MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/30/2015 Run Time: 08:07 Version: 2015.03 (05/21/2015)

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: 05/30/2015 Time: 08:07 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 certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRIS HOSPITAL (14-0101) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2014 and ending 12/31/2014, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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		198,143	165,186	-63,087		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		198,143	165,186	-63,087		200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control
number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,
search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions
for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence
not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions
or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/30/2015 Run Time: 08:07 Version: 2015.03 (05/21/2015)

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

Hospital and Hospital Health Care 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	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	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 / 2014	To: 12 / 31 / 2014	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	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
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,850						24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

	Teaching Hospitals	1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86

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? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, Section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	820,814	4,000		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 cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

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

141	Name:	Contractor's Name:		Contractor's Number:	141
142	Street:	P.O. Box:			142
143	City:	State:	ZIP Code:		143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are the 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	4	
155	Hospital	N	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. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	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)	0.50			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2014	09 / 30 / 2014	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accnountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	04/21/2015	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for 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 instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

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

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/12/2015	Y	05/12/2015	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 padi-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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

General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

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

	Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

	Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

	Purchased Services		
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

	Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

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

	Cost Report Preparer Contact Information			
41	First name: THOMAS	Last name: CURTIS	Title: CPA	41
42	Employer: THE CURTIS GROUP, INC.			42
43	Phone number: 217-483-9092	E-mail Address: TOM@THECURTISGROUP.NET		43

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	81	29,565			7,212	1,104	11,396	1
2	HMO and other (see instructions)						74			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	29,565			7,212	1,104	11,396	7
8	Intensive Care Unit	31	8	2,920			1,455	262	2,606	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						484	1,094	13
14	Total (see instructions)		89	32,485			8,667	1,850	15,096	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								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		89							27
28	Observation Bed Days								2,052	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								135	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)								30	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,111	621	4,430	1
2	HMO and other (see instructions)								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)		885.00			2,111	621	4,430	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)		885.00						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/30/2015 Run Time: 08:07 Version: 2015.03 (05/21/2015)

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	56,191,769		56,191,769	1,840,924.80	30.52	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		7,576,186		7,576,186	56,650.00	133.74	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)		170,909	47,575	218,484	10,713.00	20.39	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		121,083		121,083	1,926.00	62.87	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)		11,746,875		11,746,875			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		52,978		52,978			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		1,837,075		1,837,075			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		386,090		386,090			26
27	Administrative & General		7,746,613	479,771	8,226,384			27
28	Administrative & General under contract (see instructions)		1,977,011		1,977,011	1,132.00	1,746.48	28
29	Maintenance & Repairs							29
30	Operation of Plant		864,637		864,637			30
31	Laundry & Linen Service		26,949		26,949			31
32	Housekeeping		1,196,817		1,196,817			32
33	Housekeeping under contract (see instructions)							33
34	Dietary		989,061	-705,649	283,412			34
35	Dietary under contract (see instructions)							35
36	Cafeteria			596,626	596,626			36
37	Maintenance of Personnel							37
38	Nursing Administration		781,779		781,779			38
39	Central Services and Supply		685,664	-324,917	360,747			39
40	Pharmacy		1,674,819		1,674,819			40
41	Medical Records & Medical Records Library		1,517,985	-93,406	1,424,579			41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		50,592,594		50,592,594	1,785,406.80	28.34	1
2	Excluded area salaries (see instructions)		170,909	47,575	218,484	10,713.00	20.39	2
3	Subtotal salarles (line 1 minus line 2)		50,421,685	-47,575	50,374,110	1,774,693.80	28.38	3
4	Subtotal other wages & related costs (see instructions)		121,083		121,083	1,926.00	62.87	4
5	Subtotal wage-related costs (see instructions)		11,746,875		11,746,875		23.32%	5
6	Total (sum of lines 3 through 5)		62,289,643	-47,575	62,242,068	1,776,619.80	35.03	6
7	Total overhead cost (see instructions)		17,847,425	-47,575	17,799,850	1,132.00	15,724.25	7

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

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	1,201,945	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)	7,403,667	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	259,431	10
11	Life Insurance (If employee is owner or beneficiary)	73,822	11
12	Accident Insurance (If employee is owner or beneficiary)	296,432	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	408,298	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	3,823,774	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	57,696	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	100,327	23
24	Total Wage Related cost (Sum of lines 1-23)	13,625,392	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

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

	STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date			1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)			2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month			3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)			4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	Effective Date of Pension Plan			6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date			7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)			8

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

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable			9
10	Ending Date of Averaging Period from Line 5			10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	**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

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			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

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)	0.246268	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid		2
3	Did you receive DSH or supplemental payments from Medicaid?		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		6
7	Medicaid cost (line 1 times line 6)		7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		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				20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)				21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)				23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)		26
27	Medicare bad debts for the entire hospital complex (see instructions)	366,255	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-366,255	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-90,197	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	-90,197	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	-90,197	31

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/30/2015 Run Time: 08:07 Version: 2015.03 (05/21/2015)

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				3,478,187	3,478,187		3,478,187	1
2	00200	Cap Rel Costs-Mvble Equip				4,778,740	4,778,740		4,778,740	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	386,090	13,878,246	14,264,336	-2,382	14,261,954	-7,872,061	6,389,893	4
5	00500	Administrative & General	7,746,613	20,465,075	28,211,688	-3,372,371	24,839,317	-9,735,241	15,104,076	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	864,637	2,032,132	2,896,769	-19,994	2,876,775		2,876,775	7
8	00800	Laundry & Linen Service	26,949	430,869	457,818	-361	457,457		457,457	8
9	00900	Housekeeping	1,196,817	454,487	1,651,304	-8,851	1,642,453		1,642,453	9
10	01000	Dietary	989,061	529,667	1,518,728	-1,126,306	392,422		392,422	10
11	01100	Cafeteria				916,134	916,134	-404,598	511,536	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	781,779	34,913	816,692	-547	816,145		816,145	13
14	01400	Central Services & Supply	685,664	3,944,951	4,630,615	-3,635,373	995,242		995,242	14
15	01500	Pharmacy	1,674,819	5,122,455	6,797,274	-9,825	6,787,449		6,787,449	15
16	01600	Medical Records & Library	1,517,985	297,581	1,815,566	-284,871	1,530,695		1,530,695	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	7,687,236	1,006,619	8,693,855	-1,114,500	7,579,355	-415,565	7,163,790	30
31	03100	Intensive Care Unit	2,832,891	343,131	3,176,022	-831,610	2,344,412		2,344,412	31
43	04300	Nursery				556,514	556,514		556,514	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	3,115,326	6,082,649	9,197,975	-3,862,715	5,335,260		5,335,260	50
51	05100	Recovery Room	393,712	18,831	412,543	-3,364	409,179		409,179	51
52	05200	Delivery Room & Labor Room				1,132,563	1,132,563		1,132,563	52
53	05300	Anesthesiology		81,237	81,237	-31,032	50,205		50,205	53
54	05400	Radiology-Diagnostic	2,121,065	835,835	2,956,900	-439,383	2,517,517		2,517,517	54
54.01	05401	NUCLEAR MEDICINE	297,461	353,717	651,178	-255	650,923		650,923	54.01
54.02	05402	ULTRASOUND	584,353	161,123	745,476	-94,556	650,920		650,920	54.02
55	05500	Radiology-Therapeutic	427,727	1,066,430	1,494,157	-8,097	1,486,060		1,486,060	55
57	05700	CT Scan	682,261	654,892	1,337,153	-334,119	1,003,034		1,003,034	57
58	05800	MRI	330,888	454,859	785,747	-295,660	490,087		490,087	58
59	05900	Cardiac Catheterization	851,607	1,968,223	2,819,830	-1,367,838	1,451,992		1,451,992	59
59.97	05901	CARDIAC REHAB	163,969	23,044	187,013	-7,190	179,823		179,823	59.97
60	06000	Laboratory	3,075,545	3,291,428	6,366,973	-132,361	6,234,612	-646,398	5,588,214	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,617,552	330,770	1,948,322	-75,689	1,872,633		1,872,633	65
66	06600	Physical Therapy	803,628	154,958	958,586	-5,618	952,968		952,968	66
67	06700	Occupational Therapy	416,602	94,537	511,139	-3,594	507,545		507,545	67
68	06800	Speech Pathology	86,567	12,996	99,563		99,563		99,563	68
71	07100	Medical Supplies Charged to Patients				2,381,775	2,381,775		2,381,775	71
72	07200	Impl. Dev. Charged to Patients				4,577,336	4,577,336		4,577,336	72
73	07300	Drugs Charged to Patients								73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	11,719,139	3,668,344	15,387,483	-739,563	14,647,920	-6,514,223	8,133,697	90
90.01	09001	HOSPITAL SURGEON								90.01
91	09100	Emergency	2,942,917	790,964	3,733,881	-43,660	3,690,221		3,690,221	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	56,020,860	68,584,963	124,605,823	-30,436	124,575,387	-25,588,086	98,987,301	118
		NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS				73,052	73,052	-22,287	50,765	190.01
191.01	19101	PATIENT TRANSPORTATION	170,909	179,138	350,047	-42,616	307,431		307,431	191.01

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	
200		TOTAL (sum of lines 118-199)	56,191,769	68,764,101	124,955,870		124,955,870	-25,610,373	99,345,497	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	CAFETERIA FOOD SERVICE	A	Cafeteria	11	596,626	319,508	1
2			Administrative & General	5	61,448	32,907	2
3			MEALS ON WHEELS	190.01	47,575	25,477	3
500	Total reclassifications				705,649	377,892	500
	Code Letter - A						
1	PURCHASING MATERIALS MANAGMENT	B	Administrative & General	5	418,323	1,005,919	1
500	Total reclassifications				418,323	1,005,919	500
	Code Letter - B						
1	IMPLANTABLE DEVICES	C	Impl. Dev. Charged to Patient	72		1,147,129	1
2			Impl. Dev. Charged to Patient	72		3,430,207	2
500	Total reclassifications					4,577,336	500
	Code Letter - C						
1	CENTRAL SERVICES	D	Central Services & Supply	14	93,406	101,819	1
500	Total reclassifications				93,406	101,819	500
	Code Letter - D						
1	CHARGEABLE SUPPLY COST RECLASS	E	Medical Supplies Charged to P	71		2,381,775	1
500	Total reclassifications					2,381,775	500
	Code Letter - E						
1	ICU RECLASS	F	Adults & Pediatrics	30	630,935	76,421	1
500	Total reclassifications				630,935	76,421	500
	Code Letter - F						
1	BUILDING LAND FIXED RECLASS	G	Cap Rel Costs-Bldg & Fixt	1		3,478,187	1
2							2
3							3
4							4
500	Total reclassifications					3,478,187	500
	Code Letter - G						
1	MOVEABLE EQUIPMENT RECLASS	H	Cap Rel Costs-Mvble Equip	2		4,778,740	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
500	Total reclassifications					4,778,740	500
	Code Letter - H						
1	LDR & NURSERY	I	Delivery Room & Labor Room	52	1,012,568	119,995	1
2			Nursery	43	497,551	58,963	2
500	Total reclassifications				1,510,119	178,958	500

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
	Code Letter - I						
	GRAND TOTAL (Increases)				3,358,432	16,957,047	

(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.

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	CAFETERIA FOOD SERVICE	A	Dietary	10	596,626	319,508		1
2			Dietary	10	61,448	32,907		2
3			Dietary	10	47,575	25,477		3
500	Total reclassifications				705,649	377,892		500
	Code letter - A							
1	PURCHASING MATERIALS MANAGMENT	B	Central Services & Supply	14	418,323	1,005,919		1
500	Total reclassifications				418,323	1,005,919		500
	Code letter - B							
1	IMPLANTABLE DEVICES	C	Cardiac Catheterization	59		1,147,129		1
2			Operating Room	50		3,430,207		2
500	Total reclassifications					4,577,336		500
	Code letter - C							
1	CENTRAL SERVICES	D	Medical Records & Library	16	93,406	101,819		1
500	Total reclassifications				93,406	101,819		500
	Code letter - D							
1	CHARGEABLE SUPPLY COST RECLASS	E	Central Services & Supply	14		2,381,775		1
500	Total reclassifications					2,381,775		500
	Code letter - E							
1	ICU RECLASS	F	Intensive Care Unit	31	630,935	76,421		1
500	Total reclassifications				630,935	76,421		500
	Code letter - F							
1	BUILDING LAND FIXED RECLASS	G	Administrative & General	5		2,886,760	9	1
2			Radiology-Therapeutic	55		3,094	9	2
3			CT Scan	57		8,773	9	3
4			Clinic	90		579,560	9	4
500	Total reclassifications					3,478,187		500
	Code letter - G							
1	MOVEABLE EQUIPMENT RECLASS	H	Employee Benefits Department	4		2,382	9	1
2			Administrative & General	5		2,004,208	9	2
3			Operation of Plant	7		19,994	9	3
4			Laundry & Linen Service	8		361	9	4
5			Housekeeping	9		8,851	9	5
6			Dietary	10		42,765	9	6
7			Nursing Administration	13		547	9	7
8			Central Services & Supply	14		24,581	9	8
9			Pharmacy	15		9,825	9	9
10			Medical Records & Library	16		89,646	9	10
11			Adults & Pediatrics	30		132,779	9	11
12			Intensive Care Unit	31		124,254	9	12
13			Operating Room	50		432,508	9	13
14			Recovery Room	51		3,364	9	14
15			Anesthesiology	53		31,032	9	15
16			Radiology-Diagnostic	54		439,383	9	16
17			NUCLEAR MEDICINE	54.01		255	9	17
18			ULTRASOUND	54.02		94,556	9	18
19			Radiology-Therapeutic	55		5,003	9	19
20			CT Scan	57		325,346	9	20
21			MRI	58		295,660	9	21
22			Cardiac Catheterization	59		220,709	9	22
23			CARDIAC REHAB	59.97		7,190	9	23
24			Laboratory	60		132,361	9	24
25			Respiratory Therapy	65		75,689	9	25
26			Physical Therapy	66		5,618	9	26
27			Occupational Therapy	67		3,594	9	27
28			Clinic	90		160,003	9	28
29			Emergency	91		43,660	9	29
30			PATIENT TRANSPORTATION	191.01		42,616	9	30
500	Total reclassifications					4,778,740		500
	Code letter - H							
1	LDR & NURSERY	I	Adults & Pediatrics	30	1,012,568	119,995		1
2			Adults & Pediatrics	30	497,551	58,963		2

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	
500	Total reclassifications				1,510,119	178,958		500
	Code letter - I							
	GRAND TOTAL (Decreases)				3,358,432	16,957,047		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	6,803,639	38,072		38,072		6,841,711		1
2	Land Improvements	5,594,741	597,596		597,596		6,192,337		2
3	Buildings and Fixtures	68,128,816	1,859,424		1,859,424		69,988,240		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	84,378,322	5,377,122		5,377,122		89,755,444		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	164,905,518	7,872,214		7,872,214		172,777,732		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	164,905,518	7,872,214		7,872,214		172,777,732		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)								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	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				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	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	3,478,187						3,478,187	1
2	Cap Rel Costs-Mvble Equip	4,778,740						4,778,740	2
3	Total (sum of lines 1-2)	8,256,927						8,256,927	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.)

				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	-97,378	Administrative & General	5		3
4	Trace, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)	B	-13,301	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-8-2	-7,576,186				10
11	Sale of scrap, waste, etc. (chapter 23)	B	-76,833	Administrative & General	5		11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-404,598	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	-2,168	Administrative & General	5		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-3,803	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						32
33	EMPLOYEE SELF INSURANCE	A	-7,872,061	Employee Benefits Department	4		33
34	LIFELINE	A	-63,098	Administrative & General	5		34
35	LOBBYING COSTS	A	-22,943	Administrative & General	5		35
36	MEALS ON WHEELS	B	-22,287	MEALS ON WHEELS	190.01		36
37	SERVICE FEES	A	-39,961	Administrative & General	5		37
38	INTEREST-NET SETTLEMENT DERIVATIVE	A	-841,986	Administrative & General	5		38
39	PHYSICIAN RECRUITMENT	A	-1,095,006	Administrative & General	5		39
40	BAD DEBT EXPENSE	A	-7,353,957	Administrative & General	5		40
41	MISC INCOME	B	-98,707	Administrative & General	5		41
42	DIABETES	B	-100	Administrative & General	5		42
43	EMS EDUCATION	B	-21,322	Administrative & General	5		43
44	WELLNESS	A	-4,678	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)		-25,610,373				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined

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	

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

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

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

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

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

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

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

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

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

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

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

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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	415,565	415,565						1
2	60	Laboratory AGGREGATE	646,398	646,398						2
3	90	Clinic AGGREGATE	6,514,223	6,514,223						3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	7,576,186	7,576,186						200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE							415,565	1
2	60	Laboratory AGGREGATE							646,398	2
3	90	Clinic AGGREGATE							6,514,223	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							7,576,186	200

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	3,478,187	3,478,187					1
2	Cap Rel Costs-Mvble Equip	4,778,740		4,778,740				2
4	Employee Benefits Department	6,389,893	11,321	15,554	6,416,768			4
5	Administrative & General	15,104,076	794,227	1,091,208	945,903	17,935,414	17,935,414	5
6	Maintenance & Repairs							6
7	Operation of Plant	2,876,775	339,109	465,907	99,419	3,781,210	833,035	7
8	Laundry & Linen Service	457,457	32,982	45,315	3,099	538,853	118,714	8
9	Housekeeping	1,642,453	25,504	35,041	137,615	1,840,613	405,504	9
10	Dietary	392,422	102,771	141,198	32,588	668,979	147,382	10
11	Cafeteria	511,536	52,610	72,281	68,602	705,029	155,324	11
12	Maintenance of Personnel							12
13	Nursing Administration	816,145	28,725	39,466	89,892	974,228	214,631	13
14	Central Services & Supply	995,242	125,619	172,590	41,480	1,334,931	294,097	14
15	Pharmacy	6,787,449	20,456	28,105	192,577	7,028,587	1,548,461	15
16	Medical Records & Library	1,530,695	80,883	111,126	163,804	1,886,508	415,615	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,163,790	628,038	862,872	782,817	9,437,517	2,079,170	30
31	Intensive Care Unit	2,344,412	56,942	78,234	253,190	2,732,778	602,056	31
43	Nursery	556,514	10,737	14,751	57,210	639,212	140,824	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,335,260	108,986	149,738	358,213	5,952,197	1,311,323	50
51	Recovery Room	409,179	114,487	157,295	45,271	726,232	159,995	51
52	Delivery Room & Labor Room	1,132,563	8,062	11,076	116,429	1,268,130	279,380	52
53	Anesthesiology	50,205	9,795	13,457		73,457	16,183	53
54	Radiology-Diagnostic	2,517,517	196,895	270,518	243,889	3,228,819	711,338	54
54.01	NUCLEAR MEDICINE	650,923	8,137	11,180	34,203	704,443	155,195	54.01
54.02	ULTRASOUND	650,920	14,768	20,289	67,191	753,168	165,930	54.02
55	Radiology-Therapeutic	1,486,060			49,182	1,535,242	338,228	55
57	CT Scan	1,003,034	23,093	31,728	78,449	1,136,304	250,338	57
58	MRI	490,087	131,176	180,224	38,047	839,534	184,957	58
59	Cardiac Catheterization	1,451,992	29,460	40,475	97,921	1,619,848	356,867	59
59.97	CARDIAC REHAB	179,823			18,854	198,677	43,770	59.97
60	Laboratory	5,588,214	102,281	140,525	353,638	6,184,658	1,362,536	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,872,633	101,414	139,335	185,993	2,299,375	506,573	65
66	Physical Therapy	952,968	75,138	103,233	92,404	1,223,743	269,602	66
67	Occupational Therapy	507,545	20,136	27,665	47,903	603,249	132,901	67
68	Speech Pathology	99,563	4,427	6,082	9,954	120,026	26,443	68
71	Medical Supplies Charged to Patients	2,381,775				2,381,775	524,726	71
72	Impl. Dev. Charged to Patients	4,577,336				4,577,336	1,008,428	72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	8,133,697	12,225	16,796	1,347,521	9,510,239	2,095,232	90
90.01	HOSPITAL SURGEON							90.01
91	Emergency	3,690,221	207,783	285,476	338,388	4,521,868	996,208	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	98,987,301	3,478,187	4,778,740	6,391,646	98,962,179	17,850,966	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS	50,765			5,470	56,235	12,389	190.01
191.01	PATIENT TRANSPORTATION	307,431			19,652	327,083	72,059	191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	99,345,497	3,478,187	4,778,740	6,416,768	99,345,497	17,935,414	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	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	4,614,245						7
8	Laundry & Linen Service	65,218	722,785					8
9	Housekeeping	50,431		2,296,548				9
10	Dietary	203,215		103,742	1,123,318			10
11	Cafeteria	104,029		53,107		1,017,489		11
12	Maintenance of Personnel							12
13	Nursing Administration	56,800		28,997		20,538	1,295,194	13
14	Central Services & Supply	248,395		126,806		31,264		14
15	Pharmacy	40,449		20,650		27,930		15
16	Medical Records & Library	159,935		81,647		53,218		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,241,865	545,632	633,976	847,995	171,589	545,336	30
31	Intensive Care Unit	112,595	124,773	57,480	193,917	49,569	157,538	31
43	Nursery	21,230	52,380	10,838	81,406	11,527	36,636	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	215,506		110,017		73,489	233,559	50
51	Recovery Room	226,382		115,569		7,281	23,141	51
52	Delivery Room & Labor Room	15,941		8,138		23,479	74,621	52
53	Anesthesiology	19,368		9,887				53
54	Radiology-Diagnostic	389,334		198,757		65,673		54
54.01	NUCLEAR MEDICINE	16,090		8,214		4,781		54.01
54.02	ULTRASOUND	29,201		14,907		13,304		54.02
55	Radiology-Therapeutic							55
57	CT Scan	45,664		23,312		14,751		57
58	MRI	259,383		132,416		6,731		58
59	Cardiac Catheterization	58,253		29,738		15,538	49,381	59
59.97	CARDIAC REHAB					4,671		59.97
60	Laboratory	202,247		103,248		82,579		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	200,534		102,373		55,058	174,982	65
66	Physical Therapy	148,575		75,848		20,020		66
67	Occupational Therapy	39,816		20,326		6,762		67
68	Speech Pathology	8,753		4,468		1,337		68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	24,173		12,340		188,448		90
90.01	HOSPITAL SURGEON							90.01
91	Emergency	410,863		209,747		59,838		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,614,245	722,785	2,296,548	1,123,318	1,009,375	1,295,194	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS					2,390		190.01
191.01	PATIENT TRANSPORTATION					5,724		191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,614,245	722,785	2,296,548	1,123,318	1,017,489	1,295,194	202

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	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	2,035,493						14
15	Pharmacy	15,146	8,681,223					15
16	Medical Records & Library	19,200		2,616,123				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	94,235		78,233	15,675,548		15,675,548	30
31	Intensive Care Unit	39,749		48,103	4,118,558		4,118,558	31
43	Nursery			5,343	999,396		999,396	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,234,349		332,392	9,462,832		9,462,832	50
51	Recovery Room	3,742		35,528	1,297,870		1,297,870	51
52	Delivery Room & Labor Room			10,927	1,680,616		1,680,616	52
53	Anesthesiology	11,261		32,375	162,531		162,531	53
54	Radiology-Diagnostic	33,071		123,950	4,750,942		4,750,942	54
54.01	NUCLEAR MEDICINE	628		32,405	921,756		921,756	54.01
54.02	ULTRASOUND	3,203		73,861	1,053,574		1,053,574	54.02
55	Radiology-Therapeutic	1,711		50,821	1,926,002		1,926,002	55
57	CT Scan	9,013		293,818	1,773,200		1,773,200	57
58	MRI	1,102		80,161	1,504,284		1,504,284	58
59	Cardiac Catheterization	342,698		90,044	2,562,367		2,562,367	59
59.97	CARDIAC REHAB	1,083		3,210	251,411		251,411	59.97
60	Laboratory	57,449		452,477	8,445,194		8,445,194	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	30,165		120,785	3,489,845		3,489,845	65
66	Physical Therapy	3,808		29,363	1,770,959		1,770,959	66
67	Occupational Therapy	1,846		7,600	812,500		812,500	67
68	Speech Pathology	331		2,266	163,624		163,624	68
71	Medical Supplies Charged to Patients			87,334	2,993,835		2,993,835	71
72	Impl. Dev. Charged to Patients			88,617	5,674,381		5,674,381	72
73	Drugs Charged to Patients		8,681,223	165,696	8,846,919		8,846,919	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	63,342		137,839	12,031,613		12,031,613	90
90.01	HOSPITAL SURGEON							90.01
91	Emergency	66,707		232,975	6,498,206		6,498,206	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,033,839	8,681,223	2,616,123	98,867,963		98,867,963	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS				71,014		71,014	190.01
191.01	PATIENT TRANSPORTATION	1,654			406,520		406,520	191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,035,493	8,681,223	2,616,123	99,345,497		99,345,497	202

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		11,321	15,554	26,875	26,875		4
5	Administrative & General		794,227	1,091,208	1,885,435	3,965	1,889,400	5
6	Maintenance & Repairs							6
7	Operation of Plant		339,109	465,907	805,016	417	87,754	7
8	Laundry & Linen Service		32,982	45,315	78,297	13	12,506	8
9	Housekeeping		25,504	35,041	60,545	577	42,717	9
10	Dietary		102,771	141,198	243,969	137	15,526	10
11	Cafeteria		52,610	72,281	124,891	288	16,362	11
12	Maintenance of Personnel							12
13	Nursing Administration		28,725	39,466	68,191	377	22,610	13
14	Central Services & Supply		125,619	172,590	298,209	174	30,981	14
15	Pharmacy		20,456	28,105	48,561	807	163,119	15
16	Medical Records & Library		80,883	111,126	192,009	687	43,782	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		628,038	862,872	1,490,910	3,281	219,026	30
31	Intensive Care Unit		56,942	78,234	135,176	1,061	63,422	31
43	Nursery		10,737	14,751	25,488	240	14,835	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		108,986	149,738	258,724	1,502	138,139	50
51	Recovery Room		114,487	157,295	271,782	190	16,854	51
52	Delivery Room & Labor Room		8,062	11,076	19,138	488	29,431	52
53	Anesthesiology		9,795	13,457	23,252		1,705	53
54	Radiology-Diagnostic		196,895	270,518	467,413	1,022	74,934	54
54.01	NUCLEAR MEDICINE		8,137	11,180	19,317	143	16,349	54.01
54.02	ULTRASOUND		14,768	20,289	35,057	282	17,480	54.02
55	Radiology-Therapeutic					206	35,630	55
57	CT Scan		23,093	31,728	54,821	329	26,371	57
58	MRI		131,176	180,224	311,400	159	19,484	58
59	Cardiac Catheterization		29,460	40,475	69,935	410	37,593	59
59.97	CARDIAC REHAB					79	4,611	59.97
60	Laboratory		102,281	140,525	242,806	1,482	143,534	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		101,414	139,335	240,749	780	53,364	65
66	Physical Therapy		75,138	103,233	178,371	387	28,401	66
67	Occupational Therapy		20,136	27,665	47,801	201	14,000	67
68	Speech Pathology		4,427	6,082	10,509	42	2,786	68
71	Medical Supplies Charged to Patients						55,276	71
72	Impl. Dev. Charged to Patients						106,231	72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		12,225	16,796	29,021	5,626	220,747	90
90.01	HOSPITAL SURGEON							90.01
91	Emergency		207,783	285,476	493,259	1,418	104,944	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		3,478,187	4,778,740	8,256,927	26,770	1,880,504	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS					23	1,305	190.01
191.01	PATIENT TRANSPORTATION					82	7,591	191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,478,187	4,778,740	8,256,927	26,875	1,889,400	202

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	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	893,187						7
8	Laundry & Linen Service	12,624	103,440					8
9	Housekeeping	9,762		113,601				9
10	Dietary	39,337		5,132	304,101			10
11	Cafeteria	20,137		2,627		164,305		11
12	Maintenance of Personnel							12
13	Nursing Administration	10,995		1,434		3,317	106,924	13
14	Central Services & Supply	48,082		6,273		5,049		14
15	Pharmacy	7,830		1,021		4,510		15
16	Medical Records & Library	30,959		4,039		8,594		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	240,391	78,087	31,362	229,566	27,708	45,021	30
31	Intensive Care Unit	21,795	17,857	2,843	52,497	8,004	13,005	31
43	Nursery	4,110	7,496	536	22,038	1,861	3,024	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	41,716		5,442		11,867	19,281	50
51	Recovery Room	43,821		5,717		1,176	1,910	51
52	Delivery Room & Labor Room	3,086		403		3,791	6,160	52
53	Anesthesiology	3,749		489				53
54	Radiology-Diagnostic	75,364		9,832		10,605		54
54.01	NUCLEAR MEDICINE	3,115		406		772		54.01
54.02	ULTRASOUND	5,652		737		2,148		54.02
55	Radiology-Therapeutic							55
57	CT Scan	8,839		1,153		2,382		57
58	MRI	50,209		6,550		1,087		58
59	Cardiac Catheterization	11,276		1,471		2,509	4,077	59
59.97	CARDIAC REHAB					754		59.97
60	Laboratory	39,149		5,107		13,335		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	38,818		5,064		8,891	14,446	65
66	Physical Therapy	28,760		3,752		3,233		66
67	Occupational Therapy	7,707		1,005		1,092		67
68	Speech Pathology	1,694		221		216		68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	4,679		610		30,431		90
90.01	HOSPITAL SURGEON							90.01
91	Emergency	79,531		10,375		9,663		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	893,187	103,440	113,601	304,101	162,995	106,924	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS					386		190.01
191.01	PATIENT TRANSPORTATION					924		191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	893,187	103,440	113,601	304,101	164,305	106,924	202

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	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	388,768						14
15	Pharmacy	2,893	228,741					15
16	Medical Records & Library	3,667		283,737				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	17,998		8,488	2,391,838		2,391,838	30
31	Intensive Care Unit	7,592		5,219	328,471		328,471	31
43	Nursery			580	80,208		80,208	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	235,755		36,065	748,491		748,491	50
51	Recovery Room	715		3,855	346,020		346,020	51
52	Delivery Room & Labor Room			1,186	63,683		63,683	52
53	Anesthesiology	2,151		3,513	34,859		34,859	53
54	Radiology-Diagnostic	6,316		13,449	658,935		658,935	54
54.01	NUCLEAR MEDICINE	120		3,516	43,738		43,738	54.01
54.02	ULTRASOUND	612		8,014	69,982		69,982	54.02
55	Radiology-Therapeutic	327		5,514	41,677		41,677	55
57	CT Scan	1,721		31,880	127,496		127,496	57
58	MRI	210		8,698	397,797		397,797	58
59	Cardiac Catheterization	65,453		9,770	202,494		202,494	59
59.97	CARDIAC REHAB	207		348	5,999		5,999	59.97
60	Laboratory	10,972		48,977	505,362		505,362	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,761		13,105	380,978		380,978	65
66	Physical Therapy	727		3,186	246,817		246,817	66
67	Occupational Therapy	353		825	72,984		72,984	67
68	Speech Pathology	63		246	15,777		15,777	68
71	Medical Supplies Charged to Patients			9,476	64,752		64,752	71
72	Impl. Dev. Charged to Patients			9,615	115,846		115,846	72
73	Drugs Charged to Patients		228,741	17,978	246,719		246,719	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	12,098		14,956	318,168		318,168	90
90.01	HOSPITAL SURGEON							90.01
91	Emergency	12,741		25,278	737,209		737,209	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	388,452	228,741	283,737	8,246,300		8,246,300	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS				1,714		1,714	190.01
191.01	PATIENT TRANSPORTATION	316			8,913		8,913	191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	388,768	228,741	283,737	8,256,927		8,256,927	202

	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	55,805,679				4
5	Administrative & General	42,165	42,165	8,226,384	-17,935,414	81,410,083		5
6	Maintenance & Repairs							6
7	Operation of Plant	18,003	18,003	864,637		3,781,210	123,885	7
8	Laundry & Linen Service	1,751	1,751	26,949		538,853	1,751	8
9	Housekeeping	1,354	1,354	1,196,817		1,840,613	1,354	9
10	Dietary	5,456	5,456	283,412		668,979	5,456	10
11	Cafeteria	2,793	2,793	596,626		705,029	2,793	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,525	1,525	781,779		974,228	1,525	13
14	Central Services & Supply	6,669	6,669	360,747		1,334,931	6,669	14
15	Pharmacy	1,086	1,086	1,674,819		7,028,587	1,086	15
16	Medical Records & Library	4,294	4,294	1,424,579		1,886,508	4,294	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	33,342	33,342	6,808,052		9,437,517	33,342	30
31	Intensive Care Unit	3,023	3,023	2,201,956		2,732,778	3,023	31
43	Nursery	570	570	497,551		639,212	570	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,786	5,786	3,115,326		5,952,197	5,786	50
51	Recovery Room	6,078	6,078	393,712		726,232	6,078	51
52	Delivery Room & Labor Room	428	428	1,012,568		1,268,130	428	52
53	Anesthesiology	520	520			73,457	520	53
54	Radiology-Diagnostic	10,453	10,453	2,121,065		3,228,819	10,453	54
54.01	NUCLEAR MEDICINE	432	432	297,461		704,443	432	54.01
54.02	ULTRASOUND	784	784	584,353		753,168	784	54.02
55	Radiology-Therapeutic			427,727		1,535,242		55
57	CT Scan	1,226	1,226	682,261		1,136,304	1,226	57
58	MRI	6,964	6,964	330,888		839,534	6,964	58
59	Cardiac Catheterization	1,564	1,564	851,607		1,619,848	1,564	59
59.97	CARDIAC REHAB			163,969		198,677		59.97
60	Laboratory	5,430	5,430	3,075,545		6,184,658	5,430	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,384	5,384	1,617,552		2,299,375	5,384	65
66	Physical Therapy	3,989	3,989	803,628		1,223,743	3,989	66
67	Occupational Therapy	1,069	1,069	416,602		603,249	1,069	67
68	Speech Pathology	235	235	86,567		120,026	235	68
71	Medical Supplies Charged to Patients					2,381,775		71
72	Impl. Dev. Charged to Patients					4,577,336		72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	649	649	11,719,139		9,510,239	649	90
90.01	HOSPITAL SURGEON							90.01
91	Emergency	11,031	11,031	2,942,917		4,521,868	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	55,587,195	-17,935,414	81,026,765	123,885	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS			47,575		56,235		190.01
191.01	PATIENT TRANSPORTATION			170,909		327,083		191.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,478,187	4,778,740	6,416,768		17,935,414	4,614,245	202

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	
203	Unit Cost Multiplier (Wkst. B, Part I)	18.836240	25.879429	0.114984		0.220309	37.246196	203
204	Cost to be allocated (Per Wkst. B, Part II)			26,875		1,889,400	893,187	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000482		0.023208	7.209807	205

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA 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	15,096						8
9	Housekeeping		120,780					9
10	Dietary		5,456	15,096				10
11	Cafeteria		2,793		64,700			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,525		1,306	25,914		13
14	Central Services & Supply		6,669		1,988		7,989,610	14
15	Pharmacy		1,086		1,776		59,452	15
16	Medical Records & Library		4,294		3,384		75,364	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,396	33,342	11,396	10,911	10,911	369,886	30
31	Intensive Care Unit	2,606	3,023	2,606	3,152	3,152	156,020	31
43	Nursery	1,094	570	1,094	733	733		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		5,786		4,673	4,673	4,845,007	50
51	Recovery Room		6,078		463	463	14,686	51
52	Delivery Room & Labor Room		428		1,493	1,493		52
53	Anesthesiology		520				44,200	53
54	Radiology-Diagnostic		10,453		4,176		129,808	54
54.01	NUCLEAR MEDICINE		432		304		2,465	54.01
54.02	ULTRASOUND		784		846		12,571	54.02
55	Radiology-Therapeutic						6,717	55
57	CT Scan		1,226		938		35,378	57
58	MRI		6,964		428		4,324	58
59	Cardiac Catheterization		1,564		988	988	1,345,137	59
59.97	CARDIAC REHAB				297		4,250	59.97
60	Laboratory		5,430		5,251		225,494	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,384		3,501	3,501	118,403	65
66	Physical Therapy		3,989		1,273		14,947	66
67	Occupational Therapy		1,069		430		7,247	67
68	Speech Pathology		235		85		1,300	68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		649		11,983		248,626	90
90.01	HOSPITAL SURGEON							90.01
91	Emergency		11,031		3,805		261,836	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	15,096	120,780	15,096	64,184	25,914	7,983,118	118
	NONREIMBURSABLE COST CENTERS							
190.01	MEALS ON WHEELS				152			190.01
191.01	PATIENT TRANSPORTATION				364		6,492	191.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	722,785	2,296,548	1,123,318	1,017,489	1,295,194	2,035,493	202
203	Unit Cost Multiplier (Wkst. B, Part I)	47.879240	19.014307	74.411632	15.726260	49.980474	0.254768	203

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
204	Cost to be allocated (Per Wkst. B, Part II)	103,440	113,601	304,101	164,305	106,924	388,768	204
205	Unit Cost Multiplier (Wkst. B, Part II)	6.852146	0.940561	20.144475	2.539490	4.126109	0.048659	205

	COST CENTER DESCRIPTIONS	PHARMACY 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	100						15
16	Medical Records & Library		401,464,315					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		12,006,244					30
31	Intensive Care Unit		7,382,223					31
43	Nursery		819,957					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		51,011,674					50
51	Recovery Room		5,452,379					51
52	Delivery Room & Labor Room		1,676,997					52
53	Anesthesiology		4,968,477					53
54	Radiology-Diagnostic		19,022,345					54
54.01	NUCLEAR MEDICINE		4,973,175					54.01
54.02	ULTRASOUND		11,335,308					54.02
55	Radiology-Therapeutic		7,799,474					55
57	CT Scan		45,091,740					57
58	MRI		12,302,214					58
59	Cardiac Catheterization		13,818,971					59
59.97	CARDIAC REHAB		492,628					59.97
60	Laboratory		69,413,291					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		18,536,651					65
66	Physical Therapy		4,506,263					66
67	Occupational Therapy		1,166,304					67
68	Speech Pathology		347,836					68
71	Medical Supplies Charged to Patients		13,402,989					71
72	Impl. Dev. Charged to Patients		13,599,865					72
73	Drugs Charged to Patients	100	25,429,136					73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		21,153,894					90
90.01	HOSPITAL SURGEON							90.01
91	Emergency		35,754,280					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	401,464,315					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 centers							201

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE					
		15	16					
202	Cost to be allocated (Per Wkst. B, Part I)	8,681,223	2,616,123					202
203	Unit Cost Multiplier (Wkst. B, Part I)	86,812.230000	0.006516					203
204	Cost to be allocated (Per Wkst. B, Part II)	228,741	283,737					204
205	Unit Cost Multiplier (Wkst. B, Part II)	2,287.410000	0.000707					205

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	15,675,548		15,675,548		15,675,548	30
31	Intensive Care Unit	4,118,558		4,118,558		4,118,558	31
43	Nursery	999,396		999,396		999,396	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	9,462,832		9,462,832		9,462,832	50
51	Recovery Room	1,297,870		1,297,870		1,297,870	51
52	Delivery Room & Labor Room	1,680,616		1,680,616		1,680,616	52
53	Anesthesiology	162,531		162,531		162,531	53
54	Radiology-Diagnostic	4,750,942		4,750,942		4,750,942	54
54.01	NUCLEAR MEDICINE	921,756		921,756		921,756	54.01
54.02	ULTRASOUND	1,053,574		1,053,574		1,053,574	54.02
55	Radiology-Therapeutic	1,926,002		1,926,002		1,926,002	55
57	CT Scan	1,773,200		1,773,200		1,773,200	57
58	MRI	1,504,284		1,504,284		1,504,284	58
59	Cardiac Catheterization	2,562,367		2,562,367		2,562,367	59
59.97	CARDIAC REHAB	251,411		251,411		251,411	59.97
60	Laboratory	8,445,194		8,445,194		8,445,194	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	3,489,845		3,489,845		3,489,845	65
66	Physical Therapy	1,770,959		1,770,959		1,770,959	66
67	Occupational Therapy	812,500		812,500		812,500	67
68	Speech Pathology	163,624		163,624		163,624	68
71	Medical Supplies Charged to Patients	2,993,835		2,993,835		2,993,835	71
72	Impl. Dev. Charged to Patients	5,674,381		5,674,381		5,674,381	72
73	Drugs Charged to Patients	8,846,919		8,846,919		8,846,919	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	12,031,613		12,031,613		12,031,613	90
90.01	HOSPITAL SURGEON						90.01
91	Emergency	6,498,206		6,498,206		6,498,206	91
92	Observation Beds (Non-Distinct Part)	2,391,893		2,391,893		2,391,893	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	101,259,856		101,259,856		101,259,856	200
201	Less Observation Beds	2,391,893		2,391,893		2,391,893	201
202	Total (line 200 minus line 201)	98,867,963		98,867,963		98,867,963	202

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 SERVICE COST CENTERS							
30	Adults & Pediatrics	10,297,054		10,297,054				30
31	Intensive Care Unit	7,382,223		7,382,223				31
43	Nursery	819,957		819,957				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	18,127,569	32,884,105	51,011,674	0.185503	0.185503	0.185503	50
51	Recovery Room	1,663,107	3,789,272	5,452,379	0.238037	0.238037	0.238037	51
52	Delivery Room & Labor Room	1,676,997		1,676,997	1.002158	1.002158	1.002158	52
53	Anesthesiology	1,675,788	3,292,689	4,968,477	0.032712	0.032712	0.032712	53
54	Radiology-Diagnostic	3,903,509	15,118,836	19,022,345	0.249756	0.249756	0.249756	54
54.01	NUCLEAR MEDICINE	696,322	4,276,853	4,973,175	0.185346	0.185346	0.185346	54.01
54.02	ULTRASOUND	1,675,099	9,660,209	11,335,308	0.092946	0.092946	0.092946	54.02
55	Radiology-Therapeutic	2,305	7,797,169	7,799,474	0.246940	0.246940	0.246940	55
57	CT Scan	7,278,346	37,813,394	45,091,740	0.039324	0.039324	0.039324	57
58	MRI	1,396,503	10,905,711	12,302,214	0.122278	0.122278	0.122278	58
59	Cardiac Catheterization	6,305,370	7,513,601	13,818,971	0.185424	0.185424	0.185424	59
59.97	CARDIAC REHAB	560	492,068	492,628	0.510347	0.510347	0.510347	59.97
60	Laboratory	17,428,782	51,984,509	69,413,291	0.121665	0.121665	0.121665	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,332,444	9,204,207	18,536,651	0.188267	0.188267	0.188267	65
66	Physical Therapy	1,918,052	2,588,211	4,506,263	0.392999	0.392999	0.392999	66
67	Occupational Therapy	454,108	712,196	1,166,304	0.696645	0.696645	0.696645	67
68	Speech Pathology	224,988	122,848	347,836	0.470406	0.470406	0.470406	68
71	Medical Supplies Charged to Patients	7,101,282	6,301,707	13,402,989	0.223371	0.223371	0.223371	71
72	Impl. Dev. Charged to Patients	5,738,833	7,861,032	13,599,865	0.417238	0.417238	0.417238	72
73	Drugs Charged to Patients	12,018,503	13,410,633	25,429,136	0.347905	0.347905	0.347905	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	21,070	21,132,824	21,153,894	0.568766	0.568766	0.568766	90
90.01	HOSPITAL SURGEON							90.01
91	Emergency	7,380,861	28,373,419	35,754,280	0.181746	0.181746	0.181746	91
92	Observation Beds (Non-Distinct Part)	654,595	1,054,595	1,709,190	1.399431	1.399431	1.399431	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	125,174,227	276,290,088	401,464,315				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	125,174,227	276,290,088	401,464,315				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,391,838		2,391,838	13,448	177.86	7,212	1,282,726	30
31	Intensive Care Unit	328,471		328,471	2,606	126.04	1,455	183,388	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	80,208		80,208	1,094	73.32			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,800,517		2,800,517	17,148		8,667	1,466,114	200

(A) Worksheet A line numbers

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	748,491	51,011,674	0.014673	8,328,204	122,200	50
51	Recovery Room	346,020	5,452,379	0.063462	930,726	59,066	51
52	Delivery Room & Labor Room	63,683	1,676,997	0.037974	1,103	42	52
53	Anesthesiology	34,859	4,968,477	0.007016	831,492	5,834	53
54	Radiology-Diagnostic	658,935	19,022,345	0.034640	2,420,118	83,833	54
54.01	NUCLEAR MEDICINE	43,738	4,973,175	0.008795	533,128	4,689	54.01
54.02	ULTRASOUND	69,982	11,335,308	0.006174	499,468	3,084	54.02
55	Radiology-Therapeutic	41,677	7,799,474	0.005344			55
57	CT Scan	127,496	45,091,740	0.002827	5,578,421	15,770	57
58	MRI	397,797	12,302,214	0.032335	864,493	27,953	58
59	Cardiac Catheterization	202,494	13,818,971	0.014653	1,501,812	22,006	59
59.97	CARDIAC REHAB	5,999	492,628	0.012178	560	7	59.97
60	Laboratory	505,362	69,413,291	0.007280	12,685,343	92,349	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	380,978	18,536,651	0.020553	8,197,791	168,489	65
66	Physical Therapy	246,817	4,506,263	0.054772	1,403,262	76,859	66
67	Occupational Therapy	72,984	1,166,304	0.062577	344,551	21,561	67
68	Speech Pathology	15,777	347,836	0.045358	183,696	8,332	68
71	Medical Supplies Charged to Patients	64,752	13,402,989	0.004831	5,412,582	26,148	71
72	Impl. Dev. Charged to Patients	115,846	13,599,865	0.008518	5,085,402	43,317	72
73	Drugs Charged to Patients	246,719	25,429,136	0.009702	8,071,755	78,312	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	318,168	21,153,894	0.015041			90
90.01	HOSPITAL SURGEON						90.01
91	Emergency	737,209	35,754,280	0.020619	4,387,961	90,475	91
92	Observation Beds (Non-Distinct Part)	364,965	1,709,190	0.213531	315,183	67,301	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,810,748	382,965,081		67,577,051	1,017,627	200

(A) Worksheet A line numbers

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 [ ] Other

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	13,448		7,212		30
31	Intensive Care Unit	2,606		1,455		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	1,094				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	17,148		8,667		200

(A) Worksheet A line numbers

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 [ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
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

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 [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	51,011,674			8,328,204		12,027,652		50
51	Recovery Room	5,452,379			930,726		1,960,760		51
52	Delivery Room & Labor Room	1,676,997			1,103				52
53	Anesthesiology	4,968,477			831,492		786,240		53
54	Radiology-Diagnostic	19,022,345			2,420,118		4,387,964		54
54.01	NUCLEAR MEDICINE	4,973,175			533,128		1,876,597		54.01
54.02	ULTRASOUND	11,335,308			499,468		1,031,464		54.02
55	Radiology-Therapeutic	7,799,474							55
57	CT Scan	45,091,740			5,578,421		11,193,567		57
58	MRI	12,302,214			864,493		2,871,573		58
59	Cardiac Catheterization	13,818,971			1,501,812		1,231,980		59
59.97	CARDIAC REHAB	492,628			560		267,307		59.97
60	Laboratory	69,413,291			12,685,343		6,661,015		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	18,536,651			8,197,791		3,185,183		65
66	Physical Therapy	4,506,263			1,403,262		146,669		66
67	Occupational Therapy	1,166,304			344,551				67
68	Speech Pathology	347,836			183,696				68
71	Medical Supplies Charged to Patients	13,402,989			5,412,582		3,788,621		71
72	Impl. Dev. Charged to Patients	13,599,865			5,085,402		1,770,914		72
73	Drugs Charged to Patients	25,429,136			8,071,755		5,776,971		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	21,153,894					1,291,934		90
90.01	HOSPITAL SURGEON								90.01
91	Emergency	35,754,280			4,387,961		5,344,299		91
92	Observation Beds (Non-Distinct Part)	1,709,190			315,183		951,003		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	382,965,081			67,577,051		66,551,713		200

(A) Worksheet A line numbers

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
[XX] Title XVIII, Part B [ ] IPF [ ] SNF [ ] Swing Bed NF
[ ] 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	0.185503	12,027,652			2,231,166			50
51	Recovery Room	0.238037	1,960,760			466,733			51
52	Delivery Room & Labor Room	1.002158							52
53	Anesthesiology	0.032712	786,240			25,719			53
54	Radiology-Diagnostic	0.249756	4,387,964			1,095,920			54
54.01	NUCLEAR MEDICINE	0.185346	1,876,597			347,820			54.01
54.02	ULTRASOUND	0.092946	1,031,464			95,870			54.02
55	Radiology-Therapeutic	0.246940							55
57	CT Scan	0.039324	11,193,567			440,176			57
58	MRI	0.122278	2,871,573			351,130			58
59	Cardiac Catheterization	0.185424	1,231,980			228,439			59
59.97	CARDIAC REHAB	0.510347	267,307			136,419			59.97
60	Laboratory	0.121665	6,661,015			810,412			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.188267	3,185,183			599,665			65
66	Physical Therapy	0.392999	146,669			57,641			66
67	Occupational Therapy	0.696645							67
68	Speech Pathology	0.470406							68
71	Medical Supplies Charged to Patients	0.223371	3,788,621			846,268			71
72	Impl. Dev. Charged to Patients	0.417238	1,770,914			738,893			72
73	Drugs Charged to Patients	0.347905	5,776,971			2,009,837			73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.568766	1,291,934			734,808			90
90.01	HOSPITAL SURGEON								90.01
91	Emergency	0.181746	5,344,299			971,305			91
92	Observation Beds (Non-Distinct Part)	1.399431	951,003			1,330,863			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		66,551,713			13,519,084			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		66,551,713			13,519,084			202

(A) Worksheet A line numbers

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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,391,838		2,391,838	13,448	177.86	1,104	196,357	30
31	Intensive Care Unit	328,471		328,471	2,606	126.04	262	33,022	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	80,208		80,208	1,094	73.32	484	35,487	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,800,517		2,800,517	17,148		1,850	264,866	200

(A) Worksheet A line numbers

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	748,491	51,011,674	0.014673			50
51	Recovery Room	346,020	5,452,379	0.063462			51
52	Delivery Room & Labor Room	63,683	1,676,997	0.037974			52
53	Anesthesiology	34,859	4,968,477	0.007016			53
54	Radiology-Diagnostic	658,935	19,022,345	0.034640			54
54.01	NUCLEAR MEDICINE	43,738	4,973,175	0.008795			54.01
54.02	ULTRASOUND	69,982	11,335,308	0.006174			54.02
55	Radiology-Therapeutic	41,677	7,799,474	0.005344			55
57	CT Scan	127,496	45,091,740	0.002827			57
58	MRI	397,797	12,302,214	0.032335			58
59	Cardiac Catheterization	202,494	13,818,971	0.014653			59
59.97	CARDIAC REHAB	5,999	492,628	0.012178			59.97
60	Laboratory	505,362	69,413,291	0.007280			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	380,978	18,536,651	0.020553			65
66	Physical Therapy	246,817	4,506,263	0.054772			66
67	Occupational Therapy	72,984	1,166,304	0.062577			67
68	Speech Pathology	15,777	347,836	0.045358			68
71	Medical Supplies Charged to Patients	64,752	13,402,989	0.004831			71
72	Impl. Dev. Charged to Patients	115,846	13,599,865	0.008518			72
73	Drugs Charged to Patients	246,719	25,429,136	0.009702			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	318,168	21,153,894	0.015041			90
90.01	HOSPITAL SURGEON						90.01
91	Emergency	737,209	35,754,280	0.020619			91
92	Observation Beds (Non-Distinct Part)	364,965	1,709,190	0.213531			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,810,748	382,965,081				200

(A) Worksheet A line numbers

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 [ ] Other

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	13,448		1,104		30
31	Intensive Care Unit	2,606		262		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	1,094		484		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	17,148		1,850		200

(A) Worksheet A line numbers

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 [ ] Other

(A)	Cost Center Description	Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
		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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
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

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 [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	51,011,674							50
51	Recovery Room	5,452,379							51
52	Delivery Room & Labor Room	1,676,997							52
53	Anesthesiology	4,968,477							53
54	Radiology-Diagnostic	19,022,345							54
54.01	NUCLEAR MEDICINE	4,973,175							54.01
54.02	ULTRASOUND	11,335,308							54.02
55	Radiology-Therapeutic	7,799,474							55
57	CT Scan	45,091,740							57
58	MRI	12,302,214							58
59	Cardiac Catheterization	13,818,971							59
59.97	CARDIAC REHAB	492,628							59.97
60	Laboratory	69,413,291							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	18,536,651							65
66	Physical Therapy	4,506,263							66
67	Occupational Therapy	1,166,304							67
68	Speech Pathology	347,836							68
71	Medical Supplies Charged to Patients	13,402,989							71
72	Impl. Dev. Charged to Patients	13,599,865							72
73	Drugs Charged to Patients	25,429,136							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	21,153,894							90
90.01	HOSPITAL SURGEON								90.01
91	Emergency	35,754,280							91
92	Observation Beds (Non-Distinct Part)	1,709,190							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	382,965,081							200

(A) Worksheet A line numbers

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	0.185503							50
51	Recovery Room	0.238037							51
52	Delivery Room & Labor Room	1.002158							52
53	Anesthesiology	0.032712							53
54	Radiology-Diagnostic	0.249756							54
54.01	NUCLEAR MEDICINE	0.185346							54.01
54.02	ULTRASOUND	0.092946							54.02
55	Radiology-Therapeutic	0.246940							55
57	CT Scan	0.039324							57
58	MRI	0.122278							58
59	Cardiac Catheterization	0.185424							59
59.97	CARDIAC REHAB	0.510347							59.97
60	Laboratory	0.121665							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.188267							65
66	Physical Therapy	0.392999							66
67	Occupational Therapy	0.696645							67
68	Speech Pathology	0.470406							68
71	Medical Supplies Charged to Patients	0.223371							71
72	Impl. Dev. Charged to Patients	0.417238							72
73	Drugs Charged to Patients	0.347905							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.568766							90
90.01	HOSPITAL SURGEON								90.01
91	Emergency	0.181746							91
92	Observation Beds (Non-Distinct Part)	1.399431							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

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)	13,448	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,448	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)	11,396	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7,212	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	15,675,548	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,675,548	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,675,548	37

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)					1,165.64	38
39	Program general inpatient routine service cost (line 9 x line 38)					8,406,596	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)					8,406,596	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	4,118,558	2,606	1,580.41	1,455	2,299,497	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					14,490,538	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					25,196,631	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,466,114	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,017,627	51
52	Total Program excludable cost (sum of lines 50 and 51)	2,483,741	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	22,712,890	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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)					2,052	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,165.64	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,391,893	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	2,391,838	15,675,548	0.152584	2,391,893	364,965	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,448	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,448	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)	11,396	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,104	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,094	15
16	Nursery days (title V or XIX only)	484	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)	15,675,548	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,675,548	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,675,548	37

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)	1,165.64	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,286,867	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)	1,286,867	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)	999,396	1,094	913.52	484	442,144	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,118,558	2,606	1,580.41	262	414,067	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,143,078	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	264,866	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	264,866	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,878,212	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

Check Applicable Boxes:

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,052	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		8,384,698		30
31	Intensive Care Unit		1,080,540		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.185503	8,328,204	1,544,907	50
51	Recovery Room	0.238037	930,726	221,547	51
52	Delivery Room & Labor Room	1.002158	1,103	1,105	52
53	Anesthesiology	0.032712	831,492	27,200	53
54	Radiology-Diagnostic	0.249756	2,420,118	604,439	54
54.01	NUCLEAR MEDICINE	0.185346	533,128	98,813	54.01
54.02	ULTRASOUND	0.092946	499,468	46,424	54.02
55	Radiology-Therapeutic	0.246940			55
57	CT Scan	0.039324	5,578,421	219,366	57
58	MRI	0.122278	864,493	105,708	58
59	Cardiac Catheterization	0.185424	1,501,812	278,472	59
59.97	CARDIAC REHAB	0.510347	560	286	59.97
60	Laboratory	0.121665	12,685,343	1,543,362	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.188267	8,197,791	1,543,374	65
66	Physical Therapy	0.392999	1,403,262	551,481	66
67	Occupational Therapy	0.696645	344,551	240,030	67
68	Speech Pathology	0.470406	183,696	86,412	68
71	Medical Supplies Charged to Patients	0.223371	5,412,582	1,209,014	71
72	Impl. Dev. Charged to Patients	0.417238	5,085,402	2,121,823	72
73	Drugs Charged to Patients	0.347905	8,071,755	2,808,204	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.568766			90
90.01	HOSPITAL SURGEON				90.01
91	Emergency	0.181746	4,387,961	797,494	91
92	Observation Beds (Non-Distinct Part)	1.399431	315,183	441,077	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		67,577,051	14,490,538	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		67,577,051		202

(A) Worksheet A line numbers

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

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.185503			50
51	Recovery Room	0.238037			51
52	Delivery Room & Labor Room	1.002158			52
53	Anesthesiology	0.032712			53
54	Radiology-Diagnostic	0.249756			54
54.01	NUCLEAR MEDICINE	0.185346			54.01
54.02	ULTRASOUND	0.092946			54.02
55	Radiology-Therapeutic	0.246940			55
57	CT Scan	0.039324			57
58	MRI	0.122278			58
59	Cardiac Catheterization	0.185424			59
59.97	CARDIAC REHAB	0.510347			59.97
60	Laboratory	0.121665			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.188267			65
66	Physical Therapy	0.392999			66
67	Occupational Therapy	0.696645			67
68	Speech Pathology	0.470406			68
71	Medical Supplies Charged to Patients	0.223371			71
72	Impl. Dev. Charged to Patients	0.417238			72
73	Drugs Charged to Patients	0.347905			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.568766			90
90.01	HOSPITAL SURGEON				90.01
91	Emergency	0.181746			91
92	Observation Beds (Non-Distinct Part)	1.399431			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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	16,992,786			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	1,117,489			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges 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)	83.38			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)				30
31	Percentage of Medicaid patient days to total patient days (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**		
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 (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	18,110,275			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 (see instructions)	18,110,275			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,528,675			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	19,638,950			59
60	Primary payer payments	7,554			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	19,631,396			61
62	Deductibles billed to program beneficiaries	1,813,696			62
63	Coinsurance billed to program beneficiaries	6,080			63
64	Allowable bad debts (see instructions)	304,142			64
65	Adjusted reimbursable bad debts (see instructions)	197,692			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	287,620			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,009,312			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)	-21,819			70
71	Amount due provider (see instructions)	17,987,493			71
71.01	Sequestration adjustment (see instructions)	359,750			71.01
72	Interim payments	17,429,600			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	198,143			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1,034,087			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

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

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

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

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

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

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)	13,519,084			2
3	PPS payments	11,435,361			3
4	Outlier payment (see instructions)	35,836			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	11,471,197			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	2,486,956			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	8,984,241			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)	8,984,241			30
31	Primary payer payments	88			31
32	Subtotal (line 30 minus line 31)	8,984,153			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)	259,327			34
35	Adjusted reimbursable bad debts (see instructions)	168,563			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	163,174			36
37	Subtotal (see instructions)	9,152,716			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	9,152,716			40
40.01	Sequestration adjustment (see instructions)	183,054			40.01
41	Interim payments	8,804,476			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	165,186			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] 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				17,429,600		8,804,476	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				17,429,600		8,804,476	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.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	4,430	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	8,667	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	74	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	14,002	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	401,464,315	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)		6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	829,133	8
9	Sequestration adjustment amount (see instructions)	16,583	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	812,550	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s)	875,637	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-63,087	32

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	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	23,525,164				1
2	Temporary investments	34,086				2
3	Notes receivable					3
4	Accounts receivable	38,952,751				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-12,266,870				6
7	Inventory	3,729,200				7
8	Prepaid expenses	1,716,113				8
9	Other current assets	1,034,076				9
10	Due from other funds	53,659,359				10
11	Total current assets (sum of lines 1-10)	110,383,879				11
	FIXED ASSETS					
12	Land	6,841,711				12
13	Land improvements	6,192,337				13
14	Accumulated depreciation	-4,488,651				14
15	Buildings	67,835,300				15
16	Accumulated depreciation	-33,818,988				16
17	Leasehold improvements	1,588,265				17
18	Accumulated depreciation	-95,431				18
19	Fixed equipment	21,826,405				19
20	Accumulated depreciation	-16,395,551				20
21	Audomobiles and trucks	54,729				21
22	Accumulated depreciation	-56,970				22
23	Major movable equipment	67,726,830				23
24	Accumulated depreciation	-52,168,213				24
25	Minor equipment depreciable	455,440				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)	65,497,213				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	1,819,715				34
35	Total other assets (sum of lines 31-34)	1,819,715				35
36	Total assets (sum of lines 11, 30 and 35)	177,700,807				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	16,902,862				37
38	Salaries, wages and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	1,785,857				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	8,109,519				44
45	Total current liabilities (sum of lines 37 thru 44)	26,798,238				45
	LONG TERM LIABILITIES					
46	Mortgage payable	37,163,589				46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	1				49
50	Total long term liabilities (sum of lines 46 thru 49)	37,163,590				50
51	Total liabilities (sum of lines 45 and 50)	63,961,828				51
	CAPITAL ACCOUNTS					
52	General fund balance	113,738,979				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

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 thru 58)	113,738,979				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	177,700,807				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		106,921,283			1
2	Net income (loss) (from Worksheet G-3, line 29)		6,817,706			2
3	Total (sum of line 1 and line 2)		113,738,989			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		113,738,989			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		113,738,989			19

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	16,755,925		16,755,925	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)	16,755,925		16,755,925	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				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)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	16,755,925		16,755,925	17
18	Ancillary services	111,292,199	221,361,391	332,653,590	18
19	Outpatient services		63,794,258	63,794,258	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (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)	128,048,124	285,155,649	413,203,773	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		124,955,870	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)		124,955,870	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	413,203,773	1
2	Less contractual allowances and discounts on patients' accounts	275,386,133	2
3	Net patient revenues (line 1 minus line 2)	137,817,640	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	124,955,870	4
5	Net income from service to patients (line 3 minus line 4)	12,861,770	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		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 otehr 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, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	96,675	22
23	Governmental appropriations		23
24	Other (OTHER)	2,141,722	24
24.01	Other (UNRESTRICTED DONATIONS)	1,403	24.01
25	Total other income (sum of lines 6-24)	2,239,800	25
26	Total (line 5 plus line 25)	15,101,570	26
27	Other expenses (OTHER ITEMS)	8,283,864	27
28	Total other expenses (sum of line 27 and subscripts)	8,283,864	28
29	Net income (or loss) for the period (line 26 minus line 28)	6,817,706	29

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	1,528,675	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)	1,528,675	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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

MORRIS HOSPITAL Provider CCN: 14-0101	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/30/2015 Run Time: 08:07 Version: 2015.03 (05/21/2015)

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

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
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 Centers							201
202	TOTAL (sum of lines 118-201)							202