

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

WORKSHEET S  
 PARTS I, II & III

PART I - COST REPORT STATUS

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

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY COMMUNITY HOSPITAL (15-0125) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2011 AND ENDING 06/30/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		-340,637	-268,418			1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF		52,152				3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		-288,485	-268,418			200

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 901 MACARTHUR BOULEVARD  
 2 CITY: MUNSTER STATE: IN

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

1  
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	1	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N)		
							6	7	8
3	HOSPITAL	COMMUNITY HOSPITAL	15-0125	23844	1	10/03/1973	N	P	P
4	SUBPROVIDER - IPF								
5	SUBPROVIDER - IRF	THE REHAB CENTER AT COMMUNITY	15-T125	23844	5	06/30/1996	N	P	P
6	SUBPROVIDER - (OTHER)								
7	SWING BEDS - SNF								
8	SWING BEDS - NF								
9	HOSPITAL-BASED SNF								
10	HOSPITAL-BASED NF								
11	HOSPITAL-BASED OLTC								
12	HOSPITAL-BASED HHA	COMMUNITY HOME HEALTH SERVICES	15-7487	23844		01/07/1997	N	P	N
13	SEPARATELY CERTIFIED ASC								
14	HOSPITAL-BASED HOSPIECE								
15	HOSPITAL-BASED HEALTH CLINIC - RHC								
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								
17	HOSPITAL-BASED (CMHC)								
18	RENAL DIALYSIS								
19	OTHER								
20	COST REPORTING PERIOD (MM/DD/YYYY) FROM: 07/01/2011 TO: 06/30/2012								
21	TYPE OF CONTROL								

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID		OUT-OF-STATE MEDICAID		OTHER MEDICAID		
		PAID	UNPAID	PAID	UNPAID	HMO	MEDICAID	
		DAYS	DAYS	DAYS	DAYS	DAYS	DAYS	
		1	2	3	4	5	6	
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	3,802	812	1,023	971	7,873	670	24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.		153					25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				1			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR 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.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	
1	2	3	4	5	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

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

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/(COL.3+COL.4))
1	2	3	4	5
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			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 XIX 2 N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
<b>RURAL PROVIDERS</b>				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 N 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 1 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

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

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

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

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2012.11  
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs?  
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

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

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
<b>PS&amp;R REPORT DATA</b>					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 N	2	3 N	4 16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	10/02/2012	Y	10/02/2012 17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: CONNIE	LAST NAME: BIEGEL	TITLE: DIRECTOR OF REIMBURS	41
42	EMPLOYER: COMMUNITY HOSPITAL			42
43	PHONE NUMBER: 12198366789	E-MAIL ADDRESS: CBIEGEL@COMHS.ORG		43





HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200		167,495,501	5,760,640.00	29.08	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B	2,970,492		2,970,492	34,409.00	86.33	3
4	PHYSICIAN-PART A ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B	6,462,110		6,462,110	35,587.00	181.59	5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	22,954,464	61,464	23,015,928	699,736.00	32.89	10
	OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)	1,603,462		1,603,462	16,473.00	97.34	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE	920,881		920,881	5,849.00	157.44	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS	15,956,413		15,956,413	371,108.00	43.00	14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)	40,567,790		40,567,790			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS	5,590,393		5,590,393			19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B	564,343		564,343			21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B	948,204		948,204			23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS	862,262		862,262	31,041.00	27.78	26
27	ADMINISTRATIVE & GENERAL	15,837,858	-71,050	15,766,808	564,058.00	27.95	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)	4,299,633		4,299,633	29,084.00	147.83	28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT	4,339,112		4,339,112	173,722.00	24.98	30
31	LAUNDRY & LINEN SERVICE	157,441		157,441	9,924.00	15.86	31
32	HOUSEKEEPING	3,040,545		3,040,545	212,147.00	14.33	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY	3,638,733	-1,364,870	2,273,863	128,270.00	17.73	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA		1,364,870	1,364,870	98,372.00	13.87	36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION	1,416,027		1,416,027	31,708.00	44.66	38
39	CENTRAL SERVICES AND SUPPLY		71,050	71,050	4,992.00	14.23	39
40	PHARMACY	3,905,102		3,905,102	105,735.00	36.93	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	3,445,251		3,445,251	169,778.00	20.29	41
42	SOCIAL SERVICE	697,969		697,969	25,155.00	27.75	42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	162,362,532		162,362,532	5,719,728.00	28.39	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	22,954,464	61,464	23,015,928	699,736.00	32.89	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	139,408,068	-61,464	139,346,604	5,019,992.00	27.76	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	18,480,756		18,480,756	393,430.00	46.97	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	40,567,790		40,567,790		29.11	5
6	TOTAL (SUM OF LINES 3 THRU 5)	198,456,614	-61,464	198,395,150	5,413,422.00	36.65	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	41,639,933		41,639,933	1,583,986.00	26.29	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	2,187,042	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	12,924,858	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	225,056	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	18,593,467	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	1,157,013	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	121,125	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	83,365	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	523,184	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	9,171,356	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	2,333,675	18
19 UNEMPLOYMENT INSURANCE	185,199	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	165,390	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	47,670,730	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3  
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 15-7487

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: LAKE

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		4,096	53	191	4,340	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		1,106.00		484.00	1,590.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			
	STAFF 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			1.13	4
5 OTHER ADMINISTRATIVE PERSONNEL			11.11	5
6 DIRECT NURSING SERVICE			7.76	6
7 NURSING SUPERVISOR				7
8 PHYSICAL THERAPY SERVICE			6.58	8
9 PHYSICAL THERAPY SUPERVISOR				9
10 OCCUPATIONAL THERAPY SERVICE			1.53	10
11 OCCUPATIONAL THERAPY SUPERVISOR				11
12 SPEECH PATHOLOGY SERVICE			0.17	12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE			0.01	14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE			1.99	16
17 HOME HEALTH AIDE SUPERVISOR				17
18 PRIVATE DUTY			15.58	18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

	FULL EPISODES				TOTAL (COLS. 1-4) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	14,682	1,432	297	102	16,513	21
22 SKILLED NURSING VISIT CHARGES	2,334,438	227,688	47,223	16,218	2,625,567	22
23 PHYSICAL THERAPY VISITS	10,964	269	72	97	11,402	23
24 PHYSICAL THERAPY VISIT CHARGES	2,028,340	49,765	13,320	17,945	2,109,370	24
25 OCCUPATIONAL THERAPY VISITS	2,608	77	7	23	2,715	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	482,480	14,245	1,295	4,255	502,275	26
27 SPEECH PATHOLOGY VISITS	244	42	3		289	27
28 SPEECH PATHOLOGY VISIT CHARGES	45,140	770	555		46,465	28
29 MEDICAL SOCIAL SERVICE VISITS	15	2	2		19	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	3,165	422	422		4,009	30
31 HOME HEALTH AIDE VISITS	3,615	267	9	10	3,901	31
32 HOME HEALTH AIDE VISIT CHARGES	430,185	31,773	1,071	1,190	464,219	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	32,128	2,089	390	232	34,839	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	5,323,748	324,663	63,886	39,608	5,751,905	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	1,373		143	16	1,532	36
37 TOTAL NUMBER OF OUTLIER EPISODES		20			20	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	254,211	33,740	5,126	2,562	295,639	38

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.321179	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				12,677,571	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				96,740,611	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				31,071,053	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				18,393,482	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)				72,111	13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)				394,902	14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)				126,834	15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.				54,723	16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				6,085	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				18,448,205	19
			UNINSURED PATIENTS	INSURED PATIENTS		TOTAL
			1	2		3
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	19,906,286			19,906,286	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	6,393,481			6,393,481	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	67,737			67,737	22
23	COST OF CHARITY CARE	6,325,744			6,325,744	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				18,676,169	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				1,167,876	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				17,508,293	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				5,623,296	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				11,949,040	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				30,397,245	31

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				10,165,609	1
2	00200				9,982,096	2
3	00300					3
4	00400	862,262	368,370	1,230,632	45,107,836	4
5	00500	15,837,858	137,192,792	153,030,650	-65,733,968	5
6	00600					6
7	00700	4,339,112	7,332,186	11,671,298	535,281	7
8	00800	157,441	1,302,060	1,459,501		8
9	00900	3,040,545	930,536	3,971,081	-195	9
10	01000	3,638,733	3,098,360	6,737,093	-2,880,848	10
11	01100				2,827,587	11
12	01200					12
13	01300	1,416,027	156,018	1,572,045	-19,687	13
14	01400		710,940	710,940	71,050	14
15	01500	3,905,102	12,824,810	16,729,912	-3,804	15
16	01600	3,445,251	416,526	3,861,777	-270	16
17	01700	697,969	18,622	716,591	-197	17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	32,911,158	4,448,443	37,359,601	-607,856	30
31	03100	7,452,509	822,935	8,275,444	-22,434	31
32.01	02060	3,001,723	275,962	3,277,685	22,992	32.01
41	04100	3,803,113	1,694,678	5,497,791	29,981	41
43	04300	1,634,336	260,671	1,895,007	14,689	43
ANCILLARY SERVICE COST CENTERS						
50	05000	23,241,476	35,165,721	58,407,197	-22,905,058	50
52	05200	2,142,951	302,346	2,445,297	-43,939	52
54	05400	7,357,659	6,788,676	14,146,335	-137,226	54
60	06000	5,473,583	5,666,876	11,140,459	-1,335	60
62	06200	389,716	3,003,546	3,393,262		62
62.30	06250					62.30
65	06500	3,391,987	513,553	3,905,540		65
66	06600	4,489,378	3,977,888	8,467,266	-2,386	66
70	07000	639,641	360,146	999,787	-2,008	70
71	07100				15,503,104	71
72	07200				25,965,680	72
73	07300					73
76	03140	6,805,221	23,829,437	30,634,658	-17,836,609	76
76.97	07697	535,784	18,130	553,914		76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	1,576,923	507,929	2,084,852	-14,311	90
91	09100	6,156,692	1,464,336	7,621,028	-56,084	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	2,078,378	1,270,588	3,348,966	-16,134	101
SPECIAL PURPOSE COST CENTERS						
118		150,422,528	254,723,081	405,145,609	-58,444	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
191	19100	275,536	142,108	417,644	-2,214	191
192	19200	14,528,218	4,859,051	19,387,269	-228,129	192
194	07950				558,556	194
194.01	07951	1,580,041	795,255	2,375,296	-269,769	194.01
194.02	07952	292,279	98,807	391,086		194.02
194.03	07953	396,899	3,711,536	4,108,435		194.03
194.04	07954					194.04
194.05	07955					194.05
200		167,495,501	264,329,838	431,825,339		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	10,165,609	14,104	10,179,713	1
2	00200	9,982,096	5,435,496	15,417,592	2
3	00300				3
4	00400	46,338,468	-2,162,382	44,176,086	4
5	00500	87,296,682	-31,505,413	55,791,269	5
6	00600				6
7	00700	12,206,579	16,052	12,222,631	7
8	00800	1,459,501		1,459,501	8
9	00900	3,970,886	2,222	3,973,108	9
10	01000	3,856,245	-11,156	3,845,089	10
11	01100	2,827,587	-1,913,235	914,352	11
12	01200				12
13	01300	1,552,358		1,552,358	13
14	01400	781,990		781,990	14
15	01500	16,726,108	-600	16,725,508	15
16	01600	3,861,507	-42,240	3,819,267	16
17	01700	716,394		716,394	17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	36,751,745	-85,902	36,665,843	30
31	03100	8,253,010		8,253,010	31
32.01	02060	3,300,677	-37,630	3,263,047	32.01
41	04100	5,527,772		5,527,772	41
43	04300	1,909,696	-560	1,909,136	43
ANCILLARY SERVICE COST CENTERS					
50	05000	35,502,139	-11,327,176	24,174,963	50
52	05200	2,401,358		2,401,358	52
54	05400	14,009,109	-113,423	13,895,686	54
60	06000	11,139,124	-8,136	11,130,988	60
62	06200	3,393,262		3,393,262	62
62.30	06250				62.30
65	06500	3,905,540	-225	3,905,315	65
66	06600	8,464,880	32,741	8,497,621	66
70	07000	997,779	-17,442	980,337	70
71	07100	15,503,104		15,503,104	71
72	07200	25,965,680		25,965,680	72
73	07300				73
76	03140	12,798,049	-901,147	11,896,902	76
76.97	07697	553,914		553,914	76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	2,070,541	-35,722	2,034,819	90
91	09100	7,564,944	-130,217	7,434,727	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
101	10100	3,332,832	-14	3,332,818	101
SPECIAL PURPOSE COST CENTERS					
118		405,087,165	-42,792,005	362,295,160	118
NONREIMBURSABLE COST CENTERS					
190	19000				190
191	19100	415,430		415,430	191
192	19200	19,159,140	-108,834	19,050,306	192
194	07950	558,556		558,556	194
194.01	07951	2,105,527		2,105,527	194.01
194.02	07952	391,086		391,086	194.02
194.03	07953	4,108,435	43,457	4,151,892	194.03
194.04	07954				194.04
194.05	07955				194.05
200		431,825,339	-42,857,382	388,967,957	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		OTHER
			LINE #	SALARY	
1	1	2	3	4	5
1 OPERATING RM SUPPLIES	A	MEDICAL SUPPLIES CHRGED TO PA	71		14,862,280
2		IMPL. DEV. CHARGED TO PATIENT	72		25,965,680
3		MEDICAL SUPPLIES CHRGED TO PA	71		640,824
4					
5					
6					
7					
8					
9					
10					
500 TOTAL RECLASSIFICATIONS					41,468,784
CODE LETTER - A					500
1 NURSING FLOAT SALARIES	B	INTENSIVE CARE UNIT	31	95,578	1
2		NURSERY	43	22,574	2
3		NEONATAL INTENSIVE CARE	32.01	33,764	3
4		DELIVERY ROOM & LABOR ROOM	52	27,358	4
5		EMERGENCY	91	96,572	5
6		SUBPROVIDER - IRF	41	61,464	6
500 TOTAL RECLASSIFICATIONS				337,310	500
CODE LETTER - B					
1 STOREROOM SALARY RECLASS	C	CENTRAL SERVICES & SUPPLY	14	71,050	1
500 TOTAL RECLASSIFICATIONS				71,050	500
CODE LETTER - C					
1 CAFETERIA EXPENSE	D	CAFETERIA	11	1,364,870	1,462,717
500 TOTAL RECLASSIFICATIONS				1,364,870	1,462,717
CODE LETTER - D					500
1 INTEREST EXPENSE	E	CAP REL COSTS-MVBLE EQUIP	2		512,797
2					
500 TOTAL RECLASSIFICATIONS					512,797
CODE LETTER - E					500
1 BUILDING INSURANCE	F	CAP REL COSTS-BLDG & FIXT	1		346,723
2		CAP REL COSTS-MVBLE EQUIP	2		7,417
500 TOTAL RECLASSIFICATIONS					354,140
CODE LETTER - F					500
1 UTILITY RECLASS	G	OPERATION OF PLANT	7		535,555
2					
3					
4					
5					
6					
7					
8					
500 TOTAL RECLASSIFICATIONS					535,555
CODE LETTER - G					500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		OTHER
			LINE #	SALARY	
1	1	2	3	4	5
1 ADVERTISING NON-REIMBURSABLE	H	ADVERTISING	194		558,556
2		DELIVERY ROOM & LABOR ROOM	52		2
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
500 TOTAL RECLASSIFICATIONS					558,558
CODE LETTER - H					500
1 DEPRECIATION AND BENEFIT RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		9,818,886
2		CAP REL COSTS-MVBLE EQUIP	2		9,461,882
3		EMPLOYEE BENEFITS	4		45,111,996
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
500 TOTAL RECLASSIFICATIONS					64,392,764
CODE LETTER - I					500
GRAND TOTAL (INCREASES)				1,773,230	109,285,315

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 OPERATING RM SUPPLIES	A	OPERATING ROOM	50		22,894,851	1
2		CARDIOLOGY	76		17,834,787	2
3		RADIOLOGY-DIAGNOSTIC	54		98,322	3
4		ADULTS & PEDIATRICS	30		262,718	4
5		INTENSIVE CARE UNIT	31		112,529	5
6		NEONATAL INTENSIVE CARE	32.01		8,217	6
7		SUBPROVIDER - IRF	41		31,483	7
8		NURSERY	43		7,831	8
9		DELIVERY ROOM & LABOR ROOM	52		71,299	9
10		EMERGENCY	91		146,747	10
500 TOTAL RECLASSIFICATIONS					41,468,784	500
CODE LETTER - A						
1 NURSING FLOAT SALARIES	B	ADULTS & PEDIATRICS	30	337,310		1
2						2
3						3
4						4
5						5
6						6
500 TOTAL RECLASSIFICATIONS				337,310		500
CODE LETTER - B						
1 STOREROOM SALARY RECLASS	C	ADMINISTRATIVE & GENERAL	5	71,050		1
500 TOTAL RECLASSIFICATIONS				71,050		500
CODE LETTER - C						
1 CAFETERIA EXPENSE	D	DIETARY	10	1,364,870	1,462,717	1
500 TOTAL RECLASSIFICATIONS				1,364,870	1,462,717	500
CODE LETTER - D						
1 INTEREST EXPENSE	E	ADMINISTRATIVE & GENERAL	5		504,798	11 1
2		NURSING ADMINISTRATION	13		7,999	11 2
500 TOTAL RECLASSIFICATIONS					512,797	500
CODE LETTER - E						
1 BUILDING INSURANCE	F	ADMINISTRATIVE & GENERAL	5		354,140	12 1
2						12 2
500 TOTAL RECLASSIFICATIONS					354,140	500
CODE LETTER - F						
1 UTILITY RECLASS	G	HOME HEALTH AGENCY	101		8,650	1
2		ADMINISTRATIVE & GENERAL	5		108,188	2
3		FITNESS POINTE	194.01		269,769	3
4		PHYSICIANS' PRIVATE OFFICES	192		97,696	4
5		RADIOLOGY-DIAGNOSTIC	54		36,821	5
6		CLINIC	90		8,808	6
7		RESEARCH	191		2,214	7
8		EMERGENCY	91		3,409	8
500 TOTAL RECLASSIFICATIONS					535,555	500
CODE LETTER - G						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		OTHER	WKST A-7 REF.
			LINE #	SALARY		
	1	6	7	8	9	10
1 ADVERTISING NON-REIMBURSABLE	H	CLINIC	90		5,503	1
2		HOME HEALTH AGENCY	101		7,484	2
3		NURSING ADMINISTRATION	13		9,020	3
4		ADMINISTRATIVE & GENERAL	5		461,044	4
5		OPERATION OF PLANT	7		274	5
6		HOUSEKEEPING	9		195	6
7		PHARMACY	15		3,804	7
8		MEDICAL RECORDS & LIBRARY	16		270	8
9		SOCIAL SERVICE	17		197	9
10		ADULTS & PEDIATRICS	30		1,328	10
11		INTENSIVE CARE UNIT	31		983	11
12		NEONATAL INTENSIVE CARE	32.01		55	12
13		NURSERY	43		54	13
14		PHYSICAL THERAPY	66		2,386	14
15		ELECTROENCEPHALOGRAPHY	70		2,008	15
16		LABORATORY	60		1,335	16
17		RADIOLOGY-DIAGNOSTIC	54		2,083	17
18		DIETARY	10		53,261	18
19		OPERATING ROOM	50		1,292	19
20		EMPLOYEE BENEFITS	4		4,160	20
21		CARDIOLOGY	76		1,822	21
500 TOTAL RECLASSIFICATIONS					558,558	500
CODE LETTER - H						
1 DEPRECIATION AND BENEFIT RECLASS	I	ADMINISTRATIVE & GENERAL	5		9,763,875	9 1
2		OPERATING ROOM	50		990	9 2
3		PHYSICIANS' PRIVATE OFFICES	192		54,021	3
4		ADMINISTRATIVE & GENERAL	5		9,380,322	4
5		OPERATING ROOM	50		5,148	5
6		PHYSICIANS' PRIVATE OFFICES	192		76,412	6
7		ADMINISTRATIVE & GENERAL	5		45,090,551	7
8		NURSING ADMINISTRATION	13		2,668	8
9		ADULTS & PEDIATRICS	30		6,500	9
10		INTENSIVE CARE UNIT	31		4,500	10
11		NEONATAL INTENSIVE CARE	32.01		2,500	11
12		OPERATING ROOM	50		2,777	12
13		EMERGENCY	91		2,500	13
500 TOTAL RECLASSIFICATIONS					64,392,764	500
CODE LETTER - I						
GRAND TOTAL (DECREASES)				1,773,230	109,285,315	

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	2,393,212	416,185		416,185		2,809,397	1
2 LAND IMPROVEMENTS	6,444,488				14,150	6,430,338	2
3 BUILDINGS AND FIXTURES	233,737,515	1,754,069		1,754,069	1,560,447	233,931,137	3
4 BUILDING IMPROVEMENTS	52,409,984	3,209,465		3,209,465	258,063	55,361,386	4
5 FIXED EQUIPMENT	2,379,122					2,379,122	5
6 MOVABLE EQUIPMENT	120,106,856	7,929,850		7,929,850	7,892,957	120,143,749	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	417,471,177	13,309,569		13,309,569	9,725,617	421,055,129	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	417,471,177	13,309,569		13,309,569	9,725,617	421,055,129	10

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

SUMMARY OF CAPITAL

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	RATIOS		INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8
			FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4				
1 CAP REL COSTS-BLDG & FIXT	300,911,380		300,911,380	0.714660				1
2 CAP REL COSTS-MVBLE EQUIP	120,143,749		120,143,749	0.285340				2
3 TOTAL (SUM OF LINES 1-2)	421,055,129		421,055,129	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	9,832,990			346,723			10,179,713 1
2 CAP REL COSTS-MVBLE EQUIP	15,410,175			7,417			15,417,592 2
3 TOTAL	25,243,165			354,140			25,597,305 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-512,797	CAP REL COSTS-MVBLE EQUIP	2	11 2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-752	ADMINISTRATIVE & GENERAL	5	4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-12,240,247			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-4,139,655			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-600	PHARMACY	15	17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-42,240	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 OFFSET IHA LOBBYING DUES	A	-5,549	ADMINISTRATIVE & GENERAL	5	33
34 BABY PHOTO INCOME	B	-560	NURSERY	43	34
35 A&G OTHER INCOME	B	-208,675	ADMINISTRATIVE & GENERAL	5	35
36 OFFSET PROFESSIONAL FEES	A	-12,835	RADIOLOGY-DIAGNOSTIC	54	36
37 OFFSET MAMMO FEES	A	-14,700	RADIOLOGY-DIAGNOSTIC	54	37
38 PHYSICIAN RENTAL/X RAY SALES-RA	B	-5,014	RADIOLOGY-DIAGNOSTIC	54	38
39 VARIOUS OTHER REV OFFSET	B	-52,827	CARDIOLOGY	76	39
40 PHYSICIAN RENTAL-LAB	B	-555	LABORATORY	60	40
41 REMOVE MEDICAID ASSESSMENT FEES	A	-20,587,824	ADMINISTRATIVE & GENERAL	5	41
42 VARIOUS EH&W OFFSETS	B	-15,289	EMPLOYEE BENEFITS	4	42
43 OFFSET HEART SCAN COSTS	A	-450	RADIOLOGY-DIAGNOSTIC	54	43
43.02 OFFSET RESEARCH COSTS HEART CTR	A	-179,234	CARDIOLOGY	76	43.02
44 OFFSET BIOTERRORISM GRANT	B	-29,102	ADMINISTRATIVE & GENERAL	5	44
45 MEDICAL RESTRICTED	A	-93,710	ADMINISTRATIVE & GENERAL	5	45
45.01 EMPLOYEE CAFETERIA REVENUE	B	-1,913,235	CAFETERIA	11	45.01
45.03 GUEST TRAYS/CANDLELIGHT DINNERS	B	-388	DIETARY	10	45.03
45.04 TELEPHONE SERVICE	A	-85,252	ADMINISTRATIVE & GENERAL	5	45.04
45.05 TELEPHONE SERVICE	A	-2,133	CAP REL COSTS-BLDG & FIXT	1	9 45.05
45.06 TELEPHONE SERVICE	A	-11,686	CAP REL COSTS-MVBLE EQUIP	2	9 45.06
45.07 TELEPHONE SERVICE	A	-22,235	EMPLOYEE BENEFITS	4	45.07
45.08 TELEVISION SERVICE	A	-9,611	OPERATION OF PLANT	7	45.08
45.09 TELEVISION SERVICE	A	-33,361	CAP REL COSTS-MVBLE EQUIP	2	9 45.09
45.10 PENSION CONTRIBTN EXCESS OF EXP	A	-2,124,858	EMPLOYEE BENEFITS	4	45.10
45.11 SERVICE CHGS ON CHECKING	A	-145,145	ADMINISTRATIVE & GENERAL	5	45.11
45.13 OFFSET COPYING FEES	B	-14	HOME HEALTH AGENCY	101	45.13
45.18 MOB-DEPRECIATION	A	-248,404	CAP REL COSTS-BLDG & FIXT	1	9 45.18
45.19 CAPITALIZED INTEREST	A	1,589	CAP REL COSTS-BLDG & FIXT	1	9 45.19
45.20 1992 MME DEPRECIATION	A	592	CAP REL COSTS-MVBLE EQUIP	2	9 45.20
45.21 PARETN ASSET DEP AJE	A	-2,672	CAP REL COSTS-BLDG & FIXT	1	9 45.21

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2012.11  
 12/27/2012 19:29

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
45.24 1997 TRADE-IN DEPRECIATION	A	188	CAP REL COSTS-MVBLE EQUIP	2	9 45.24
45.28 1996 ASSET LIFE ADJUSTMENT	A	6,312	CAP REL COSTS-BLDG & FIXT	1	9 45.28
45.30 OFFSET RELEASED TEMP REST OP IN	B	-1,500	CARDIOLOGY	76	45.30
45.33 NON-PT CARE RELATED EXPENSES	A	-3,690	ADMINISTRATIVE & GENERAL	5	45.33
45.36 OFFSET MISC ER PHYS COSTS 2800	A	-87,291	EMERGENCY	91	45.36
45.37 OTHER DIETARY INCOME	B	-10,768	DIETARY	10	45.37
45.40 OFFSET PHYSICIAN RENTAL	B	-4,840	NEONATAL INTENSIVE CARE	32.01	45.40
46 OFFSET ANEST COSTS	A	-16,365	OPERATING ROOM	50	46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-42,857,382			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	50	OPERATING ROOM		837,147	-837,147	1
2	76	CARDIOLOGY		313,752	-313,752	2
3	70	ELECTROENCEPHALOGRAPHY		66,176	-66,176	3
4	5	ADMINISTRATIVE & GENERAL		355,634	-355,634	4
4.01	192	PHYSICIANS' PRIVATE OFFICES		198,262	-198,262	4.01
4.03	5	ADMINISTRATIVE & GENERAL	101,969		101,969	4.03
4.04	7	OPERATION OF PLANT	22,276		22,276	4.04
4.05	50	OPERATING ROOM	491,279		491,279	4.05
4.06	66	PHYSICAL THERAPY	20,906		20,906	4.06
4.07	70	ELECTROENCEPHALOGRAPHY	38,745		38,745	4.07
4.08	76	CARDIOLOGY	198,347		198,347	4.08
4.09	194.03	RETAIL PHARMACY	27,748		27,748	4.09
4.10	9	HOUSEKEEPING	1,419		1,419	4.10
4.11	60	LABORATORY	2,965		2,965	4.11
4.12	192	PHYSICIANS' PRIVATE OFFICES	57,102		57,102	4.12
4.15	7	OPERATION OF PLANT	12,611		12,611	4.15
4.16	9	HOUSEKEEPING	803		803	4.16
4.17	50	OPERATING ROOM	278,122		278,122	4.17
4.18	66	PHYSICAL THERAPY	11,835		11,835	4.18
4.19	60	LABORATORY	1,678		1,678	4.19
4.20	70	ELECTROENCEPHALOGRAPHY	21,934		21,934	4.20
4.21	76	CARDIOLOGY	112,288		112,288	4.21
4.22	5	ADMINISTRATIVE & GENERAL	57,726		57,726	4.22
4.23	192	PHYSICIANS' PRIVATE OFFICES	32,326		32,326	4.23
4.24	194.03	RETAIL PHARMACY	15,709		15,709	4.24
4.27	5	ADMINISTRATIVE & GENERAL	51,524		51,524	4.27
4.28	7	OPERATION OF PLANT	16,120		16,120	4.28
4.29	54	RADIOLOGY-DIAGNOSTIC	78,367		78,367	4.29
4.30	76	CARDIOLOGY	2,384		2,384	4.30
4.31	90	CLINIC	12,459		12,459	4.31
4.32	60	LABORATORY	7,480		7,480	4.32
4.37	5	ADMINISTRATIVE & GENERAL		75,026	-75,026	4.37
4.38	7	OPERATION OF PLANT		25,344	-25,344	4.38
4.39	54	RADIOLOGY-DIAGNOSTIC		125,511	-125,511	4.39
4.40	60	LABORATORY		11,800	-11,800	4.40
4.41	90	CLINIC		12,851	-12,851	4.41
4.42	76	CARDIOLOGY		11,187	-11,187	4.42
4.44	1	CAP REL COSTS-BLDG & FIXT	259,412		259,412	9 4.44
4.45	5	ADMINISTRATIVE & GENERAL	33,086,562	43,121,621	-10,035,059	4.45
4.46	2	CAP REL COSTS-MVBLE EQUIP	5,992,560		5,992,560	9 4.46
5		TOTALS (SUM OF LINES 1-4)	41,014,656	45,154,311	-4,139,655	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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

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

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

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

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

WORKSHEET A-8-1

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE NO.	1	2	3	4	5	6	7	8	9	
1	5	ADMINISTRATIVE & GENERAL	256,187	7,890	248,297	171,400	2,002	164,973	8,249	1
2	32.01	NEONATAL INTENSIVE CARE	38,723	30,000	8,723	171,400	72	5,933	297	2
3	54	RADIOLOGY-DIAGNOSTIC	20,000		20,000	231,100	100	11,111	556	3
4	50	OPERATING ROOM	11,239,715	11,239,715						4
5	60	LABORATORY	25,000		25,000	219,500	162	17,096	855	5
6	65	RESPIRATORY THERAPY	29,225	225	29,000	171,400	387	31,890	1,595	6
7	76	CARDIOLOGY	761,802	480,380	281,422	171,400	1,288	106,136	5,307	7
8	54	RADIOLOGY-DIAGNOSTIC	45,834		45,834	231,100	193	21,443	1,072	8
9	30	ADULTS & PEDIATRICS	30,750		30,750	171,400	103	8,488	424	9
10	30	ADULTS & PEDIATRICS	35,870	35,870		171,400				10
11	90	CLINIC	75,873	13,348	62,525	171,400	492	40,543	2,027	11
12	70	ELECTROENCEPHALOGRAPHY	22,575		22,575	171,400	129	10,630	532	12
13	91	EMERGENCY	99,455		99,455	171,400	686	56,529	2,826	13
14	30	ADULTS & PEDIATRICS	47,300		47,300	171,400	237	19,530	977	14
15	50	OPERATING ROOM	3,350	3,350						15
200		TOTAL	12,731,659	11,810,778	920,881		5,851	494,302	24,717	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11		12	13	14	15	16	17	18	
1	5	ADMINISTRATIVE & GENERAL	AGGREGATE				164,973	83,324	91,214	1
2	32.01	NEONATAL INTENSIVE CARE	AGGREGATE				5,933	2,790	32,790	2
3	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE				11,111	8,889	8,889	3
4	50	OPERATING ROOM	ANESTHESIA						11,239,715	4
5	60	LABORATORY	AGGREGATE				17,096	7,904	7,904	5
6	65	RESPIRATORY THERAPY	AGGREGATE				31,890		225	6
7	76	CARDIOLOGY	AGGREGATE				106,136	175,286	655,666	7
8	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE				21,443	24,391	24,391	8
9	30	ADULTS & PEDIATRICS	AGGREGATE				8,488	22,262	22,262	9
10	30	ADULTS & PEDIATRICS	AGGREGATE						35,870	10
11	90	CLINIC	AGGREGATE				40,543	21,982	35,330	11
12	70	ELECTROENCEPHALOGRAPHY	AGGREGATE				10,630	11,945	11,945	12
13	91	EMERGENCY	AGGREGATE				56,529	42,926	42,926	13
14	30	ADULTS & PEDIATRICS	AGGREGATE				19,530	27,770	27,770	14
15	50	OPERATING ROOM	AGGREGATE						3,350	15
200		TOTAL					494,302	429,469	12,240,247	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	10,179,713	10,179,713				1
2 CAP REL COSTS-MVBLE EQUIP	15,417,592		15,417,592			2
4 EMPLOYEE BENEFITS	44,176,086	37,900	30,654	44,244,640		4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	55,791,269	2,814,655	631,946	4,186,419	63,424,289	5
7 OPERATION OF PLANT	12,222,631	1,157,074	521,317	1,152,125	15,053,147	7
8 LAUNDRY & LINEN SERVICE	1,459,501	15,778		41,804	1,517,083	8
9 HOUSEKEEPING	3,973,108	38,044	43,031	807,329	4,861,512	9
10 DIETARY	3,845,089	125,690	46,070	603,758	4,620,607	10
11 CAFETERIA	914,352	132,200	44,869	362,402	1,453,823	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,552,358	18,435	496,564	375,985	2,443,342	13
14 CENTRAL SERVICES & SUPPLY	781,990			18,865	800,855	14
15 PHARMACY	16,725,508	50,688	414,030	1,036,887	18,227,113	15
16 MEDICAL RECORDS & LIBRARY	3,819,267	92,618	7,168	914,786	4,833,839	16
17 SOCIAL SERVICE	716,394	21,513	1,972	185,325	925,204	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	36,665,843	1,713,456	880,219	8,649,056	47,908,574	30
31 INTENSIVE CARE UNIT	8,253,010	242,788	627,029	2,004,176	11,127,003	31
32.01 NEONATAL INTENSIVE CARE	3,263,047	66,023	150,395	805,986	4,285,451	32.01
41 SUBPROVIDER - IRF	5,527,772	284,209	56,607	1,026,126	6,894,714	41
43 NURSERY	1,909,136	25,322	6,695	439,944	2,381,097	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	24,174,963	403,145	2,423,064	6,171,100	33,172,272	50
52 DELIVERY ROOM & LABOR ROOM	2,401,358	139,740	206,063	576,263	3,323,424	52
54 RADIOLOGY-DIAGNOSTIC	13,895,686	469,433	4,691,086	1,953,613	21,009,818	54
60 LABORATORY	11,130,988	219,581	500,441	1,453,351	13,304,361	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	3,393,262	16,741	32,934	103,478	3,546,415	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,905,315	38,498	237,307	900,644	5,081,764	65
66 PHYSICAL THERAPY	8,497,621	386,813	90,175	1,192,024	10,166,633	66
70 ELECTROENCEPHALOGRAPHY	980,337	26,241	189,597	169,838	1,366,013	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	15,503,104				15,503,104	71
72 IMPL. DEV. CHARGED TO PATIENT	25,965,680				25,965,680	72
73 DRUGS CHARGED TO PATIENTS						73
76 RADIOLOGY	11,896,902	279,370	1,993,777	1,806,929	15,976,978	76
76.97 CARDIAC REHABILITATION	553,914	26,407	4,351	142,262	726,934	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,034,819	82,974	44,237	418,706	2,580,736	90
91 EMERGENCY	7,434,727	342,935	741,879	1,660,373	10,179,914	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	3,332,818	39,583	36,922	551,853	3,961,176	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	362,295,160	9,307,854	15,150,399	39,711,407	356,622,875	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		25,023			25,023	190
191 RESEARCH	415,430		1,964	73,161	490,555	191
192 PHYSICIANS' PRIVATE OFFICES	19,050,306	222,582	59,927	3,857,547	23,190,362	192
194 ADVERTISING	558,556				558,556	194
194.01 FITNESS POINTE	2,105,527	465,536	160,380	419,534	3,150,977	194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY	391,086	80,516	6,209	77,606	555,417	194.02
194.03 RETAIL PHARMACY	4,151,892		38,713	105,385	4,295,990	194.03
194.04 HOSPICE		78,202			78,202	194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	388,967,957	10,179,713	15,417,592	44,244,640	388,967,957	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	63,424,289					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,932,744	17,985,891				7
8 LAUNDRY & LINEN SERVICE	295,567	45,992	1,858,642			8
9 HOUSEKEEPING	947,149	110,898		5,919,559		9
10 DIETARY	900,214	366,388	872	8,868	5,896,949	10
11 CAFETERIA	283,243	385,366		27,717		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	476,027	53,738		1,650		13
14 CENTRAL SERVICES & SUPPLY	156,027			4,620		14
15 PHARMACY	3,551,116	147,756		16,663		15
16 MEDICAL RECORDS & LIBRARY	941,758	269,982		60,301		16
17 SOCIAL SERVICE	180,254	62,711		13,859		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	9,333,753	4,994,755	595,459	1,723,036	4,610,480	30
31 INTENSIVE CARE UNIT	2,167,829	707,731	105,964	321,668	407,963	31
32.01 NEONATAL INTENSIVE CARE	834,917	192,457	20,667	82,673		32.01
41 SUBPROVIDER - IRF	1,343,270	828,473	94,219	276,256	795,677	41
43 NURSERY	463,900	73,813	59,532	69,227		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,462,821	1,175,174	270,296	1,284,304		50
52 DELIVERY ROOM & LABOR ROOM	647,489	407,346	71,338	223,948	82,829	52
54 RADIOLOGY-DIAGNOSTIC	4,093,259	1,368,405	105,205	180,690		54
60 LABORATORY	2,592,035	640,082		109,136		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	690,934	48,800				62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	990,060	112,221	12,876	15,715		65
66 PHYSICAL THERAPY	1,980,724	1,127,568	43,691	86,163		66
70 ELECTROENCEPHALOGRAPHY	266,135	76,492	9,147	9,981		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,020,408					71
72 IMPL. DEV. CHARGED TO PATIENT	5,058,790					72
73 DRUGS CHARGED TO PATIENTS						73
76 RADIOLOGY	3,112,731	814,369	178,944	371,815		76
76.97 CARDIAC REHABILITATION	141,626	76,976	947			76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	502,794	241,871	7,222	19,105		90
91 EMERGENCY	1,983,312	999,661	164,375	763,675		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	771,740	115,384		9,899		101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	57,122,626	15,444,409	1,740,754	5,680,969	5,896,949	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,875	72,942				190
191 RESEARCH	95,573					191
192 PHYSICIANS' PRIVATE OFFICES	4,518,085	648,829	377	221,630		192
194 ADVERTISING	108,821					194
194.01 FITNESS POINTE	613,892	1,357,045	117,511	16,960		194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY	108,210	234,706				194.02
194.03 RETAIL PHARMACY	836,971					194.03
194.04 HOSPICE	15,236	227,960				194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	63,424,289	17,985,891	1,858,642	5,919,559	5,896,949	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	2,150,149					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	17,344	2,992,101				13
14 CENTRAL SERVICES & SUPPLY	2,694		964,196			14
15 PHARMACY	58,915			22,001,563		15
16 MEDICAL RECORDS & LIBRARY	92,750				6,198,630	16
17 SOCIAL SERVICE	13,954					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	678,214	1,386,712			532,902	30
31 INTENSIVE CARE UNIT	135,915	277,898			83,564	31
32.01 NEONATAL INTENSIVE CARE	48,014	98,172			54,562	32.01
41 SUBPROVIDER - IRF	87,407	178,716			55,365	41
43 NURSERY	32,107	65,647			18,152	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	284,638	581,985			802,217	50
52 DELIVERY ROOM & LABOR ROOM	38,910	79,557			42,130	52
54 RADIOLOGY-DIAGNOSTIC	97,061				1,149,066	54
60 LABORATORY	109,174				790,033	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	6,118				58,979	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	56,063				161,563	65
66 PHYSICAL THERAPY	47,408				216,594	66
70 ELECTROENCEPHALOGRAPHY	3,738				46,575	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			964,196		259,386	71
72 IMPL. DEV. CHARGED TO PATIENT					323,758	72
73 DRUGS CHARGED TO PATIENTS				22,001,563	568,795	73
76 RADIOLOGY	112,205				603,310	76
76.97 CARDIAC REHABILITATION	8,644				8,189	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	27,190	42,625			28,348	90
91 EMERGENCY	137,329	280,789			395,142	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	42,008					101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	2,137,800	2,992,101	964,196	22,001,563	6,198,630	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
191 RESEARCH	5,512					191
192 PHYSICIANS' PRIVATE OFFICES						192
194 ADVERTISING						194
194.01 FITNESS POINTE						194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03 RETAIL PHARMACY	6,837					194.03
194.04 HOSPICE						194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,150,149	2,992,101	964,196	22,001,563	6,198,630	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	1,195,982				17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	1,044,974	72,808,859		72,808,859	30
31 INTENSIVE CARE UNIT	107,785	15,443,320		15,443,320	31
32.01 NEONATAL INTENSIVE CARE	1,089	5,618,002		5,618,002	32.01
41 SUBPROVIDER - IRF	6,097	10,560,194		10,560,194	41
43 NURSERY		3,163,475		3,163,475	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	5,444	44,039,151		44,039,151	50
52 DELIVERY ROOM & LABOR ROOM		4,916,971		4,916,971	52
54 RADIOLOGY-DIAGNOSTIC		28,003,504		28,003,504	54
60 LABORATORY		17,544,821		17,544,821	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		4,351,246		4,351,246	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		6,430,262		6,430,262	65
66 PHYSICAL THERAPY		13,668,781		13,668,781	66
70 ELECTROENCEPHALOGRAPHY		1,778,081		1,778,081	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		19,747,094		19,747,094	71
72 IMPL. DEV. CHARGED TO PATIENT		31,348,228		31,348,228	72
73 DRUGS CHARGED TO PATIENTS		22,570,358		22,570,358	73
76 CARDIOLOGY	1,306	21,171,658		21,171,658	76
76.97 CARDIAC REHABILITATION		963,316		963,316	76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		3,449,891		3,449,891	90
91 EMERGENCY	29,287	14,933,484		14,933,484	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY		4,900,207		4,900,207	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	1,195,982	347,410,903		347,410,903	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		102,840		102,840	190
191 RESEARCH		591,640		591,640	191
192 PHYSICIANS' PRIVATE OFFICES		28,579,283		28,579,283	192
194 ADVERTISING		667,377		667,377	194
194.01 FITNESS POINTE		5,256,385		5,256,385	194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY		898,333		898,333	194.02
194.03 RETAIL PHARMACY		5,139,798		5,139,798	194.03
194.04 HOSPICE		321,398		321,398	194.04
194.05 RUSH RESIDENTS					194.05
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	1,195,982	388,967,957		388,967,957	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS	21,600	37,900	30,654	90,154	90,154	4
5 ADMINISTRATIVE & GENERAL	157,715	2,814,655	631,946	3,604,316	8,530	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	3,824	1,157,074	521,317	1,682,215	2,347	7
8 LAUNDRY & LINEN SERVICE		15,778		15,778	85	8
9 HOUSEKEEPING	9,111	38,044	43,031	90,186	1,645	9
10 DIETARY	409	125,690	46,070	172,169	1,230	10
11 CAFETERIA		132,200	44,869	177,069	738	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,681	18,435	496,564	516,680	766	13
14 CENTRAL SERVICES & SUPPLY	169,238			169,238	38	14
15 PHARMACY	17,934	50,688	414,030	482,652	2,113	15
16 MEDICAL RECORDS & LIBRARY	243,086	92,618	7,168	342,872	1,864	16
17 SOCIAL SERVICE	1,365	21,513	1,972	24,850	378	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	73,332	1,713,456	880,219	2,667,007	17,628	30
31 INTENSIVE CARE UNIT	20,439	242,788	627,029	890,256	4,084	31
32.01 NEONATAL INTENSIVE CARE	231	66,023	150,395	216,649	1,642	32.01
41 SUBPROVIDER - IRF	7,038	284,209	56,607	347,854	2,091	41
43 NURSERY	118	25,322	6,695	32,135	896	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	981,213	403,145	2,423,064	3,807,422	12,574	50
52 DELIVERY ROOM & LABOR ROOM	117	139,740	206,063	345,920	1,174	52
54 RADIOLOGY-DIAGNOSTIC	622,986	469,433	4,691,086	5,783,505	3,980	54
60 LABORATORY	129,681	219,581	500,441	849,703	2,961	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		16,741	32,934	49,675	211	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	29,294	38,498	237,307	305,099	1,835	65
66 PHYSICAL THERAPY	11,461	386,813	90,175	488,449	2,429	66
70 ELECTROENCEPHALOGRAPHY	183,829	26,241	189,597	399,667	346	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 RADIOLOGY	1,621,815	279,370	1,993,777	3,894,962	3,682	76
76.97 CARDIAC REHABILITATION		26,407	4,351	30,758	290	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	56,326	82,974	44,237	183,537	853	90
91 EMERGENCY	4,494	342,935	741,879	1,089,308	3,383	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	505	39,583	36,922	77,010	1,124	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	4,368,842	9,307,854	15,150,399	28,827,095	80,917	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		25,023		25,023		190
191 RESEARCH	11,180		1,964	13,144	149	191
192 PHYSICIANS' PRIVATE OFFICES	488,569	222,582	59,927	771,078	7,860	192
194 ADVERTISING						194
194.01 FITNESS POINTE	55	465,536	160,380	625,971	855	194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY		80,516	6,209	86,725	158	194.02
194.03 RETAIL PHARMACY			38,713	38,713	215	194.03
194.04 HOSPICE		78,202		78,202		194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,868,646	10,179,713	15,417,592	30,465,951	90,154	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	3,612,846					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	167,060	1,851,622				7
8	LAUNDRY & LINEN SERVICE	16,837	4,735	37,435			8
9	HOUSEKEEPING	53,953	11,417		157,201		9
10	DIETARY	51,279	37,719	18	235	262,650	10
11	CAFETERIA	16,135	39,673		736		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	27,116	5,532		44		13
14	CENTRAL SERVICES & SUPPLY	8,888			123		14
15	PHARMACY	202,285	15,211		443		15
16	MEDICAL RECORDS & LIBRARY	53,646	27,794		1,601		16
17	SOCIAL SERVICE	10,268	6,456		368		17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	531,650	514,203	11,993	45,761	205,351	30
31	INTENSIVE CARE UNIT	123,487	72,860	2,134	8,542	18,171	31
32.01	NEONATAL INTENSIVE CARE	47,560	19,813	416	2,195		32.01
41	SUBPROVIDER - IRF	76,518	85,290	1,898	7,336	35,439	41
43	NURSERY	26,425	7,599	1,199	1,838		43
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	368,146	120,982	5,444	34,106		50
52	DELIVERY ROOM & LABOR ROOM	36,883	41,936	1,437	5,947	3,689	52
54	RADIOLOGY-DIAGNOSTIC	233,167	140,875	2,119	4,798		54
60	LABORATORY	147,652	65,896		2,898		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,358	5,024				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	56,397	11,553	259	417		65
66	PHYSICAL THERAPY	112,829	116,081	880	2,288		66
70	ELECTROENCEPHALOGRAPHY	15,160	7,875	184	265		70
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	172,053					71
72	IMPL. DEV. CHARGED TO PATIENT	288,167					72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIOLOGY	177,313	83,838	3,604	9,874		76
76.97	CARDIAC REHABILITATION	8,068	7,925	19			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	28,641	24,900	145	507		90
91	EMERGENCY	112,977	102,914	3,311	20,280		91
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	43,961	11,879		263		101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (SUM OF LINES 1-117)	3,253,879	1,589,980	35,060	150,865	262,650	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	7,509				190
191	RESEARCH	5,444					191
192	PHYSICIANS' PRIVATE OFFICES	257,367	66,796	8	5,886		192
194	ADVERTISING	6,199					194
194.01	FITNESS POINTE	34,970	139,706	2,367	450		194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	6,164	24,163				194.02
194.03	RETAIL PHARMACY	47,677					194.03
194.04	HOSPICE	868	23,468				194.04
194.05	RUSH RESIDENTS						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	3,612,846	1,851,622	37,435	157,201	262,650	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	234,351					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,890	552,028				13
14 CENTRAL SERVICES & SUPPLY	294		178,581			14
15 PHARMACY	6,421			709,125		15
16 MEDICAL RECORDS & LIBRARY	10,109				437,886	16
17 SOCIAL SERVICE	1,521					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	73,921	255,842			37,622	30
31 INTENSIVE CARE UNIT	14,814	51,271			5,900	31
32.01 NEONATAL INTENSIVE CARE	5,233	18,112			3,852	32.01
41 SUBPROVIDER - IRF	9,527	32,972			3,909	41
43 NURSERY	3,499	12,112			1,282	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	31,024	107,373			56,635	50
52 DELIVERY ROOM & LABOR ROOM	4,241	14,678			2,974	52
54 RADIOLOGY-DIAGNOSTIC	10,579				81,395	54
60 LABORATORY	11,899				55,775	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	667				4,164	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	6,110				11,406	65
66 PHYSICAL THERAPY	5,167				15,291	66
70 ELECTROENCEPHALOGRAPHY	407				3,288	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			178,581		18,312	71
72 IMPL. DEV. CHARGED TO PATIENT					22,857	72
73 DRUGS CHARGED TO PATIENTS				709,125	40,156	73
76 CARDIOLOGY	12,230				42,593	76
76.97 CARDIAC REHABILITATION	942				578	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,963	7,864			2,001	90
91 EMERGENCY	14,968	51,804			27,896	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	4,579					101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	233,005	552,028	178,581	709,125	437,886	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
191 RESEARCH	601					191
192 PHYSICIANS' PRIVATE OFFICES						192
194 ADVERTISING						194
194.01 FITNESS POINTE						194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03 RETAIL PHARMACY	745					194.03
194.04 HOSPICE						194.04
194.05 RUSH RESIDENTS						194.05
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	234,351	552,028	178,581	709,125	437,886	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	43,841				17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	38,305	4,399,283		4,399,283	30
31 INTENSIVE CARE UNIT	3,951	1,195,470		1,195,470	31
32.01 NEONATAL INTENSIVE CARE	40	315,512		315,512	32.01
41 SUBPROVIDER - IRF	223	603,057		603,057	41
43 NURSERY		86,985		86,985	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	200	4,543,906		4,543,906	50
52 DELIVERY ROOM & LABOR ROOM		458,879		458,879	52
54 RADIOLOGY-DIAGNOSTIC		6,260,418		6,260,418	54
60 LABORATORY		1,136,784		1,136,784	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		99,099		99,099	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		393,076		393,076	65
66 PHYSICAL THERAPY		743,414		743,414	66
70 ELECTROENCEPHALOGRAPHY		427,192		427,192	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		368,946		368,946	71
72 IMPL. DEV. CHARGED TO PATIENT		311,024		311,024	72
73 DRUGS CHARGED TO PATIENTS		749,281		749,281	73
76 CARDIOLOGY	48	4,228,144		4,228,144	76
76.97 CARDIAC REHABILITATION		48,580		48,580	76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		251,411		251,411	90
91 EMERGENCY	1,074	1,427,915		1,427,915	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY		138,816		138,816	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	43,841	28,187,192		28,187,192	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		32,810		32,810	190
191 RESEARCH		19,338		19,338	191
192 PHYSICIANS' PRIVATE OFFICES		1,108,995		1,108,995	192
194 ADVERTISING		6,199		6,199	194
194.01 FITNESS POINTE		804,319		804,319	194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY		117,210		117,210	194.02
194.03 RETAIL PHARMACY		87,350		87,350	194.03
194.04 HOSPICE		102,538		102,538	194.04
194.05 RUSH RESIDENTS					194.05
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	43,841	30,465,951		30,465,951	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- \$ VALUE	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	919,406					1
2 CAP REL COSTS-MVBLE EQUIP		9,358,588				2
4 EMPLOYEE BENEFITS	3,423	18,607	166,633,239			4
5 ADMINISTRATIVE & GENERAL	254,213	383,596	15,766,808	-63,424,289	325,543,668	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	104,504	316,443	4,339,112		15,053,147	7
8 LAUNDRY & LINEN SERVICE	1,425		157,441		1,517,083	8
9 HOUSEKEEPING	3,436	26,120	3,040,545		4,861,512	9
10 DIETARY	11,352	27,965	2,273,863		4,620,607	10
11 CAFETERIA	11,940	27,236	1,364,870		1,453,823	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,665	301,418	1,416,027		2,443,342	13
14 CENTRAL SERVICES & SUPPLY			71,050		800,855	14
15 PHARMACY	4,578	251,319	3,905,102		18,227,113	15
16 MEDICAL RECORDS & LIBRARY	8,365	4,351	3,445,251		4,833,839	16
17 SOCIAL SERVICE	1,943	1,197	697,969		925,204	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	154,755	534,299	32,573,848		47,908,574	30
31 INTENSIVE CARE UNIT	21,928	380,611	7,548,087		11,127,003	31
32.01 NEONATAL INTENSIVE CARE	5,963	91,291	3,035,487		4,285,451	32.01
41 SUBPROVIDER - IRF	25,669	34,361	3,864,577		6,894,714	41
43 NURSERY	2,287	4,064	1,656,910		2,381,097	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	36,411	1,470,817	23,241,476		33,172,272	50
52 DELIVERY ROOM & LABOR ROOM	12,621	125,082	2,170,309		3,323,424	52
54 RADIOLOGY-DIAGNOSTIC	42,398	2,847,522	7,357,659		21,009,818	54
60 LABORATORY	19,832	303,771	5,473,583		13,304,361	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,512	19,991	389,716		3,546,415	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,477	144,047	3,391,987		5,081,764	65
66 PHYSICAL THERAPY	34,936	54,737	4,489,378		10,166,633	66
70 ELECTROENCEPHALOGRAPHY	2,370	115,087	639,641		1,366,013	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					15,503,104	71
72 IMPL. DEV. CHARGED TO PATIENT					25,965,680	72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIOLOGY	25,232	1,210,237	6,805,221		15,976,978	76
76.97 CARDIAC REHABILITATION	2,385	2,641	535,784		726,934	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	7,494	26,852	1,576,923		2,580,736	90
91 EMERGENCY	30,973	450,326	6,253,264		10,179,914	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	3,575	22,412	2,078,378		3,961,176	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	840,662	9,196,400	149,560,266	-63,424,289	293,198,586	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,260				25,023	190
191 RESEARCH		1,192	275,536		490,555	191
192 PHYSICIANS' PRIVATE OFFICES	20,103	36,376	14,528,218		23,190,362	192
194 ADVERTISING					558,556	194
194.01 FITNESS POINTE	42,046	97,352	1,580,041		3,150,977	194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY	7,272	3,769	292,279		555,417	194.02
194.03 RETAIL PHARMACY		23,499	396,899		4,295,990	194.03
194.04 HOSPICE	7,063				78,202	194.04
194.05 RUSH RESIDENTS						194.05

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

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES NEW- SQ FT 1	CAP MOVABLE EQUIPMENT NEW- \$ VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	10,179,713	15,417,592	44,244,640		63,424,289	202
203	UNIT COST MULT-WS B PT I	11.072054	1.647427	0.265521		0.194826	203
204	COST TO BE ALLOC PER B PT II			90,154		3,612,846	204
205	UNIT COST MULT-WS B PT II			0.000541		0.011098	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE POUNDS	HOUSE-KEEPING TIME SPENT	DIETARY PATIENT MEALS	CAFETERIA FTES	
	SQUARE FEET					
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	557,266					7
8 LAUNDRY & LINEN SERVICE	1,425	5,391,283				8
9 HOUSEKEEPING	3,436		717,595			9
10 DIETARY	11,352	2,528	1,075	340,450		10
11 CAFETERIA	11,940		3,360		191,531	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,665		200		1,545	13
14 CENTRAL SERVICES & SUPPLY			560		240	14
15 PHARMACY	4,578		2,020		5,248	15
16 MEDICAL RECORDS & LIBRARY	8,365		7,310		8,262	16
17 SOCIAL SERVICE	1,943		1,680		1,243	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	154,755	1,727,218	208,874	266,178	60,414	30
31 INTENSIVE CARE UNIT	21,928	307,367	38,994	23,553	12,107	31
32.01 NEONATAL INTENSIVE CARE	5,963	59,947	10,022		4,277	32.01
41 SUBPROVIDER - IRF	25,669	273,298	33,489	45,937	7,786	41
43 NURSERY	2,287	172,681	8,392		2,860	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	36,411	784,037	155,689		25,355	50
52 DELIVERY ROOM & LABOR ROOM	12,621	206,928	27,148	4,782	3,466	52
54 RADIOLOGY-DIAGNOSTIC	42,398	305,165	21,904		8,646	54
60 LABORATORY	19,832		13,230		9,725	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,512				545	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,477	37,348	1,905		4,994	65
66 PHYSICAL THERAPY	34,936	126,733	10,445		4,223	66
70 ELECTROENCEPHALOGRAPHY	2,370	26,531	1,210		333	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIOLOGY	25,232	519,057	45,073		9,995	76
76.97 CARDIAC REHABILITATION	2,385	2,748			770	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	7,494	20,948	2,316		2,422	90
91 EMERGENCY	30,973	476,797	92,576		12,233	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	3,575		1,200		3,742	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	478,522	5,049,331	688,672	340,450	190,431	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,260					190
191 RESEARCH					491	191
192 PHYSICIANS' PRIVATE OFFICES	20,103	1,093	26,867			192
194 ADVERTISING						194
194.01 FITNESS POINTE	42,046	340,859	2,056			194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY	7,272					194.02
194.03 RETAIL PHARMACY					609	194.03
194.04 HOSPICE	7,063					194.04
194.05 RUSH RESIDENTS						194.05

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS	TIME SPENT	PATIENT ME ALS	FTES	
		7	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	17,985,891	1,858,642	5,919,559	5,896,949	2,150,149	202
203	UNIT COST MULT-WS B PT I	32.275235	0.344749	8.249164	17.321043	11.226115	203
204	COST TO BE ALLOC PER B PT II	1,851,622	37,435	157,201	262,650	234,351	204
205	UNIT COST MULT-WS B PT II	3.322690	0.006944	0.219066	0.771479	1.223567	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING HO URS	CENTRAL SERVICES & SUPPLY COSTED REQ	PHARMACY COSTED REQ	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	
	13	14	15	16	17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,711,385					13
14 CENTRAL SERVICES & SUPPLY		100				14
15 PHARMACY			10,000			15
16 MEDICAL RECORDS & LIBRARY				1,075,157,224		16
17 SOCIAL SERVICE					274,625	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,256,611			92,437,408	239,950	30
31 INTENSIVE CARE UNIT	251,826			14,495,143	24,750	31
32.01 NEONATAL INTENSIVE CARE	88,962			9,464,358	250	32.01
41 SUBPROVIDER - IRF	161,949			9,603,679	1,400	41
43 NURSERY	59,488			3,148,670		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	527,384			139,152,922	1,250	50
52 DELIVERY ROOM & LABOR ROOM	72,093			7,307,816		52
54 RADIOLOGY-DIAGNOSTIC				199,257,278		54
60 LABORATORY				137,039,492		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				10,230,495		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY				28,024,845		65
66 PHYSICAL THERAPY				37,570,521		66
70 ELECTROENCEPHALOGRAPHY				8,078,842		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		100		44,993,174		71
72 IMPL. DEV. CHARGED TO PATIENT				56,159,253		72
73 DRUGS CHARGED TO PATIENTS			10,000	98,663,525		73
76 CARDIOLOGY				104,650,505	300	76
76.97 CARDIAC REHABILITATION				1,420,554		76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	38,626			4,917,196		90
91 EMERGENCY	254,446			68,541,548	6,725	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY						101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	2,711,385	100	10,000	1,075,157,224	274,625	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
191 RESEARCH						191
192 PHYSICIANS' PRIVATE OFFICES						192
194 ADVERTISING						194
194.01 FITNESS POINTE						194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03 RETAIL PHARMACY						194.03
194.04 HOSPICE						194.04
194.05 RUSH RESIDENTS						194.05

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NURSING ADMINIS- TRATION NURSING HO URS 13	CENTRAL SERVICES & SUPPLY COSTED REQ 14	PHARMACY COSTED REQ 15	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	2,992,101	964,196	22,001,563	6,198,630	1,195,982	202
203	UNIT COST MULT-WS B PT I	1.103532	9,641.960000	2,200.156300	0.005765	4.354964	203
204	COST TO BE ALLOC PER B PT II	552,028	178,581	709,125	437,886	43,841	204
205	UNIT COST MULT-WS B PT II	0.203596	1,785.810000	70.912500	0.000407	0.159640	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

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

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

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

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	72,808,859		72,808,859	50,032	72,858,891	30
31 INTENSIVE CARE UNIT	15,443,320		15,443,320		15,443,320	31
32.01 NEONATAL INTENSIVE CARE	5,618,002		5,618,002	2,790	5,620,792	32.01
41 SUBPROVIDER - IRF	10,560,194		10,560,194		10,560,194	41
43 NURSERY	3,163,475		3,163,475		3,163,475	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	44,039,151		44,039,151		44,039,151	50
52 DELIVERY ROOM & LABOR ROOM	4,916,971		4,916,971		4,916,971	52
54 RADIOLOGY-DIAGNOSTIC	28,003,504		28,003,504	33,280	28,036,784	54
60 LABORATORY	17,544,821		17,544,821	7,904	17,552,725	60
62 WHOLE BLOOD & PACKED RED BL	4,351,246		4,351,246		4,351,246	62
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	6,430,262		6,430,262		6,430,262	65
66 PHYSICAL THERAPY	13,668,781		13,668,781		13,668,781	66
70 ELECTROENCEPHALOGRAPHY	1,778,081		1,778,081	11,945	1,790,026	70
71 MEDICAL SUPPLIES CHRGD TO	19,747,094		19,747,094		19,747,094	71
72 IMPL. DEV. CHARGED TO PATIE	31,348,228		31,348,228		31,348,228	72
73 DRUGS CHARGED TO PATIENTS	22,570,358		22,570,358		22,570,358	73
76 CARDIOLOGY	21,171,658		21,171,658	175,286	21,346,944	76
76.97 CARDIAC REHABILITATION	963,316		963,316		963,316	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,449,891		3,449,891	21,982	3,471,873	90
91 EMERGENCY	14,933,484		14,933,484	42,926	14,976,410	91
92 OBSERVATION BEDS	6,813,869		6,813,869		6,813,869	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	4,900,207		4,900,207		4,900,207	101
200 SUBTOTAL (SEE INSTRUCTIONS)	354,224,772		354,224,772	346,145	354,570,917	200
201 LESS OBSERVATION BEDS	6,813,869		6,813,869		6,813,869	201
202 TOTAL (SEE INSTRUCTIONS)	347,410,903		347,410,903		347,757,048	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	77,628,757		77,628,757			30
31 INTENSIVE CARE UNIT	14,495,143		14,495,143			31
32.01 NEONATAL INTENSIVE CARE	9,464,358		9,464,358			32.01
41 SUBPROVIDER - IRF	9,603,679		9,603,679			41
43 NURSERY	3,148,670		3,148,670			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	63,499,234	75,653,688	139,152,922	0.316480	0.316480	0.316480 50
52 DELIVERY ROOM & LABOR ROOM	5,332,292	1,975,524	7,307,816	0.672837	0.672837	0.672837 52
54 RADIOLOGY-DIAGNOSTIC	56,798,927	142,458,351	199,257,278	0.140539	0.140539	0.140706 54
60 LABORATORY	64,994,206	72,045,286	137,039,492	0.128027	0.128027	0.128085 60
62 WHOLE BLOOD & PACKED RED BL	7,523,740	2,706,755	10,230,495	0.425321	0.425321	0.425321 62
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	26,449,166	1,575,679	28,024,845	0.229449	0.229449	0.229449 65
66 PHYSICAL THERAPY	23,572,316	13,998,205	37,570,521	0.363817	0.363817	0.363817 66
70 ELECTROENCEPHALOGRAPHY	2,024,649	6,054,193	8,078,842	0.220091	0.220091	0.221570 70
71 MEDICAL SUPPLIES CHRGD TO	24,227,688	20,765,486	44,993,174	0.438891	0.438891	0.438891 71
72 IMPL. DEV. CHARGED TO PATIE	37,956,741	18,202,512	56,159,253	0.558202	0.558202	0.558202 72
73 DRUGS CHARGED TO PATIENTS	76,008,394	22,655,131	98,663,525	0.228761	0.228761	0.228761 73
76 CARDIOLOGY	48,316,411	56,334,094	104,650,505	0.202308	0.202308	0.203983 76
76.97 CARDIAC REHABILITATION	317,815	1,102,739	1,420,554	0.678127	0.678127	0.678127 76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	259,290	4,657,906	4,917,196	0.701597	0.701597	0.706068 90
91 EMERGENCY	24,558,424	43,983,124	68,541,548	0.217875	0.217875	0.218501 91
92 OBSERVATION BEDS	1,298,128	13,510,523	14,808,651	0.460128	0.460128	0.460128 92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		6,515,825	6,515,825			101
200 SUBTOTAL (SEE INSTRUCTIONS)	577,478,028	504,195,021	1,081,673,049			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	577,478,028	504,195,021	1,081,673,049			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	REDUCED	TOTAL	PER	INPAT	INPAT PGM	
	COST	CAP-REL		DIEM			
	(FROM WKST B, PT. II, COL. 26)	COST (COL.1 MINUS COL.2)		(COL.3 ÷ COL.4)			
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	4,399,283		4,399,283	92,610	47.50	51,402	2,441,595 30
31 INTENSIVE CARE UNIT	1,195,470		1,195,470	9,804	121.94	5,246	639,697 31
32 CORONARY CARE UNIT							32
32.01 NEONATAL INTENSIVE CARE	315,512		315,512	5,439	58.01		32.01
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF	603,057		603,057	15,375	39.22	13,917	545,825 41
42 SUBPROVIDER I							42
43 NURSERY	86,985		86,985	4,493	19.36		43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	6,600,307		6,600,307	127,721		70,565	3,627,117 200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

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

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL	
	(FROM WKST B, PT. II, COL. 26)	(FROM WKST C, PT. I, COL. 8)	(COL.1 ÷ COL.2)		(COL.3 x COL.4)	
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,543,906	139,152,922	0.032654	28,440,615	928,700	50
52 DELIVERY ROOM & LABOR ROOM	458,879	7,307,816	0.062793	16,959	1,065	52
54 RADIOLOGY-DIAGNOSTIC	6,260,418	199,257,278	0.031419	32,120,064	1,009,180	54
60 LABORATORY	1,136,784	137,039,492	0.008295	36,408,087	302,005	60
62 WHOLE BLOOD & PACKED RED BLOO	99,099	10,230,495	0.009687	3,950,579	38,269	62
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	393,076	28,024,845	0.014026	16,918,329	237,296	65
66 PHYSICAL THERAPY	743,414	37,570,521	0.019787	6,828,725	135,120	66
70 ELECTROENCEPHALOGRAPHY	427,192	8,078,842	0.052878	1,200,685	63,490	70
71 MEDICAL SUPPLIES CHRGED TO PA	368,946	44,993,174	0.008200	14,248,277	116,836	71
72 IMPL. DEV. CHARGED TO PATIENT	311,024	56,159,253	0.005538	23,305,808	129,068	72
73 DRUGS CHARGED TO PATIENTS	749,281	98,663,525	0.007594	41,451,484	314,783	73
76 CARDIOLOGY	4,228,144	104,650,505	0.040403	33,959,262	1,372,056	76
76.97 CARDIAC REHABILITATION	48,580	1,420,554	0.034198	189,107	6,467	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	251,411	4,917,196	0.051129	75,810	3,876	90
91 EMERGENCY	1,427,915	68,541,548	0.020833	13,988,951	291,432	91
92 OBSERVATION BEDS	411,428	14,808,651	0.027783			92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	21,859,497	960,816,617		253,102,742	4,949,643	200

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

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

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM
				PASS THRU COSTS (COL.7 x COL.8) 9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	92,610		51,402	30
31 INTENSIVE CARE UNIT	9,804		5,246	31
32 CORONARY CARE UNIT				32
32.01 NEONATAL INTENSIVE CARE	5,439			32.01
33 BURN INTENSIVE CARE UNIT				33
34 SURGICAL INTENSIVE CARE UNIT				34
35 OTHER SPECIAL CARE (SPECIFY)				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF	15,375		13,917	41
42 SUBPROVIDER I				42
43 NURSERY	4,493			43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	127,721		70,565	200

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-0125)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF				
COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST		NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS. 1-4) 5	TOTAL O/P COST (SUM OF COLS. 2-4) 6			
	1									
ANCILLARY SERVICE COST CENTERS										
50		OPERATING ROOM					50			
52		DELIVERY ROOM & LABOR ROOM					52			
54		RADIOLOGY-DIAGNOSTIC					54			
60		LABORATORY					60			
62		WHOLE BLOOD & PACKED RED BLOO					62			
62.30		BLOOD CLOTTING FOR HEMOPHILIA					62.30			
65		RESPIRATORY THERAPY					65			
66		PHYSICAL THERAPY					66			
70		ELECTROENCEPHALOGRAPHY					70			
71		MEDICAL SUPPLIES CHRGED TO PA					71			
72		IMPL. DEV. CHARGED TO PATIENT					72			
73		DRUGS CHARGED TO PATIENTS					73			
76		CARDIOLOGY					76			
76.97		CARDIAC REHABILITATION					76.97			
76.98		HYPERBARIC OXYGEN THERAPY					76.98			
76.99		LITHOTRIPSY					76.99			
OUTPATIENT SERVICE COST CENTERS										
90		CLINIC					90			
91		EMERGENCY					91			
92		OBSERVATION BEDS					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	[ ] TITLE V	[XX] HOSPITAL (15-0125)	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA		
BOXES	[ ] TITLE XIX	[ ] IRF	[ ] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	139,152,922		28,440,615		22,813,767	50
52	DELIVERY ROOM & LABOR ROOM	7,307,816		16,959			52
54	RADIOLOGY-DIAGNOSTIC	199,257,278		32,120,064		48,848,111	54
60	LABORATORY	137,039,492		36,408,087		3,747,861	60
62	WHOLE BLOOD & PACKED RED BLO	10,230,495		3,950,579		959,823	62
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	28,024,845		16,918,329		494,225	65
66	PHYSICAL THERAPY	37,570,521		6,828,725		135,925	66
70	ELECTROENCEPHALOGRAPHY	8,078,842		1,200,685		1,885,339	70
71	MEDICAL SUPPLIES CHRGED TO P	44,993,174		14,248,277		10,211,061	71
72	IMPL. DEV. CHARGED TO PATIEN	56,159,253		23,305,808		7,843,016	72
73	DRUGS CHARGED TO PATIENTS	98,663,525		41,451,484		9,624,009	73
76	CARDIOLOGY	104,650,505		33,959,262		29,732,540	76
76.97	CARDIAC REHABILITATION	1,420,554		189,107		616,260	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	4,917,196		75,810		2,510,066	90
91	EMERGENCY	68,541,548		13,988,951		8,015,956	91
92	OBSERVATION BEDS	14,808,651				3,909,722	92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	960,816,617		253,102,742		151,347,681	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS				
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.316480	22,813,767			7,220,101		50
52 DELIVERY ROOM & LABOR ROOM	0.672837						52
54 RADIOLOGY-DIAGNOSTIC	0.140539	48,848,111			6,865,065		54
60 LABORATORY	0.128027	3,747,861			479,827		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.425321	959,823			408,233		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.229449	494,225			113,399		65
66 PHYSICAL THERAPY	0.363817	135,925			49,452		66
70 ELECTROENCEPHALOGRAPHY	0.220091	1,885,339			414,946		70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.438891	10,211,061			4,481,543		71
72 IMPL. DEV. CHARGED TO PATIENT	0.558202	7,843,016			4,377,987		72
73 DRUGS CHARGED TO PATIENTS	0.228761	9,624,009		60,081	2,201,598	13,744	73
76 CARDIOLOGY	0.202308	29,732,540			6,015,131		76
76.97 CARDIAC REHABILITATION	0.678127	616,260			417,903		76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.701597	2,510,066			1,761,055		90
91 EMERGENCY	0.217875	8,015,956			1,746,476		91
92 OBSERVATION BEDS	0.460128	3,909,722			1,798,973		92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)		151,347,681		60,081	38,351,689	13,744	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		151,347,681		60,081	38,351,689	13,744	202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX	[ ] HOSPITAL [ ] IPF [XX] IRF (15-T125)	[ ] SUB (OTHER)	[XX] PPS [ ] TEFRA				
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5			
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	4,543,906	139,152,922	0.032654	240,240	7,845		50
52	DELIVERY ROOM & LABOR ROOM	458,879	7,307,816	0.062793				52
54	RADIOLOGY-DIAGNOSTIC	6,260,418	199,257,278	0.031419	1,102,410	34,637		54
60	LABORATORY	1,136,784	137,039,492	0.008295	2,314,452	19,198		60
62	WHOLE BLOOD & PACKED RED BLOO	99,099	10,230,495	0.009687	211,940	2,053		62
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY	393,076	28,024,845	0.014026	713,626	10,009		65
66	PHYSICAL THERAPY	743,414	37,570,521	0.019787	12,235,974	242,113		66
70	ELECTROENCEPHALOGRAPHY	427,192	8,078,842	0.052878	245,578	12,986		70
71	MEDICAL SUPPLIES CHRGED TO PA	368,946	44,993,174	0.008200	1,042,225	8,546		71
72	IMPL. DEV. CHARGED TO PATIENT	311,024	56,159,253	0.005538	33,180	184		72
73	DRUGS CHARGED TO PATIENTS	749,281	98,663,525	0.007594	4,496,135	34,144		73
76	CARDIOLOGY	4,228,144	104,650,505	0.040403	438,523	17,718		76
76.97	CARDIAC REHABILITATION	48,580	1,420,554	0.034198	326	11		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	251,411	4,917,196	0.051129	6,245	319		90
91	EMERGENCY	1,427,915	68,541,548	0.020833	1,108	23		91
92	OBSERVATION BEDS	411,428	14,808,651	0.027783				92
OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	21,859,497	960,816,617		23,081,962	389,786		200

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

  

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN					
	ANESTHETIST			EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS. 1-4)	COLS. 2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM					50
52	DELIVERY ROOM & LABOR ROOM					52
54	RADIOLOGY-DIAGNOSTIC					54
60	LABORATORY					60
62	WHOLE BLOOD & PACKED RED BLOO					62
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
70	ELECTROENCEPHALOGRAPHY					70
71	MEDICAL SUPPLIES CHRGED TO PA					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
76	CARDIOLOGY					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC					90
91	EMERGENCY					91
92	OBSERVATION BEDS					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	[ ] TITLE V	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA		
BOXES	[ ] TITLE XIX	[XX] IRF (15-T125)	[ ] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	139,152,922		240,240			50
52	DELIVERY ROOM & LABOR ROOM	7,307,816					52
54	RADIOLOGY-DIAGNOSTIC	199,257,278		1,102,410			54
60	LABORATORY	137,039,492		2,314,452			60
62	WHOLE BLOOD & PACKED RED BLO	10,230,495		211,940			62
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	28,024,845		713,626			65
66	PHYSICAL THERAPY	37,570,521		12,235,974			66
70	ELECTROENCEPHALOGRAPHY	8,078,842		245,578			70
71	MEDICAL SUPPLIES CHRGD TO P	44,993,174		1,042,225			71
72	IMPL. DEV. CHARGED TO PATIEN	56,159,253		33,180			72
73	DRUGS CHARGED TO PATIENTS	98,663,525		4,496,135			73
76	CARDIOLOGY	104,650,505		438,523			76
76.97	CARDIAC REHABILITATION	1,420,554		326			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	4,917,196		6,245			90
91	EMERGENCY	68,541,548		1,108			91
92	OBSERVATION BEDS	14,808,651					92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	960,816,617		23,081,962			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.316480						50
52 DELIVERY ROOM & LABOR ROOM	0.672837						52
54 RADIOLOGY-DIAGNOSTIC	0.140539						54
60 LABORATORY	0.128027						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.425321						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.229449						65
66 PHYSICAL THERAPY	0.363817						66
70 ELECTROENCEPHALOGRAPHY	0.220091						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.438891						71
72 IMPL. DEV. CHARGED TO PATIENT	0.558202						72
73 DRUGS CHARGED TO PATIENTS	0.228761						73
76 CARDIOLOGY	0.202308						76
76.97 CARDIAC REHABILITATION	0.678127						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.701597						90
91 EMERGENCY	0.217875						91
92 OBSERVATION BEDS	0.460128						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	4,399,283		4,399,283	92,610	47.50	3,378	160,455	30
31 INTENSIVE CARE UNIT	1,195,470		1,195,470	9,804	121.94	338	41,216	31
32 CORONARY CARE UNIT								32
32.01 NEONATAL INTENSIVE CARE	315,512		315,512	5,439	58.01	464	26,917	32.01
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF	603,057		603,057	15,375	39.22	153	6,001	41
42 SUBPROVIDER I								42
43 NURSERY	86,985		86,985	4,493	19.36	359	6,950	43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	6,600,307		6,600,307	127,721		4,692	241,539	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

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

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL (COL. 3 x COL. 4)	
	(FROM WKST B, PT. II, COL. 26)	(FROM WKST C, PT. I, COL. 8)	(COL. 1 ÷ COL. 2)			
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,543,906	139,152,922	0.032654	1,515,424	49,485	50
52 DELIVERY ROOM & LABOR ROOM	458,879	7,307,816	0.062793	117,697	7,391	52
54 RADIOLOGY-DIAGNOSTIC	6,260,418	199,257,278	0.031419	2,481,739	77,974	54
60 LABORATORY	1,136,784	137,039,492	0.008295	2,849,525	23,637	60
62 WHOLE BLOOD & PACKED RED BLOO	99,099	10,230,495	0.009687	350,486	3,395	62
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	393,076	28,024,845	0.014026	575,862	8,077	65
66 PHYSICAL THERAPY	743,414	37,570,521	0.019787	307,676	6,088	66
70 ELECTROENCEPHALOGRAPHY	427,192	8,078,842	0.052878	57,177	3,023	70
71 MEDICAL SUPPLIES CHRGED TO PA	368,946	44,993,174	0.008200	871,402	7,145	71
72 IMPL. DEV. CHARGED TO PATIENT	311,024	56,159,253	0.005538	463,847	2,569	72
73 DRUGS CHARGED TO PATIENTS	749,281	98,663,525	0.007594	4,034,730	30,640	73
76 CARDIOLOGY	4,228,144	104,650,505	0.040403	1,242,212	50,189	76
76.97 CARDIAC REHABILITATION	48,580	1,420,554	0.034198	4,810	164	76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	251,411	4,917,196	0.051129	44,925	2,297	90
91 EMERGENCY	1,427,915	68,541,548	0.020833	859,702	17,910	91
92 OBSERVATION BEDS	411,428	14,808,651	0.027783			92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	21,859,497	960,816,617		15,777,214	289,984	200

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

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

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2012.11  
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	TOTAL	PER DIEM	INPATIENT	INPAT PGM
	PATIENT DAYS 6	COL.5 ÷ COL.6) 7	PROGRAM DAYS 8	PASS THRU COSTS (COL.7 x COL.8) 9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	92,610		3,378	30
31 INTENSIVE CARE UNIT	9,804		338	31
32 CORONARY CARE UNIT				32
32.01 NEONATAL INTENSIVE CARE	5,439		464	32.01
33 BURN INTENSIVE CARE UNIT				33
34 SURGICAL INTENSIVE CARE UNIT				34
35 OTHER SPECIAL CARE (SPECIFY)				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF	15,375		153	41
42 SUBPROVIDER I				42
43 NURSERY	4,493		359	43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	127,721		4,692	200

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2012.11  
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62 WHOLE BLOOD & PACKED RED BLOO						62
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
70 ELECTROENCEPHALOGRAPHY						70
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIOLOGY						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						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	[ ] TITLE V	[XX] HOSPITAL (15-0125)	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS		
APPLICABLE	[ ] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA		
BOXES	[XX] TITLE XIX	[ ] IRF	[ ] NF		[ ] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	139,152,922			1,515,424		50
52	DELIVERY ROOM & LABOR ROOM	7,307,816			117,697		52
54	RADIOLOGY-DIAGNOSTIC	199,257,278			2,481,739		54
60	LABORATORY	137,039,492			2,849,525		60
62	WHOLE BLOOD & PACKED RED BLO	10,230,495			350,486		62
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	28,024,845			575,862		65
66	PHYSICAL THERAPY	37,570,521			307,676		66
70	ELECTROENCEPHALOGRAPHY	8,078,842			57,177		70
71	MEDICAL SUPPLIES CHRGD TO P	44,993,174			871,402		71
72	IMPL. DEV. CHARGED TO PATIEN	56,159,253			463,847		72
73	DRUGS CHARGED TO PATIENTS	98,663,525			4,034,730		73
76	CARDIOLOGY	104,650,505			1,242,212		76
76.97	CARDIAC REHABILITATION	1,420,554			4,810		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	4,917,196			44,925		90
91	EMERGENCY	68,541,548			859,702		91
92	OBSERVATION BEDS	14,808,651					92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	960,816,617			15,777,214		200

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2012.11  
 12/27/2012 19:29

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST	COST	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.316480						50
52 DELIVERY ROOM & LABOR ROOM	0.672837						52
54 RADIOLOGY-DIAGNOSTIC	0.140539						54
60 LABORATORY	0.128027						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.425321						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.229449						65
66 PHYSICAL THERAPY	0.363817						66
70 ELECTROENCEPHALOGRAPHY	0.220091						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.438891						71
72 IMPL. DEV. CHARGED TO PATIENT	0.558202						72
73 DRUGS CHARGED TO PATIENTS	0.228761						73
76 CARDIOLOGY	0.202308						76
76.97 CARDIAC REHABILITATION	0.678127						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.701597						90
91 EMERGENCY	0.217875						91
92 OBSERVATION BEDS	0.460128						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[ ] HOSPITAL [ ] IPF [XX] IRF (15-T125)	[ ] SUB (OTHER)	[XX] PPS [ ] TEFRA [ ] OTHER				
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5			
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	4,543,906	139,152,922	0.032654				50
52	DELIVERY ROOM & LABOR ROOM	458,879	7,307,816	0.062793				52
54	RADIOLOGY-DIAGNOSTIC	6,260,418	199,257,278	0.031419	20,146	633		54
60	LABORATORY	1,136,784	137,039,492	0.008295	19,401	161		60
62	WHOLE BLOOD & PACKED RED BLOO	99,099	10,230,495	0.009687	424	4		62
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY	393,076	28,024,845	0.014026	5,621	79		65
66	PHYSICAL THERAPY	743,414	37,570,521	0.019787	125,721	2,488		66
70	ELECTROENCEPHALOGRAPHY	427,192	8,078,842	0.052878	2,022	107		70
71	MEDICAL SUPPLIES CHRGED TO PA	368,946	44,993,174	0.008200	4,522	37		71
72	IMPL. DEV. CHARGED TO PATIENT	311,024	56,159,253	0.005538				72
73	DRUGS CHARGED TO PATIENTS	749,281	98,663,525	0.007594	49,867	379		73
76	CARDIOLOGY	4,228,144	104,650,505	0.040403	2,673	108		76
76.97	CARDIAC REHABILITATION	48,580	1,420,554	0.034198				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	251,411	4,917,196	0.051129				90
91	EMERGENCY	1,427,915	68,541,548	0.020833				91
92	OBSERVATION BEDS	411,428	14,808,651	0.027783				92
OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	21,859,497	960,816,617		230,397	3,996		200

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input type="checkbox"/>	HOSPITAL	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	ICF/MR	<input checked="" type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>		<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input checked="" type="checkbox"/>	IRF (15-T125)	<input type="checkbox"/>	NF	<input type="checkbox"/>		<input type="checkbox"/>	OTHER
COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P				
	PHYSICIAN ANESTHETIST COST 1	SCHOOL 2	HEALTH 3	MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6				
ANCILLARY SERVICE COST CENTERS										
50	OPERATING ROOM					50				
52	DELIVERY ROOM & LABOR ROOM					52				
54	RADIOLOGY-DIAGNOSTIC					54				
60	LABORATORY					60				
62	WHOLE BLOOD & PACKED RED BLOO					62				
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30				
65	RESPIRATORY THERAPY					65				
66	PHYSICAL THERAPY					66				
70	ELECTROENCEPHALOGRAPHY					70				
71	MEDICAL SUPPLIES CHRGED TO PA					71				
72	IMPL. DEV. CHARGED TO PATIENT					72				
73	DRUGS CHARGED TO PATIENTS					73				
76	CARDIOLOGY					76				
76.97	CARDIAC REHABILITATION					76.97				
76.98	HYPERBARIC OXYGEN THERAPY					76.98				
76.99	LITHOTRIPSY					76.99				
OUTPATIENT SERVICE COST CENTERS										
90	CLINIC					90				
91	EMERGENCY					91				
92	OBSERVATION BEDS					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	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[XX]	IRF (15-T125)	[ ]	NF			[ ]	OTHER
COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT	INPAT PGM	O/P PGM	O/P PGM			
	CHARGES	COST TO	OF COST TO		PASS-THRU		PASS-THRU	PASS-THRU		
	(FROM WKST	CHARGES	CHARGES	PGM	COSTS	CHARGES	COSTS			
	C, PT. I,	(COL. 5 +	(COL. 6 +	CHARGES	(COL. 8 x	CHARGES	(COL. 9 x			
	COL. 8)	COL. 7)	COL. 7)	10	COL. 10)	12	COL. 12)			
	7	8	9		11		13			
ANCILLARY SERVICE COST CENTERS										
50	OPERATING ROOM	139,152,922								50
52	DELIVERY ROOM & LABOR ROOM	7,307,816								52
54	RADIOLOGY-DIAGNOSTIC	199,257,278		20,146						54
60	LABORATORY	137,039,492		19,401						60
62	WHOLE BLOOD & PACKED RED BLO	10,230,495		424						62
62.30	BLOOD CLOTTING FOR HEMOPHILI									62.30
65	RESPIRATORY THERAPY	28,024,845		5,621						65
66	PHYSICAL THERAPY	37,570,521		125,721						66
70	ELECTROENCEPHALOGRAPHY	8,078,842		2,022						70
71	MEDICAL SUPPLIES CHRGED TO P	44,993,174		4,522						71
72	IMPL. DEV. CHARGED TO PATIEN	56,159,253								72
73	DRUGS CHARGED TO PATIENTS	98,663,525		49,867						73
76	CARDIOLOGY	104,650,505		2,673						76
76.97	CARDIAC REHABILITATION	1,420,554								76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
OUTPATIENT SERVICE COST CENTERS										
90	CLINIC	4,917,196								90
91	EMERGENCY	68,541,548								91
92	OBSERVATION BEDS	14,808,651								92
OTHER REIMBURSABLE COST CENTERS										
200	TOTAL (SUM OF LINES 50-199)	960,816,617		230,397						200

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

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

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST	COST	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.316480						50
52 DELIVERY ROOM & LABOR ROOM	0.672837						52
54 RADIOLOGY-DIAGNOSTIC	0.140539						54
60 LABORATORY	0.128027						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.425321						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.229449						65
66 PHYSICAL THERAPY	0.363817						66
70 ELECTROENCEPHALOGRAPHY	0.220091						70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.438891						71
72 IMPL. DEV. CHARGED TO PATIENT	0.558202						72
73 DRUGS CHARGED TO PATIENTS	0.228761						73
76 CARDIOLOGY	0.202308						76
76.97 CARDIAC REHABILITATION	0.678127						76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.701597						90
91 EMERGENCY	0.217875						91
92 OBSERVATION BEDS	0.460128						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	92,610	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	92,610	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,000	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	73,949	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)	51,402	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)	72,858,891	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	72,858,891	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	67,581,390	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,365,795	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	59,215,595	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.078091	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	836.58	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	800.76	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	35.82	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	38.62	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	386,200	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	72,472,691	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 786.73 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 40,439,495 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) 40,439,495 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	15,443,320	9,804	1,575.21	5,246	8,263,552	43
44 CORONARY CARE UNIT						44
44.01 NEONATAL INTENSIVE CARE	5,620,792	5,439	1,033.42			44.01
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					65,418,464	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					114,121,511	49
PASS-THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					3,081,292	50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					4,949,643	51
52 TOTAL PROGRAM EXCLUDABLE COST					8,030,935	52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					106,090,576	53
TARGET AMOUNT AND LIMIT COMPUTATION						
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT (LINE 54 x LINE 55)						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT (SEE INSTRUCTIONS)						58
59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)						61
62 RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
PROGRAM INPATIENT ROUTINE SWING BED COST						
64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)						64
65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)						65
66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						66
67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 8,661 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 786.73 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 6,813,869 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	4,399,283	72,858,891	0.060381	6,813,869	411,428	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	15,375	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	15,375	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,524	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,851	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	13,917	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	1,317	14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	10,560,194	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	10,560,194	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,447,659	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	646,362	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,801,297	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.938483	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	424.12	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	346.64	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	77.48	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	150.19	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	228,890	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	10,331,304	37

WORKSHEET D-1  
PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	686.84 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	9,558,752 39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)	40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	9,558,752 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	6,886,353 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	16,445,105 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	545,825 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	389,786 51
52	TOTAL PROGRAM EXCLUDABLE COST	935,611 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	15,509,494 53
TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES	54
55	TARGET AMOUNT PER DISCHARGE	55
56	TARGET AMOUNT (LINE 54 x LINE 55)	56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58	BONUS PAYMENT (SEE INSTRUCTIONS)	58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)	61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	92,610	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	92,610	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,000	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	73,949	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,378	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)	4,493	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	359	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)	72,858,891	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	72,858,891	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	67,581,390	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,365,795	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	59,215,595	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.078091	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	836.58	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	800.76	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	35.82	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	38.62	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	386,200	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	72,472,691	37

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 786.73 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,657,574 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 2,657,574 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	3,163,475	4,493	704.09	359	252,768 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	15,443,320	9,804	1,575.21	338	532,421 43
44 CORONARY CARE UNIT					44
44.01 NEONATAL INTENSIVE CARE	5,620,792	5,439	1,033.42	464	479,507 44.01
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					3,719,353 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					7,641,623 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 235,538 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 289,984 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 525,522 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 7,116,101 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 8,661 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	15,375	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	15,375	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,524	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,851	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)	153	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	10,560,194	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	10,560,194	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,447,659	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	646,362	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,801,297	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.938483	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	424.12	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	346.64	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	77.48	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	150.19	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	228,890	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	10,331,304	37

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	686.84 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	105,087 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)	105,087 41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	66,915 48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	172,002 49
PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	6,001 50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	3,996 51
52	TOTAL PROGRAM EXCLUDABLE COST	9,997 52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	162,005 53
TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES	54
55	TARGET AMOUNT PER DISCHARGE	55
56	TARGET AMOUNT (LINE 54 x LINE 55)	56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	57
58	BONUS PAYMENT (SEE INSTRUCTIONS)	58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)	61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)	62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	63
PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)	67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)	68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)	69

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		49,164,571		30
31 INTENSIVE CARE UNIT		9,297,481		31
32.01 NEONATAL INTENSIVE CARE				32.01
41 SUBPROVIDER - IRF				41
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.316480	28,440,615	9,000,886	50
52 DELIVERY ROOM & LABOR ROOM	0.672837	16,959	11,411	52
54 RADIOLOGY-DIAGNOSTIC	0.140706	32,120,064	4,519,486	54
60 LABORATORY	0.128085	36,408,087	4,663,330	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.425321	3,950,579	1,680,264	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.229449	16,918,329	3,881,894	65
66 PHYSICAL THERAPY	0.363817	6,828,725	2,484,406	66
70 ELECTROENCEPHALOGRAPHY	0.221570	1,200,685	266,036	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.438891	14,248,277	6,253,441	71
72 IMPL. DEV. CHARGED TO PATIENT	0.558202	23,305,808	13,009,349	72
73 DRUGS CHARGED TO PATIENTS	0.228761	41,451,484	9,482,483	73
76 CARDIOLOGY	0.203983	33,959,262	6,927,112	76
76.97 CARDIAC REHABILITATION	0.678127	189,107	128,239	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.706068	75,810	53,527	90
91 EMERGENCY	0.218501	13,988,951	3,056,600	91
92 OBSERVATION BEDS	0.460128			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		253,102,742	65,418,464	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		253,102,742		202

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2012.11  
 12/27/2012 19:29

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
32.01 NEONATAL INTENSIVE CARE				32.01
41 SUBPROVIDER - IRF		8,867,835		41
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.316480	240,240	76,031	50
52 DELIVERY ROOM & LABOR ROOM	0.672837			52
54 RADIOLOGY-DIAGNOSTIC	0.140706	1,102,410	155,116	54
60 LABORATORY	0.128085	2,314,452	296,447	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.425321	211,940	90,143	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.229449	713,626	163,741	65
66 PHYSICAL THERAPY	0.363817	12,235,974	4,451,655	66
70 ELECTROENCEPHALOGRAPHY	0.221570	245,578	54,413	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.438891	1,042,225	457,423	71
72 IMPL. DEV. CHARGED TO PATIENT	0.558202	33,180	18,521	72
73 DRUGS CHARGED TO PATIENTS	0.228761	4,496,135	1,028,540	73
76 CARDIOLOGY	0.203983	438,523	89,451	76
76.97 CARDIAC REHABILITATION	0.678127	326	221	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.706068	6,245	4,409	90
91 EMERGENCY	0.218501	1,108	242	91
92 OBSERVATION BEDS	0.460128			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		23,081,962	6,886,353	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		23,081,962		202

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
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KPMG LLP COMPU-MAX MICRO SYSTEM  
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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (15-0125)	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	S/B SNF	<input checked="" type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>	S/B NF	<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF	<input type="checkbox"/>	ICF/MR	<input type="checkbox"/>	OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		3,194,286		30
31 INTENSIVE CARE UNIT		534,815		31
32.01 NEONATAL INTENSIVE CARE		589,242		32.01
41 SUBPROVIDER - IRF				41
43 NURSERY		142,498		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.316480	1,515,424	479,601	50
52 DELIVERY ROOM & LABOR ROOM	0.672837	117,697	79,191	52
54 RADIOLOGY-DIAGNOSTIC	0.140706	2,481,739	349,196	54
60 LABORATORY	0.128085	2,849,525	364,981	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.425321	350,486	149,069	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.229449	575,862	132,131	65
66 PHYSICAL THERAPY	0.363817	307,676	111,938	66
70 ELECTROENCEPHALOGRAPHY	0.221570	57,177	12,669	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.438891	871,402	382,450	71
72 IMPL. DEV. CHARGED TO PATIENT	0.558202	463,847	258,920	72
73 DRUGS CHARGED TO PATIENTS	0.228761	4,034,730	922,989	73
76 CARDIOLOGY	0.203983	1,242,212	253,390	76
76.97 CARDIAC REHABILITATION	0.678127	4,810	3,262	76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.706068	44,925	31,720	90
91 EMERGENCY	0.218501	859,702	187,846	91
92 OBSERVATION BEDS	0.460128			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		15,777,214	3,719,353	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		15,777,214		202

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32.01 NEONATAL INTENSIVE CARE					32.01
41 SUBPROVIDER - IRF		81,602			41
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.316480				50
52 DELIVERY ROOM & LABOR ROOM	0.672837				52
54 RADIOLOGY-DIAGNOSTIC	0.140706	20,146	2,835		54
60 LABORATORY	0.128085	19,401	2,485		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.425321	424	180		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.229449	5,621	1,290		65
66 PHYSICAL THERAPY	0.363817	125,721	45,739		66
70 ELECTROENCEPHALOGRAPHY	0.221570	2,022	448		70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.438891	4,522	1,985		71
72 IMPL. DEV. CHARGED TO PATIENT	0.558202				72
73 DRUGS CHARGED TO PATIENTS	0.228761	49,867	11,408		73
76 CARDIOLOGY	0.203983	2,673	545		76
76.97 CARDIAC REHABILITATION	0.678127				76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	0.706068				90
91 EMERGENCY	0.218501				91
92 OBSERVATION BEDS	0.460128				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		230,397	66,915		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		230,397			202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	83,917,306	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	2,259,440	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	382.34	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0314	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1441	31
32	SUM OF LINES 30 AND 31	0.1755	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0416	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	3,490,960	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	89,667,706	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	89,667,706	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	7,192,120	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	96,859,826	59
60	PRIMARY PAYER PAYMENTS	50,143	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	96,809,683	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	7,994,527	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	627,649	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	956,866	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	669,806	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	241,457	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	88,857,313	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SEQUESTRATION PER PSR)	4,714	70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	88,862,027	71
72	INTERIM PAYMENTS	89,202,664	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-340,637	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	40,000	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	13,744	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	38,351,689	2
3	PPS PAYMENTS	36,055,097	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	123,690	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)	13,744	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	60,081	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)	60,081	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)	60,081	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	46,337	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)	13,744	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)	36,178,787	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	7,933,371	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	28,259,160	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)	28,259,160	30
31	PRIMARY PAYER PAYMENTS	2,978	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	28,256,182	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)	703,304	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	492,313	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	240,682	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	28,748,495	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	1,676	38
39	OTHER ADJUSTMENTS (FDO LOSS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	28,746,819	40
41	INTERIM PAYMENTS	29,015,237	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-268,418	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [XX] HOSPITAL (15-0125) [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOX: [ ] IRF [ ] SWING BED SNF

INPATIENT  
 PART A PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		88,615,990		28,250,960
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.		754,146		720,809
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE	04/16/2012	43,468
PROGRAM .01				3.01
TO .02				3.02
PROVIDER .03				3.03
TO .04				3.04
PROVIDER .05				3.05
TO .06				3.06
PROVIDER .07				3.07
TO .08				3.08
PROVIDER .09				3.09
TO .50				3.50
PROVIDER .51	04/16/2012	167,472		NONE
TO .52				3.51
PROVIDER .53				3.52
TO .54				3.53
PROVIDER .55				3.54
TO .56				3.55
PROVIDER .57				3.56
TO .58				3.57
PROVIDER .59				3.58
TO .99				3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-167,472		43,468
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		89,202,664		29,015,237

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE
PROGRAM .01				5.01
TO .02				5.02
PROVIDER .03				5.03
TO .04				5.04
PROVIDER .05				5.05
TO .06				5.06
PROVIDER .07				5.07
TO .08				5.08
PROVIDER .09				5.09
TO .50				5.50
PROVIDER .51		NONE		NONE
TO .52				5.51
PROVIDER .53				5.52
TO .54				5.53
PROVIDER .55				5.54
TO .56				5.55
PROVIDER .57				5.56
TO .58				5.57
PROVIDER .59				5.58
TO .99				5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT				
PROGRAM .01				6.01
TO .02				6.02
PROVIDER .03				6.03
TO .04				6.04
PROVIDER .05				6.05
TO .06				6.06
PROVIDER .07				6.07
TO .08				6.08
PROVIDER .09				6.09
TO .50				6.50
PROVIDER .51		-340,637		-268,418
TO .52				6.51
PROVIDER .53				6.52
TO .54				6.53
PROVIDER .55				6.54
TO .56				6.55
PROVIDER .57				6.56
TO .58				6.57
PROVIDER .59				6.58
TO .99				6.59
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		88,862,027		28,746,819
8 NAME OF CONTRACTOR:	CONTRACTOR NUMBER:		NPR DATE:	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [ ] HOSPITAL [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOX: [XX] IRF (15-T125) [ ] SWING BED SNF

INPATIENT  
 PART A PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		20,224,735			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 04/16/2012	65,927		NONE	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99	65,927			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		65,927			
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		20,290,662			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	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01	52,152			6.01
	TO .02				6.02
	PROVIDER .03				6.03
	TO .04				6.04
	PROGRAM .05				6.05
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		20,342,814			7
8 NAME OF CONTRACTOR: _____		CONTRACTOR NUMBER: _____		NPR DATE: _____	8

PROVIDER CCN: 15-0125 COMMUNITY HOSPITAL  
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2012.11  
12/27/2012 19:29

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK  HOSPITAL (15-0125)  CAH  
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	22,375	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	56,648	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	2,667	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	99,192	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,081,673,049	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	19,906,286	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART III

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	20,089,382	1
2	MEDICARE SSI RATIO (SEE INSTRUCTIONS)	0.017200	2
3	INPATIENT REHABILITATION LIP PAYMENTS (SEE INSTRUCTIONS)	249,791	3
4	OUTLIER PAYMENTS	213,332	4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		5
5.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)		5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R 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)	42.008197	10
11	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (\text{LINE 9}/\text{LINE 10})) \text{ RAISED TO THE POWER OF } .6876 - 1\}$		11
12	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 11)		12
13	TOTAL PPS PAYMENT (SUM OF LINES 1, 3, 4 AND 12)	20,552,505	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)	20,552,505	17
18	PRIMARY PAYER PAYMENTS	3,018	18
19	SUBTOTAL LINE 17b LESS LINE 18)	20,549,487	19
20	DEDUCTIBLES	135,860	20
21	SUBTOTAL (LINE 19 MINUS LINE 20)	20,413,627	21
22	COINSURANCE	76,570	22
23	SUBTOTAL (LINE 21 MINUS LINE 22)	20,337,057	23
24	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	8,224	24
25	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	5,757	25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	3,364	26
27	SUBTOTAL (SUM OF LINES 23 AND 25)	20,342,814	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IRF ONLY)		28
29	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		29
30	OUTLIER PAYMENTS RECONCILIATION		30
31	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	20,342,814	32
33	INTERIM PAYMENTS	20,290,662	33
34	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		34
35	BALANCE DUE PROVIDER/PROGRAM (LINE 32 MINUS THE SUM OF LINES 33 AND 34)	52,152	35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		36

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

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

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

		INPATIENT	OUTPATIENT
		TITLE V OR	TITLE V OR
		TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES		1
2	MEDICAL AND OTHER SERVICES		2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)		4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)		7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	3,194,286	8
9	ANCILLARY SERVICE CHARGES	15,777,214	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)	18,971,500	12
CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	18,971,500	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	18,971,500	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS		22
23	OUTLIER PAYMENTS		23
24	PROGRAM CAPITAL PAYMENTS		24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29	SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (FROM LINE 18)		30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32	DEDUCTIBLES		32
33	COINSURANCE		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	UTILIZATION REVIEW		35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

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

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

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES		1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)		4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)		7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES	230,397	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)	230,397	12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000 15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	230,397	16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	230,397	17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)		38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	13,076,610			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	103,165,839			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-40,603,027			6
7	INVENTORY	8,253,829			7
8	PREPAID EXPENSES	10,928,708			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	94,821,959			11
FIXED ASSETS					
12	LAND	2,809,397			12
13	LAND IMPROVEMENTS	6,430,338			13
14	ACCUMULATED DEPRECIATION	-4,739,547			14
15	BUILDINGS	288,221,964			15
16	ACCUMULATED DEPRECIATION	-173,218,712			16
17	LEASEHOLD IMPROVEMENTS	1,070,559			17
18	ACCUMULATED AMORTIZATION	-844,596			18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS	419,142			21
22	ACCUMULATED DEPRECIATION	-330,869			22
23	MAJOR MOVABLE EQUIPMENT	121,667,258			23
24	ACCUMULATED DEPRECIATION	-86,529,796			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE	78,620			29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	155,033,758			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	3,193,573			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	3,193,573			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	253,049,290			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	12,415,675			37
38	SALARIES, WAGES & FEES PAYABLE	22,025,089			38
39	PAYROLL TAXES PAYABLE	839,193			39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	27,859,272			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	63,139,229			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	103,512,208			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	103,512,208			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	166,651,437			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	86,397,853			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	86,397,853			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	253,049,290			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		123,047,360							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		33,136,062							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		156,183,422							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 NET ASSETS TRANSFERRED TO AF									5
6 PENSION-RELATED CHGS-NOT NET									6
7 RELEASED ASSETS									7
8 RESTRICTED CONTRIBUTIONS		674,000							8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		674,000							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		156,857,422							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 NET ASSETS RELEASED FROM RES		46,000							13
14 PENSION CHANGE		29,182,000							14
15 NET ASSETS TRANSFERRED		40,441,000							15
16 ASSETS RELEASED		790,569							16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		70,459,569							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		86,397,853							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	80,156,448		80,156,448	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF	9,734,995		9,734,995	5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	89,891,443		89,891,443	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	14,956,317		14,956,317	12
12.01 CORONARY CARE UNIT				12.01
13 NEONATAL INTENSIVE CARE	9,508,920		9,508,920	13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	24,465,237		24,465,237	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	114,356,680		114,356,680	17
18 ANCILLARY SERVICES	481,925,724		481,925,724	18
19 OUTPATIENT SERVICES		512,913,026	512,913,026	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY		6,515,825	6,515,825	22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
27.01 PHYSICIAN REVENUES		30,085,485	30,085,485	27.01
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	596,282,404	549,514,336	1,145,796,740	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		431,825,339	29
30 ADD (SPECIFY)			30
31 BAD DEBTS	19,799,000		31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		19,799,000	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)		451,624,339	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	1,145,796,740	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	675,316,740	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	470,480,000	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	451,624,339	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	18,855,661	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,048	6
7	INCOME FROM INVESTMENTS	394,200	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	11,520	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	1,913,622	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	4,690,184	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	42,240	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	11,493	21
22	RENTAL OF HOSPITAL SPACE	247,788	22
23	GOVERNMENTAL APPROPRIATIONS	854,135	23
24	OTHER (OTHER REVENUE)	324,619	24
24.01	OTHER (REVENUE-CLASSES)	88,062	24.01
24.02	OTHER (ASSETS RELEASED FROM RESTRICTION)	832,730	24.02
24.03	OTHER (FITNESS REVENUE)	4,188,891	24.03
24.04	OTHER (SALE OF XRAY SCRAP)	3,238	24.04
24.05	OTHER (OTHER INVESTMENT GAINS)	676,631	24.05
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	14,280,401	25
26	TOTAL (LINE 5 PLUS LINE 25)	33,136,062	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)	33,136,062	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 15-7487

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS. 1-5) 6	
1							1
2							2
3							3
4							4
5	614,241		33,079	3,225	49,013	699,558	5
	HHA REIMBURSABLE SERVICES						
6	1,045,940					1,045,940	6
7				821,017		821,017	7
8				191,079		191,079	8
9							9
10	1,143					1,143	10
11	76,890					76,890	11
12					165,826	165,826	12
13							13
14							14
	HHA NONREIMBURSABLE SERVICES						
15							15
16							16
17	340,164				7,349	347,513	17
18							18
19							19
20							20
21							21
22							22
23							23
24	2,078,378		33,079	1,015,321	222,188	3,348,966	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 15-7487

WORKSHEET H  
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5	-16,134	683,424	-14	683,410	5
6		1,045,940		1,045,940	6
7		821,017		821,017	7
8		191,079		191,079	8
9					9
10		1,143		1,143	10
11		76,890		76,890	11
12		165,826		165,826	12
13					13
14					14
15					15
16					16
17		347,513		347,513	17
18					18
19					19
20					20
21					21
22					22
23					23
24	-16,134	3,332,832	-14	3,332,818	24



COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 15-7487

WORKSHEET H-1  
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-683,410	2,650,462	5
6 SKILLED NURSING CARE						1,045,940	6
7 PHYSICAL THERAPY					1,054	822,071	7
8 OCCUPATIONAL THERAPY						191,079	8
9 SPEECH PATHOLOGY							9
10 MEDICAL SOCIAL SERVICES						1,143	10
11 HOME HEALTH AIDE						76,890	11
12 SUPPLIES (SEE INSTRUCTIONS)						165,826	12
13 DRUGS							13
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING						347,513	17
18 CLINIC							18
19 HEALTH PROMOTION ACTIVITIES							19
20 DAY CARE PROGRAM							20
21 HOME DELIVERED MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL (SUM OF LINES 1-23)					-682,356	2,650,462	24
25 COST TO BE ALLOC (PER W/S H)						683,410	25
26 UNIT COST MULTIPLIER						0.257846	26







ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 15-7487

WORKSHEET H-2  
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (SUM OF COL. 4A-23) 26	ALLOCATED HHA A&G (SEE PT. 2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	918,069		918,069			1
2 SKILLED NURSING CARE	1,571,948		1,571,948	362,407	1,934,355	2
3 PHYSICAL THERAPY	1,234,237		1,234,237	284,550	1,518,787	3
4 OCCUPATIONAL THERAPY	287,174		287,174	66,207	353,381	4
5 SPEECH PATHOLOGY						5
6 MEDICAL SOCIAL SERVICES	1,718		1,718	396	2,114	6
7 HOME HEALTH AIDE	115,559		115,559	26,642	142,201	7
8 SUPPLIES	249,222		249,222	57,457	306,679	8
9 DRUGS						9
10 DME						10
11 HOME DIALYSIS AIDE SERVICES						11
12 RESPIRATORY THERAPY						12
13 PRIVATE DUTY NURSING	522,280		522,280	120,410	642,690	13
14 CLINIC						14
15 HEALTH PROMOTION ACTIVITIES						15
16 DAY CARE PROGRAM						16
17 HOME DELIVERED MEALS PROGRAM						17
18 HOMEMAKER SERVICE						18
19 ALL OTHERS						19
20 TOTAL (SUM OF LINES 1-19)	4,900,207		4,900,207	918,069	4,900,207	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.230547		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 15-7487

WORKSHEET H-2  
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- \$ VALUE	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
	1	2	3	4	4A	5	6	7	
1 ADMINISTRATIVE AND GENERAL	3,575	22,412		2,078,378		628,358		3,575	1
2 SKILLED NURSING CARE						1,315,629			2
3 PHYSICAL THERAPY						1,032,985			3
4 OCCUPATIONAL THERAPY						240,348			4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES						1,438			6
7 HOME HEALTH AIDE						96,716			7
8 SUPPLIES						208,584			8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING						437,118			13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)	3,575	22,412		2,078,378		3,961,176		3,575	20
21 TOTAL COST TO BE ALLOCATED	39,583	36,922		551,853		771,740		115,384	21
22 UNIT COST MULTIPLIER	11.072168								22
22 UNIT COST MULTIPLIER		1.647421		0.265521		0.194826		32.275245	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 15-7487

WORKSHEET H-2  
 PART II

HHA COST CENTER	LAUNDRY + LINEN SERVICE POUNDS	HOUSE- KEEPING TIME SPENT	DIETARY PATIENT MEALS	CAFETERIA ME FTES	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS- TRATION NURSING HO URS	CENTRAL SERVICES & SUPPLY COSTED REQ	PHARMACY COSTED REQ	
	8	9	10	11	12	13	14	15	
1 ADMINISTRATIVE AND GENERAL		1,200		3,742					1
2 SKILLED NURSING CARE									2
3 PHYSICAL THERAPY									3
4 OCCUPATIONAL THERAPY									4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE									7
8 SUPPLIES									8
9 DRUGS									9
10 DME									10
11 HOME DIALYSIS AIDE SERVICES									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIES									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGRAM									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTAL (SUM OF LINES 1-19)		1,200		3,742					20
21 TOTAL COST TO BE ALLOCATED		9,899		42,008					21
22 UNIT COST MULTIPLIER									22
22 UNIT COST MULTIPLIER		8.249167		11.226082					22



APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 15-7487

WORKSHEET H-3  
 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	4	(COL.3 ÷ COL.4)	
1	SKILLED NURSING CARE	2	1,934,355	2	1,934,355	21,361	90.56	1
2	PHYSICAL THERAPY	3	1,518,787	24,096	1,542,883	13,705	112.58	2
3	OCCUPATIONAL THERAPY	4	353,381		353,381	3,164	111.69	3
4	SPEECH PATHOLOGY	5				358		4
5	MEDICAL SOCIAL SERVICES	6	2,114		2,114	15	140.93	5
6	HOME HEALTH AIDE	7	142,201		142,201	4,340	32.77	6
7	TOTAL (SUM OF LINES 1-6)		3,950,838	24,096	3,974,934	42,943		7

PATIENT SERVICES

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

SUPPLIES AND DRUGS COST COMPUTATIONS

OTHER PATIENT SERVICES		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	
		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	(FROM HHA RECORD)	(COL.3 ÷ COL.4)	
15	COST OF MEDICAL SUPPLIES	8	306,679	2	306,679	361,287	0.848851	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 15-7487

WORKSHEET H-3  
 PARTS I & II  
 (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART B			PART B			
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
	6	7	8	9	10	11	12
1 SKILLED NURSING CARE	10,487	6,026		949,703	545,715		1,495,418
2 PHYSICAL THERAPY	7,527	3,875		847,390	436,248		1,283,638
3 OCCUPATIONAL THERAPY	1,995	720		222,822	80,417		303,239
4 SPEECH PATHOLOGY	251	38					
5 MEDICAL SOCIAL SERVICES	11	8		1,550	1,127		2,677
6 HOME HEALTH AIDE	2,175	1,726		71,275	56,561		127,836
7 TOTAL (SUM OF LINES 1-6)	22,446	12,393		2,092,740	1,120,068		3,212,808

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS			TOTAL
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
		2	3	4	
8 SKILLED NURSING CARE	23844	10,487	6,026		8
9 PHYSICAL THERAPY	23844	7,527	3,875		9
10 OCCUPATIONAL THERAPY	23844	1,995	720		10
11 SPEECH PATHOLOGY	23844	251	38		11
12 MEDICAL SOCIAL SERVICES	23844	11	8		12
13 HOME HEALTH AIDE	23844	2,175	1,726		13
14 TOTAL (SUM OF LINES 8-13)		22,446	12,393		14

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

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

	FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
			2	3		
1 PHYSICAL THERAPY	66	0.363817	66,230	24,096	COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY	67				COL 2, LINE 3	2
3 SPEECH PATHOLOGY	68				COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHRGED TO PAT	71	0.438891			COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	73	0.228761			COL 2, LINE 16	5

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 15-7487

WORKSHEET H-4  
 PARTS I & II

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

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	2,957,112	1,528,167	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	70,419	47,167	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	31,390	17,506	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES	8,267	13,153	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	14,118	18,378	15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	3,081,306	1,624,371	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	3,081,306	1,624,371	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	3,081,306	1,624,371	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	3,081,306	1,624,371	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	3,081,306	1,624,371	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	3,081,306	1,624,371	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35



CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [ ] TITLE V [XX] HOSPITAL ((15-012) [XX] PPS  
APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB (OTHER) [ ] COST METHOD  
BOXES [ ] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	6,795,796	1
2	CAPITAL DRG OUTLIER PAYMENTS	150,316	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	271.02	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.0314	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.1441	8
9	SUM OF LINES 7 AND 8	0.1755	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0362	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	246,008	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	7,192,120	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [ ] TITLE V [XX] HOSPITAL ((15-012) [XX] PPS  
APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB (OTHER) [ ] COST METHOD  
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32.01 NEONATAL INTENSIVE CARE					32.01
41 SUBPROVIDER - IRF					41
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62 WHOLE BLOOD & PACKED RED BLOOD					62
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
70 ELECTROENCEPHALOGRAPHY					70
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76 CARDIOLOGY					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
191 RESEARCH					191
192 PHYSICIANS' PRIVATE OFFICES					192
194 ADVERTISING					194
194.01 FITNESS POINTE					194.01
194.02 FITNESS POINTE SPA/PRO SHOP/DI					194.02
194.03 RETAIL PHARMACY					194.03
194.04 HOSPICE					194.04
194.05 RUSH RESIDENTS					194.05
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE

EXHIBIT 4

	Amounts From E Part A (1)	Prior to 10/1/10 or after 9/30/12 Pre/Post Entitlement (2)	10/01/2010 through 09/30/2011 (3)	10/01/2011 through 09/30/2012 (4)	(Columns 2 through 4) TOTAL (5)
1	DRG Amounts Other than Outlier Payments (E Part A Line 1)	83,917,306			1
2	Outlier payments for discharges (E Part A Line 2 - see instructions)	2,259,440			2
3	Operating outlier reconciliation (E Part A Line 2.01)				3
4	Managed Care Simulated Payments (E Part A Line 3)				4
INDIRECT MEDICAL EDUCATION ADJUSTMENT					
5	Amount from Worksheet E Part A, Line 21 (see instructions)				5
6	IME payment adjustment (E Part A Line 22 - see instructions)				6
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422					
7	Amount from Worksheet E Part A, Line 27 (see instructions)				7
8	IME add-on adjustment (E Part A Line 28 - see instructions)				8
9	Total IME payment (sum of lines 6 and 8 - ties to E Part A Line 29)				9
DISPROPORTIONATE SHARE ADJUSTMENT					
10	Allowable disproportionate share percentage (E Part A Line 33 - see instructions)	0.0416	0.0416	0.0416	10
11	Disproportionate share adjustment (E Part A Line 34 - see instructions)	3,490,960			11
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES					
12	Total ESRD additional payment (E Part A Line 46 - see instructions)				12
13	Subtotal (ties to E Part A Line 47 - see instructions)	89,667,706			13
14	Hospital specific payments (SCH/MDH, small rural hospitals only (E Part A Line 48 - see instructions))				14
15	Total payment for inpatient operating costs - E Part A Line 49 (SCH/MDH see instructions)	89,667,706			15
16	Payment for inpatient program capital (E Part A Line 50 - from Worksheet L Part I, as applicable)	7,192,120			16
17	Special add-on payments for new technologies (E Part A Line 54)				17
18	Capital outlier reconciliation adjustment amount (E Part A Line 93 - see instructions)				18
19	SUBTOTAL (SEE INSTRUCTIONS)				19
CAPITAL PAYMENTS (FROM WORKSHEET L PART I)					
20	Capital DRG other than outlier (L Part I Line 1)	6,795,796			20
21	Capital DRG outlier payments (L Part I Line 2)	150,316			21
22	Indirect medical education percentage (L Part I Line 5 - see instructions)				22
23	Indirect medical education adjustment (line 20 times line 22 - ties to L Part I Line 6)				23
24	Allowable disproportionate share percentage (L Part I Line 10 - see instructions)	0.0362	0.0362	0.0362	24
25	Disproportionate share adjustment (line 20 times line 24 - ties to L Part I Line 11)	246,008			25
26	Total prospective capital payments (sum of lines 20, 21, 22 and 25 - ties to L Part I Line 12)	7,192,120			26
LOW VOLUME ADJUSTMENT					
27	Low volume adjustment factor (enter into Column 3 and/or 4 as applicable - enter as a six-place ratio: 10%=0.100000, 20.3214%=0.203214)				27
28	Low volume adjustment (Line 19 times Line 27 - transfer amount to Worksheet E Part A Line 70.96)(FY 2011)				28
29	Low volume adjustment (Line 19 times Line 27 - transfer amount to Worksheet E Part A Line 70.97)(FY 2012)				29