRANSITION PERIOD 3 (25-75%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2013 BUT BEFORE 1/1/2014			5.03
5.04	100% PPS BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2014			5.04
5.05	TOTAL BAD DEBTS (SUM OF LINE 5 THROUGH LINE 5.04)			5.05
6	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			6
7	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			7
8	NET DEDUCTIBLES AND COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			8
9	PROGRAM PAYMENT (SEE INSTRUCTIONS)			9
10	UNRECOVERED FROM MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			10
11	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) (TRANSFER TO WKST E, PART B, LINE 33)			11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE RATE PERCENTAGE

12	TOTAL ALLOWABLE EXPENSES (SEE INSTRUCTIONS)			12
13	TOTAL COMPOSITE COSTS (FROM WKST I-4, COL. 2, LINE 11)			13
14	FACILITY SPECIFIC COMPOSITE COST PERCENTAGE (LINE 13 DIVIDED BY LINE 12)			14

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-003) [XX] PPS
APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT		
1 CAPITAL DRG OTHER THAN OUTLIER	3,516,966	1
2 CAPITAL DRG OUTLIER PAYMENTS	122,624	2
3 TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	140.23	3
4 NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5 INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6 INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.0466	7
8 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)	0.1207	8
9 SUM OF LINES 7 AND 8	0.1673	9
10 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0345	10
11 DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	121,335	11
12 TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	3,760,925	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-003) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT	
1 CAPITAL DRG OTHER THAN OUTLIER	1
2 CAPITAL DRG OUTLIER PAYMENTS	2
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 (LINE 1 TIMES LINE 5)	6
7 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST 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 (LINE 10 TIMES LINE 1)	11
12 TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	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
4.01 MAINTENANCE OF PERSONNEL						4.01
5.01 NON-PATIENT TELEPHONES						5.01
5.02 PURCHASING, RECEIVING & STORES						5.02
5.03 PATIENT REGISTRATION						5.03
5.04 PATIENT ACCOUNTING						5.04
5.05 ADMINISTRATIVE & GENERAL						5.05
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
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS						30
31 INTENSIVE CARE UNIT						31
41 SUBPROVIDER - IRF						41
43 NURSERY						43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 RADIOLOGY - ULTRASOUND						54.01
56 RADIOISOTOPE						56
57 CT SCAN						57
59 CARDIAC CATHETERIZATION						59
60 LABORATORY						60
62 WHOLE BLOOD & PACKED RED BLOOD						62
62.30 BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHARGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINCT						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
101 HOME HEALTH AGENCY						101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)						118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 OTHER NON-REIMBURSEABLE COST C						194
194.01 OTHER NONREIMBURSABLE						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINE 118 AND						202
LINES 190-201)						
203 TOTAL STATISTICAL BASIS						203
204 UNIT COST MULTIPLIER						204
204 UNIT COST MULTIPLIER						204

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

EXHIBIT 3

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