

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: 05/16/2012 TIME: 18:08  
 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 HEALTHSOUTH DEACONESS REHAB (15-3025) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2011 AND ENDING 12/31/2011, 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 IDENTIFIED IN THIS COST REPORT WERE PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 05/16/2012 18:08  
 c.CX0nw2PPr9VsF1nF1onHtMFrBQs0  
 9mFHz01lcwbTAKmDE7wKD69cvKP1K8  
 c8.80iq1d10bGMxs

(SIGNED)

*Rob Wisner*  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
**ROB WISNER, SVP - REIMBURSEMENT**

TITLE

**MAY 21 2012**

DATE

PI Encryption: 05/16/2012 18:08  
 GYvt7ytYiOQ2OXSyQAvumho00fvn10  
 Zvtpd0z:v6AJYq8KBPPNyC2qW6GSm:  
 DMTl0MqnG40Y6f:6

PART III - SETTLEMENT SUMMARY

	TITLE XVIII				
	TITLE V 1	PART A 2	PART B 3	HIT 4	TITLE XIX 5
1 HOSPITAL		152,804			114,899
2 SUBPROVIDER - IPF					
3 SUBPROVIDER - IRF					
4 SUBPROVIDER (OTHER)					
5 SWING BED - SNF					
6 SWING BED - NF					
7 SKILLED NURSING FACILITY					
8 NURSING FACILITY					
9 HOME HEALTH AGENCY					
10 HEALTH CLINIC - RHC					
11 HEALTH CLINIC - FQHC					
12 OUTPATIENT REHABILITATION PROVIDER					
200 TOTAL		152,804			114,899

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.



MEDICARE COST REPORT INFORMATION PACKAGE

**CERTIFICATION SHEET**

This sheet must be completed and signed in order for the Medicare Information Package to be considered complete. A MEDICARE COST REPORT WILL NOT BE FILED IF THE CERTIFICATION SHEET IS NOT COMPLETED, AND SIGNED. Failure to file a cost report may result in a suspension of payments to the hospital, and could ultimately lead to a recoupment of all Medicare payments received, as well as termination of the hospital's provider agreement.

Hospital Name: HEALTHSOUTH Deaconess Rehabilitation Hospital

Medicare Provider #: 15-3025

Medicare FYE: 12/31/2011

I hereby certify that I have examined the accompanying Medicare Information Package and to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the records of the reporting entity.

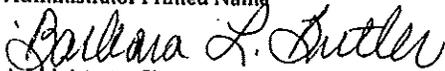
I further certify that there were no expenditures of a personal nature included in the facilities books, or if there were, they are disclosed below. Additionally, I certify that no expenditures were made to induce referrals.

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 the Medicare Information Package were provided in compliance with such laws and regulations.

Only for Florida facilities: I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services were provided in compliance with such laws and regulations.

Barbara L. Butler

Administrator Printed Name

  
Administrator Signature

12/28/2011

Date

**Comments:**

I have used data from the financial statements supplied by the Corporate Office in Birmingham, AL, in completion of the Medicare information package.

**(4) HEALTHSOUTH,**

MEDICARE COST REPORT INFORMATION PACKAGE

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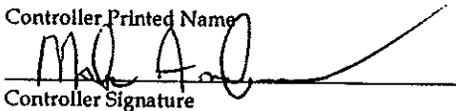
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**Mark Ambrose**

Controller Printed Name



Controller Signature

**1/27/2012**

Date

**Comments:**

I have used data from the financial statements supplied by the Corporate Office in Birmingham, AL, in completion of the Medicare information package.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 4100 COVERT AVENUE P.O.BOX: 1  
 2 CITY: EVANSVILLE STATE: IN ZIP CODE: 47714 COUNTY: VANDERBURGH 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			3	
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	HEALTHSOUTH DEACONESS REHAB	15-3025	21780	5	06/08/1989	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									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									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: 01/01/2011			TO: 12/31/2011					20
21	TYPE OF CONTROL				5					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
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.	N	N
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	3	N

24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	24
		24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.					
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	737	46	356	199	77	17	
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			
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1			
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							
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:		
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	V 1	XVIII 2	XIX 3	45
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? 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		1	2	3	56
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			
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.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	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)				64
ENTER IN LINES 65-65.49, 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	
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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	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
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.	250,000	5,000,000 119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? 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.	N	121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 Y	2 019005 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: HEALTHSOUTH CORPORATION	CONTRACTOR'S NAME: CAHABA GBA	CONTRACTOR'S NUMBER: 10101	141
142	STREET: 3660 GRANDVIEW PARKWAY, SUIT P.O. BOX:			142
143	CITY: BIRMINGHAM	STATE: AL	ZIP CODE: 35243	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	149

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

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

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.	N	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.		169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

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

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1 N	2	1	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	Y/N N	DATE 2	V/I 3	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1 N	2	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?	1 N		2 6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y/N Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 N	2	3 Y	4 03/04/2012
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	03/04/2012	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: SPLIT UB CODES FOR SUA SITUATION. S	Y		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 DEBRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.                                | 26 |
| 27 | HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.                                     | 27 |

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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





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	9,621,681		398,798.40		1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A						4
4.01	PHYSICIANS-PART A - DIRECT TEACHING						4.01
5	PHYSICIAN-PART B						5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		34,921		1,049.60		10
	OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)						11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A		85,013		605.00		13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		795,684		10,415.00		14
15	HOME OFFICE: PHYSICIAN-PART A						15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)		1,646,097				17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		5,996				19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A						22
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		91,705		3,806.40		26
27	ADMINISTRATIVE & GENERAL	1,655,276	-124,453		47,694.00		27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		227,417		10,961.60		30
31	LAUNDRY & LINEN SERVICE			25,737	2,070.49		31
32	HOUSEKEEPING		231,881	-25,737	17,534.40		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		268,767		20,924.80		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA						36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		297,661		10,545.60		38
39	CENTRAL SERVICES AND SUPPLY						39
40	PHARMACY						40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		121,338		7,051.20		41
42	SOCIAL SERVICE		454,187		16,952.00		42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	9,621,681		9,621,681	398,798.40	24.13	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		34,921	34,921	1,049.60	33.27	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	9,621,681	-34,921	9,586,760	397,748.80	24.10	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	880,697		880,697	11,020.00	79.92	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	1,646,097		1,646,097		17.178	5
6	TOTAL (SUM OF LINES 3 THRU 5)	12,148,475	-34,921	12,113,554	408,768.80	29.63	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,256,527	-32,748	3,223,779	137,540.49	23.44	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	130,052	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST		3
4 PRIOR YEAR PENSION SERVICE COST		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	1,087,672	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN		10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	18,456	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	62,514	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	689,149	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE		19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	30,463	20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION		21
22 DAY CARE COSTS AND ALLOWANCES	-366,213	22
23 TUITION REIMBURSEMENT		23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	1,652,093	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3  
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL		2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS
		1	2	3	4
GENERAL SERVICE COST CENTERS					
1	00100		910,126	910,126	119,816
2	00200		263,463	263,463	105,994
3	00300		203,068	203,068	-203,068
4	00400		1,719,881	1,719,881	137,239
5	00500	1,655,276	2,452,536	4,107,812	-206,867
7	00700	227,417	559,230	786,647	2,725
8	00800		18,803	18,803	25,737
9	00900	231,881	72,105	303,986	-26,479
10	01000	268,767	308,417	577,184	
11	01100				
13	01300	297,661	15,472	313,133	
16	01600	121,338	84,707	206,045	
17	01700	454,187	10,257	464,444	
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	3,139,711	185,291	3,325,002	-45,078
ANCILLARY SERVICE COST CENTERS					
54	05400		151,910	151,910	176,177
54.01	05401				27,419
60	06000		258,133	258,133	-2,725
65	06500	176,945	61,391	238,336	
66	06600	1,117,562	22,175	1,139,737	-3,683
67	06700	967,326	9,640	976,966	1,615
68	06800	520,732	6,368	527,100	1,941
71	07100	51,806	155,566	207,372	127
73	07300	343,494	583,661	927,155	
76	03550	47,578	3,561	51,139	2,538
76.01	03950		198,336	198,336	-150,521
76.02	03020				
76.03	03951				1,738
OUTPATIENT SERVICE COST CENTERS					
92	09200				
OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113	11300		7,120	7,120	
118		9,621,681	8,261,217	17,882,898	-35,355
NONREIMBURSABLE COST CENTERS					
192	19200		1,204	1,204	1,289
194	07950				34,066
194.01	07951				
200		9,621,681	8,262,421	17,884,102	

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100 CAP REL COSTS-BLDG & FIXT	1,029,942	179,414	1,209,356	1
2	00200 CAP REL COSTS-MVBLE EQUIP	369,457	-22,781	346,676	2
3	00300 OTHER CAPITAL RELATED COSTS				3
4	00400 EMPLOYEE BENEFITS	1,857,120	-90,048	1,767,072	4
5	00500 ADMINISTRATIVE & GENERAL	3,900,945	305,767	4,206,712	5
7	00700 OPERATION OF PLANT	789,372	-69,777	719,595	7
8	00800 LAUNDRY & LINEN SERVICE	44,540		44,540	8
9	00900 HOUSEKEEPING	277,507	-96	277,411	9
10	01000 DIETARY	577,184	-22,939	554,245	10
11	01100 CAFETERIA				11
13	01300 NURSING ADMINISTRATION	313,133	-7,863	305,270	13
16	01600 MEDICAL RECORDS & LIBRARY	206,045	-57	205,988	16
17	01700 SOCIAL SERVICE	464,444	-175	464,269	17
INPATIENT ROUTINE SERV COST CENTERS					
30	03000 ADULTS & PEDIATRICS	3,279,924	-4,881	3,275,043	30
ANCILLARY SERVICE COST CENTERS					
54	05400 RADIOLOGY-DIAGNOSTIC	328,087	-90,713	237,374	54
54.01	05401 RADIOLOGY SUA	27,419	-7,814	19,605	54.01
60	06000 LABORATORY	255,408	-205,760	49,648	60
65	06500 RESPIRATORY THERAPY	238,336	-23,627	214,709	65
66	06600 PHYSICAL THERAPY	1,136,054	-540	1,135,514	66
67	06700 OCCUPATIONAL THERAPY	978,581		978,581	67
68	06800 SPEECH PATHOLOGY	529,041		529,041	68
71	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	207,499	-858	206,641	71
73	07300 DRUGS CHARGED TO PATIENTS	927,155	-9,216	917,939	73
76	03550 PSYCHOLOGY	53,677	-1,145	52,532	76
76.01	03950 AMBULANCE	47,815	-38,421	9,394	76.01
76.02	03020 DAY TREATMENT				76.02
76.03	03951 AMBULANCE SUA	1,738	-495	1,243	76.03
OUTPATIENT SERVICE COST CENTERS					
92	09200 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113	11300 INTEREST EXPENSE	7,120	-7,120		113
118	SUBTOTALS (SUM OF LINES 1-117)	17,847,543	-119,145	17,728,398	118
NONREIMBURSABLE COST CENTERS					
192	19200 PHYSICIANS' PRIVATE OFFICES	2,493		2,493	192
194	07950 NRCC MARKETING	34,066		34,066	194
194.01	07951 GUEST MEALS				194.01
200	TOTAL (SUM OF LINES 118-199)	17,884,102	-119,145	17,764,957	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 INSURANCE	A	CAP REL COSTS-BLDG & FIXT	1			12,067 1
2 INSURANCE	A	CAP REL COSTS-MVBLE EQUIP	2			10,675 2
3 INSURANCE	A					3
500 TOTAL RECLASSIFICATIONS CODE LETTER - A						22,742 500
1 MARKETING	B	NRCC MARKETING	194		32,428	1,638 1
2 MARKETING	B					2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					32,428	1,638 500
1 PHYSICIANS	C	ADULTS & PEDIATRICS	30			11,166 1
2 PHYSICIANS	C	PSYCHOLOGY	76			2,538 2
3 PHYSICIANS	C					3
500 TOTAL RECLASSIFICATIONS CODE LETTER - C						13,704 500
1 SERVICE UNDER ARRANGEMENT	D	RADIOLOGY SUA	54.01			27,419 1
2 SERVICE UNDER ARRANGEMENT	D	AMBULANCE SUA	76.03			1,738 2
3 SERVICE UNDER ARRANGEMENT	D					3
4 SERVICE UNDER ARRANGEMENT	D					4
500 TOTAL RECLASSIFICATIONS CODE LETTER - D						29,157 500
1 HR RECLASS	E	EMPLOYEE BENEFITS	4		91,705	45,534 1
2 HR RECLASS	E					2
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					91,705	45,534 500
1 RELATED PARTY DEACONESS	F	RADIOLOGY-DIAGNOSTIC	54			742 1
2 RELATED PARTY DEACONESS	F					2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F						742 500
1 DAY TREATMENT	G	OCCUPATIONAL THERAPY	67			1,615 1
2 DAY TREATMENT	G	SPEECH PATHOLOGY	68			1,941 2
3 DAY TREATMENT	G					3
500 TOTAL RECLASSIFICATIONS CODE LETTER - G						3,556 500
1 LAB RECLASS	H	OPERATION OF PLANT	7			2,725 1
2 LAB RECLASS	H	RADIOLOGY-DIAGNOSTIC	54			112,208 2
3 LAB RECLASS	H					3
4 LAB RECLASS	H					4
500 TOTAL RECLASSIFICATIONS CODE LETTER - H						114,933 500
1 COMS RECLASS	I	MEDICAL SUPPLIES CHRGED TO PA	71			127 1
2 COMS RECLASS	I					2
500 TOTAL RECLASSIFICATIONS CODE LETTER - I						127 500
1 LAUNDRY RECLASS	J	LAUNDRY & LINEN SERVICE	8		25,737	1
2 LAUNDRY RECLASS	J					2
500 TOTAL RECLASSIFICATIONS CODE LETTER - J					25,737	500
1 PHYSICIAN RECLASS	K	PHYSICIANS' PRIVATE OFFICES	192		2,493	1
2 PHYSICIAN RECLASS	K					2
3 PHYSICIAN RECLASS	K					3
500 TOTAL RECLASSIFICATIONS CODE LETTER - K					2,493	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE				
		COST CENTER	LINE #	SALARY		OTHER
	1	2	3	4	5	
1 MISC RECLASS	L	ADMINISTRATIVE & GENERAL	5		1,204	1
2 MISC RECLASS	L	RADIOLOGY-DIAGNOSTIC	54		90,646	2
3 MISC RECLASS	L	AMBULANCE	76.01		54,071	3
4 MISC RECLASS	L					4
5 MISC RECLASS	L					5
6 MISC RECLASS	L					6
500 TOTAL RECLASSIFICATIONS					145,921	500
CODE LETTER - L						
GRAND TOTAL (INCREASES)				152,363	378,054	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 INSURANCE	A					12 1
2 INSURANCE	A					12 2
3 INSURANCE	A	ADMINISTRATIVE & GENERAL	5		22,742	3
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					22,742	500
1 MARKETING	B					1
2 MARKETING	B	ADMINISTRATIVE & GENERAL	5	32,428	1,638	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B				32,428	1,638	500
1 PHYSICIANS	C					1
2 PHYSICIANS	C					2
3 PHYSICIANS	C	ADMINISTRATIVE & GENERAL	5		13,704	3
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					13,704	500
1 SERVICE UNDER ARRANGEMENT	D					1
2 SERVICE UNDER ARRANGEMENT	D					2
3 SERVICE UNDER ARRANGEMENT	D	RADIOLOGY-DIAGNOSTIC	54		27,419	3
4 SERVICE UNDER ARRANGEMENT	D	AMBULANCE	76.01		1,738	4
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					29,157	500
1 HR RECLASS	E					1
2 HR RECLASS	E	ADMINISTRATIVE & GENERAL	5	91,705	45,534	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - E				91,705	45,534	500
1 RELATED PARTY DEACONESS	F					1
2 RELATED PARTY DEACONESS	F	HOUSEKEEPING	9		742	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					742	500
1 DAY TREATMENT	G					1
2 DAY TREATMENT	G					2
3 DAY TREATMENT	G	PHYSICAL THERAPY	66		3,556	3
500 TOTAL RECLASSIFICATIONS CODE LETTER - G					3,556	500
1 LAB RECLASS	H					1
2 LAB RECLASS	H					2
3 LAB RECLASS	H	LABORATORY	60		2,725	3
4 LAB RECLASS	H	AMBULANCE	76.01		112,208	4
500 TOTAL RECLASSIFICATIONS CODE LETTER - H					114,933	500
1 COMS RECLASS	I					1
2 COMS RECLASS	I	PHYSICAL THERAPY	66		127	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - I					127	500
1 LAUNDRY RECLASS	J					1
2 LAUNDRY RECLASS	J	HOUSEKEEPING	9	25,737		2
500 TOTAL RECLASSIFICATIONS CODE LETTER - J				25,737		500
1 PHYSICIAN RECLASS	K					1
2 PHYSICIAN RECLASS	K	ADMINISTRATIVE & GENERAL	5	320		2
3 PHYSICIAN RECLASS	K	ADULTS & PEDIATRICS	30	2,173		3
500 TOTAL RECLASSIFICATIONS CODE LETTER - K				2,493		500

PROVIDER CCN: 15-3025 HEALTHSOUTH DEACONESS REHAB  
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10  
 05/16/2012 18:08

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
	1	6	7	8	9	10
1 MISC RECLASS	L					1
2 MISC RECLASS	L					2
3 MISC RECLASS	L					3
4 MISC RECLASS	L	ADULTS & PEDIATRICS	30		54,071	4
5 MISC RECLASS	L	AMBULANCE	76.01		90,646	5
6 MISC RECLASS	L	PHYSICIANS' PRIVATE OFFICES	192		1,204	6
500 TOTAL RECLASSIFICATIONS					145,921	500
CODE LETTER - L						
GRAND TOTAL (DECREASES)				152,363	378,054	

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
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS	1,931,940	214,901		214,901		2,146,841		4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	2,021,100	100,285		100,285	222,218	1,899,167		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	3,953,040	315,186		315,186	222,218	4,046,008		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	3,953,040	315,186		315,186	222,218	4,046,008		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	135,408	774,718					910,126 1
2 CAP REL COSTS-MVBLE EQUIP	144,905	118,558					263,463 2
3 TOTAL (SUM OF LINES 1-2)	280,313	893,276					1,173,589 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	2,146,840		2,146,840	0.530607		107,749		107,749 1
2 CAP REL COSTS-MVBLE EQUIP	1,899,168		1,899,168	0.469393		95,319		95,319 2
3 TOTAL (SUM OF LINES 1-2)	4,046,008		4,046,008	1.000000		203,068		203,068 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	270,259	774,718	49,339	12,067	102,973		1,209,356 1
2 CAP REL COSTS-MVBLE EQUIP	127,774	117,133		10,675	91,094		346,676 2
3 TOTAL	398,033	891,851	49,339	22,742	194,067		1,556,032 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)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-4,574			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	405,994			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33					33
34					34
35					35
36					36
37 INTEREST	A	-7,120	INTEREST EXPENSE	113	11 37
37.03 INSURANCE	A	-67,787	EMPLOYEE BENEFITS	4	37.03
37.04 INSURANCE	A	-24,304	ADMINISTRATIVE & GENERAL	5	37.04
37.05 PROPERTY TAX	A	-4,776	CAP REL COSTS-BLDG & FIXT	1	13 37.05
37.06 PROPERTY TAX	A	-4,225	CAP REL COSTS-MVBLE EQUIP	2	13 37.06
37.07 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-173,405	ADMINISTRATIVE & GENERAL	5	37.07
37.08 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-88	OPERATION OF PLANT	7	37.08
37.09 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-48	HOUSEKEEPING	9	37.09
37.10 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-7,733	NURSING ADMINISTRATION	13	37.10
37.11 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-40	PHYSICAL THERAPY	66	37.11
37.12 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-40	MEDICAL SUPPLIES CHRGD TO PATI	71	37.12
37.13 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-46	DRUGS CHARGED TO PATIENTS	73	37.13
37.14 PATIENT TELEPHONE	A	-3,347	EMPLOYEE BENEFITS	4	37.14
37.15 PATIENT TELEPHONE	A	-25,773	ADMINISTRATIVE & GENERAL	5	37.15
37.16 PATIENT TELEVISION	A	-486	ADMINISTRATIVE & GENERAL	5	37.16
37.17 PRINTING	A	-21,515	ADMINISTRATIVE & GENERAL	5	37.17
37.18 PRINTING	A	-22	OPERATION OF PLANT	7	37.18
37.19 PRINTING	A	-48	HOUSEKEEPING	9	37.19
37.20 PRINTING	A	-31	NURSING ADMINISTRATION	13	37.20
37.21 PRINTING	A	-23	PHYSICAL THERAPY	66	37.21
37.22 LOBBYING EXPENSE	A	-72	EMPLOYEE BENEFITS	4	37.22
37.23 LOBBYING EXPENSE	A	-2,087	ADMINISTRATIVE & GENERAL	5	37.23
37.24 MISCELLANEOUS INCOME	B	-4,351	CAP REL COSTS-BLDG & FIXT	1	11 37.24
37.25 MISCELLANEOUS INCOME	B	-3,029	ADMINISTRATIVE & GENERAL	5	37.25
37.26 MISCELLANEOUS INCOME	B	-22,939	DIETARY	10	37.26

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
			COST CENTER	LINE NO.	
	1	2	3	4	5
37.27 MISCELLANEOUS INCOME	B	-57	MEDICAL RECORDS & LIBRARY	16	37.27
37.28 PATIENT TRANSPORTATION	A	-17,123	CAP REL COSTS-MVBLE EQUIP	2	9 37.28
37.29 PATIENT TRANSPORTATION	A	-9,288	EMPLOYEE BENEFITS	4	37.29
37.30 PATIENT TRANSPORTATION	A	-69,109	OPERATION OF PLANT	7	37.30
37.31 PATIENT TRANSPORTATION	A	-38,421	AMBULANCE	76.01	37.31
37.32 PROFESSIONAL FEES	A	-8,467	ADMINISTRATIVE & GENERAL	5	37.32
37.33 PHYSICIAN SUPPORT STAFF	A	455	ADMINISTRATIVE & GENERAL	5	37.33
37.34 WAYPORT WIRELESS	A	-5,095	ADMINISTRATIVE & GENERAL	5	37.34
37.35 PHYSICIAN ADJUSTMENT	A	-125	ADMINISTRATIVE & GENERAL	5	37.35
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50					50
TOTAL (SUM OF LINES 1 THRU 49)		-119,145			
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	ADMINISTRATIVE & GENERAL		1,515,609	-1,515,609	1
2	1	CAP REL COSTS-BLDG & FIXT	134,851		134,851	9
3	1	CAP REL COSTS-BLDG & FIXT	53,690		53,690	11
4	5	ADMINISTRATIVE & GENERAL	1,605,538		1,605,538	4
4.01	5	ADMINISTRATIVE & GENERAL	487,159		487,159	4.01
4.02	2	CAP REL COSTS-MVBLE EQUIP		23,341		10
4.03	4	EMPLOYEE BENEFITS	2,716,370	2,716,370		4.03
4.04	5	ADMINISTRATIVE & GENERAL	302,865	302,865		4.04
4.05	7	OPERATION OF PLANT	22,159	22,159		4.05
4.06	8	LAUNDRY & LINEN SERVICE		493		4.06
4.07	9	HOUSEKEEPING	5,817	5,817		4.07
4.08	10	DIETARY	-5,984	-5,984		4.08
4.09	13	NURSING ADMINISTRATION	1,966	1,966		4.09
4.10	16	MEDICAL RECORDS & LIBRARY	246	246		4.10
4.11	17	SOCIAL SERVICE	1,924	1,924		4.11
4.12	30	ADULTS & PEDIATRICS	6,948	6,948		4.12
4.13	54	RADIOLOGY-DIAGNOSTIC	-5,781	-5,781		4.13
4.14	60	LABORATORY	1	1		4.14
4.15	65	RESPIRATORY THERAPY	8	8		4.15
4.16	66	PHYSICAL THERAPY	3,130	3,130		4.16
4.17	67	OCCUPATIONAL THERAPY	2,052	2,052		4.17
4.18	68	SPEECH PATHOLOGY	2,318	2,318		4.18
4.19	71	MEDICAL SUPPLIES CHRGD TO PATI	-1,254	-1,254		4.19
4.20	73	DRUGS CHARGED TO PATIENTS	457,351	457,351		4.20
4.21	76	PSYCHOLOGY	160	160		4.21
4.22	76.01	AMBULANCE	-4,451	-4,451		4.22
4.23	113	INTEREST EXPENSE	7,102	7,102		4.23
4.24	192	PHYSICIANS' PRIVATE OFFICES	-75	-75		4.24
4.25	2	CAP REL COSTS-MVBLE EQUIP	150	158	-8	9
4.26	2	CAP REL COSTS-MVBLE EQUIP	525	1,950	-1,425	10
4.27	4	EMPLOYEE BENEFITS	3,522	13,076	-9,554	4.27
4.28	5	ADMINISTRATIVE & GENERAL	2,706	10,196	-7,490	4.28
4.29	7	OPERATION OF PLANT	206	764	-558	4.29
4.30	13	NURSING ADMINISTRATION	36	135	-99	4.30
4.31	17	SOCIAL SERVICE	65	240	-175	4.31
4.32	30	ADULTS & PEDIATRICS	660	967	-307	4.32
4.33	54	RADIOLOGY-DIAGNOSTIC	26,208	116,921	-90,713	4.33
4.34	54.01	RADIOLOGY SUA	2,258	10,072	-7,814	4.34
4.35	60	LABORATORY	52,214	257,974	-205,760	4.35
4.36	65	RESPIRATORY THERAPY	10,010	33,637	-23,627	4.36
4.37	66	PHYSICAL THERAPY	143	620	-477	4.37
4.38	71	MEDICAL SUPPLIES CHRGD TO PATI	273	1,091	-818	4.38
4.39	73	DRUGS CHARGED TO PATIENTS	2,861	12,031	-9,170	4.39
4.40	76	PSYCHOLOGY	2,105	3,250	-1,145	4.40
4.41	76.03	AMBULANCE SUA	143	638	-495	4.41
4.42	2	CAP REL COSTS-MVBLE EQUIP	8,470	8,470		9
4.43	66	PHYSICAL THERAPY	554	554		4.43
5		TOTALS (SUM OF LINES 1-4)	5,931,053	5,525,059	405,994	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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

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

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

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----

SYMBOL (1)	NAME (2)	PERCENT OF OWNERSHIP (3)	NAME (4)	PERCENT OF OWNERSHIP (5)	TYPE OF BUSINESS (6)	
6	B	78.00	HEALTHSOUTH CORPORATION		HEALTHCARE	6
7	B	22.00	DEACONESS		HEALTHCARE	7
8	G		HEALTHSOUTH CORPORATION		HEALTHCARE	8
9	G		MED CENTER DIRECT		MEDICAL SUPPLIES	9
10	G		MOTORIKA			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: FINANCIAL

PROVIDER CCN: 15-3025 HEALTHSOUTH DEACONESS REHAB  
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10  
 05/16/2012 18:08

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2			3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS	AGGREGATE	11,166		11,166	171,400	80	6,592	330	1
200		TOTAL		11,166		11,166		80	6,592	330	200

PROVIDER CCN: 15-3025 HEALTHSOUTH DEACONESS REHAB  
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10  
 05/16/2012 18:08

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO. 10	11	12	COLUMN 12 13	14	COLUMN 14 15	16	17	18
1 30	ADULTS & PEDIATRICS					6,592	4,574	4,574 1
200	TOTAL					6,592	4,574	4,574 200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS. 0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,209,356	1,209,356				1
2 CAP REL COSTS-MVBLE EQUIP	346,676		346,676			2
4 EMPLOYEE BENEFITS	1,767,072	3,972	1,139	1,772,183		4
5 ADMINISTRATIVE & GENERAL OPERATION OF PLANT	4,206,712	118,739	34,038	284,670	4,644,159	5
7 LAUNDRY & LINEN SERVICE	719,595	24,030	6,889	42,290	792,804	7
8 HOUSEKEEPING	44,540	13,461	3,859	4,786	66,646	8
9 DIETARY	277,411	9,788	2,806	38,334	328,339	9
10 CAFETERIA	554,245	85,917	24,629	49,980	714,771	10
11 NURSING ADMINISTRATION	305,270	10,170	2,915	55,353	373,708	11
16 MEDICAL RECORDS & LIBRARY	205,988	9,140	2,620	22,564	240,312	16
17 SOCIAL SERVICE	464,269	7,262	2,082	84,460	558,073	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,275,043	501,496	143,757	583,450	4,503,746	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	237,374	10,702	3,068		251,144	54
54.01 RADIOLOGY SUA	19,605				19,605	54.01
60 LABORATORY	49,648	897	257		50,802	60
65 RESPIRATORY THERAPY	214,709	2,559	734	32,905	250,907	65
66 PHYSICAL THERAPY	1,135,514	150,962	43,275	207,821	1,537,572	66
67 OCCUPATIONAL THERAPY	978,581	78,705	22,562	179,883	1,259,731	67
68 SPEECH PATHOLOGY	529,041	40,333	11,562	96,835	677,771	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	206,641	20,773	5,955	9,634	243,003	71
73 DRUGS CHARGED TO PATIENTS	917,939	6,647	1,906	63,876	990,368	73
76 PSYCHOLOGY	52,532	4,786	1,372	8,848	67,538	76
76.01 AMBULANCE	9,394				9,394	76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA	1,243				1,243	76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	17,728,398	1,100,339	315,425	1,765,689	17,581,636	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	2,493	108,718	31,165	464	142,840	192
194 NRCC MARKETING	34,066	299	86	6,030	40,481	194
194.01 GUEST MEALS						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	17,764,957	1,209,356	346,676	1,772,183	17,764,957	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	4,644,159					5
7 OPERATION OF PLANT	281,062	1,073,866				7
8 LAUNDRY & LINEN SERVICE	23,627	13,603	103,876			8
9 HOUSEKEEPING	116,402	9,892		454,633		9
10 DIETARY	253,398	86,827		37,581	1,092,577	10
11 CAFETERIA					163,718	11
13 NURSING ADMINISTRATION	132,486	10,278		4,449		13
16 MEDICAL RECORDS & LIBRARY	85,195	9,237		3,998		16
17 SOCIAL SERVICE	197,846	7,339		3,177		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,596,661	506,804	103,876	219,359	863,784	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	89,035	10,816		4,681		54
54.01 RADIOLOGY SUA						54.01
60 LABORATORY	18,010	907		393		60
65 RESPIRATORY THERAPY	88,951	2,586		1,119		65
66 PHYSICAL THERAPY	545,095	152,560		66,033		66
67 OCCUPATIONAL THERAPY	446,596	79,538		34,427		67
68 SPEECH PATHOLOGY	240,281	40,760		17,642		68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	86,149	20,993		9,086		71
73 DRUGS CHARGED TO PATIENTS	351,102	6,718		2,908		73
76 PSYCHOLOGY	23,943	4,837		2,094		76
76.01 AMBULANCE	3,330					76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA						76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	4,579,169	963,695	103,876	406,947	1,027,502	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	50,639	109,869		47,555		192
194 NRCC MARKETING	14,351	302		131		194
194.01 GUEST MEALS					65,075	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,644,159	1,073,866	103,876	454,633	1,092,577	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	MEDICAL RECORDS + LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	163,718					11
13 NURSING ADMINISTRATION	6,702	527,623				13
16 MEDICAL RECORDS & LIBRARY	2,732		341,474			16
17 SOCIAL SERVICE	10,226			776,661		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	70,649	527,623	112,616	776,661	9,281,779	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC			3,274		358,950	54
54.01 RADIOLOGY SUA					19,605	54.01
60 LABORATORY			7,334		77,446	60
65 RESPIRATORY THERAPY	3,984		13,047		360,594	65
66 PHYSICAL THERAPY	25,163		69,928		2,396,351	66
67 OCCUPATIONAL THERAPY	21,780		69,919		1,911,991	67
68 SPEECH PATHOLOGY	11,725		30,079		1,018,258	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,166		5,949		366,346	71
73 DRUGS CHARGED TO PATIENTS	7,734		25,687		1,384,517	73
76 PSYCHOLOGY	1,071		3,186		102,669	76
76.01 AMBULANCE			455		13,179	76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA					1,243	76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	162,932	527,623	341,474	776,661	17,292,928	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	56				350,959	192
194 NRCC MARKETING	730				55,995	194
194.01 GUEST MEALS					65,075	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	163,718	527,623	341,474	776,661	17,764,957	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	I&R COST &	TOTAL	
	POST STEP- DOWN ADJS		
	25	26	
GENERAL SERVICE COST CENTERS			
1			1
2			2
4			4
5			5
7			7
8			8
9			9
10			10
11			11
13			13
16			16
17			17
INPATIENT ROUTINE SERV COST CENTERS			
30		9,281,779	30
ADULTS & PEDIATRICS			
ANCILLARY SERVICE COST CENTERS			
54		358,950	54
54.01		19,605	54.01
60		77,446	60
65		360,594	65
66		2,396,351	66
67		1,911,991	67
68		1,018,258	68
71		366,346	71
73		1,384,517	73
76		102,669	76
76.01		13,179	76.01
76.02			76.02
76.03		1,243	76.03
OUTPATIENT SERVICE COST CENTERS			
92			92
OBSERVATION BEDS			
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
113			113
118		17,292,928	118
INTEREST EXPENSE			
SUBTOTALS (SUM OF LINES 1-117)			
NONREIMBURSABLE COST CENTERS			
192		350,959	192
194		55,995	194
194.01		65,075	194.01
200			200
201			201
202		17,764,957	202
TOTAL (SUM OF LINES 118-201)			

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		3,972	1,139	5,111	5,111	4
5 ADMINISTRATIVE & GENERAL		118,739	34,038	152,777	821	5
7 OPERATION OF PLANT		24,030	6,889	30,919	122	7
8 LAUNDRY & LINEN SERVICE		13,461	3,859	17,320	14	8
9 HOUSEKEEPING		9,788	2,806	12,594	110	9
10 DIETARY		85,917	24,629	110,546	144	10
11 CAFETERIA						11
13 NURSING ADMINISTRATION		10,170	2,915	13,085	160	13
16 MEDICAL RECORDS & LIBRARY		9,140	2,620	11,760	65	16
17 SOCIAL SERVICE		7,262	2,082	9,344	243	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		501,496	143,757	645,253	1,685	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC		10,702	3,068	13,770		54
54.01 RADIOLOGY SUA						54.01
60 LABORATORY		897	257	1,154		60
65 RESPIRATORY THERAPY		2,559	734	3,293	95	65
66 PHYSICAL THERAPY		150,962	43,275	194,237	599	66
67 OCCUPATIONAL THERAPY		78,705	22,562	101,267	518	67
68 SPEECH PATHOLOGY		40,333	11,562	51,895	279	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		20,773	5,955	26,728	28	71
73 DRUGS CHARGED TO PATIENTS		6,647	1,906	8,553	184	73
76 PSYCHOLOGY		4,786	1,372	6,158	26	76
76.01 AMBULANCE						76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA						76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		1,100,339	315,425	1,415,764	5,093	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		108,718	31,165	139,883	1	192
194 NRCC MARKETING		299	86	385	17	194
194.01 GUEST MEALS						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		1,209,356	346,676	1,556,032	5,111	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION		ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY + LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	153,598					5
7	OPERATION OF PLANT	9,296	40,337				7
8	LAUNDRY & LINEN SERVICE	781	511	18,626			8
9	HOUSEKEEPING	3,850	372		16,926		9
10	DIETARY	8,381	3,261		1,399	123,731	10
11	CAFETERIA					18,541	11
13	NURSING ADMINISTRATION	4,382	386		166		13
16	MEDICAL RECORDS & LIBRARY	2,818	347		149		16
17	SOCIAL SERVICE	6,543	276		118		17
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	52,806	19,036	18,626	8,167	97,821	30
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	2,945	406		174		54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY	596	34		15		60
65	RESPIRATORY THERAPY	2,942	97		42		65
66	PHYSICAL THERAPY	18,028	5,731		2,458		66
67	OCCUPATIONAL THERAPY	14,770	2,988		1,282		67
68	SPEECH PATHOLOGY	7,947	1,531		657		68
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	2,849	789		338		71
73	DRUGS CHARGED TO PATIENTS	11,612	252		108		73
76	PSYCHOLOGY	792	182		78		76
76.01	AMBULANCE	110					76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA						76.03
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	151,448	36,199	18,626	15,151	116,362	118
NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	1,675	4,127		1,770		192
194	NRCC MARKETING	475	11		5		194
194.01	GUEST MEALS					7,369	194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	153,598	40,337	18,626	16,926	123,731	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	MEDICAL RECORDS + LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	18,541					11
13 NURSING ADMINISTRATION	759	18,938				13
16 MEDICAL RECORDS & LIBRARY	309		15,448			16
17 SOCIAL SERVICE	1,158			17,682		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	8,001	18,938	5,095	17,682	893,110	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC			148		17,443	54
54.01 RADIOLOGY SUA						54.01
60 LABORATORY			332		2,131	60
65 RESPIRATORY THERAPY	451		590		7,510	65
66 PHYSICAL THERAPY	2,850		3,163		227,066	66
67 OCCUPATIONAL THERAPY	2,467		3,163		126,455	67
68 SPEECH PATHOLOGY	1,328		1,361		64,998	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	132		269		31,133	71
73 DRUGS CHARGED TO PATIENTS	876		1,162		22,747	73
76 PSYCHOLOGY	121		144		7,501	76
76.01 AMBULANCE			21		131	76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA						76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	18,452	18,938	15,448	17,682	1,400,225	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES					147,462	192
194 NRCC MARKETING	83				976	194
194.01 GUEST MEALS					7,369	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	18,541	18,938	15,448	17,682	1,556,032	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	I&R COST &	TOTAL	
	POST STEP- DOWN ADJS 25		
GENERAL SERVICE COST CENTERS			
1			1
2			2
4			4
5			5
7			7
8			8
9			9
10			10
11			11
13			13
16			16
17			17
INPATIENT ROUTINE SERV COST CENTERS			
30		893,110	30
ADULTS & PEDIATRICS			
ANCILLARY SERVICE COST CENTERS			
54		17,443	54
54.01			54.01
60		2,131	60
65		7,510	65
66		227,066	66
67		126,455	67
68		64,998	68
71		31,133	71
73		22,747	73
76		7,501	76
76.01		131	76.01
76.02			76.02
76.03			76.03
OUTPATIENT SERVICE COST CENTERS			
92			92
OBSERVATION BEDS			
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
113			113
118		1,400,225	118
INTEREST EXPENSE			
SUBTOTALS (SUM OF LINES 1-117)			
NONREIMBURSABLE COST CENTERS			
192		147,462	192
194		976	194
194.01		7,369	194.01
200			200
201			201
202		1,556,032	202
TOTAL (SUM OF LINES 118-201)			

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS  GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	72,772					1
2 CAP REL COSTS-MVBLE EQUIP		72,772				2
4 EMPLOYEE BENEFITS	239	239	9,529,975			4
5 ADMINISTRATIVE & GENERAL	7,145	7,145	1,530,822	-4,644,159	13,099,950	5
7 OPERATION OF PLANT	1,446	1,446	227,417		792,804	7
8 LAUNDRY & LINEN SERVICE	810	810	25,737		66,646	8
9 HOUSEKEEPING	589	589	206,144		328,339	9
10 DIETARY	5,170	5,170	268,767		714,771	10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	612	612	297,661		373,708	13
16 MEDICAL RECORDS & LIBRARY	550	550	121,338		240,312	16
17 SOCIAL SERVICE	437	437	454,187		558,073	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	30,177	30,177	3,137,538		4,503,746	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	644	644			251,144	54
54.01 RADIOLOGY SUA				-19,605		54.01
60 LABORATORY	54	54			50,802	60
65 RESPIRATORY THERAPY	154	154	176,945		250,907	65
66 PHYSICAL THERAPY	9,084	9,084	1,117,562		1,537,572	66
67 OCCUPATIONAL THERAPY	4,736	4,736	967,326		1,259,731	67
68 SPEECH PATHOLOGY	2,427	2,427	520,732		677,771	68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	-1,250	1,250	51,806		243,003	71
73 DRUGS CHARGED TO PATIENTS	400	400	343,494		990,368	73
76 PSYCHOLOGY	288	288	47,578		67,538	76
76.01 AMBULANCE					9,394	76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA				-1,243		76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	66,212	66,212	9,495,054	-4,665,007	12,916,629	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	6,542	6,542	2,493		142,840	192
194 NRCC MARKETING	18	18	32,428		40,481	194
194.01 GUEST MEALS						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,209,356	346,676	1,772,183		4,644,159	202
203 UNIT COST MULT-WS B PT I	16.618425	4.763865	0.185959		0.354517	203
204 COST TO BE ALLOC PER B PT II			5,111		153,598	204
205 UNIT COST MULT-WS B PT II			0.000536		0.011725	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	+ LINEN	KEEPING			
	SQUARE	SERVICE	SQUARE	MEALS	GROSS	
	FEET	PATIENT	FEET	SERVED	SALARIES	
	7	DAYS	9	10	11	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5						5
7	63,942					7
8	810	21,915				8
9	589		62,543			9
10	5,170		5,170	83,159		10
11				12,461	7,271,088	11
13	612		612		297,661	13
16	550		550		121,338	16
17	437		437		454,187	17
INPATIENT ROUTINE SERV COST CENTERS						
30	30,177	21,915	30,177	65,745	3,137,538	30
ANCILLARY SERVICE COST CENTERS						
54	644		644			54
54.01						54.01
60	54		54			60
65	154		154		176,945	65
66	9,084		9,084		1,117,562	66
67	4,736		4,736		967,326	67
68	2,427		2,427		520,732	68
71	1,250		1,250		51,806	71
73	400		400		343,494	73
76	288		288		47,578	76
76.01						76.01
76.02						76.02
76.03						76.03
OUTPATIENT SERVICE COST CENTERS						
92						92
OBSERVATION BEDS						
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118	57,382	21,915	55,983	78,206	7,236,167	118
SUBTOTALS (SUM OF LINES 1-117)						
NONREIMBURSABLE COST CENTERS						
192	6,542		6,542		2,493	192
194	18		18		32,428	194
194.01				4,953		194.01
GUEST MEALS						
CROSS FOOT ADJUSTMENTS						
200						200
201						201
202	1,073,866	103,876	454,633	1,092,577	163,718	202
203	16,794,376	4,739,950	7,269,127	13,138,410	0.022516	203
204	40,337	18,626	16,926	123,731	18,541	204
205	0.630837	0.849920	0.270630	1.487885	0.002550	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NURSING ADMINIS- TRATION PATIENT DAYS 13	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	SOCIAL SERVICE PATIENT DAYS 17	
GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT				1
2	CAP REL COSTS-MVBLE EQUIP				2
4	EMPLOYEE BENEFITS				4
5	ADMINISTRATIVE & GENERAL				5
7	OPERATION OF PLANT				7
8	LAUNDRY & LINEN SERVICE				8
9	HOUSEKEEPING				9
10	DIETARY				10
11	CAFETERIA				11
13	NURSING ADMINISTRATION	21,915			13
16	MEDICAL RECORDS & LIBRARY		50,647,889		16
17	SOCIAL SERVICE			21,915	17
INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	21,915	16,702,759	21,915	30
ANCILLARY SERVICE COST CENTERS					
54	RADIOLOGY-DIAGNOSTIC		485,657		54
54.01	RADIOLOGY SUA				54.01
60	LABORATORY		1,087,777		60
65	RESPIRATORY THERAPY		1,935,125		65
66	PHYSICAL THERAPY		10,372,062		66
67	OCCUPATIONAL THERAPY		10,370,646		67
68	SPEECH PATHOLOGY		4,461,436		68
71	MEDICAL SUPPLIES CHRGD TO PATIENTS		882,426		71
73	DRUGS CHARGED TO PATIENTS		3,809,948		73
76	PSYCHOLOGY		472,504		76
76.01	AMBULANCE		67,549		76.01
76.02	DAY TREATMENT				76.02
76.03	AMBULANCE SUA				76.03
OUTPATIENT SERVICE COST CENTERS					
92	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	21,915	50,647,889	21,915	118
NONREIMBURSABLE COST CENTERS					
192	PHYSICIANS' PRIVATE OFFICES				192
194	NRCC MARKETING				194
194.01	GUEST MEALS				194.01
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	COST TO BE ALLOC PER B PT I	527,623	341,474	776,661	202
203	UNIT COST MULT-WS B PT I	24.075884	0.006742	35.439699	203
204	COST TO BE ALLOC PER B PT II	18,938	15,448	17,682	204
205	UNIT COST MULT-WS B PT II	0.864157	0.000305	0.806845	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	9,281,779		9,281,779	4,574	9,286,353	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	358,950		358,950		358,950	54
54.01 RADIOLOGY SUA	19,605		19,605		19,605	54.01
60 LABORATORY	77,446		77,446		77,446	60
65 RESPIRATORY THERAPY	360,594		360,594		360,594	65
66 PHYSICAL THERAPY	2,396,351		2,396,351		2,396,351	66
67 OCCUPATIONAL THERAPY	1,911,991		1,911,991		1,911,991	67
68 SPEECH PATHOLOGY	1,018,258		1,018,258		1,018,258	68
71 MEDICAL SUPPLIES CHRGD TO	366,346		366,346		366,346	71
73 DRUGS CHARGED TO PATIENTS	1,384,517		1,384,517		1,384,517	73
76 PSYCHOLOGY	102,669		102,669		102,669	76
76.01 AMBULANCE	13,179		13,179		13,179	76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA	1,243		1,243		1,243	76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	17,292,928		17,292,928	4,574	17,297,502	200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	17,292,928		17,292,928		17,297,502	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			
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	16,702,760		16,702,760			30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	700,768	1,928	702,696	0.510818	0.510818	0.510818 54
54.01 RADIOLOGY SUA	59,414		59,414	0.329973	0.329973	0.329973 54.01
60 LABORATORY	1,087,423	354	1,087,777	0.071197	0.071197	0.071197 60
65 RESPIRATORY THERAPY	1,935,125		1,935,125	0.186341	0.186341	0.186341 65
66 PHYSICAL THERAPY	8,740,194	1,631,868	10,372,062	0.231039	0.231039	0.231039 66
67 OCCUPATIONAL THERAPY	9,345,672	1,024,974	10,370,646	0.184366	0.184366	0.184366 67
68 SPEECH PATHOLOGY	3,229,625	1,231,811	4,461,436	0.228235	0.228235	0.228235 68
71 MEDICAL SUPPLIES CHRGD TO	871,612	10,814	882,426	0.415158	0.415158	0.415158 71
73 DRUGS CHARGED TO PATIENTS	3,808,433	1,515	3,809,948	0.363395	0.363395	0.363395 73
76 PSYCHOLOGY	470,804	1,700	472,504	0.217287	0.217287	0.217287 76
76.01 AMBULANCE	64,292		64,292	0.204987	0.204987	0.204987 76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA	3,765		3,765	0.330146	0.330146	0.330146 76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	47,019,887	3,904,964	50,924,851			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	47,019,887	3,904,964	50,924,851			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM (COL.3 + COL.4)	INPAT PGM DAYS	INPAT FGM CAP COST (COL.5 x COL.6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)					
	1	2	3					
	4	5	6	7				
30 INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	893,110		893,110	21,915	40.75	14,595	594,746	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	893,110		893,110	21,915		14,595	594,746	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (15-3025) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF

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						
54 RADIOLOGY-DIAGNOSTIC	17,443	702,696	0.024823	489,858	12,160	54
54.01 RADIOLOGY SUA		59,414	59,414	57,200		54.01
60 LABORATORY	2,131	1,087,777	0.001959	738,147	1,446	60
65 RESPIRATORY THERAPY	7,510	1,935,125	0.003881	1,471,750	5,712	65
66 PHYSICAL THERAPY	227,066	10,372,062	0.021892	5,782,871	126,599	66
67 OCCUPATIONAL THERAPY	126,455	10,370,646	0.012194	6,237,925	76,065	67
68 SPEECH PATHOLOGY	64,998	4,461,436	0.014569	2,086,399	30,397	68
71 MEDICAL SUPPLIES CHRGD TO PA	31,133	882,426	0.035281	489,237	17,261	71
73 DRUGS CHARGED TO PATIENTS	22,747	3,809,948	0.005970	2,653,449	15,841	73
76 PSYCHOLOGY	7,501	472,504	0.015875	301,326	4,784	76
76.01 AMBULANCE	131	64,292	0.002038	28,920	59	76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA		3,765	3,765	3,483		76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	507,115	34,222,091	34,222,091	20,340,565	290,324	200

PROVIDER CCN: 15-3025 HEALTHSOUTH DEACONESS REHAB  
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10  
 05/16/2012 18:08

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

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

PROVIDER CCN: 15-3025 HEALTHSOUTH DEACONESS REHAB  
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10  
 05/16/2012 18:08

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
30 INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	21,915		14,595	30
31 INTENSIVE CARE UNIT				31
32 CORONARY CARE UNIT				32
33 BURN INTENSIVE CARE UNIT				33
34 SURGICAL INTENSIVE CARE UNIT				34
35 OTHER SPECIAL CARE (SPECIFY)				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF				41
42 SUBPROVIDER I				42
43 NURSERY				43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	21,915		14,595	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK  TITLE V  HOSPITAL (15-3025)  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII-PT A  IPF  SNF  TEFRA  
 BOXES  TITLE XIX  IRF  NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1				SCHOOL 2	HEALTH 3
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
54.01 RADIOLOGY SUA						54.01
60 LABORATORY						60
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
76 PSYCHOLOGY						76
76.01 AMBULANCE						76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA						76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	(XX) HOSPITAL (15-3025) [ ] IPF [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] NF	[ ] ICF/MR	[XX] PPS [ ] TEPRA		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 + COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 + COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	702,696			489,858	1,723	54
54.01	RADIOLOGY SUA	59,414			57,200		54.01
60	LABORATORY	1,087,777			738,147		60
65	RESPIRATORY THERAPY	1,935,125			1,471,750		65
66	PHYSICAL THERAPY	10,372,062			5,782,871		66
67	OCCUPATIONAL THERAPY	10,370,646			6,237,925		67
68	SPEECH PATHOLOGY	4,461,436			2,086,399	391	68
71	MEDICAL SUPPLIES CHRGED TO P	882,426			489,237	463	71
73	DRUGS CHARGED TO PATIENTS	3,809,948			2,653,449	1,507	73
76	PSYCHOLOGY	472,504			301,326	1,344	76
76.01	AMBULANCE	64,292			28,920		76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA	3,765			3,483		76.03
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	34,222,091			20,340,565	5,428	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (15-3025) [ ] 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 CHARGE RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCS NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES SUBJECT TO DED & COINS	COST SVCS NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
54 RADIOLOGY-DIAGNOSTIC	0.510818	1,723			880		54
54.01 RADIOLOGY SUA	0.329973						54.01
60 LABORATORY	0.071197						60
65 RESPIRATORY THERAPY	0.186341						65
66 PHYSICAL THERAPY	0.231039						66
67 OCCUPATIONAL THERAPY	0.184366						67
68 SPEECH PATHOLOGY	0.228235	391			89		68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.415158	463			192		71
73 DRUGS CHARGED TO PATIENTS	0.363395	1,507			548		73
76 PSYCHOLOGY	0.217287	1,344			292		76
76.01 AMBULANCE	0.204987						76.01
76.02 DAY TREATMENT							76.02
76.03 AMBULANCE SUA	0.330146						76.03
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)		5,428			2,001		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		5,428			2,001		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) 1	SWING-BED ADJUSTMENT 2	(COL.1 MINUS COL.2) 3	(COL.3 + COL.4) 5	PGM DAYS 6	(COL.5 x COL.6) 7
30 INPAT ROUTINE SERV COST CTRS						
30 ADULTS & PEDIATRICS	893,110		21,915	40.75	888	36,186
31 INTENSIVE CARE UNIT						31
32 CORONARY CARE UNIT						32
33 BURN INTENSIVE CARE UNIT						33
34 SURGICAL INTENSIVE CARE UNIT						34
35 OTHER SPECIAL CARE (SPECIFY)						35
40 SUBPROVIDER - IPF						40
41 SUBPROVIDER - IRF						41
42 SUBPROVIDER I						42
43 NURSERY						43
44 SKILLED NURSING FACILITY						44
45 NURSING FACILITY						45
200 TOTAL (LINES 30-199)	893,110		21,915		888	36,186

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 (15-3025) [ ] IPF [ ] IRF	[ ] SUB (OTHER)	[ ] PPS [ ] TEFRA [XX] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	17,443	702,696	0.024823	46,191	1,147	54
54.01	RADIOLOGY SUA		59,414	59,414			54.01
60	LABORATORY	2,131	1,087,777	0.001959	46,474	91	60
65	RESPIRATORY THERAPY	7,510	1,935,125	0.003881	60,586	235	65
66	PHYSICAL THERAPY	227,066	10,372,062	0.021892	376,985	8,253	66
67	OCCUPATIONAL THERAPY	126,455	10,370,646	0.012194	476,991	5,816	67
68	SPEECH PATHOLOGY	64,998	4,461,436	0.014569	208,246	3,034	68
71	MEDICAL SUPPLIES CHRGD TO PA	31,133	882,426	0.035281	39,201	1,383	71
73	DRUGS CHARGED TO PATIENTS	22,747	3,809,948	0.005970	156,535	935	73
76	PSYCHOLOGY	7,501	472,504	0.015875	23,877	379	76
76.01	AMBULANCE	131	64,292	0.002038	3,700	8	76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA		3,765	3,765			76.03
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	507,115	34,222,091	34,222,091	1,438,786	21,281	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

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

PROVIDER CCN: 15-3025 HEALTHSOUTH DEACONESS REHAB  
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10  
 05/16/2012 18:08

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	21,915		888	
31	INTENSIVE CARE UNIT				30
32	CORONARY CARE UNIT				31
33	BURN INTENSIVE CARE UNIT				32
34	SURGICAL INTENSIVE CARE UNIT				33
35	OTHER SPECIAL CARE (SPECIFY)				34
40	SUBPROVIDER - IPF				35
41	SUBPROVIDER - IRF				40
42	SUBPROVIDER I				41
43	NURSERY				42
44	SKILLED NURSING FACILITY				43
45	NURSING FACILITY				44
200	TOTAL (SUM OF LINES 30-199)	21,915		888	45
					200

PROVIDER CCN: 15-3025 HEALTHSOUTH DEACONESS REHAB  
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10  
 05/16/2012 18:08

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK  TITLE V  HOSPITAL (15-3025)  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII-PT A  IPF  SNF  TEFRA  
 BOXES  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						
54 RADIOLOGY-DIAGNOSTIC						54
54.01 RADIOLOGY SUA						54.01
60 LABORATORY						60
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
76 PSYCHOLOGY						76
76.01 AMBULANCE						76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA						76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (15-3025) [ ] IPF [ ] IRF	[ ] SUB (OTHER) [ ] SNF [ ] NF	[ ] ICF/MR	[ ] PPS [ ] TEFRA [XX] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 + COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 + COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	702,696			46,191		54
54.01	RADIOLOGY SUA	59,414					54.01
60	LABORATORY	1,087,777			46,474		60
65	RESPIRATORY THERAPY	1,935,125			60,586		65
66	PHYSICAL THERAPY	10,372,062			376,985		66
67	OCCUPATIONAL THERAPY	10,370,646			476,991		67
68	SPEECH PATHOLOGY	4,461,436			208,246		68
71	MEDICAL SUPPLIES CHRGED TO P	882,426			39,201		71
73	DRUGS CHARGED TO PATIENTS	3,809,948			156,535		73
76	PSYCHOLOGY	472,504			23,877		76
76.01	AMBULANCE	64,292			3,700		76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA	3,765					76.03
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	34,222,091			1,438,786		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (15-3025) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [ ] TITLE XVIII-PT B [ ] IPP [ ] SNF [ ] S/B-NF  
 BOXES [XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	0.510818		205		105	54
54.01 RADIOLOGY SUA	0.329973					54.01
60 LABORATORY	0.071197		50		4	60
65 RESPIRATORY THERAPY	0.186341					65
66 PHYSICAL THERAPY	0.231039		111,888		25,850	66
67 OCCUPATIONAL THERAPY	0.184366		81,220		14,974	67
68 SPEECH PATHOLOGY	0.228235		74,290		16,956	68
71 MEDICAL SUPPLIES CHRGED TO PATI	0.415158		1,070		444	71
73 DRUGS CHARGED TO PATIENTS	0.363395		8		3	73
76 PSYCHOLOGY	0.217287					76
76.01 AMBULANCE	0.204987					76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA	0.330146					76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)			268,731		58,336	200
201 LESS PBP CLINIC LAB SERVICES						201
202 NET CHARGES (LINE 200 - LINE 201)			268,731		58,336	202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (15-3025) [ ] 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)	21,915	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	21,915	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,922	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	19,993	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)	14,595	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	1,233	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)	9,286,353	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	9,286,353	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	16,702,759	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,499,160	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	15,203,599	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.555977	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	780.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	760.45	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	19.55	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	10.87	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	20,892	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	9,265,461	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK ( ) TITLE V-INPT [XX] HOSPITAL (15-3025) ( ) 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) 423.74 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 6,184,485 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) 6,184,485 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 + COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					4,798,135	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					10,982,620	49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 594,746 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 290,324 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 885,070 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 10,097,550 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 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 COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE B 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 INSTRU (TITLE XVIII ONLY) 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (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) 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 423.74 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (15-3025) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	21,915	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	21,915	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,922	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	19,993	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)	888	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)	9,281,779	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	9,281,779	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	16,702,759	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,499,160	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	15,203,599	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.555703	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	780.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	760.45	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	19.55	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	10.86	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	20,873	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	9,260,906	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (15-3025) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 422,58 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 375,251 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) 375,251 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 + COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					339,867 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					715,118 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 36,186 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 21,281 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 57,467 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 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 INSTRU (TITLE XVIII ONLY) 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (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) 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (15-3025) [ ] 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
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		11,113,058		30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	0.510818	489,858	250,228	54
54.01 RADIOLOGY SUA	0.329973	57,200	18,874	54.01
60 LABORATORY	0.071197	738,147	52,554	60
65 RESPIRATORY THERAPY	0.186341	1,471,750	274,247	65
66 PHYSICAL THERAPY	0.231039	5,782,871	1,336,069	66
67 OCCUPATIONAL THERAPY	0.184366	6,237,925	1,150,061	67
68 SPEECH PATHOLOGY	0.228235	2,086,399	476,189	68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.415158	489,237	203,111	71
73 DRUGS CHARGED TO PATIENTS	0.363395	2,653,449	964,250	73
76 PSYCHOLOGY	0.217287	301,326	65,474	76
76.01 AMBULANCE	0.204987	28,920	5,928	76.01
76.02 DAY TREATMENT				76.02
76.03 AMBULANCE SUA	0.330146	3,483	1,150	76.03
92 OUTPATIENT SERVICE COST CENTERS				
OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		20,340,565	4,798,135	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		20,340,565		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK  TITLE V  HOSPITAL (15-3025)  SUB (OTHER)  S/B SNF  PPS  
 APPLICABLE  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		744,340		30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	0.510818	46,191	23,595	54
54.01 RADIOLOGY SUA	0.329973			54.01
60 LABORATORY	0.071197	46,474	3,309	60
65 RESPIRATORY THERAPY	0.186341	60,586	11,290	65
66 PHYSICAL THERAPY	0.231039	376,985	87,098	66
67 OCCUPATIONAL THERAPY	0.184366	476,991	87,941	67
68 SPEECH PATHOLOGY	0.228235	208,246	47,529	68
71 MEDICAL SUPPLIES CHRGED TO PATI	0.415158	39,201	16,275	71
73 DRUGS CHARGED TO PATIENTS	0.363395	156,535	56,884	73
76 PSYCHOLOGY	0.217287	23,877	5,188	76
76.01 AMBULANCE	0.204987	3,700	758	76.01
76.02 DAY TREATMENT				76.02
76.03 AMBULANCE SUA	0.330146			76.03
OUTPATIENT SERVICE COST CENTERS				
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,438,786	339,867	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,438,786		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART B

CHECK APPLICABLE BOX:         HOSPITAL (15-3025)         IPF         IRF  
                                  SUB (OTHER)                     SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)	2,001	2
3	PPS PAYMENTS	1,496	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 \$2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)	1,496	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	376	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL ((LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23) (SEE INSTRUCTIONS)	1,120	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)	1,120	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	1,120	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	1,120	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	1,120	40
41	INTERIM PAYMENTS	1,120	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK APPLICABLE BOX:	{XX} HOSPITAL (15-3025)	{ } IPF	{ } IRF	{ } SUB (OTHER)	{ } SNF	{ } SWING BED SNF	INPATIENT		PART B		
							MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
DESCRIPTION							1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER							16,123,763		1,120	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.										
					PROGRAM	.01		NONE		NONE	3.01
					TO	.02					3.02
					PROVIDER	.03					3.03
					TO	.04					3.04
					PROVIDER	.05					3.05
						.06					3.06
						.07					3.07
						.08					3.08
						.09					3.09
						.50		NONE		NONE	3.50
						.51					3.51
					PROVIDER	.52					3.52
					TO	.53					3.53
					PROGRAM	.54					3.54
						.55					3.55
						.56					3.56
						.57					3.57
						.58					3.58
						.59					3.59
						.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)							16,123,763		1,120	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						
					TO						
					PROGRAM						
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)										7

8 NAME OF CONTRACTOR: \_\_\_\_\_ CONTRACTOR NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART III

CHECK (XX) HOSPITAL (15-3025)  
 APPLICABLE BOX: [ ] IRF

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	16,021,105	1
2	MEDICARE SSI RATIO (SEE INSTRUCTIONS)	0.038000	2
3	INPATIENT REHABILITATION LIP PAYMENTS (SEE INSTRUCTIONS)	743,556	3
4	OUTLIER PAYMENTS	3,291	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
6	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM (SEE INSTRUCTIONS)		7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS 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)	60.041096	10
11	MEDICAL EDUCATION ADJUSTMENT FACTOR ((1 + (LINE 9/LINE 10)) 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)	16,767,952	13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (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)	16,767,952	17
18	PRIMARY PAYER PAYMENTS	3,176	18
19	SUBTOTAL LINE 17b LESS LINE 18)	16,764,776	19
20	DEDUCTIBLES	330,878	20
21	SUBTOTAL (LINE 19 MINUS LINE 20)	16,433,898	21
22	COINSURANCE	219,237	22
23	SUBTOTAL (LINE 21 MINUS LINE 22)	16,214,661	23
24	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	88,437	24
25	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	61,906	25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	82,963	26
27	SUBTOTAL (SUM OF LINES 23 AND 25)	16,276,567	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		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)	16,276,567	32
33	INTERIM PAYMENTS	16,123,763	33
34	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		34
35	BALANCE DUE PROVIDER/PROGRAM (LINE 32 MINUS THE SUM OF LINES 33 AND 34)	152,804	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 (15-3025) [ ] SNF [ ] PPS  
 APPLICABLE [XX] TITLE XIX [ ] IPF [ ] NF [ ] TEFRA  
 BOXES: [ ] IRF [ ] ICF/MR [XX] OTHER  
 [ ] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	715,118	1
2	MEDICAL AND OTHER SERVICES	58,336	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	773,454	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	773,454	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	744,340	8
9	ANCILLARY SERVICE CHARGES	1,707,517	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)	2,451,857	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	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	2,451,857	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	1,678,403	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)	773,454	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	773,454	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)	773,454	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)	773,454	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)	773,454	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)	773,454	40
41	INTERIM PAYMENTS	658,555	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	114,899	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
<b>CURRENT ASSETS</b>					
1	CASH ON HAND AND IN BANKS	2,835,720			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	4,579,406			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,438,620			6
7	INVENTORY	30,223			7
8	PREPAID EXPENSES	28,213			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	6,034,942			11
<b>FIXED ASSETS</b>					
12	LAND				12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION BUILDINGS				14
15	ACCUMULATED DEPRECIATION LEASEHOLD IMPROVEMENTS	2,146,841			15
16	ACCUMULATED AMORTIZATION FIXED EQUIPMENT	-1,685,426			16
17	ACCUMULATED DEPRECIATION AUTOMOBILES AND TRUCKS				17
18	ACCUMULATED DEPRECIATION MAJOR MOVABLE EQUIPMENT	1,899,168			18
19	ACCUMULATED DEPRECIATION MINOR EQUIPMENT DEPRECIABLE	-1,389,596			19
20	ACCUMULATED DEPRECIATION HIT DESIGNATED ASSETS				20
21	ACCUMULATED DEPRECIATION MINOR EQUIPMENT-NONDEPRECIABLE				21
22	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	970,987			22
<b>OTHER ASSETS</b>					
23	INVESTMENTS				23
24	DEPOSITS ON LEASES				24
25	DUE FROM OWNERS/OFFICERS				25
26	OTHER ASSETS	12,307,840			26
27	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	12,307,840			27
28	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	19,313,769			28
<b>LIABILITIES AND FUND BALANCES</b>					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
<b>CURRENT LIABILITIES</b>					
29	ACCOUNTS PAYABLE	276,622			29
30	SALARIES, WAGES & FEES PAYABLE	559,140			30
31	PAYROLL TAXES PAYABLE				31
32	NOTES & LOANS PAYABLE (SHORT TERM)				32
33	DEFERRED INCOME				33
34	ACCELERATED PAYMENTS				34
35	DUE TO OTHER FUNDS				35
36	OTHER CURRENT LIABILITIES	1,977,943			36
37	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,813,705			37
<b>LONG-TERM LIABILITIES</b>					
38	MORTGAGE PAYABLE				38
39	NOTES PAYABLE				39
40	UNSECURED LOANS				40
41	OTHER LONG TERM LIABILITIES	3,806,184			41
42	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	3,806,184			42
43	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	6,619,889			43
<b>CAPITAL ACCOUNTS</b>					
44	GENERAL FUND BALANCE	12,693,880			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES (SUM OF LINES 52-58)	12,693,880			51
52	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	19,313,769			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		12,997,569							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		7,514,698							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		20,512,267							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		20,512,267							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 MINORITY INTEREST		1,653,233							13
14 DISTRIBUTIONS		6,165,154							14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		7,818,387							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		12,693,880							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	16,702,759		16,702,759	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				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)	16,702,759		16,702,759	
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	16,702,759		16,702,759	17
18 ANCILLARY SERVICES	30,317,338		30,317,338	18
19 OUTPATIENT SERVICES		3,904,751	3,904,751	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				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)	47,020,097	3,904,751	50,924,848	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		17,884,102	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 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)		17,884,102	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	50,924,848	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	25,664,701	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	25,260,147	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	17,884,102	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	7,376,045	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	14,505	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	11	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		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		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	78,711	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER INCOME)	46,008	24
24.01	OTHER (LOSS ON SALE OF FIXED ASSETS)	-582	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	138,653	25
26	TOTAL (LINE 5 PLUS LINE 25)	7,514,698	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	7,514,698	29

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		---- TITLE XIX ----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	66.60		4.05				70.65 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	69.71	0.25	6.57	0.03			76.56 54
54.01 RADIOLOGY SUA	96.27						96.27 54.01
60 LABORATORY	67.86		4.27				72.13 60
65 RESPIRATORY THERAPY	76.05		3.13				79.18 65
66 PHYSICAL THERAPY	55.75		3.63	1.08			60.46 66
67 OCCUPATIONAL THERAPY	60.15		4.60	0.78			65.53 67
68 SPEECH PATHOLOGY	46.77	0.01	4.67	1.67			53.12 68
71 MEDICAL SUPPLIES CHRGED TO PATI	55.44	0.05	4.44	0.12			60.05 71
73 DRUGS CHARGED TO PATIENTS	69.65	0.04	4.11				73.80 73
76 PSYCHOLOGY	63.77	0.28	5.05				69.10 76
76.01 AMBULANCE	44.98		5.75				50.73 76.01
76.03 AMBULANCE SUA	92.51						92.51 76.03
200 TOTAL CHARGES	59.44	0.02	4.20	0.79			64.45 200

	COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,209,356	6.81	-1,209,356	-11.97			1
2	CAP REL COSTS-MVBLE EQUIP	346,676	1.95	-346,676	-3.43			2
3	OTHER CAPITAL RELATED COSTS							3
4	EMPLOYEE BENEFITS	1,767,072	9.95	-1,767,072	-17.49			4
5	ADMINISTRATIVE & GENERAL	4,206,712	23.68	-4,206,712	-41.65			5
7	OPERATION OF PLANT	719,595	4.05	-719,595	-7.12			7
8	LAUNDRY & LINEN SERVICE	44,540	0.25	-44,540	-0.44			8
9	HOUSEKEEPING	277,411	1.56	-277,411	-2.75			9
10	DIETARY	554,245	3.12	-554,245	-5.49			10
11	CAFETERIA							11
13	NURSING ADMINISTRATION	305,270	1.72	-305,270	-3.02			13
16	MEDICAL RECORDS & LIBRARY	205,988	1.16	-205,988	-2.04			16
17	SOCIAL SERVICE	464,269	2.61	-464,269	-4.60			17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,275,043	18.44	6,006,736	59.47	9,281,779	52.25	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	237,374	1.34	121,576	1.20	358,950	2.02	54
54.01	RADIOLOGY SUA	19,605	0.11			19,605	0.11	54.01
60	LABORATORY	49,648	0.28	27,798	0.28	77,446	0.44	60
65	RESPIRATORY THERAPY	214,709	1.21	145,885	1.44	360,594	2.03	65
66	PHYSICAL THERAPY	1,135,514	6.39	1,260,837	12.48	2,396,351	13.49	66
67	OCCUPATIONAL THERAPY	978,581	5.51	933,410	9.24	1,911,991	10.76	67
68	SPEECH PATHOLOGY	529,041	2.98	489,217	4.84	1,018,258	5.73	68
71	MEDICAL SUPPLIES CHRGD TO PATI	206,641	1.16	159,705	1.58	366,346	2.06	71
73	DRUGS CHARGED TO PATIENTS	917,939	5.17	466,578	4.62	1,384,517	7.79	73
76	PSYCHOLOGY	52,532	0.30	50,137	0.50	102,669	0.58	76
76.01	AMBULANCE	9,394	0.05	3,785	0.04	13,179	0.07	76.01
76.02	DAY TREATMENT							76.02
76.03	AMBULANCE SUA	1,243	0.01			1,243	0.01	76.03
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	2,493	0.01	348,466	3.45	350,959	1.98	192
194	NRCC MARKETING	34,066	0.19	21,929	0.22	55,995	0.32	194
194.01	GUEST MEALS			65,075	0.64	65,075	0.37	194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	17,764,957	100.00			17,764,957	100.00	202

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	TOTAL	RATIO	INPATIENT	MEDICARE	
	RELATED COSTS 1	CHARGES 2	CAPITAL COST TO CHARGES 3	PROGRAM CHARGES 4	INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	17,443	702,696	0.024823	489,858	12,160	54
54.01 RADIOLOGY SUA		59,414		57,200		54.01
60 LABORATORY	2,131	1,087,777	0.001959	738,147	1,446	60
65 RESPIRATORY THERAPY	7,510	1,935,125	0.003881	1,471,750	5,712	65
66 PHYSICAL THERAPY	227,066	10,372,062	0.021892	5,782,871	126,599	66
67 OCCUPATIONAL THERAPY	126,455	10,370,646	0.012194	6,237,925	76,065	67
68 SPEECH PATHOLOGY	64,998	4,461,436	0.014569	2,086,399	30,397	68
71 MEDICAL SUPPLIES CHRGED TO PATI	31,133	882,426	0.035281	489,237	17,261	71
73 DRUGS CHARGED TO PATIENTS	22,747	3,809,948	0.005970	2,653,449	15,841	73
76 PSYCHOLOGY	7,501	472,504	0.015875	301,326	4,784	76
76.01 AMBULANCE	131	64,292	0.002038	28,920	59	76.01
76.02 DAY TREATMENT						76.02
76.03 AMBULANCE SUA		3,765		3,483		76.03
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL	507,115	34,222,091		20,340,565	290,324	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION		CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	REDUCED CAPITAL RELATED COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7
INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	893,110		893,110	21,915	40.75	14,595	594,746 30
200	TOTAL	893,110		893,110	21,915		14,595	594,746 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								594,746
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								290,324
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								885,070
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								1,010
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								14,595
PER DISCHARGE CAPITAL COSTS								876.31
PER DIEM CAPITAL COSTS								60.64

I. COST TO CHARGE RATIO FOR FREESTANDING IRF

1. TOTAL MEDICARE COSTS (WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 9 LINES 30-35 + WKST D PART IV COL 11 LINE 200))	10,982,620
2. TOTAL MEDICARE CHARGES (WKST D-3 COLUMN 2 LINES 30-35 + LINE 202)	31,453,623
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.349

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 30-35, COLUMN 7 + WKST D PART II, LINE 200, COLUMN 5)	885,070
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.028

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPFS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	1,912
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPFS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	5,037
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.380