KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 05/21/2014 TIME: 14:16 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [ ] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED 6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 MORRIS HOSPITAL (14-0101) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		130,174	219,148	39,935		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						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		130,174	219,148	39,935		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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:

1	STREET: 150 WEST HIGH STREET	P.O. BOX:		1
2	CITY: MORRIS	STATE: IL	ZIP CODE: 60450	COUNTY: GRUNDY	2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV-IDER TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	MORRIS HOSPITAL	14-0101	16974	1	07/01/1966	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	MORRIS HOSPITAL	14-U101	16974		10/07/1994	N	N	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19

20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 01 / 01 / 2013	TO: 12 / 31 / 2013	20
21	TYPE OF CONTROL (see instructions)	2		21

	INPATIENT PPS INFORMATION	1	2	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILTY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	N	N	22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES Or 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)	N	N	22.01
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	3	N	23

		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
		1	2	3	4	5	6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN 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.	1,346	365			13		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 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.							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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	38

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
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
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
	1	2	3	4	
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL 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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						64
	ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						66
	ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
INPATIENT PSYCHIATRIC FACILITY PPS				1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.						71
INPATIENT REHABILITATION FACILITY PPS				1	2	3	
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, 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.						76

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WORKSHEET S-2
PART I

LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N		85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (excluded unit) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			86

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

				V	XIX	
TITLE V AND XIX SERVICES				1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					97
RURAL PROVIDERS				1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.					106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.					107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N		108
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	N	N	109
MISCELLANEOUS COST REPORTING INFORMATION						
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'	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
		PREMIUMS		PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:	1,076,625		13,383		118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y		121
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

ALL PROVIDERS

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

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

141	NAME:	CONTRACTOR'S NAME:		CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:			142
143	CITY:	STATE:	ZIP CODE:		143

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

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

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	165
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.		166

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)			168
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. (see instructions)	0.75		169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	07/03/2012	10/01/2012	170

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3

		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	N			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

		Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES		1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR 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	
BAD DEBTS			
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	N	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	N	14
BED COMPLEMENT			
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N		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	05/12/2014	Y	05/14/2014	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

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

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

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

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

COST REORT PREPARER INFORMATION				
41	FIRST NAME: THOMAS	LAST NAME: CURTIS, CPA	TITLE: CPA	41
42	EMPLOYER: THE CURTIS GROUP, INC			42
43	PHONE NUMBER: 217-483-9092	E-MAIL ADDRESS: TOM@THECURTISGROUP.NET		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	81	28,512			7,467	833	11,222	1
2	HMO AND OTHER (see instructions)						326			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		81	28,512			7,467	833	11,222	7
8	INTENSIVE CARE UNIT	31	8	2,816			1,158	244	2,288	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						438	954	13
14	TOTAL (see instructions)		89	31,328			8,625	1,515	14,464	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30							15	24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		89							27
28	OBSERVATION BED DAYS								2,249	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)								206	30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,099	585	4,191	1
2	HMO AND OTHER (see instructions)					81			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		778.00			2,099	585	4,191	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		778.00						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	49,725,653		49,725,653	1,618,234.80	30.73	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B		5,317,235		5,317,235	42,476.00	125.18	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		152,442	66,769	219,211	11,169.00	19.63	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		165,428		165,428	2,656.00	62.28	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							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)(see instructions)		12,284,696		12,284,696			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		60,649		60,649			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B		1,475,973		1,475,973			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		336,134		336,134	11,315.00	29.71	26
27	ADMINISTRATIVE & GENERAL		7,448,089	437,521	7,885,610	280,980.00	28.06	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		576,517		576,517	1,618.00	356.31	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		753,428		753,428	26,776.00	28.14	30
31	LAUNDRY & LINEN SERVICE		24,609		24,609	2,086.00	11.80	31
32	HOUSEKEEPING		1,113,064		1,113,064	83,480.00	13.33	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		1,003,564	-705,008	298,556	19,380.00	15.41	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			575,029	575,029	37,336.00	15.40	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		664,936		664,936	21,612.00	30.77	38
39	CENTRAL SERVICES AND SUPPLY		653,125	-275,599	377,526	36,155.00	10.44	39
40	PHARMACY		1,630,481		1,630,481	36,389.00	44.81	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,421,963	-98,712	1,323,251	69,274.00	19.10	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	44,984,935		44,984,935	1,577,376.80	28.52	1
2	EXCLUDED AREA SALARIES (see instructions)	152,442	66,769	219,211	11,169.00	19.63	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	44,832,493	-66,769	44,765,724	1,566,207.80	28.58	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	165,428		165,428	2,656.00	62.28	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	12,284,696		12,284,696		27.44%	5

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		57,282,617	-66,769	57,215,848	1,568,863.80	36.47	6
7	TOTAL OVERHEAD COST (see instructions)		15,625,910	-66,769	15,559,141	626,401.00	24.84	7

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HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	822,233	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	8,218,622	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	328,452	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	64,044	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)	261,649	12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	500,828	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	3,409,639	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	86,469	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	111,048	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	13,802,984	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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MORRIS HOSPITAL Provider CCN: 14-0101	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

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

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE			1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)			2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH			3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)			4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST **WORKSHEET S-3 PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

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

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

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.293411	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	5,220,520	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	35,004,841	6
7	MEDICAID COST (line 1 times line 6)	10,270,805	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.	5,050,285	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	5,050,285	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	10,174,777	1,130,530	11,305,307	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	2,985,391	331,710	3,317,101	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	2,985,391	331,710	3,317,101	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	6,854,420	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	367,115	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	6,487,305	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	1,903,447	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	5,220,548	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	10,270,833	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		5,088,920	5,088,920		5,088,920		5,088,920	1
2	00200	CAP REL COSTS-MVBLE EQUIP		4,367,212	4,367,212		4,367,212		4,367,212	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	336,134	13,974,041	14,310,175		14,310,175	-7,210,812	7,099,363	4
5	00500	ADMINISTRATIVE & GENERAL	7,448,089	14,566,292	22,014,381	1,261,150	23,275,531	-781,869	22,493,662	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	753,428	1,842,060	2,595,488		2,595,488		2,595,488	7
8	00800	LAUNDRY & LINEN SERVICE	24,609	410,030	434,639		434,639		434,639	8
9	00900	HOUSEKEEPING	1,113,064	443,380	1,556,444		1,556,444		1,556,444	9
10	01000	DIETARY	1,003,564	434,927	1,438,491	-1,010,545	427,946		427,946	10
11	01100	CAFETERIA				824,236	824,236	-344,265	479,971	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	664,936	19,083	684,019		684,019		684,019	13
14	01400	CENTRAL SERVICES & SUPPLY	653,125	4,004,522	4,657,647	-3,656,848	1,000,799		1,000,799	14
15	01500	PHARMACY	1,630,481	4,260,490	5,890,971		5,890,971		5,890,971	15
16	01600	MEDICAL RECORDS & LIBRARY	1,421,963	206,288	1,628,251	-175,770	1,452,481		1,452,481	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	7,416,261	647,108	8,063,369	-912,712	7,150,657	-389,880	6,760,777	30
31	03100	INTENSIVE CARE UNIT	2,517,343	86,178	2,603,521	-569,076	2,034,445		2,034,445	31
43	04300	NURSERY				520,813	520,813		520,813	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	2,984,388	4,181,841	7,166,229	-2,274,973	4,891,256		4,891,256	50
51	05100	RECOVERY ROOM	375,139	4,901	380,040		380,040		380,040	51
52	05200	DELIVERY ROOM & LABOR ROOM				960,975	960,975		960,975	52
53	05300	ANESTHESIOLOGY		10,077	10,077		10,077		10,077	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,922,166	383,208	2,305,374		2,305,374		2,305,374	54
54.01	05401	NUCLEAR MEDICINE	288,982	320,363	609,345		609,345		609,345	54.01
54.02	05402	ULTRASOUND	551,123	48,401	599,524		599,524		599,524	54.02
55	05500	RADIOLOGY-THERAPEUTIC	426,518	956,611	1,383,129		1,383,129		1,383,129	55
57	05700	CT SCAN	605,694	145,994	751,688		751,688		751,688	57
58	05800	MRI	316,812	171,609	488,421		488,421		488,421	58
59	05900	CARDIAC CATHETERIZATION	673,126	1,632,188	2,305,314	-972,512	1,332,802		1,332,802	59
59.97	05901	CARDIAC REHAB	161,368	46,071	207,439		207,439		207,439	59.97
60	06000	LABORATORY	3,158,426	3,090,485	6,248,911		6,248,911	-829,393	5,419,518	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	1,503,911	182,522	1,686,433		1,686,433		1,686,433	65
66	06600	PHYSICAL THERAPY	710,482	42,736	753,218		753,218		753,218	66
67	06700	OCCUPATIONAL THERAPY	291,743	187,652	479,395		479,395		479,395	67
68	06800	SPEECH PATHOLOGY	63,570	4,173	67,743		67,743		67,743	68
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				2,649,928	2,649,928		2,649,928	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				3,259,629	3,259,629		3,259,629	72
73	07300	DRUGS CHARGED TO PATIENTS								73
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	7,327,777	2,653,237	9,981,014		9,981,014	-3,768,715	6,212,299	90
90.01	09001	HOSPITAL SURGEON	329,673	70,922	400,595		400,595	-329,247	71,348	90.01
91	09100	EMERGENCY	2,899,316	767,573	3,666,889		3,666,889		3,666,889	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
190.01	19001	MEALS ON WHEELS				95,705	95,705	-25,522	70,183	190.01
191.01	19101	PATIENT TRANSPORTATION	152,442	162,822	315,264		315,264		315,264	191.01
200		TOTAL (sum of lines 118-199)	49,725,653	65,413,917	115,139,570		115,139,570	-13,679,703	101,459,867	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	ICU RECLASS	A	ADULTS & PEDIATRICS	30	550,239	18,837	1
500	TOTAL RECLASSIFICATIONS				550,239	18,837	500
	CODE LETTER - A						
1	CAFETERIA FOOD SERVICE	B	CAFETERIA	11	575,029	249,207	1
2			ADMINISTRATIVE & GENERAL	5	63,210	27,394	2
3			MEALS ON WHEELS	190.01	66,769	28,936	3
500	TOTAL RECLASSIFICATIONS				705,008	305,537	500
	CODE LETTER - B						
1	LDR & NURSERY	C	DELIVERY ROOM & LABOR ROOM	52	910,783	50,192	1
2			NURSERY	43	493,611	27,202	2
500	TOTAL RECLASSIFICATIONS				1,404,394	77,394	500
	CODE LETTER - C						
1	PURCHASING MATERIALS MANAGEMENT	D	ADMINISTRATIVE & GENERAL	5	374,311	796,235	1
2							2
3	CHARGEABLE SUPPLY COST	D	MEDICAL SUPPLIES CHARGED TO P	71		2,649,928	3
500	TOTAL RECLASSIFICATIONS				374,311	3,446,163	500
	CODE LETTER - D						
1	IMPLANTABLE DEVICES	E	IMPL. DEV. CHARGED TO PATIENT	72		12,144	1
2			IMPL. DEV. CHARGED TO PATIENT	72		972,512	2
3			IMPL. DEV. CHARGED TO PATIENT	72		2,274,973	3
500	TOTAL RECLASSIFICATIONS					3,259,629	500
	CODE LETTER - E						
1	CENTRAL SERVICES	F	CENTRAL SERVICES & SUPPLY	14	98,712	77,058	1
500	TOTAL RECLASSIFICATIONS				98,712	77,058	500
	CODE LETTER - F						
	GRAND TOTAL (INCREASES)				3,132,664	7,184,618	

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

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	ICU RECLASS	A	INTENSIVE CARE UNIT	31	550,239	18,837		1
500	TOTAL RECLASSIFICATIONS				550,239	18,837		500
	CODE LETTER - A							
1	CAFETERIA FOOD SERVICE	B	DIETARY	10	575,029	249,207		1
2			DIETARY	10	63,210	27,394		2
3			DIETARY	10	66,769	28,936		3
500	TOTAL RECLASSIFICATIONS				705,008	305,537		500
	CODE LETTER - B							
1	LDR & NURSERY	C	ADULTS & PEDIATRICS	30	910,783	50,192		1
2			ADULTS & PEDIATRICS	30	493,611	27,202		2
500	TOTAL RECLASSIFICATIONS				1,404,394	77,394		500
	CODE LETTER - C							
1	PURCHASING MATERIALS MANAGEMENT	D	CENTRAL SERVICES & SUPPLY	14	374,311	796,235		1
2								2
3	CHARGEABLE SUPPLY COST	D	CENTRAL SERVICES & SUPPLY	14		2,649,928		3
500	TOTAL RECLASSIFICATIONS				374,311	3,446,163		500
	CODE LETTER - D							
1	IMPLANTABLE DEVICES	E	CENTRAL SERVICES & SUPPLY	14		12,144		1
2			CARDIAC CATHETERIZATION	59		972,512		2
3			OPERATING ROOM	50		2,274,973		3
500	TOTAL RECLASSIFICATIONS					3,259,629		500
	CODE LETTER - E							
1	CENTRAL SERVICES	F	MEDICAL RECORDS & LIBRARY	16	98,712	77,058		1
500	TOTAL RECLASSIFICATIONS				98,712	77,058		500
	CODE LETTER - F							
	GRAND TOTAL (DECREASES)				3,132,664	7,184,618		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	6,550,097	253,542		253,542		6,803,639		1
2	LAND IMPROVEMENTS	5,524,582	70,159		70,159		5,594,741		2
3	BUILDINGS AND FIXTURES	69,932,747	1,079,369		1,079,369		71,012,116		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	21,169,082	222,242		222,242		21,391,324		5
6	MOVABLE EQUIPMENT	59,188,413	4,700,155		4,700,155	1,092,129	62,796,439		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	162,364,921	6,325,467		6,325,467	1,092,129	167,598,259		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	162,364,921	6,325,467		6,325,467	1,092,129	167,598,259		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	5,088,920						5,088,920	1
2	CAP REL COSTS-MVBLE EQUIP	4,367,212						4,367,212	2
3	TOTAL (sum of lines 1-2)	9,456,132						9,456,132	3

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI				0.000000					1
2	CAP REL COSTS-MVBLE EQU				0.000000					2
3	TOTAL (sum of lines 1-2)				0.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	5,088,920						5,088,920	1
2	CAP REL COSTS-MVBLE EQUIP	4,367,212						4,367,212	2
3	TOTAL (sum of lines 1-2)	9,456,132						9,456,132	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)	B	-331,929	ADMINISTRATIVE & GENERAL	5		3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)	B	-9,144	ADMINISTRATIVE & GENERAL	5		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-8-3	-5,317,235				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)	B	-136,412	ADMINISTRATIVE & GENERAL	5		11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-3					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-344,265	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-6,914	ADMINISTRATIVE & GENERAL	5		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-3,188	ADMINISTRATIVE & GENERAL	5		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	EMPLOYEE SELF INSURANCE	A	-7,210,812	EMPLOYEE BENEFITS DEPARTMENT	4		33
34	LIFELINE	A	-61,294	ADMINISTRATIVE & GENERAL	5		34
35	MEALS ON WHEELS	B	-25,522	MEALS ON WHEELS	190.01		35
36	SERVICE FEES	A	-28,570	ADMINISTRATIVE & GENERAL	5		36
37	CASUALTY RECOVERY INS INCOME	B	-142,747	ADMINISTRATIVE & GENERAL	5		37
38	MISC INCOME	B	-31,345	ADMINISTRATIVE & GENERAL	5		38
39	DIABETES	B	-300	ADMINISTRATIVE & GENERAL	5		39
40	EMS EDUCATION	B	-91,670	ADMINISTRATIVE & GENERAL	5		40
41	PHYSICIAN RECRUITMENT	A	-934,008	ADMINISTRATIVE & GENERAL	5		41
42	WELLNESS	A	-5,968	ADMINISTRATIVE & GENERAL	5		42
43	INTEREST - NET SETTLEMENT DERIVATI	A	1,029,015	ADMINISTRATIVE & GENERAL	5		43
44	LOBBYING COSTS	A	-27,395	ADMINISTRATIVE & GENERAL	5		44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-13,679,703				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12							5

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

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

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

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

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

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS AGGREGATE	389,880	389,880						1
2	60	LABORATORY AGGREGATE	829,393	829,383						2
3	90	CLINIC AGGREGATE	3,768,715	3,768,715						3
4	90.01	HOSPITAL SURGEON AGGREGATE	329,247	329,247						4
200		TOTAL	5,317,235	5,317,225						200

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS AGGREGATE							389,880	1
2	60	LABORATORY AGGREGATE							829,393	2
3	90	CLINIC AGGREGATE							3,768,715	3
4	90.01	HOSPITAL SURGEON AGGREGATE							329,247	4
200		TOTAL							5,317,235	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	5,088,920	5,088,920					1
2	CAP REL COSTS-MVBLE EQUIP	4,367,212		4,367,212				2
4	EMPLOYEE BENEFITS DEPARTMENT	7,099,363	16,563	14,214	7,130,140			4
5	ADMINISTRATIVE & GENERAL	22,493,662	1,162,033	997,236	1,138,430	25,791,361	25,791,361	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,595,488	496,149	425,785	108,769	3,626,191	1,235,976	7
8	LAUNDRY & LINEN SERVICE	434,639	48,256	41,413	3,553	527,861	179,920	8
9	HOUSEKEEPING	1,556,444	37,315	32,023	160,687	1,786,469	608,913	9
10	DIETARY	427,946	150,363	129,039	43,101	750,449	255,788	10
11	CAFETERIA	479,971	76,973	66,057	83,014	706,015	240,643	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	684,019	42,028	36,067	95,993	858,107	292,483	13
14	CENTRAL SERVICES & SUPPLY	1,000,799	183,792	157,727	54,502	1,396,820	476,102	14
15	PHARMACY	5,890,971	29,929	25,685	235,384	6,181,969	2,107,106	15
16	MEDICAL RECORDS & LIBRARY	1,452,481	118,339	101,556	191,031	1,863,407	635,137	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,760,777	918,879	788,564	947,338	9,415,558	3,209,241	30
31	INTENSIVE CARE UNIT	2,034,445	83,312	71,496	283,981	2,473,234	842,994	31
43	NURSERY	520,813	15,709	13,481	71,260	621,263	211,756	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,891,256	159,458	136,843	430,841	5,618,398	1,915,014	50
51	RECOVERY ROOM	380,040	167,505	143,749	54,157	745,451	254,085	51
52	DELIVERY ROOM & LABOR ROOM	960,975	11,795	10,123	131,485	1,114,378	379,832	52
53	ANESTHESIOLOGY	10,077	14,331	12,298		36,706	12,511	53
54	RADIOLOGY-DIAGNOSTIC	2,305,374	288,077	247,222	277,493	3,118,166	1,062,818	54
54.01	NUCLEAR MEDICINE	609,345	11,906	10,217	41,719	673,187	229,454	54.01
54.02	ULTRASOUND	599,524	21,606	18,542	79,563	719,235	245,149	54.02
55	RADIOLOGY-THERAPEUTIC	1,383,129			61,574	1,444,703	492,423	55
57	CT SCAN	751,688	33,788	28,996	87,441	901,913	307,414	57
58	MRI	488,421	191,922	164,704	45,737	890,784	303,621	58
59	CARDIAC CATHETERIZATION	1,332,802	43,103	36,990	97,176	1,510,071	514,703	59
59.97	CARDIAC REHAB	207,439			23,296	230,735	78,645	59.97
60	LABORATORY	5,419,518	149,647	128,424	455,966	6,153,555	2,097,421	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,686,433	148,379	127,336	217,112	2,179,260	742,794	65
66	PHYSICAL THERAPY	753,218	109,934	94,343	102,569	1,060,064	361,320	66
67	OCCUPATIONAL THERAPY	479,395	29,461	25,283	42,117	576,256	196,415	67
68	SPEECH PATHOLOGY	67,743	6,476	5,558	9,177	88,954	30,320	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,649,928				2,649,928	903,220	71
72	IMPL. DEV. CHARGED TO PATIENTS	3,259,629				3,259,629	1,111,035	72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	6,212,299	17,886	15,349	1,057,875	7,303,409	2,489,345	90
90.01	HOSPITAL SURGEON	71,348			47,593	118,941	40,541	90.01
91	EMERGENCY	3,666,889	304,006	260,892	418,560	4,650,347	1,585,057	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	101,074,420	5,088,920	4,367,212	7,098,494	101,042,774	25,649,196	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS	70,183			9,639	79,822	27,207	190.01
191.01	PATIENT TRANSPORTATION	315,264			22,007	337,271	114,958	191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	101,459,867	5,088,920	4,367,212	7,130,140	101,459,867	25,791,361	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT A, col.7)	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING EQUIPMENT	DIETARY BENEFITS DEPARTMENT	CAFETERIA SUBTOTAL (cols.0-4)	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	4,862,167						7
8	LAUNDRY & LINEN SERVICE	68,722	776,503					8
9	HOUSEKEEPING	53,141		2,448,523				9
10	DIETARY	214,134		110,607	1,330,978			10
11	CAFETERIA	109,618		56,621		1,112,897		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	59,852		30,916		20,589	1,261,947	13
14	CENTRAL SERVICES & SUPPLY	261,741		135,198		34,440	76,197	14
15	PHARMACY	42,623		22,016		34,678	76,723	15
16	MEDICAL RECORDS & LIBRARY	168,528		87,050		66,007		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,308,588	602,455	675,930	1,032,649	205,055	453,678	30
31	INTENSIVE CARE UNIT	118,645	122,832	61,284	210,542	58,060	128,457	31
43	NURSERY	22,371	51,216	11,555	87,787	13,534	29,944	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	227,086		117,297		83,147	183,961	50
51	RECOVERY ROOM	238,546		123,217		9,095	20,123	51
52	DELIVERY ROOM & LABOR ROOM	16,798		8,677		24,988	55,285	52
53	ANESTHESIOLOGY	20,409		10,542				53
54	RADIOLOGY-DIAGNOSTIC	410,253		211,909		75,637		54
54.01	NUCLEAR MEDICINE	16,955		8,758		6,103		54.01
54.02	ULTRASOUND	30,770		15,894		12,662		54.02
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN	48,117		24,854		16,546		57
58	MRI	273,319		141,178		8,164		58
59	CARDIAC CATHETERIZATION	61,383		31,706		14,743		59
59.97	CARDIAC REHAB					4,835		59.97
60	LABORATORY	213,114		110,080		96,741	214,036	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	211,308		109,148		51,065		65
66	PHYSICAL THERAPY	156,558		80,867		20,034		66
67	OCCUPATIONAL THERAPY	41,955		21,671		5,430		67
68	SPEECH PATHOLOGY	9,223		4,764		1,268		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	25,472		13,157		164,947		90
90.01	HOSPITAL SURGEON							90.01
91	EMERGENCY	432,938		223,627		74,488		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,862,167	776,503	2,448,523	1,330,978	1,102,256	1,238,404	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS					4,122	9,119	190.01
191.01	PATIENT TRANSPORTATION					6,519	14,424	191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,862,167	776,503	2,448,523	1,330,978	1,112,897	1,261,947	202

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY & LINEN SERVICE	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	15	16	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	2,380,498						14
15	PHARMACY	25,438	8,490,553					15
16	MEDICAL RECORDS & LIBRARY	13,083		2,833,212				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	54,448		107,560	17,065,162		17,065,162	30
31	INTENSIVE CARE UNIT	19,007		44,862	4,079,917		4,079,917	31
43	NURSERY			6,439	1,055,865		1,055,865	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,400,441		324,437	9,869,781		9,869,781	50
51	RECOVERY ROOM	1,426		46,433	1,438,376		1,438,376	51
52	DELIVERY ROOM & LABOR ROOM			11,964	1,611,922		1,611,922	52
53	ANESTHESIOLOGY	3,225		32,797	116,190		116,190	53
54	RADIOLOGY-DIAGNOSTIC	46,717		151,604	5,077,104		5,077,104	54
54.01	NUCLEAR MEDICINE	1,466		31,453	967,376		967,376	54.01
54.02	ULTRASOUND	2,633		74,010	1,100,353		1,100,353	54.02
55	RADIOLOGY-THERAPEUTIC	4,290		59,877	2,001,293		2,001,293	55
57	CT SCAN	10,264		327,997	1,637,105		1,637,105	57
58	MRI	671		91,920	1,709,657		1,709,657	58
59	CARDIAC CATHETERIZATION	480,529		79,687	2,692,822		2,692,822	59
59.97	CARDIAC REHAB	14,723		3,155	332,093		332,093	59.97
60	LABORATORY	89,388		506,614	9,480,949		9,480,949	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	27,164		135,171	3,455,910		3,455,910	65
66	PHYSICAL THERAPY	3,787		28,456	1,711,086		1,711,086	66
67	OCCUPATIONAL THERAPY	1,303		7,445	850,475		850,475	67
68	SPEECH PATHOLOGY	318		2,084	136,931		136,931	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			98,406	3,651,554		3,651,554	71
72	IMPL. DEV. CHARGED TO PATIENTS			65,808	4,436,472		4,436,472	72
73	DRUGS CHARGED TO PATIENTS		8,490,553	188,199	8,678,752		8,678,752	73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	67,624		110,406	10,174,360		10,174,360	90
90.01	HOSPITAL SURGEON	2,766			162,248		162,248	90.01
91	EMERGENCY	107,485		296,428	7,370,370		7,370,370	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,378,196	8,490,553	2,833,212	100,864,123		100,864,123	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS				120,270		120,270	190.01
191.01	PATIENT TRANSPORTATION	2,302			475,474		475,474	191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,380,498	8,490,553	2,833,212	101,459,867		101,459,867	202

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		16,563	14,214	30,777	30,777		4
5	ADMINISTRATIVE & GENERAL		1,162,033	997,236	2,159,269	4,921	2,164,190	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		496,149	425,785	921,934	469	103,713	7
8	LAUNDRY & LINEN SERVICE		48,256	41,413	89,669	15	15,097	8
9	HOUSEKEEPING		37,315	32,023	69,338	693	51,095	9
10	DIETARY		150,363	129,039	279,402	186	21,464	10
11	CAFETERIA		76,973	66,057	143,030	358	20,193	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		42,028	36,067	78,095	414	24,543	13
14	CENTRAL SERVICES & SUPPLY		183,792	157,727	341,519	235	39,950	14
15	PHARMACY		29,929	25,685	55,614	1,016	176,810	15
16	MEDICAL RECORDS & LIBRARY		118,339	101,556	219,895	824	53,295	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		918,879	788,564	1,707,443	4,088	269,287	30
31	INTENSIVE CARE UNIT		83,312	71,496	154,808	1,226	70,737	31
43	NURSERY		15,709	13,481	29,190	308	17,769	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		159,458	136,843	296,301	1,859	160,692	50
51	RECOVERY ROOM		167,505	143,749	311,254	234	21,321	51
52	DELIVERY ROOM & LABOR ROOM		11,795	10,123	21,918	567	31,872	52
53	ANESTHESIOLOGY		14,331	12,298	26,629		1,050	53
54	RADIOLOGY-DIAGNOSTIC		288,077	247,222	535,299	1,198	89,183	54
54.01	NUCLEAR MEDICINE		11,906	10,217	22,123	180	19,254	54.01
54.02	ULTRASOUND		21,606	18,542	40,148	343	20,571	54.02
55	RADIOLOGY-THERAPEUTIC					266	41,320	55
57	CT SCAN		33,788	28,996	62,784	377	25,796	57
58	MRI		191,922	164,704	356,626	197	25,477	58
59	CARDIAC CATHETERIZATION		43,103	36,990	80,093	419	43,190	59
59.97	CARDIAC REHAB					101	6,599	59.97
60	LABORATORY		149,647	128,424	278,071	1,968	175,998	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		148,379	127,336	275,715	937	62,329	65
66	PHYSICAL THERAPY		109,934	94,343	204,277	443	30,319	66
67	OCCUPATIONAL THERAPY		29,461	25,283	54,744	182	16,481	67
68	SPEECH PATHOLOGY		6,476	5,558	12,034	40	2,544	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						75,791	71
72	IMPL. DEV. CHARGED TO PATIENTS						93,229	72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		17,886	15,349	33,235	4,565	208,885	90
90.01	HOSPITAL SURGEON					205	3,402	90.01
91	EMERGENCY		304,006	260,892	564,898	1,806	133,005	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		5,088,920	4,367,212	9,456,132	30,640	2,152,261	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS					42	2,283	190.01
191.01	PATIENT TRANSPORTATION					95	9,646	191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		5,088,920	4,367,212	9,456,132	30,777	2,164,190	202

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT COSTS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING EQUIPMENT	DIETARY SUBTOTAL	CAFETERIA BENEFITS DEPARTMENT	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,026,116						7
8	LAUNDRY & LINEN SERVICE	14,503	119,284					8
9	HOUSEKEEPING	11,215		132,341				9
10	DIETARY	45,191		5,978	352,221			10
11	CAFETERIA	23,134		3,060		189,775		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	12,631		1,671		3,511	120,865	13
14	CENTRAL SERVICES & SUPPLY	55,238		7,307		5,873	7,298	14
15	PHARMACY	8,995		1,190		5,913	7,348	15
16	MEDICAL RECORDS & LIBRARY	35,566		4,705		11,256		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	276,167	92,547	36,534	273,274	34,965	43,453	30
31	INTENSIVE CARE UNIT	25,039	18,869	3,312	55,716	9,901	12,303	31
43	NURSERY	4,721	7,868	625	23,231	2,308	2,868	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	47,924		6,340		14,179	17,619	50
51	RECOVERY ROOM	50,343		6,660		1,551	1,927	51
52	DELIVERY ROOM & LABOR ROOM	3,545		469		4,261	5,295	52
53	ANESTHESIOLOGY	4,307		570				53
54	RADIOLOGY-DIAGNOSTIC	86,580		11,454		12,898		54
54.01	NUCLEAR MEDICINE	3,578		473		1,041		54.01
54.02	ULTRASOUND	6,494		859		2,159		54.02
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN	10,155		1,343		2,822		57
58	MRI	57,681		7,631		1,392		58
59	CARDIAC CATHETERIZATION	12,954		1,714		2,514		59
59.97	CARDIAC REHAB					824		59.97
60	LABORATORY	44,976		5,950		16,497	20,500	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	44,595		5,899		8,708		65
66	PHYSICAL THERAPY	33,040		4,371		3,416		66
67	OCCUPATIONAL THERAPY	8,854		1,171		926		67
68	SPEECH PATHOLOGY	1,946		257		216		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	5,376		711		28,127		90
90.01	HOSPITAL SURGEON							90.01
91	EMERGENCY	91,368		12,087		12,702		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,026,116	119,284	132,341	352,221	187,960	118,611	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS					703	873	190.01
191.01	PATIENT TRANSPORTATION					1,112	1,381	191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,026,116	119,284	132,341	352,221	189,775	120,865	202

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY & LINEN SERVICE	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	15	16	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	457,420						14
15	PHARMACY	4,888	261,774					15
16	MEDICAL RECORDS & LIBRARY	2,514		328,055				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	10,462		12,450	2,760,670		2,760,670	30
31	INTENSIVE CARE UNIT	3,652		5,193	360,756		360,756	31
43	NURSERY			745	89,633		89,633	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	269,100		37,553	851,567		851,567	50
51	RECOVERY ROOM	274		5,375	398,939		398,939	51
52	DELIVERY ROOM & LABOR ROOM			1,385	69,312		69,312	52
53	ANESTHESIOLOGY	620		3,796	36,972		36,972	53
54	RADIOLOGY-DIAGNOSTIC	8,977		17,548	763,137		763,137	54
54.01	NUCLEAR MEDICINE	282		3,641	50,572		50,572	54.01
54.02	ULTRASOUND	506		8,567	79,647		79,647	54.02
55	RADIOLOGY-THERAPEUTIC	824		6,931	49,341		49,341	55
57	CT SCAN	1,972		37,965	143,214		143,214	57
58	MRI	129		10,640	459,773		459,773	58
59	CARDIAC CATHETERIZATION	92,335		9,224	242,443		242,443	59
59.97	CARDIAC REHAB	2,829		365	10,718		10,718	59.97
60	LABORATORY	17,176		58,753	619,889		619,889	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	5,220		15,646	419,049		419,049	65
66	PHYSICAL THERAPY	728		3,294	279,888		279,888	66
67	OCCUPATIONAL THERAPY	250		862	83,470		83,470	67
68	SPEECH PATHOLOGY	61		241	17,339		17,339	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			11,390	87,181		87,181	71
72	IMPL. DEV. CHARGED TO PATIENTS			7,617	100,846		100,846	72
73	DRUGS CHARGED TO PATIENTS		261,774	21,784	283,558		283,558	73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	12,994		12,779	306,672		306,672	90
90.01	HOSPITAL SURGEON	531			4,138		4,138	90.01
91	EMERGENCY	20,654		34,311	870,831		870,831	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	456,978	261,774	328,055	9,439,555		9,439,555	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS				3,901		3,901	190.01
191.01	PATIENT TRANSPORTATION	442			12,676		12,676	191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	457,420	261,774	328,055	9,456,132		9,456,132	202

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	184,654						1
2	CAP REL COSTS-MVBLE EQUIP		184,654					2
4	EMPLOYEE BENEFITS DEPARTMENT	601	601	49,389,519				4
5	ADMINISTRATIVE & GENERAL	42,165	42,165	7,885,610	-25,791,361	75,668,506		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	18,003	18,003	753,428		3,626,191	123,885	7
8	LAUNDRY & LINEN SERVICE	1,751	1,751	24,609		527,861	1,751	8
9	HOUSEKEEPING	1,354	1,354	1,113,064		1,786,469	1,354	9
10	DIETARY	5,456	5,456	298,556		750,449	5,456	10
11	CAFETERIA	2,793	2,793	575,029		706,015	2,793	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,525	1,525	664,936		858,107	1,525	13
14	CENTRAL SERVICES & SUPPLY	6,669	6,669	377,526		1,396,820	6,669	14
15	PHARMACY	1,086	1,086	1,630,481		6,181,969	1,086	15
16	MEDICAL RECORDS & LIBRARY	4,294	4,294	1,323,251		1,863,407	4,294	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	33,342	33,342	6,562,106		9,415,558	33,342	30
31	INTENSIVE CARE UNIT	3,023	3,023	1,967,104		2,473,234	3,023	31
43	NURSERY	570	570	493,611		621,263	570	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,786	5,786	2,984,388		5,618,398	5,786	50
51	RECOVERY ROOM	6,078	6,078	375,139		745,451	6,078	51
52	DELIVERY ROOM & LABOR ROOM	428	428	910,783		1,114,378	428	52
53	ANESTHESIOLOGY	520	520			36,706	520	53
54	RADIOLOGY-DIAGNOSTIC	10,453	10,453	1,922,166		3,118,166	10,453	54
54.01	NUCLEAR MEDICINE	432	432	288,982		673,187	432	54.01
54.02	ULTRASOUND	784	784	551,123		719,235	784	54.02
55	RADIOLOGY-THERAPEUTIC			426,518		1,444,703		55
57	CT SCAN	1,226	1,226	605,694		901,913	1,226	57
58	MRI	6,964	6,964	316,812		890,784	6,964	58
59	CARDIAC CATHETERIZATION	1,564	1,564	673,126		1,510,071	1,564	59
59.97	CARDIAC REHAB			161,368		230,735		59.97
60	LABORATORY	5,430	5,430	3,158,426		6,153,555	5,430	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	5,384	5,384	1,503,911		2,179,260	5,384	65
66	PHYSICAL THERAPY	3,989	3,989	710,482		1,060,064	3,989	66
67	OCCUPATIONAL THERAPY	1,069	1,069	291,743		576,256	1,069	67
68	SPEECH PATHOLOGY	235	235	63,570		88,954	235	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					2,649,928		71
72	IMPL. DEV. CHARGED TO PATIENTS					3,259,629		72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	649	649	7,327,777		7,303,409	649	90
90.01	HOSPITAL SURGEON			329,673		118,941		90.01
91	EMERGENCY	11,031	11,031	2,899,316		4,650,347	11,031	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	184,654	184,654	49,170,308	-25,791,361	75,251,413	123,885	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS			66,769		79,822		190.01
191.01	PATIENT TRANSPORTATION			152,442		337,271		191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	5,088,920	4,367,212	7,130,140		25,791,361	4,862,167	202
203	UNIT COST MULT-WS B PT I	27.559219	23.650785	0.144365		0.340847	39.247423	203
204	COST TO BE ALLOC PER B PT II			30,777		2,164,190	1,026,116	204
205	UNIT COST MULT-WS B PT II			0.000623		0.028601	8.282811	205

KPMG LLP COMPU-MAX

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING EQUIPMENT SQUARE FEET	DIETARY BENEFITS DEPARTMENT PATIENT DAYS	CAFETERIA RECON-CILIATION MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	14,464						8
9	HOUSEKEEPING		120,780					9
10	DIETARY		5,456	14,464				10
11	CAFETERIA		2,793		56,162			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		1,525		1,039	28,784		13
14	CENTRAL SERVICES & SUPPLY		6,669		1,738	1,738	5,671,114	14
15	PHARMACY		1,086		1,750	1,750	60,601	15
16	MEDICAL RECORDS & LIBRARY		4,294		3,331		31,169	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	11,222	33,342	11,222	10,348	10,348	129,714	30
31	INTENSIVE CARE UNIT	2,288	3,023	2,288	2,930	2,930	45,280	31
43	NURSERY	954	570	954	683	683		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		5,786		4,196	4,196	3,336,301	50
51	RECOVERY ROOM		6,078		459	459	3,397	51
52	DELIVERY ROOM & LABOR ROOM		428		1,261	1,261		52
53	ANESTHESIOLOGY		520				7,682	53
54	RADIOLOGY-DIAGNOSTIC		10,453		3,817		111,295	54
54.01	NUCLEAR MEDICINE		432		308		3,493	54.01
54.02	ULTRASOUND		784		639		6,272	54.02
55	RADIOLOGY-THERAPEUTIC						10,220	55
57	CT SCAN		1,226		835		24,451	57
58	MRI		6,964		412		1,598	58
59	CARDIAC CATHETERIZATION		1,564		744		1,144,777	59
59.97	CARDIAC REHAB				244		35,075	59.97
60	LABORATORY		5,430		4,882	4,882	212,951	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		5,384		2,577		64,714	65
66	PHYSICAL THERAPY		3,989		1,011		9,022	66
67	OCCUPATIONAL THERAPY		1,069		274		3,104	67
68	SPEECH PATHOLOGY		235		64		757	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		649		8,324		161,103	90
90.01	HOSPITAL SURGEON						6,589	90.01
91	EMERGENCY		11,031		3,759		256,065	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	14,464	120,780	14,464	55,625	28,247	5,665,630	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS				208	208		190.01
191.01	PATIENT TRANSPORTATION				329	329	5,484	191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	776,503	2,448,523	1,330,978	1,112,897	1,261,947	2,380,498	202
203	UNIT COST MULT-WS B PT I	53.685218	20.272587	92.020050	19.815836	43.841961	0.419758	203
204	COST TO BE ALLOC PER B PT II	119,284	132,341	352,221	189,775	120,865	457,420	204
205	UNIT COST MULT-WS B PT II	8.246958	1.095719	24.351563	3.379064	4.199034	0.080658	205

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

	COST CENTER DESCRIPTIONS	PHARMACY & LINEN SERVICE COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE					
		15	16					
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	10,000						15
16	MEDICAL RECORDS & LIBRARY		343,763,456					16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		13,050,238					30
31	INTENSIVE CARE UNIT		5,443,152					31
43	NURSERY		781,204					43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		39,363,827					50
51	RECOVERY ROOM		5,633,678					51
52	DELIVERY ROOM & LABOR ROOM		1,451,633					52
53	ANESTHESIOLOGY		3,979,309					53
54	RADIOLOGY-DIAGNOSTIC		18,394,084					54
54.01	NUCLEAR MEDICINE		3,816,163					54.01
54.02	ULTRASOUND		8,979,643					54.02
55	RADIOLOGY-THERAPEUTIC		7,264,891					55
57	CT SCAN		39,795,862					57
58	MRI		11,152,622					58
59	CARDIAC CATHETERIZATION		9,668,372					59
59.97	CARDIAC REHAB		382,752					59.97
60	LABORATORY		61,477,669					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		16,400,318					65
66	PHYSICAL THERAPY		3,452,573					66
67	OCCUPATIONAL THERAPY		903,307					67
68	SPEECH PATHOLOGY		252,797					68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		11,939,605					71
72	IMPL. DEV. CHARGED TO PATIENTS		7,984,508					72
73	DRUGS CHARGED TO PATIENTS	10,000	22,834,142					73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		13,395,583					90
90.01	HOSPITAL SURGEON							90.01
91	EMERGENCY		35,965,524					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,000	343,763,456					118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS							190.01
191.01	PATIENT TRANSPORTATION							191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	8,490,553	2,833,212					202
203	UNIT COST MULT-WS B PT I	849.055300	0.008242					203
204	COST TO BE ALLOC PER B PT II	261,774	328,055					204
205	UNIT COST MULT-WS B PT II	26.177400	0.000954					205

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	17,065,162		17,065,162		17,065,162	30
31	INTENSIVE CARE UNIT	4,079,917		4,079,917		4,079,917	31
43	NURSERY	1,055,865		1,055,865		1,055,865	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	9,869,781		9,869,781		9,869,781	50
51	RECOVERY ROOM	1,438,376		1,438,376		1,438,376	51
52	DELIVERY ROOM & LABOR ROOM	1,611,922		1,611,922		1,611,922	52
53	ANESTHESIOLOGY	116,190		116,190		116,190	53
54	RADIOLOGY-DIAGNOSTIC	5,077,104		5,077,104		5,077,104	54
54.01	NUCLEAR MEDICINE	967,376		967,376		967,376	54.01
54.02	ULTRASOUND	1,100,353		1,100,353		1,100,353	54.02
55	RADIOLOGY-THERAPEUTIC	2,001,293		2,001,293		2,001,293	55
57	CT SCAN	1,637,105		1,637,105		1,637,105	57
58	MRI	1,709,657		1,709,657		1,709,657	58
59	CARDIAC CATHETERIZATION	2,692,822		2,692,822		2,692,822	59
59.97	CARDIAC REHAB	332,093		332,093		332,093	59.97
60	LABORATORY	9,480,949		9,480,949		9,480,949	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	3,455,910		3,455,910		3,455,910	65
66	PHYSICAL THERAPY	1,711,086		1,711,086		1,711,086	66
67	OCCUPATIONAL THERAPY	850,475		850,475		850,475	67
68	SPEECH PATHOLOGY	136,931		136,931		136,931	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,651,554		3,651,554		3,651,554	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,436,472		4,436,472		4,436,472	72
73	DRUGS CHARGED TO PATIENTS	8,678,752		8,678,752		8,678,752	73
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	10,174,360		10,174,360		10,174,360	90
90.01	HOSPITAL SURGEON	162,248		162,248		162,248	90.01
91	EMERGENCY	7,370,370		7,370,370		7,370,370	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,849,056		2,849,056		2,849,056	92
	OTHER REIMBURSABLE COST CENTERS						
200	SUBTOTAL (SEE INSTRUCTIONS)	103,713,179		103,713,179		103,713,179	200
201	LESS OBSERVATION BEDS	2,849,056		2,849,056		2,849,056	201
202	TOTAL (SEE INSTRUCTIONS)	100,864,123		100,864,123		100,864,123	202

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	11,196,988		11,196,988				30
31	INTENSIVE CARE UNIT	5,443,152		5,443,152				31
43	NURSERY	781,204		781,204				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,527,830	27,835,997	39,363,827	0.250732	0.250732	0.250732	50
51	RECOVERY ROOM	1,577,600	4,056,078	5,633,678	0.255317	0.255317	0.255317	51
52	DELIVERY ROOM & LABOR ROOM	1,451,633		1,451,633	1.110420	1.110420	1.110420	52
53	ANESTHESIOLOGY	1,259,050	2,720,259	3,979,309	0.029199	0.029199	0.029199	53
54	RADIOLOGY-DIAGNOSTIC	3,272,185	15,121,899	18,394,084	0.276018	0.276018	0.276018	54
54.01	NUCLEAR MEDICINE	628,096	3,188,067	3,816,163	0.253494	0.253494	0.253494	54.01
54.02	ULTRASOUND	1,399,808	7,579,835	8,979,643	0.122539	0.122539	0.122539	54.02
55	RADIOLOGY-THERAPEUTIC	3,031	7,261,860	7,264,891	0.275475	0.275475	0.275475	55
57	CT SCAN	6,733,155	33,062,707	39,795,862	0.041138	0.041138	0.041138	57
58	MRI	1,399,206	9,753,416	11,152,622	0.153296	0.153296	0.153296	58
59	CARDIAC CATHETERIZATION	3,818,878	5,849,494	9,668,372	0.278519	0.278519	0.278519	59
59.97	CARDIAC REHAB	1,625	381,127	382,752	0.867645	0.867645	0.867645	59.97
60	LABORATORY	15,868,592	45,609,077	61,477,669	0.154218	0.154218	0.154218	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	8,506,450	7,893,868	16,400,318	0.210722	0.210722	0.210722	65
66	PHYSICAL THERAPY	1,544,315	1,908,258	3,452,573	0.495597	0.495597	0.495597	66
67	OCCUPATIONAL THERAPY	302,629	600,678	903,307	0.941513	0.941513	0.941513	67
68	SPEECH PATHOLOGY	137,387	115,410	252,797	0.541664	0.541664	0.541664	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,765,919	6,173,686	11,939,605	0.305835	0.305835	0.305835	71
72	IMPL. DEV. CHARGED TO PATIENTS	3,117,598	4,866,910	7,984,508	0.555635	0.555635	0.555635	72
73	DRUGS CHARGED TO PATIENTS	10,683,153	12,150,989	22,834,142	0.380078	0.380078	0.380078	73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	11,095	13,384,488	13,395,583	0.759531	0.759531	0.759531	90
90.01	HOSPITAL SURGEON							90.01
91	EMERGENCY	7,382,606	28,582,918	35,965,524	0.204929	0.204929	0.204929	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	926,625	926,625	1,853,250	1.537330	1.537330	1.537330	92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)	104,739,810	239,023,646	343,763,456				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	104,739,810	239,023,646	343,763,456				202

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII, PART A** **[ ] TITLE XIX** **[XX] PPS** **[ ] TEFRA**

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	2,760,670		2,760,670	13,471	204.93	7,467	1,530,212	30
31	INTENSIVE CARE UNIT	360,756		360,756	2,288	157.67	1,158	182,582	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	89,633		89,633	954	93.95			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	3,211,059		3,211,059	16,713		8,625	1,712,794	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0101** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	851,567	39,363,827	0.021633	5,569,585	120,487	50
51	RECOVERY ROOM	398,939	5,633,678	0.070813	959,762	67,964	51
52	DELIVERY ROOM & LABOR ROOM	69,312	1,451,633	0.047748	11,931	570	52
53	ANESTHESIOLOGY	36,972	3,979,309	0.009291	623,962	5,797	53
54	RADIOLOGY-DIAGNOSTIC	763,137	18,394,084	0.041488	2,104,605	87,316	54
54.01	NUCLEAR MEDICINE	50,572	3,816,163	0.013252	462,655	6,131	54.01
54.02	ULTRASOUND	79,647	8,979,643	0.008870	431,820	3,830	54.02
55	RADIOLOGY-THERAPEUTIC	49,341	7,264,891	0.006792			55
57	CT SCAN	143,214	39,795,862	0.003599	5,228,342	18,817	57
58	MRI	459,773	11,152,622	0.041226	1,041,631	42,942	58
59	CARDIAC CATHETERIZATION	242,443	9,668,372	0.025076			59
59.97	CARDIAC REHAB	10,718	382,752	0.028002	672	19	59.97
60	LABORATORY	619,889	61,477,669	0.010083	11,808,529	119,065	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	419,049	16,400,318	0.025551	7,979,906	203,895	65
66	PHYSICAL THERAPY	279,888	3,452,573	0.081066	1,247,690	101,145	66
67	OCCUPATIONAL THERAPY	83,470	903,307	0.092405	241,491	22,315	67
68	SPEECH PATHOLOGY	17,339	252,797	0.068589	123,873	8,496	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,181	11,939,605	0.007302	3,762,913	27,477	71
72	IMPL. DEV. CHARGED TO PATIENTS	100,846	7,984,508	0.012630	2,918,699	36,863	72
73	DRUGS CHARGED TO PATIENTS	283,558	22,834,142	0.012418	7,555,120	93,819	73
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	306,672	13,395,583	0.022894			90
90.01	HOSPITAL SURGEON	4,138					90.01
91	EMERGENCY	870,831	35,965,524	0.024213	3,898,093	94,385	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	460,897	1,853,250	0.248697	299,348	74,447	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,689,393	326,342,112		56,270,627	1,135,780	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS; [XX] TITLE XVIII, PART A [ ] TEFRA; [ ] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] PPS**
[XX] TITLE XVIII, PART A **[ ] TEFRA**
[ ] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	13,471		7,467		30
31	INTENSIVE CARE UNIT	2,288		1,158		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	954				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	16,713		8,625		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0101** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	NUCLEAR MEDICINE							54.01
54.02	ULTRASOUND							54.02
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
59.97	CARDIAC REHAB							59.97
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	HOSPITAL SURGEON							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0101** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	39,363,827			5,569,585		11,921,787		50
51	RECOVERY ROOM	5,633,678			959,762		2,008,833		51
52	DELIVERY ROOM & LABOR ROOM	1,451,633			11,931				52
53	ANESTHESIOLOGY	3,979,309			623,962		733,129		53
54	RADIOLOGY-DIAGNOSTIC	18,394,084			2,104,605		4,338,153		54
54.01	NUCLEAR MEDICINE	3,816,163			462,655		1,435,026		54.01
54.02	ULTRASOUND	8,979,643			431,820		1,057,006		54.02
55	RADIOLOGY-THERAPEUTIC	7,264,891							55
57	CT SCAN	39,795,862			5,228,342		10,074,317		57
58	MRI	11,152,622			1,041,631		2,710,121		58
59	CARDIAC CATHETERIZATION	9,668,372							59
59.97	CARDIAC REHAB	382,752			672		226,179		59.97
60	LABORATORY	61,477,669			11,808,529		1,372,620		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	16,400,318			7,979,906		3,792,748		65
66	PHYSICAL THERAPY	3,452,573			1,247,690		6,024		66
67	OCCUPATIONAL THERAPY	903,307			241,491				67
68	SPEECH PATHOLOGY	252,797			123,873				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,939,605			3,762,913		2,972,101		71
72	IMPL. DEV. CHARGED TO PATIENTS	7,984,508			2,918,699		1,656,731		72
73	DRUGS CHARGED TO PATIENTS	22,834,142			7,555,120		6,267,973		73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	13,395,583					959,373		90
90.01	HOSPITAL SURGEON								90.01
91	EMERGENCY	35,965,524			3,898,093		5,553,001		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,853,250			299,348		669,662		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	326,342,112			56,270,627		57,754,784		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0101** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.250732	11,921,787			2,989,173			50
51	RECOVERY ROOM	0.255317	2,008,833			512,889			51
52	DELIVERY ROOM & LABOR ROOM	1.110420							52
53	ANESTHESIOLOGY	0.029199	733,129			21,407			53
54	RADIOLOGY-DIAGNOSTIC	0.276018	4,338,153			1,197,408			54
54.01	NUCLEAR MEDICINE	0.253494	1,435,026			363,770			54.01
54.02	ULTRASOUND	0.122539	1,057,006			129,524			54.02
55	RADIOLOGY-THERAPEUTIC	0.275475							55
57	CT SCAN	0.041138	10,074,317			414,437			57
58	MRI	0.153296	2,710,121			415,451			58
59	CARDIAC CATHETERIZATION	0.278519							59
59.97	CARDIAC REHAB	0.867645	226,179			196,243			59.97
60	LABORATORY	0.154218	1,372,620			211,683			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.210722	3,792,748			799,215			65
66	PHYSICAL THERAPY	0.495597	6,024			2,985			66
67	OCCUPATIONAL THERAPY	0.941513							67
68	SPEECH PATHOLOGY	0.541664							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.305835	2,972,101			908,973			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.555635	1,656,731			920,538			72
73	DRUGS CHARGED TO PATIENTS	0.380078	6,267,973			2,382,319			73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.759531	959,373			728,674			90
90.01	HOSPITAL SURGEON								90.01
91	EMERGENCY	0.204929	5,553,001			1,137,971			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.537330	669,662			1,029,491			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		57,754,784			14,362,151			200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		57,754,784			14,362,151			202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES:
[ ] TITLE V [XX] PPS
[ ] TITLE XVIII, PART A [ ] TEFRA
[XX] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	2,760,670		2,760,670	13,471	204.93	833	170,707	30
31	INTENSIVE CARE UNIT	360,756		360,756	2,288	157.67	244	38,471	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	89,633		89,633	954	93.95	438	41,150	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	3,211,059		3,211,059	16,713		1,515	250,328	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0101** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
[XX] TITLE XIX [ ] IRF

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	851,567	39,363,827	0.021633			50
51	RECOVERY ROOM	398,939	5,633,678	0.070813			51
52	DELIVERY ROOM & LABOR ROOM	69,312	1,451,633	0.047748			52
53	ANESTHESIOLOGY	36,972	3,979,309	0.009291			53
54	RADIOLOGY-DIAGNOSTIC	763,137	18,394,084	0.041488			54
54.01	NUCLEAR MEDICINE	50,572	3,816,163	0.013252			54.01
54.02	ULTRASOUND	79,647	8,979,643	0.008870			54.02
55	RADIOLOGY-THERAPEUTIC	49,341	7,264,891	0.006792			55
57	CT SCAN	143,214	39,795,862	0.003599			57
58	MRI	459,773	11,152,622	0.041226			58
59	CARDIAC CATHETERIZATION	242,443	9,668,372	0.025076			59
59.97	CARDIAC REHAB	10,718	382,752	0.028002			59.97
60	LABORATORY	619,889	61,477,669	0.010083			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	419,049	16,400,318	0.025551			65
66	PHYSICAL THERAPY	279,888	3,452,573	0.081066			66
67	OCCUPATIONAL THERAPY	83,470	903,307	0.092405			67
68	SPEECH PATHOLOGY	17,339	252,797	0.068589			68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,181	11,939,605	0.007302			71
72	IMPL. DEV. CHARGED TO PATIENTS	100,846	7,984,508	0.012630			72
73	DRUGS CHARGED TO PATIENTS	283,558	22,834,142	0.012418			73
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	306,672	13,395,583	0.022894			90
90.01	HOSPITAL SURGEON	4,138					90.01
91	EMERGENCY	870,831	35,965,524	0.024213			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	460,897	1,853,250	0.248697			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,689,393	326,342,112				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS; [ ] TITLE XVIII, PART A [ ] TEFRA; [XX] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] PPS**
[ ] TITLE XVIII, PART A **[ ] TEFRA**
[XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	13,471		833		30
31	INTENSIVE CARE UNIT	2,288		244		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	954		438		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	16,713		1,515		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0101** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	NUCLEAR MEDICINE							54.01
54.02	ULTRASOUND							54.02
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
59.97	CARDIAC REHAB							59.97
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	HOSPITAL SURGEON							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0101** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	39,363,827							50
51	RECOVERY ROOM	5,633,678							51
52	DELIVERY ROOM & LABOR ROOM	1,451,633							52
53	ANESTHESIOLOGY	3,979,309							53
54	RADIOLOGY-DIAGNOSTIC	18,394,084							54
54.01	NUCLEAR MEDICINE	3,816,163							54.01
54.02	ULTRASOUND	8,979,643							54.02
55	RADIOLOGY-THERAPEUTIC	7,264,891							55
57	CT SCAN	39,795,862							57
58	MRI	11,152,622							58
59	CARDIAC CATHETERIZATION	9,668,372							59
59.97	CARDIAC REHAB	382,752							59.97
60	LABORATORY	61,477,669							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	16,400,318							65
66	PHYSICAL THERAPY	3,452,573							66
67	OCCUPATIONAL THERAPY	903,307							67
68	SPEECH PATHOLOGY	252,797							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,939,605							71
72	IMPL. DEV. CHARGED TO PATIENTS	7,984,508							72
73	DRUGS CHARGED TO PATIENTS	22,834,142							73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	13,395,583							90
90.01	HOSPITAL SURGEON								90.01
91	EMERGENCY	35,965,524							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,853,250							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	326,342,112							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0101** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[ ] TITLE XVIII, PART B [ ] IPF [ ] SNF [ ] SWING BED NF
[XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.250732							50
51	RECOVERY ROOM	0.255317							51
52	DELIVERY ROOM & LABOR ROOM	1.110420							52
53	ANESTHESIOLOGY	0.029199							53
54	RADIOLOGY-DIAGNOSTIC	0.276018							54
54.01	NUCLEAR MEDICINE	0.253494							54.01
54.02	ULTRASOUND	0.122539							54.02
55	RADIOLOGY-THERAPEUTIC	0.275475							55
57	CT SCAN	0.041138							57
58	MRI	0.153296							58
59	CARDIAC CATHETERIZATION	0.278519							59
59.97	CARDIAC REHAB	0.867645							59.97
60	LABORATORY	0.154218							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.210722							65
66	PHYSICAL THERAPY	0.495597							66
67	OCCUPATIONAL THERAPY	0.941513							67
68	SPEECH PATHOLOGY	0.541664							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.305835							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.555635							72
73	DRUGS CHARGED TO PATIENTS	0.380078							73
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.759531							90
90.01	HOSPITAL SURGEON								90.01
91	EMERGENCY	0.204929							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.537330							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0101** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	13,471	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	13,471	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	11,222	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	7,467	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)	17,065,162	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	17,065,162	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	17,065,162	37

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0101** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,266.81	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					9,459,270	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)					9,459,270	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,079,917	2,288	1,783.18	1,158	2,064,922	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					14,118,004	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					25,642,196	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					1,712,794	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					1,135,780	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					2,848,574	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					22,793,622	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE 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

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0101** **WORKSHEET D-1**
PARTS III & IV

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					2,249	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,266.81	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					2,849,056	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	2,760,670	17,065,162	0.161772	2,849,056	460,897	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0101** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	13,471	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	13,471	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	11,222	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	833	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)	954	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	438	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)	17,065,162	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	17,065,162	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	17,065,162	37

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0101** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
[XX] TITLE XIX - I/P [ ] IRF [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,266.81	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					1,055,253	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					1,055,253	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)	1,055,865	954	1,106.78	438	484,770	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,079,917	2,288	1,783.18	244	435,096	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					1,975,119	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					250,328	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					250,328	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					1,724,791	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE 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

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0101** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					2,249	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)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0101** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

(A)	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		8,029,033		30
31	INTENSIVE CARE UNIT		1,012,090		31
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.250732	5,569,585	1,396,473	50
51	RECOVERY ROOM	0.255317	959,762	245,044	51
52	DELIVERY ROOM & LABOR ROOM	1.110420	11,931	13,248	52
53	ANESTHESIOLOGY	0.029199	623,962	18,219	53
54	RADIOLOGY-DIAGNOSTIC	0.276018	2,104,605	580,909	54
54.01	NUCLEAR MEDICINE	0.253494	462,655	117,280	54.01
54.02	ULTRASOUND	0.122539	431,820	52,915	54.02
55	RADIOLOGY-THERAPEUTIC	0.275475			55
57	CT SCAN	0.041138	5,228,342	215,084	57
58	MRI	0.153296	1,041,631	159,678	58
59	CARDIAC CATHETERIZATION	0.278519			59
59.97	CARDIAC REHAB	0.867645	672	583	59.97
60	LABORATORY	0.154218	11,808,529	1,821,088	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.210722	7,979,906	1,681,542	65
66	PHYSICAL THERAPY	0.495597	1,247,690	618,351	66
67	OCCUPATIONAL THERAPY	0.941513	241,491	227,367	67
68	SPEECH PATHOLOGY	0.541664	123,873	67,098	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.305835	3,762,913	1,150,830	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.555635	2,918,699	1,621,731	72
73	DRUGS CHARGED TO PATIENTS	0.380078	7,555,120	2,871,535	73
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.759531			90
90.01	HOSPITAL SURGEON				90.01
91	EMERGENCY	0.204929	3,898,093	798,832	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.537330	299,348	460,197	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		56,270,627	14,118,004	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		56,270,627		202

(A) Worksheet A line numbers

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0101** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

(A)	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
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.250732			50
51	RECOVERY ROOM	0.255317			51
52	DELIVERY ROOM & LABOR ROOM	1.110420			52
53	ANESTHESIOLOGY	0.029199			53
54	RADIOLOGY-DIAGNOSTIC	0.276018			54
54.01	NUCLEAR MEDICINE	0.253494			54.01
54.02	ULTRASOUND	0.122539			54.02
55	RADIOLOGY-THERAPEUTIC	0.275475			55
57	CT SCAN	0.041138			57
58	MRI	0.153296			58
59	CARDIAC CATHETERIZATION	0.278519			59
59.97	CARDIAC REHAB	0.867645			59.97
60	LABORATORY	0.154218			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.210722			65
66	PHYSICAL THERAPY	0.495597			66
67	OCCUPATIONAL THERAPY	0.941513			67
68	SPEECH PATHOLOGY	0.541664			68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.305835			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.555635			72
73	DRUGS CHARGED TO PATIENTS	0.380078			73
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.759531			90
90.01	HOSPITAL SURGEON				90.01
91	EMERGENCY	0.204929			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.537330			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

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

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	15,699,272			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)				1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	694,005			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	79.63			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) 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)				30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)				31
32	SUM OF LINES 30 AND 31				32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)				33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)				34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		

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

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)				35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)				35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)				36
	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)	16,393,277			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)	16,393,277			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	1,336,728			50
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)	17,730,005			59
60	PRIMARY PAYER PAYMENTS	5,973			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	17,724,032			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	1,721,992			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	25,451			63
64	ALLOWABLE BAD DEBTS (see instructions)	230,276			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	149,679			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	182,405			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	16,126,268			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-57,232			70.94
71	AMOUNT DUE PROVIDER (see instructions)	16,069,036			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	242,642			71.01
72	INTERIM PAYMENTS	15,696,220			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	130,174			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2				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

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0101** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	14,362,151			2
3	PPS PAYMENTS	10,513,417			3
4	OUTLIER PAYMENT (see instructions)	59,825			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	10,573,242			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	2,417,591			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	8,155,651			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)	8,155,651			30
31	PRIMARY PAYER PAYMENTS	1,335			31
32	SUBTOTAL (line 30 minus line 31)	8,154,316			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)	334,517			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	217,436			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	237,258			36
37	SUBTOTAL (see instructions)	8,371,752			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	-212			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	8,371,964			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	126,417			40.01
41	INTERIM PAYMENTS	8,026,399			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	219,148			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 (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0101** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				15,696,220		8,026,399	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				15,696,220		8,026,399	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT **WORKSHEET E-1 PART II**

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	4,191	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	8,625	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	326	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	13,510	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	343,763,456	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	11,305,307	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)	1,340,261	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,300,326	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	39,935	32

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0101** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] NF**	**[XX] PPS**
	[XX] TITLE XIX	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[ ] OTHER**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A 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	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF 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 Worksheet 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

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	22,198,773				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	22,157,485				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	5,959,734				7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	44,063				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	50,360,055				11
	FIXED ASSETS					
12	LAND	6,803,639				12
13	LAND IMPROVEMENTS	5,594,741				13
14	ACCUMULATED DEPRECIATION	-4,302,790				14
15	BUILDINGS	68,128,816				15
16	ACCUMULATED DEPRECIATION	-46,960,990				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	157,618				19
20	ACCUMULATED DEPRECIATION	-145,568				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	84,378,322				23
24	ACCUMULATED DEPRECIATION	-48,446,441				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	65,207,347				30
	OTHER ASSETS					
31	INVESTMENTS	1,348,648				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	62,509,577				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	63,858,225				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	179,425,627				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	10,581,082				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	1,844,116				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	165,361				43
44	OTHER CURRENT LIABILITIES	8,677,836				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	21,268,395				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE	38,700,549				46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	10,180,476				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	48,881,025				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	70,149,420				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	109,276,207				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
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)	109,276,207				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	179,425,627				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		101,208,372			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		8,067,835			2
3	TOTAL (sun of line 1 and line 2)		109,276,207			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		109,276,207			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		109,276,207			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	14,230,773		14,230,773	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				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)	14,230,773		14,230,773	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	7,123,090		7,123,090	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	7,123,090		7,123,090	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	21,353,863		21,353,863	17
18	ANCILLARY SERVICES	85,980,243	234,027,065	320,007,308	18
19	OUTPATIENT SERVICES		13,464,649	13,464,649	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	107,334,106	247,491,714	354,825,820	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		115,139,570	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		115,139,570	43

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	354,825,820	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	231,977,822	2
3	NET PATIENT REVENUES (line 1 minus line 2)	122,847,998	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	115,139,570	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	7,708,428	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,440	6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)		24
24.01	OTHER (TOTAL NON OPERATING REVENUE)	3,709,253	24.01
24.02	OTHER (PROVISION FOR UNCOLLECTIBLE ACCOUNT)	-6,854,420	24.02
24.03	OTHER (NET ASSETS RELEASED FROM RESTRICTIO)	526,204	24.03
24.04	OTHER (OTHER INCOME)	2,976,776	24.04
24.05	OTHER (ROUNDING)	154	24.05
25	TOTAL OTHER INCOME (sum of lines 6-24)	359,407	25
26	TOTAL (line 5 plus line 25)	8,067,835	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	8,067,835	29

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0101** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] SUB (OTHER) | [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	1,336,728	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,336,728	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0101** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 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 (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	NUCLEAR MEDICINE							54.01
54.02	ULTRASOUND							54.02
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
59.97	CARDIAC REHAB							59.97
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	HOSPITAL SURGEON							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS							190.01
191.01	PATIENT TRANSPORTATION							191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202

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MORRIS HOSPITAL Provider CCN: 14-0101	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/21/2014 Run Time: 14:16 Version: 2014.03

REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	55.43		6.18				61.61	30
31	INTENSIVE CARE UNIT	50.61		10.66				61.27	31
43	NURSERY			45.91				45.91	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	14.15	30.29					44.44	50
51	RECOVERY ROOM	17.04	35.66					52.70	51
52	DELIVERY ROOM & LABOR ROOM	0.82						0.82	52
53	ANESTHESIOLOGY	15.68	18.42					34.10	53
54	RADIOLOGY-DIAGNOSTIC	11.44	23.58					35.02	54
54.01	NUCLEAR MEDICINE	12.12	37.60					49.72	54.01
54.02	ULTRASOUND	4.81	11.77					16.58	54.02
57	CT SCAN	13.14	25.31					38.45	57
58	MRI	9.34	24.30					33.64	58
59.97	CARDIAC REHAB	0.18	59.09					59.27	59.97
60	LABORATORY	19.21	2.23					21.44	60
65	RESPIRATORY THERAPY	48.66	23.13					71.79	65
66	PHYSICAL THERAPY	36.14	0.17					36.31	66
67	OCCUPATIONAL THERAPY	26.73						26.73	67
68	SPEECH PATHOLOGY	49.00						49.00	68
71	MEDICAL SUPPLIES CHARGED TO PAT	31.52	24.89					56.41	71
72	IMPL. DEV. CHARGED TO PATIENTS	36.55	20.75					57.30	72
73	DRUGS CHARGED TO PATIENTS	33.09	27.45					60.54	73
90	CLINIC		7.16					7.16	90
91	EMERGENCY	10.84	15.44					26.28	91
92	OBSERVATION BEDS (NON-DISTINCT	16.15	36.13					52.28	92
200	TOTAL CHARGES	17.24	17.70					34.94	200

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REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	5,088,920	5.02	-5,088,920	-9.50			1
2	CAP REL COSTS-MVBLE EQUIP	4,367,212	4.30	-4,367,212	-8.15			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	7,099,363	7.00	-7,099,363	-13.25			4
5	ADMINISTRATIVE & GENERAL	22,493,662	22.17	-22,493,662	-41.99			5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,595,488	2.56	-2,595,488	-4.84			7
8	LAUNDRY & LINEN SERVICE	434,639	0.43	-434,639	-0.81			8
9	HOUSEKEEPING	1,556,444	1.53	-1,556,444	-2.91			9
10	DIETARY	427,946	0.42	-427,946	-0.80			10
11	CAFETERIA	479,971	0.47	-479,971	-0.90			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	684,019	0.67	-684,019	-1.28			13
14	CENTRAL SERVICES & SUPPLY	1,000,799	0.99	-1,000,799	-1.87			14
15	PHARMACY	5,890,971	5.81	-5,890,971	-11.00			15
16	MEDICAL RECORDS & LIBRARY	1,452,481	1.43	-1,452,481	-2.71			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	ADULTS & PEDIATRICS	6,760,777	6.66	10,304,385	19.23	17,065,162	16.82	30
31	INTENSIVE CARE UNIT	2,034,445	2.01	2,045,472	3.82	4,079,917	4.02	31
43	NURSERY	520,813	0.51	535,052	1.00	1,055,865	1.04	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,891,256	4.82	4,978,525	9.29	9,869,781	9.73	50
51	RECOVERY ROOM	380,040	0.37	1,058,336	1.98	1,438,376	1.42	51
52	DELIVERY ROOM & LABOR ROOM	960,975	0.95	650,947	1.22	1,611,922	1.59	52
53	ANESTHESIOLOGY	10,077	0.01	106,113	0.20	116,190	0.11	53
54	RADIOLOGY-DIAGNOSTIC	2,305,374	2.27	2,771,730	5.17	5,077,104	5.00	54
54.01	NUCLEAR MEDICINE	609,345	0.60	358,031	0.67	967,376	0.95	54.01
54.02	ULTRASOUND	599,524	0.59	500,829	0.93	1,100,353	1.08	54.02
55	RADIOLOGY-THERAPEUTIC	1,383,129	1.36	618,164	1.15	2,001,293	1.97	55
57	CT SCAN	751,688	0.74	885,417	1.65	1,637,105	1.61	57
58	MRI	488,421	0.48	1,221,236	2.28	1,709,657	1.69	58
59	CARDIAC CATHETERIZATION	1,332,802	1.31	1,360,020	2.54	2,692,822	2.65	59
59.97	CARDIAC REHAB	207,439	0.20	124,654	0.23	332,093	0.33	59.97
60	LABORATORY	5,419,518	5.34	4,061,431	7.58	9,480,949	9.34	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,686,433	1.66	1,769,477	3.30	3,455,910	3.41	65
66	PHYSICAL THERAPY	753,218	0.74	957,868	1.79	1,711,086	1.69	66
67	OCCUPATIONAL THERAPY	479,395	0.47	371,080	0.69	850,475	0.84	67
68	SPEECH PATHOLOGY	67,743	0.07	69,188	0.13	136,931	0.13	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,649,928	2.61	1,001,626	1.87	3,651,554	3.60	71
72	IMPL. DEV. CHARGED TO PATIENTS	3,259,629	3.21	1,176,843	2.20	4,436,472	4.37	72
73	DRUGS CHARGED TO PATIENTS			8,678,752	16.20	8,678,752	8.55	73
90	CLINIC	6,212,299	6.12	3,962,061	7.40	10,174,360	10.03	90
90.01	HOSPITAL SURGEON	71,348	0.07	90,900	0.17	162,248	0.16	90.01
91	EMERGENCY	3,666,889	3.61	3,703,481	6.91	7,370,370	7.26	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS	70,183	0.07	50,087	0.09	120,270	0.12	190.01
191.01	PATIENT TRANSPORTATION	315,264	0.31	160,210	0.30	475,474	0.47	191.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	101,459,867	100.00			101,459,867	100.00	202

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

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	851,567	39,363,827	0.021633	5,569,585	120,487	50
51	RECOVERY ROOM	398,939	5,633,678	0.070813	959,762	67,964	51
52	DELIVERY ROOM & LABOR ROOM	69,312	1,451,633	0.047748	11,931	570	52
53	ANESTHESIOLOGY	36,972	3,979,309	0.009291	623,962	5,797	53
54	RADIOLOGY-DIAGNOSTIC	763,137	18,394,084	0.041488	2,104,605	87,316	54
54.01	NUCLEAR MEDICINE	50,572	3,816,163	0.013252	462,655	6,131	54.01
54.02	ULTRASOUND	79,647	8,979,643	0.008870	431,820	3,830	54.02
55	RADIOLOGY-THERAPEUTIC	49,341	7,264,891	0.006792			55
57	CT SCAN	143,214	39,795,862	0.003599	5,228,342	18,817	57
58	MRI	459,773	11,152,622	0.041226	1,041,631	42,942	58
59	CARDIAC CATHETERIZATION	242,443	9,668,372	0.025076			59
59.97	CARDIAC REHAB	10,718	382,752	0.028002	672	19	59.97
60	LABORATORY	619,889	61,477,669	0.010083	11,808,529	119,065	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	419,049	16,400,318	0.025551	7,979,906	203,895	65
66	PHYSICAL THERAPY	279,888	3,452,573	0.081066	1,247,690	101,145	66
67	OCCUPATIONAL THERAPY	83,470	903,307	0.092405	241,491	22,315	67
68	SPEECH PATHOLOGY	17,339	252,797	0.068589	123,873	8,496	68
71	MEDICAL SUPPLIES CHARGED TO PAT	87,181	11,939,605	0.007302	3,762,913	27,477	71
72	IMPL. DEV. CHARGED TO PATIENTS	100,846	7,984,508	0.012630	2,918,699	36,863	72
73	DRUGS CHARGED TO PATIENTS	283,558	22,834,142	0.012418	7,555,120	93,819	73
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	306,672	13,395,583	0.022894			90
90.01	HOSPITAL SURGEON	4,138					90.01
91	EMERGENCY	870,831	35,965,524	0.024213	3,898,093	94,385	91
92	OBSERVATION BEDS (NON-DISTINCT	460,897	1,853,250	0.248697	299,348	74,447	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	6,689,393	326,342,112		56,270,627	1,135,780	200

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

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	2,760,670		2,760,670	13,471	204.93	7,467	1,530,212	30
31	INTENSIVE CARE UNIT	360,756		360,756	2,288	157.67	1,158	182,582	31
200	TOTAL	3,121,426		3,121,426	15,759		8,625	1,712,794	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	1,712,794
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	1,135,780
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	2,848,574
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	2,099
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	8,625
PER DISCHARGE CAPITAL COSTS	1,357.11

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I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	22,793,622
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	65,311,750
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.349

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	2,848,574
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.044

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	14,359,166
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	57,748,760
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.249