

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

WORKSHEET S
 PARTS I & II

INTERMEDIARY [] AUDITED DATE RECEIVED _____ [] INITIAL [] RE-OPENING
 USE ONLY: [] DESK REVIEWED INTERMEDIARY NO. _____ [] FINAL [] MCR CODE

PART I - CERTIFICATION

CHECK _____ ELECTRONICALLY FILED COST REPORT DATE: _____
 APPLICABLE BOX _____ MANUALLY SUBMITTED COST REPORT TIME: _____

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ORTHOPAEDIC HOSPITAL AT PARKVIEW NORTH, (15-0167) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2008 AND ENDING 12/31/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
	1	2	3	4	
1	HOSPITAL				1
2	SUBPROVIDER I	138387	20100		2
3	SWING BED - SNF				3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY				5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	OUTPATIENT REHABILITATION PROVIDER				8
9	HEALTH CLINIC				9
100	TOTAL	138387	20100		100

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 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: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 11119 PARKVIEW PLAZA DRIVE
 1.01 CITY: FORT WAYNE STATE: IN

P.O.BOX: 1
 ZIP CODE: 46845-1705 COUNTY: ALLEN 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)			
				V 4	XVIII 5	XIX 6	
2	HOSPITAL	ORTHOPAEDIC HOSPITAL AT PARKVIEW N 15-0167	11/08/2007	N	P	P	2
3	SUBPROVIDER I						3
4	SWING BEDS - SNF						4
5	SWING BEDS - NF						5
6	HOSPITAL-BASED SNF						6
7	HOSPITAL-BASED NF						7
8	HOSPITAL-BASED OLTC						8
9	HOSPITAL-BASED HHA						9
11	SEPARATELY CERTIFIED ASC						11
12	HOSPITAL-BASED HOSPICE						12
14	HOSP-BASED RHC						14
15	OUTPATIENT REHABILITATION PROVID						15
16	RENAL DIALYSIS						16
17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2008	TO: 12/31/2008	1	2		17
18	TYPE OF CONTROL			4			18
TYPE OF HOSPITAL/SUBPROVIDER							
19	HOSPITAL		9				19
20	SUBPROVIDER I						20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.						21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 'Y' OR 'N' FOR NO.			NO			21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.						21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.			1	N	Y 23060	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.			1			21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.			1			21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105 OR MIPPA 147? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES AND 'N' FOR NO.			NO			21.06
21.07	DOES THIS HOSPITAL QUALIFY AS AN SCH WITH UNDER 100 BEDS OR FEWER BEDS UNDER MIPPA 147? ENTER 'Y' FOR YES AND 'N' FOR NO (SEE INSTRUCTIONS).			NO			21.07
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS? ENTER IN COLUMN 1, 1 IF IT IS BASED ON DATE OF ADMISSION, 2 IF IT IS BASED ON CENSUS DAYS, OR 3 IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE LAST COST REPORTING PERIOD? ENTER IN COLUMN 2, 'Y' FOR YES AND 'N' FOR NO.						21.08
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?			NO			22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW			NO			23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.						23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.						24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.						24.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	YES		25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	YES		25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	YES		25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO		25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO		25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO	NO	25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	YES	NO	25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:			26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.			26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:			26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	NO		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st			28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.			28.02
A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)				
28.03	STAFFING	0.00	NO	28.03
28.04	RECRUITMENT	0.00	NO	28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO	28.05
28.06	TRAINING	0.00	NO	28.06
28.07	OTHER (SPECIFY)		NO	28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO		29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	NO		30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.			30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?			30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)			30.03
30.04	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. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.			30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO		31

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO			32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	NO			33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO			34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO			35

		V	XVIII	XIX	
		1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	YES	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	NO	NO	NO	37.01

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES			38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO			38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO			38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO			38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO			38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COL. 2 THE HOME OFFICE CHAIN NUMBER. (SEE INST.) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE ON LINES 40.01-40.03.	YES	15H032		40
40.01	NAME: PARKVIEW HEALTH SYSTEM, INC FI/CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICEFI/CONTRACTOR'S NUMBER:				40.01
40.02	STREET: 10501 CORPORATE DRIVE		P.O.BOX: 5600		40.02
40.03	CITY:		STATE: IN ZIP CODE: 46895-5600		40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	NO			41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO			42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO			42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO			42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO			43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO			44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO			45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?				45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?				45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?				45.03
46	IF YOU ARE PARTICIPATING IN THE NCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.				46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
	1	2	3	4	5	
47	HOSPITAL	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N			49
50	HOME HEALTH AGENCY	N	N			50
52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?					52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.					52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					53
53.01	MDH PERIOD: BEGINNING: ENDING:					53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: AND/OR SELF INSURANCE:					54
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.					54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.					55

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

		DATE	Y/N	LIMIT	Y/N	FEE\$	
		0	1	2	3	4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		NO				58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)						58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				59
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES 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. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)						60.01
MULTICAMPUS							
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.		NO				61
	COUNTY:			STATE:	ZIP CODE	CBSA	FTE/ CAMPUS
	1			2	3	4	5
SETTLEMENT DATA							
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)		NO				63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

-----DISCHARGES-----						
COMPONENT	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15		
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		520	17	1401	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		520	17	1401	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION

PART II - WAGE DATA		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	WORKSHEET S-3 PART II
	1	2	3	4	5	6		
1	TOTAL SALARIES	4020103		4020103	157465.00	25.53		1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL	2636233		2636233	74439.00	35.41	A-8-1 WORKPAPER	7
8	SNF							8
8.01	EXCLUDED AREA SALARIES							8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS	2636233		2636233	74439.00	35.41	A-8-1 WORKPAPER	11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	4829347		4829347			CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS						CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)						CMS 339	19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	516528		516528	20060.00	25.75		21
22	ADMINISTRATIVE & GENERAL	346494		346494	11880.00	29.17		22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT							24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING							26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY							27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION							30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR							33
34	SOCIAL SERVICE							34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

PART III - HOSPITAL WAGE INDEX SUMMARY		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	WORKSHEET S-3 PART III
	1	2	3	4	5		
1	NET SALARIES	1383870		1383870	83026.00	16.67	1
2	EXCLUDED AREA SALARIES						2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	1383870		1383870	83026.00	16.67	3
4	SUBTOTAL OTHER WAGES & REL COSTS	2636233		2636233	74439.00	35.41	4
5	SUBTOTAL WAGE-RELATED COSTS	4829347		4829347		348.97%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	8849450		8849450	157465.00	56.20	6
7	NET SALARIES						7
8	EXCLUDED AREA SALARIES						8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10	SUBTOTAL OTHER WAGES & REL COSTS						10
11	SUBTOTAL WAGE-RELATED COSTS						11
12	TOTAL (SUM OF LINES 9 THRU 11)						12
13	TOTAL OVERHEAD COSTS	863022		863022	31940.00	27.02	13

HOSPITAL UNCOMPENSATED CARE DATA

WORKSHEET S-10

UNCOMPENSATED CARE INFORMATION

1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	1
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	2
2.01	IS IT AT THE TIME OF ADMISSION?	2.01
2.02	IS IT AT THE TIME OF FIRST BILLING?	2.02
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	2.03
2.04	OTHER METHODS OF WRITE-OFFS (SPECIFY)	2.04
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	3
4	ARE CHARITY DETERMINATION BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	4
5	ARE CHARITY DETERMINATION BASED UPON INCOME DATA ONLY?	5
6	ARE CHARITY DETERMINATION BASED UPON NET WORTH DATA?	6
7	ARE CHARITY DETERMINATION BASED UPON INCOME AND NET WORTH DATA?	7
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	8
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	8.01
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	9
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	9.01
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	9.02
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	9.03
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	9.04
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE-OFF?	10
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER LINES 11 THRU 11.04	11
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	11.01
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	11.02
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	11.03
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	11.04
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	12
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	13
14	IS YOUR HOSPITAL STATE AND LOCAL GOVERNMENT OWNED? IF YES ANSWER LINE 14.01	14
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THE GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING UNCOMPENSATED CARE?	14.01
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	14.02
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	15
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	16
17	REVENUE RELATED TO UNCOMPENSATED CARE	17
17.01	GROSS MEDICAID REVENUES	17.01
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	18
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	19
20	RESTRICTED GRANTS	20
21	NON-RESTRICTED GRANTS	21
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	22
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	23
24	COST TO CHARGE RATIO	0.352171 24
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST	25
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	26
27	TOTAL SCHIP COST	27
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	28
29	TOTAL GROSS MEDICAID COST	29
30	OTHER UNCOMPENSATED CARE CHARGES (FROM YOUR RECORDS)	30
31	UNCOMPENSATED CARE COST	31
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL	32

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL 3	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
GENERAL SERVICE COST CENTERS									
1	0100 OLD CAP REL COSTS-BLDG & FIXT								1
2	0200 OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300 NEW CAP REL COSTS-BLDG & FIXT				274157	274157	256609	530766	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		920734	920734		920734	810243	1730977	4
5	0500 EMPLOYEE BENEFITS	516528	1244035	1760563		1760563	-1124790	635773	5
6	0600 ADMINISTRATIVE & GENERAL	346494	6065316	6411810	-272750	6139060	1082751	7221811	6
7	0700 MAINTENANCE & REPAIRS								7
8	0800 OPERATION OF PLANT		408856	408856		408856		408856	8
9	0900 LAUNDRY & LINEN SERVICE								9
10	1000 HOUSEKEEPING		226086	226086		226086		226086	10
11	1100 DIETARY		128323	128323		128323		128323	11
12	1200 CAFETERIA								12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION								14
15	1500 CENTRAL SERVICES & SUPPLY		21996	21996		21996		21996	15
16	1600 PHARMACY		17879	17879		17879		17879	16
17	1700 MEDICAL RECORDS & LIBRARY						110651	110651	17
18	1800 SOCIAL SERVICE		53233	53233		53233		53233	18
20	2000 NONPHYSICIAN ANESTHETISTS								20
21	2100 NURSING SCHOOL								21
22	2200 I&R SERVICES-SALARY & FRINGES A								22
23	2300 I&R SERVICES-OTHER PRGM COSTS A								23
24	2400 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS									
25	2500 ADULTS & PEDIATRICS	1162614	183686	1346300	-64497	1281803		1281803	25
ANCILLARY SERVICE COST CENTERS									
37	3700 OPERATING ROOM	1545289	21977977	23523266	-20816124	2707142	-995902	1711240	37
40	4000 ANESTHESIOLOGY		829016	829016		829016		829016	40
41	4100 RADIOLOGY-DIAGNOSTIC		617177	617177		617177		617177	41
44	4400 LABORATORY		299621	299621		299621		299621	44
46	4600 WHOLE BLOOD & PACKED RED BLOOD		54468	54468		54468		54468	46
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900 RESPIRATORY THERAPY		144430	144430		144430		144430	49
50	5000 PHYSICAL THERAPY	449178	-114142	335036	-81	334955		334955	50
55	5500 MEDICAL SUPPLIES CHARGED TO PAT				20879295	20879295		20879295	55
56	5600 DRUGS CHARGED TO PATIENTS		792743	792743		792743		792743	56
OUTPATIENT SERVICE COST CENTERS									
60	6000 CLINIC		388	388		388		388	60
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 RHC								63.50
63.60	6320 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS									
69.10	6910 CMHC								69.10
69.20	6920 OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940 OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS									
85.01	8510 PANCREAS ACQUISITION								85.01
85.02	8520 INTESTINAL ACQUISITION								85.02
85.03	8530 ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	4020103	33871822	37891925		37891925	139562	38031487	95
NONREIMBURSABLE COST CENTERS									
100	7950 STUDENT NURSE PROGRAM		78300	78300		78300		78300	100
101	TOTAL	4020103	33950122	37970225		37970225	139562	38109787	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----			
		COST CENTER	LINE #	SALARY	OTHER
	1	2	3	4	5
1 TO RECLASSIFY BUILDING DEPRECIATION	A	NEW CAP REL COSTS-BLDG & FIXT	3		274157
2 TO RECLASSIFY MED AND IV SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	55		20879295
3	B				3
4	B				4
5 TELEPHONE EXPENSE RECLASS	C	ADMINISTRATIVE & GENERAL	6		1407
6	C				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
31					31
32					32
33					33
34					34
35					35
36 TOTAL RECLASSIFICATIONS					21154859

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF. 10
			LINE #	SALARY	OTHER	
	1	6	7	8	9	
1 TO RECLASSIFY BUILDING DEPRECIATI	A	ADMINISTRATIVE & GENERAL	6		274157	9 1
2 TO RECLASSIFY MED AND IV SUPPLIES	B	ADULTS & PEDIATRICS	25		64497	2
3	B	OPERATING ROOM	37		20814729	3
4	B	PHYSICAL THERAPY	50		69	4
5 TELEPHONE EXPENSE RECLASS	C	OPERATING ROOM	37		1395	5
6	C	PHYSICAL THERAPY	50		12	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
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS					21154859	36

ANALYSIS OF CHANGES DURING COST REPORTING
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL								7
8 RECONCILING ITEMS								8
9 TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	2321940	154967		154967		2476907		6
7 SUBTOTAL	2321940	154967		154967		2476907		7
8 RECONCILING ITEMS	2824				853303	-850479		8
9 TOTAL	2319116	154967		154967	853303	3327386		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF		OTHER CAPITAL	TOTAL
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	RELATED COSTS	
	1	2	3	4	5	6	7	
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT				.000000				3
4 NEW CAP REL COSTS-MVBLE EQUIP	3327386	92427	3234959	1.000000				4
5 TOTAL	3327386	92427	3234959	1.000000				5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT		530766					530766 3
4 NEW CAP REL COSTS-MVBLE EQUIP		1730977					1730977 4
5 TOTAL		2261743					2261743 5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT							3
4 NEW CAP REL COSTS-MVBLE EQUIP		920734					920734 4
5 TOTAL		920734					920734 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5 INVESTMENT INCOME-OTHER					5
6 TRADE, QUANTITY, AND TIME DISCOUNTS					6
7 REFUNDS AND REBATES OF EXPENSES					7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)					9
10 TELEVISION AND RADIO SERVICE					10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2				12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST				
	A-8-1	3177409			14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS					16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19 SALE OF DRUGS TO OTHER THAN PATIENTS					19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS					20
21 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					21
22 VENDING MACHINES					22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST		HOME HEALTH AGENCY	71	27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				
	WKST A-8-4				35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				
	WKST A-8-4				36
37 PVN SURGERIES AT ORT	B	-995902	OPERATING ROOM	37	37
38 OOR	B	-1250	ADMINISTRATIVE & GENERAL	6	38
39 SELF-INSURANCE OFFSET	A	-2040695	EMPLOYEE BENEFITS	5	39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL		139562			50

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ-USTMENTS	WKST A-7 REF	
1	2	3	4	5	6	7	
1	4	NEW CAP REL COSTS-MVBLE EQUIP	HOME OFFICE COST REPORT	810243		810243	9 1
2	6	ADMINISTRATIVE & GENERAL	HOME OFFICE COST REPORT	4266702	3182701	1084001	2
3	3	NEW CAP REL COSTS-BLDG & FIXT	HOME OFFICE COST REPORT	256609		256609	9 3
4	5	EMPLOYEE BENEFITS	HOME OFFICE COST REPORT	915905		915905	4
4.01	17	MEDICAL RECORDS & LIBRARY	HOME OFFICE COST REPORT	110651		110651	4.01
5		TOTALS		6360110	3182701	3177409	5

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

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

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

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

SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	B		PARKVIEW HEALTH SYSTEM, INC		HOME OFFICE
2					
3					
4					
5					

(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 NO. 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVI
PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2010.02
05/19/2010 10:13

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.		2	3	4	5	6	7	8	9
101		TOTAL							

PROVIDER NO. 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVI
PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2010.02
05/19/2010 10:13

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO.		12	13	14	15	16	17	18
101	TOTAL							

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP	NEW CAP	NEW CAP	EMPLOYEE	SUBTOTAL	ADMINIS-	OPERATION	HOUSE-	
	FOR COST	BLDGS &	MOVABLE	BENEFITS		TRATIVE &	OF PLANT	KEEPING	
	ALLOCATION	FIXTURES	EQUIPMENT			GENERAL			
	0	3	4	5	5A	6	8	10	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT	530766	530766							3
4 NEW CAP REL COSTS-MVBLE EQUIP	1730977		1730977						4
5 EMPLOYEE BENEFITS	635773			635773					5
6 ADMINISTRATIVE & GENERAL	7221811			62876	7284687	7284687			6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	408856				408856	96622	505478		8
9 LAUNDRY & LINEN SERVICE									9
10 HOUSEKEEPING	226086				226086	53429		279515	10
11 DIETARY	128323				128323	30326			11
12 CAFETERIA									12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION									14
15 CENTRAL SERVICES & SUPPLY	21996				21996	5198			15
16 PHARMACY	17879				17879	4225			16
17 MEDICAL RECORDS & LIBRARY	110651				110651	26149			17
18 SOCIAL SERVICE	53233				53233	12580			18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	1281803	293531	200743	210973	1987050	469586	279546	154581	25
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	1711240	222167	1514197	280414	3728018	881016	211582	116999	37
40 ANESTHESIOLOGY	829016				829016	195916			40
41 RADIOLOGY-DIAGNOSTIC	617177				617177	145853			41
44 LABORATORY	299621				299621	70807			44
46 WHOLE BLOOD & PACKED RED BLOOD	54468				54468	12872			46
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	144430				144430	34132			49
50 PHYSICAL THERAPY	334955	15068	16037	81510	447570	105771	14350	7935	50
55 MEDICAL SUPPLIES CHARGED TO PAT	20879295				20879295	4934266			55
56 DRUGS CHARGED TO PATIENTS	792743				792743	187343			56
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC	388				388	92			60
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	38031487	530766	1730977	635773	38031487	7266183	505478	279515	95
NONREIMBURSABLE COST CENTERS									
100 STUDENT NURSE PROGRAM	78300				78300	18504			100
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	38109787	530766	1730977	635773	38109787	7284687	505478	279515	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY 11	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING								10
11 DIETARY	158649							11
12 CAFETERIA								12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION								14
15 CENTRAL SERVICES & SUPPLY		27194						15
16 PHARMACY			22104					16
17 MEDICAL RECORDS & LIBRARY				136800				17
18 SOCIAL SERVICE					65813			18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
25 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	158649	272		136800	65813	3252297		3252297 25
37 ANCILLARY SERVICE COST CENTERS OPERATING ROOM		26922				4964537		4964537 37
40 ANESTHESIOLOGY						1024932		1024932 40
41 RADIOLOGY-DIAGNOSTIC						763030		763030 41
44 LABORATORY						370428		370428 44
46 WHOLE BLOOD & PACKED RED BLOOD						67340		67340 46
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY						178562		178562 49
50 PHYSICAL THERAPY						575626		575626 50
55 MEDICAL SUPPLIES CHARGED TO PAT						25813561		25813561 55
56 DRUGS CHARGED TO PATIENTS			22104			1002190		1002190 56
60 OUTPATIENT SERVICE COST CENTERS CLINIC						480		480 60
62 OBSERVATION BEDS (NON-DISTINCT)								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	158649	27194	22104	136800	65813	38012983		38012983 95
NONREIMBURSABLE COST CENTERS								
100 STUDENT NURSE PROGRAM						96804		96804 100
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	158649	27194	22104	136800	65813	38109787		38109787 103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIR ASSGND	NEW CAP	NEW CAP	CAP REL	ADMINIS-	OPERATION	HOUSE-	DIETARY	
	CAP-REL COSTS 0	BLDGS & FIXTURES 3	MOVABLE EQUIPMENT 4	COST TO BE ALLOC 4A	TRATIVE & GENERAL 6	OF PLANT 8	KEEPING 10	11	
GENERAL SERVICE COST CENTERS									
1									1
2									2
3									3
4									4
5									5
6	1144719			1144719	1144719				6
7									7
8					15183	15183			8
9									9
10					8396		8396		10
11					4765			4765	11
12									12
13									13
14									14
15					817				15
16					664				16
17					4109				17
18					1977				18
20									20
21									21
22									22
23									23
24									24
INPATIENT ROUTINE SERV COST CENTERS									
25	2944	293531	200743	497218	73791	8397	4644	4765	25
ANCILLARY SERVICE COST CENTERS									
37	34432	222167	1514197	1770796	138444	6355	3514		37
40					30786				40
41					22919				41
44					11127				44
46					2023				46
46.30									46.30
49					5364				49
50	368	15068	16037	31473	16621	431	238		50
55					775372				55
56					29439				56
OUTPATIENT SERVICE COST CENTERS									
60									60
62					14				62
63.50									63.50
63.60									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10									69.10
69.20									69.20
69.30									69.30
69.40									69.40
71									71
SPECIAL PURPOSE COST CENTERS									
85.01									85.01
85.02									85.02
85.03									85.03
95	1182463	530766	1730977	3444206	1141811	15183	8396	4765	95
NONREIMBURSABLE COST CENTERS									
100					2908				100
101									101
102									102
103	1182463	530766	1730977	3444206	1144719	15183	8396	4765	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 27	
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING								10
11 DIETARY								11
12 CAFETERIA								12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION								14
15 CENTRAL SERVICES & SUPPLY	817							15
16 PHARMACY		664						16
17 MEDICAL RECORDS & LIBRARY			4109					17
18 SOCIAL SERVICE				1977				18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	8		4109	1977	594909		594909	25
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	809				1919918		1919918	37
40 ANESTHESIOLOGY					30786		30786	40
41 RADIOLOGY-DIAGNOSTIC					22919		22919	41
44 LABORATORY					11127		11127	44
46 WHOLE BLOOD & PACKED RED BLOOD					2023		2023	46
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY					5364		5364	49
50 PHYSICAL THERAPY					48763		48763	50
55 MEDICAL SUPPLIES CHARGED TO PAT					775372		775372	55
56 DRUGS CHARGED TO PATIENTS		664			30103		30103	56
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC					14		14	60
62 OBSERVATION BEDS (NON-DISTINCT)								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	817	664	4109	1977	3441298		3441298	95
NONREIMBURSABLE COST CENTERS								
100 STUDENT NURSE PROGRAM					2908		2908	100
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	817	664	4109	1977	3444206		3444206	103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP	NEW CAP	EMPLOYEE	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL	OPERATION	HOUSE-	
	BLDGS & FIXTURES SQUARE FEET	MOVABLE EQUIPMENT DOLLAR VALUE	BENEFITS GROSS SALARIES		ACCUM COST	OF PLANT SQUARE FEET	KEEPING SQUARE FEET	
	3	4	5	6A	6	8	10	
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT	42200							3
4 NEW CAP REL COSTS-MVBLE EQUIP		140320						4
5 EMPLOYEE BENEFITS			3503575					5
6 ADMINISTRATIVE & GENERAL			346494	-7284687	30825100			6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT					408856	42200		8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING					226086		42200	10
11 DIETARY					128323			11
12 CAFETERIA								12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION								14
15 CENTRAL SERVICES & SUPPLY					21996			15
16 PHARMACY					17879			16
17 MEDICAL RECORDS & LIBRARY					110651			17
18 SOCIAL SERVICE					53233			18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES								22
23 I&R SERVICES-OTHER PRGM COSTS								23
24 PARAMED ED PRGM-(SPECIFY)								24
25 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	23338	16273	1162614		1987050	23338	23338	25
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	17664	122747	1545289		3728018	17664	17664	37
40 ANESTHESIOLOGY					829016			40
41 RADIOLOGY-DIAGNOSTIC					617177			41
44 LABORATORY					299621			44
46 WHOLE BLOOD & PACKED RED BLOO					54468			46
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY					144430			49
50 PHYSICAL THERAPY	1198	1300	449178		447570	1198	1198	50
55 MEDICAL SUPPLIES CHARGED TO P					20879295			55
56 DRUGS CHARGED TO PATIENTS					792743			56
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC					388			60
62 OBSERVATION BEDS (NON-DISTINC								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERA								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	42200	140320	3503575	-7284687	30746800	42200	42200	95
NONREIMBURSABLE COST CENTERS								
100 STUDENT NURSE PROGRAM					78300			100
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	530766	1730977	635773		7284687	505478	279515	103
104 UNIT COST MULT-WS B PT I		12.335925				11.978152		104
104 UNIT COST MULT-WS B PT I	12.577393		.181464		.236323		6.623578	104
105 COST TO BE ALLOC PER B PT II								105
106 UNIT COST MULT-WS B PT II								106
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III					1144719	15183	8396	107
108 UNIT COST MULT-WS B PT III						.359787		108
108 UNIT COST MULT-WS B PT III					.037136		.198957	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	DIETARY	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	MEALS SERVED 11	COSTED REQUIS. 15	COSTED REQUIS. 16	TIME SPENT 17	TIME SPENT 18	
GENERAL SERVICE COST CENTERS						
1 OLD CAP REL COSTS-BLDG & FIXT						1
2 OLD CAP REL COSTS-MVBLE EQUIP						2
3 NEW CAP REL COSTS-BLDG & FIXT						3
4 NEW CAP REL COSTS-MVBLE EQUIP						4
5 EMPLOYEE BENEFITS						5
6 ADMINISTRATIVE & GENERAL						6
7 MAINTENANCE & REPAIRS						7
8 OPERATION OF PLANT						8
9 LAUNDRY & LINEN SERVICE						9
10 HOUSEKEEPING						10
11 DIETARY	11955					11
12 CAFETERIA						12
13 MAINTENANCE OF PERSONNEL						13
14 NURSING ADMINISTRATION						14
15 CENTRAL SERVICES & SUPPLY		10000				15
16 PHARMACY			10000			16
17 MEDICAL RECORDS & LIBRARY				10000		17
18 SOCIAL SERVICE					10000	18
20 NONPHYSICIAN ANESTHETISTS						20
21 NURSING SCHOOL						21
22 I&R SERVICES-SALARY & FRINGES						22
23 I&R SERVICES-OTHER PRGM COSTS						23
24 PARAMED ED PRGM-(SPECIFY)						24
25 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	11955	100		10000	10000	25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM		9900				37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC						41
44 LABORATORY						44
46 WHOLE BLOOD & PACKED RED BLOO						46
46.30 BLOOD CLOTTING FACTORS ADMIN						46.30
49 RESPIRATORY THERAPY						49
50 PHYSICAL THERAPY						50
55 MEDICAL SUPPLIES CHARGED TO P						55
56 DRUGS CHARGED TO PATIENTS			10000			56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC						60
62 OBSERVATION BEDS (NON-DISTINC						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
69.10 CMHC						69.10
69.20 OUTPATIENT PHYSICAL THERAPY						69.20
69.30 OUTPATIENT OCCUPATIONAL THERA						69.30
69.40 OUTPATIENT SPEECH PATHOLOGY						69.40
71 HOME HEALTH AGENCY						71
SPECIAL PURPOSE COST CENTERS						
85.01 PANCREAS ACQUISITION						85.01
85.02 INTESTINAL ACQUISITION						85.02
85.03 ISLET CELL ACQUISITION						85.03
95 SUBTOTALS	11955	10000	10000	10000	10000	95
NONREIMBURSABLE COST CENTERS						
100 STUDENT NURSE PROGRAM						100
101 CROSS FOOT ADJUSTMENTS						101
102 NEGATIVE COST CENTER						102
103 COST TO BE ALLOC PER B PT I	158649	27194	22104	136800	65813	103
104 UNIT COST MULT-WS B PT I	13.270514		2.210400		6.581300	104
104 UNIT COST MULT-WS B PT I		2.719400		13.680000		104
105 COST TO BE ALLOC PER B PT II						105
106 UNIT COST MULT-WS B PT II						106
106 UNIT COST MULT-WS B PT II						106
107 COST TO BE ALLOC PER B PT III	4765	817	664	4109	1977	107
108 UNIT COST MULT-WS B PT III	.398578		.066400		.197700	108
108 UNIT COST MULT-WS B PT III		.081700		.410900		108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 27)	LIMIT ADJUSTMENT				
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	3252297		3252297		3252297	25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	4964537		4964537		4964537	37
40 ANESTHESIOLOGY	1024932		1024932		1024932	40
41 RADIOLOGY-DIAGNOSTIC	763030		763030		763030	41
44 LABORATORY	370428		370428		370428	44
46 WHOLE BLOOD & PACKED RED BL	67340		67340		67340	46
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	178562		178562		178562	49
50 PHYSICAL THERAPY	575626		575626		575626	50
55 MEDICAL SUPPLIES CHARGED TO	25813561		25813561		25813561	55
56 DRUGS CHARGED TO PATIENTS	1002190		1002190		1002190	56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	480		480		480	60
62 OBSERVATION BEDS (NON-DISTI	226104		226104		226104	62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	38239087		38239087		38239087	101
102 LESS OBSERVATION BEDS	226104		226104		226104	102
103 TOTAL	38012983		38012983		38012983	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
25 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	4500876		4500876			25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	13214774	9397972	22612746	.219546	.219546	.219546 37
40 ANESTHESIOLOGY	1174200	967210	2141410	.478625	.478625	.478625 40
41 RADIOLOGY-DIAGNOSTIC	807347	273353	1080700	.706052	.706052	.706052 41
44 LABORATORY	988566	129823	1118389	.331216	.331216	.331216 44
46 WHOLE BLOOD & PACKED RED BL	78658	1222	79880	.843015	.843015	.843015 46
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	272406	11605	284011	.628715	.628715	.628715 49
50 PHYSICAL THERAPY	1510562	12439	1523001	.377955	.377955	.377955 50
55 MEDICAL SUPPLIES CHARGED TO	60871276	8754262	69625538	.370748	.370748	.370748 55
56 DRUGS CHARGED TO PATIENTS	3505545	1128473	4634018	.216268	.216268	.216268 56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	682		682	.703812	.703812	.703812 60
62 OBSERVATION BEDS (NON-DISTI		337745	337745	.669452	.669452	.669452 62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	86924892	21014104	107938996			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	86924892	21014104	107938996			103

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	----- OLD CAPITAL -----			----- NEW CAPITAL -----		
	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST
	1	2	3	4	5	6
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS				594909		594909
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL				594909		594909

COST CENTER DESCRIPTION	---- OLD CAPITAL ----			---- NEW CAPITAL ----		
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST
	7	8	9	10	11	12
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS	4344	1513			136.95	207205
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL	4344	1513				207205

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB III [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SUB IV [] TEFRA
 BOXES [] TITLE XIX [] SUB II

COST CENTER DESCRIPTION	OLD	NEW	TOTAL	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----		
	CAPITAL RELATED COST	CAPITAL RELATED COST			RATIO OF COST TO CHARGES	CAPITAL COSTS	RATIO OF COST TO CHARGES	CAPITAL COSTS	
	1	2	3	4	5	6	7	8	
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM		1919918	22612746	4489047			.084904	381138	37
40 ANESTHESIOLOGY		30786	2141410	392061			.014377	5637	40
41 RADIOLOGY-DIAGNOSTIC		22919	1080700	291363			.021208	6179	41
44 LABORATORY		11127	1118389	365326			.009949	3635	44
46 WHOLE BLOOD & PACKED RED BLOO		2023	79880	42970			.025325	1088	46
46.30 BLOOD CLOTTING FACTORS ADMIN									46.30
49 RESPIRATORY THERAPY		5364	284011	104589			.018887	1975	49
50 PHYSICAL THERAPY		48763	1523001	562442			.032018	18008	50
55 MEDICAL SUPPLIES CHARGED TO P		775372	69625538	20374804			.011136	226894	55
56 DRUGS CHARGED TO PATIENTS		30103	4634018	1201673			.006496	7806	56
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC		14	682	455			.020528	9	60
62 OBSERVATION BEDS (NON-DISTINC		41359	337745				.122456		62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
101 TOTAL		2887748	103438120	27824730				652369	101

PROVIDER NO. 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVI
 PERIOD FROM 01/01/2008 TO 12/31/2008

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL COSTS	TOTAL	PER DIEM	INPATIENT	INPATIENT
	ANESTHETIST COST	EDUCATION COST	ADJUSTMENT AMOUNT		PATIENT DAYS		PROGRAM DAYS	PROGRAM PASS THRU COSTS
	1	2	3	4	5	6	7	8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					4344		1513	25
26 INTENSIVE CARE UNIT								26
27 CORONARY CARE UNIT								27
28 BURN INTENSIVE CARE UNIT								28
29 SURGICAL INTENSIVE CARE UNIT								29
30 OTHER SPECIAL CARE (SPECIFY)								30
31 SUBPROVIDER I								31
33 NURSERY								33
34 SKILLED NURSING FACILITY								34
35 NURSING FACILITY								35
101 TOTAL					4344		1513	101

PROVIDER NO. 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVI
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46 WHOLE BLOOD & PACKED RED BLOO							46
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	CHARGES
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		22612746			4489047		1234199 37
40 ANESTHESIOLOGY		2141410			392061		148296 40
41 RADIOLOGY-DIAGNOSTIC		1080700			291363		51182 41
44 LABORATORY		1118389			365326		7313 44
46 WHOLE BLOOD & PACKED RED BLOO		79880			42970		46
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		284011			104589		1756 49
50 PHYSICAL THERAPY		1523001			562442		50
55 MEDICAL SUPPLIES CHARGED TO P		69625538			20374804		765711 55
56 DRUGS CHARGED TO PATIENTS		4634018			1201673		947898 56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		682			455		60
62 OBSERVATION BEDS (NON-DISTINC		337745					58048 62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		103438120			27824730		3214403 101

PROVIDER NO. 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVI
 PERIOD FROM 01/01/2008 TO 12/31/2008

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 IN LIEU OF FORM CMS-2552-96 (9/2000)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM						37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC						41
44 LABORATORY						44
46 WHOLE BLOOD & PACKED RED BLOO						46
46.30 BLOOD CLOTTING FACTORS ADMIN						46.30
49 RESPIRATORY THERAPY						49
50 PHYSICAL THERAPY						50
55 MEDICAL SUPPLIES CHARGED TO P						55
56 DRUGS CHARGED TO PATIENTS						56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC						60
62 OBSERVATION BEDS (NON-DISTINC						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 TOTAL						101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0167) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES			
	PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4	
37 ANCILLARY SERVICE COST CENTERS							
49 OPERATING ROOM	.219546	.219546	.219546				37
40 ANESTHESIOLOGY	.478625	.478625	.478625				40
41 RADIOLOGY-DIAGNOSTIC	.706052	.706052	.706052				41
44 LABORATORY	.331216	.331216	.331216				44
46 WHOLE BLOOD & PACKED RED BLOOD	.843015	.843015	.843015				46
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	.628715	.628715	.628715				49
50 PHYSICAL THERAPY	.377955	.377955	.377955				50
55 MEDICAL SUPPLIES CHARGED TO PAT	.370748	.370748	.370748				55
56 DRUGS CHARGED TO PATIENTS	.216268	.216268	.216268				56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC	.703812	.703812	.703812				60
62 OBSERVATION BEDS (NON-DISTINCT	.669452	.669452	.669452				62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE CHARGES (S-2 LINE 56.							65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.							65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.							65.03
101 SUBTOTAL							101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.216268	1
2 PROGRAM VACCINE CHARGES		2
2.01 PROGRAM VACCINE CHARGES		2.01
3 PROGRAM COSTS		3
3.01 PROGRAM COSTS		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0167) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL OTHER (1)	PPS SER- VICES	ALL OTHER (SEE INSTRU.)	PPS SER- VICES	PPS SER- VICES	OUTPATIENT AMBULATORY CENTER	OUTPATIENT RADIOLOGY	OUTPATIENT OTHER DIAGNOSTIC
	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	6	7	8
37 ANCILLARY SERVICE COST CENTERS								
OPERATING ROOM		1234199						37
40 ANESTHESIOLOGY		148296						40
41 RADIOLOGY-DIAGNOSTIC		51182						41
44 LABORATORY		7313						44
46 WHOLE BLOOD & PACKED RED BLOOD								46
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
49 RESPIRATORY THERAPY		1756						49
50 PHYSICAL THERAPY								50
55 MEDICAL SUPPLIES CHARGED TO PA		765711						55
56 DRUGS CHARGED TO PATIENTS		947898						56
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC								60
62 OBSERVATION BEDS (NON-DISTINCT)		58048						62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65.01 AMBULANCE CHARGES (S-2 LINE 56								65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56								65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56								65.03
101 SUBTOTAL		3214403						101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES		3214403						104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0167) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL	
	ALL OTHER (COLS 1x5) 9	PPS SERVICES (COLUMNS 1.01x5.01) 9.01	ALL OTHER (COLUMNS 1.01x5.02) 9.02	PPS SERVICES (COLUMNS 1.01x5.03) 9.03	PPS SERVICES (COLUMNS 1.01x5.04) 9.04	I/P PART B CHARGES (SEE INSTRU.) 10	I/P PART B COST (COLUMNS 1.02x10) 11
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		270963					37
40 ANESTHESIOLOGY		70978					40
41 RADIOLOGY-DIAGNOSTIC		36137					41
44 LABORATORY		2422					44
46 WHOLE BLOOD & PACKED RED BLOOD							46
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY		1104					49
50 PHYSICAL THERAPY							50
55 MEDICAL SUPPLIES CHARGED TO PAT		283886					55
56 DRUGS CHARGED TO PATIENTS		205000					56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
62 OBSERVATION BEDS (NON-DISTINCT		38860					62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE CHARGES (S-2 LINE 56.							65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.							65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.							65.03
101 SUBTOTAL		909350					101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES		909350					104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	----- OLD CAPITAL -----			----- NEW CAPITAL -----		
	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST
	1	2	3	4	5	6
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS				594909		594909
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL				594909		594909

COST CENTER DESCRIPTION	---- OLD CAPITAL ----			---- NEW CAPITAL ----		
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST
	7	8	9	10	11	12
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS	4344	47			136.95	6437
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL	4344	47				6437

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB III [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SUB IV [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] OTHER

COST CENTER DESCRIPTION	OLD	NEW	TOTAL	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----		
	CAPITAL RELATED COST 1	CAPITAL RELATED COST 2			RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM		1919918	22612746	837159			.084904	71078	37
40 ANESTHESIOLOGY		30786	2141410	13380			.014377	192	40
41 RADIOLOGY-DIAGNOSTIC		22919	1080700	10839			.021208	230	41
44 LABORATORY		11127	1118389	11706			.009949	116	44
46 WHOLE BLOOD & PACKED RED BLOO		2023	79880	611			.025325	15	46
46.30 BLOOD CLOTTING FACTORS ADMIN									46.30
49 RESPIRATORY THERAPY		5364	284011	3042			.018887	57	49
50 PHYSICAL THERAPY		48763	1523001	17065			.032018	546	50
55 MEDICAL SUPPLIES CHARGED TO P		775372	69625538	133721			.011136	1489	55
56 DRUGS CHARGED TO PATIENTS		30103	4634018	33416			.006496	217	56
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC		14	682				.020528	60	
62 OBSERVATION BEDS (NON-DISTINC		41359	337745				.122456	62	
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
101 TOTAL		2887748	103438120	1060939				73940	101

PROVIDER NO. 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVI
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2010.02
 05/19/2010 10:13

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL COSTS	TOTAL	PER DIEM	INPATIENT	INPATIENT
	ANESTHETIST COST	EDUCATION COST	ADJUSTMENT AMOUNT		PATIENT DAYS		PROGRAM DAYS	PROGRAM PASS THRU COSTS
	1	2	3	4	5	6	7	8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					4344		47	25
26 INTENSIVE CARE UNIT								26
27 CORONARY CARE UNIT								27
28 BURN INTENSIVE CARE UNIT								28
29 SURGICAL INTENSIVE CARE UNIT								29
30 OTHER SPECIAL CARE (SPECIFY)								30
31 SUBPROVIDER I								31
33 NURSERY								33
34 SKILLED NURSING FACILITY								34
35 NURSING FACILITY								35
101 TOTAL					4344		47	101

PROVIDER NO. 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVI
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2010.02
 05/19/2010 10:13

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46 WHOLE BLOOD & PACKED RED BLOO							46
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL CHARGES	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH COSTS		COST TO CHARGES	RATIO OF COST TO CHARGES	PROGRAM CHARGES	PROGRAM CHARGES	PROGRAM CHARGES
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		22612746			837159		37
40 ANESTHESIOLOGY		2141410			13380		40
41 RADIOLOGY-DIAGNOSTIC		1080700			10839		41
44 LABORATORY		1118389			11706		44
46 WHOLE BLOOD & PACKED RED BLOO		79880			611		46
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		284011			3042		49
50 PHYSICAL THERAPY		1523001			17065		50
55 MEDICAL SUPPLIES CHARGED TO P		69625538			133721		55
56 DRUGS CHARGED TO PATIENTS		4634018			33416		56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		682					60
62 OBSERVATION BEDS (NON-DISTINC		337745					62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		103438120			1060939		101

PROVIDER NO. 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVI
 PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2010.02
 05/19/2010 10:13

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (15-0167)	[]	SUB IV	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	SUB I	[]	SNF	[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	SUB II	[]	NF	[]	OTHER
			[]	SUB III	[]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS
	8.01	8.02	9	9.01	9.02
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46 WHOLE BLOOD & PACKED RED BLOO					46
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
101 TOTAL					101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0167) [] SNF
 APPLICABLE [] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [XX] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES			
	PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4	
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	.219546	.219546	.219546				37
40 ANESTHESIOLOGY	.478625	.478625	.478625				40
41 RADIOLOGY-DIAGNOSTIC	.706052	.706052	.706052				41
44 LABORATORY	.331216	.331216	.331216				44
46 WHOLE BLOOD & PACKED RED BLOOD	.843015	.843015	.843015				46
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	.628715	.628715	.628715				49
50 PHYSICAL THERAPY	.377955	.377955	.377955				50
55 MEDICAL SUPPLIES CHARGED TO PAT	.370748	.370748	.370748				55
56 DRUGS CHARGED TO PATIENTS	.216268	.216268	.216268				56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC	.703812	.703812	.703812				60
62 OBSERVATION BEDS (NON-DISTINCT	.669452	.669452	.669452				62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE CHARGES (S-2 LINE 56.							65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.							65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.							65.03
101 SUBTOTAL							101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.216268	1
2 PROGRAM VACCINE CHARGES		2
2.01 PROGRAM VACCINE CHARGES		2.01
3 PROGRAM COSTS		3
3.01 PROGRAM COSTS		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0167) [] SNF
 APPLICABLE [] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [XX] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL OTHER (1)	PPS SER- VICES	ALL OTHER (SEE INSTRU.)	PPS SER- VICES	PPS SER- VICES	OUTPATIENT AMBULATORY CENTER	OUTPATIENT RADIOLOGY	OUTPATIENT OTHER DIAGNOSTIC
	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	6	7	8
37 ANCILLARY SERVICE COST CENTERS								
40 OPERATING ROOM	434058							37
41 ANESTHESIOLOGY	28004							40
44 RADIOLOGY-DIAGNOSTIC	7531							41
46 LABORATORY	3576							44
46.30 WHOLE BLOOD & PACKED RED BLOOD								46
49 BLOOD CLOTTING FACTORS ADMIN C								46.30
50 RESPIRATORY THERAPY	120							49
55 PHYSICAL THERAPY								50
56 MEDICAL SUPPLIES CHARGED TO PA	142219							55
60 DRUGS CHARGED TO PATIENTS	28039							56
60 OUTPATIENT SERVICE COST CENTERS								
62 CLINIC								60
62 OBSERVATION BEDS (NON-DISTINCT	13638							62
63.50 RHC								63.50
63.60 FQHC								63.60
65.01 OTHER REIMBURSABLE COST CENTERS								
65.02 AMBULANCE CHARGES (S-2 LINE 56								65.01
65.03 AMBULANCE CHARGES (S-2 LINE 56								65.02
101 SUBTOTAL	657185							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	657185							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0167) [] SNF
 APPLICABLE [] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [XX] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL
	ALL OTHER (COLS 1x5) 9	PPS SERVICES (COLUMNS 1.01x5.01) 9.01	ALL OTHER (COLUMNS (COLUMNS 1.01x5.02) 9.02	PPS SERVICES (COLUMNS (COLUMNS 1.01x5.03 9.03	PPS SERVICES (COLUMNS (COLUMNS 1.01x5.04 9.04	I/P PART B CHARGES (SEE INSTRU.) 10
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	95296					37
40 ANESTHESIOLOGY	13403					40
41 RADIOLOGY-DIAGNOSTIC	5317					41
44 LABORATORY	1184					44
46 WHOLE BLOOD & PACKED RED BLOOD						46
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	75					49
50 PHYSICAL THERAPY						50
55 MEDICAL SUPPLIES CHARGED TO PAT	52727					55
56 DRUGS CHARGED TO PATIENTS	6064					56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC						60
62 OBSERVATION BEDS (NON-DISTINCT	9130					62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65.01 AMBULANCE CHARGES (S-2 LINE 56.						65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.						65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.						65.03
101 SUBTOTAL	183196					101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES	183196					104

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	SNF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	4344						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	4344						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4344						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							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1513						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							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							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							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	3252297						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3252297						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	4500876						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4500876						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.722592						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1036.11						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3252297						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	748.69					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1132768					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1132768					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	9628601					48
49 TOTAL PROGRAM INPATIENT COSTS	10761369					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	207205					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	652369					51
52 TOTAL PROGRAM EXCLUDABLE COST	859574					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	9901795					53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

SNF

1

66 SNF/NF/ICF/MR ROUTINE SERVICE COST	66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	67
68 PROGRAM ROUTINE SERVICE COST	68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	71
72 PER DIEM CAPITAL RELATED COSTS	72
73 PROGRAM CAPITAL RELATED COSTS	73
74 INPATIENT ROUTINE SERVICE COST	74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	77
78 INPATIENT ROUTINE SERVICE COST LIMITATION	78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS	79
80 PROGRAM INPATIENT ANCILLARY SERVICES	80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION	81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS	82

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PARTS III & IV

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

HOSPITAL SUB I SUB II SUB III SUB IV
 (PPS)
 (15-0167)
 1 1 1 1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	302	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	748.69	84
85 OBSERVATION BED COST	226104	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

	COST 1	ROUTINE COST (FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5	
86 OLD CAPITAL-RELATED COST		3252297		226104		86
87 NEW CAPITAL-RELATED COST	594909	3252297	.182920	226104	41359	87
88 NON PHYSICIAN ANESTHETIST		3252297		226104		88
89 MEDICAL EDUCATION		3252297		226104		89

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	NF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	4344						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	4344						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4344						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							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	47						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							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							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							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	3252297						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3252297						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	4500876						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4500876						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.722592						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1036.11						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3252297						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	748.69					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	35188					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	35188					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	267411					48
49 TOTAL PROGRAM INPATIENT COSTS	302599					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	6437					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	73940					51
52 TOTAL PROGRAM EXCLUDABLE COST	80377					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	222222					53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

PROVIDER NO. 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVI
PERIOD FROM 01/01/2008 TO 12/31/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2010.02
05/19/2010 10:13

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY NF

	1	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST		66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		67
68 PROGRAM ROUTINE SERVICE COST		68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS		71
72 PER DIEM CAPITAL RELATED COSTS		72
73 PROGRAM CAPITAL RELATED COSTS		73
74 INPATIENT ROUTINE SERVICE COST		74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT		76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78 INPATIENT ROUTINE SERVICE COST LIMITATION		78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS		79
80 PROGRAM INPATIENT ANCILLARY SERVICES		80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS		82

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PARTS III & IV

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

HOSPITAL SUB I SUB II SUB III SUB IV
 (PPS)
 (15-0167)
 1 1 1 1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	302	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	748.69	84
85 OBSERVATION BED COST	226104	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

	COST 1	ROUTINE COST (FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5	
86 OLD CAPITAL-RELATED COST		3252297		226104		86
87 NEW CAPITAL-RELATED COST	594909	3252297	.182920	226104	41359	87
88 NON PHYSICIAN ANESTHETIST		3252297		226104		88
89 MEDICAL EDUCATION		3252297		226104		89

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[] TITLE V [XX] HOSPITAL (15-0167) [] SNF [XX] PPS
 [XX] TITLE XVIII-PT A [] SUB I [] NF [] TEFRA
 [] TITLE XIX [] SUB II [] S/B-SNF [] OTHER
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		1684172		25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.219546	4489047	985552	37
40 ANESTHESIOLOGY	.478625	392061	187650	40
41 RADIOLOGY-DIAGNOSTIC	.706052	291363	205717	41
44 LABORATORY	.331216	365326	121002	44
46 WHOLE BLOOD & PACKED RED BLOOD	.843015	42970	36224	46
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.628715	104589	65757	49
50 PHYSICAL THERAPY	.377955	562442	212578	50
55 MEDICAL SUPPLIES CHARGED TO PAT	.370748	20374804	7553918	55
56 DRUGS CHARGED TO PATIENTS	.216268	1201673	259883	56
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	.703812	455	320	60
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.669452			62
63.50 RHC				63.50
63.60 FQHC				63.60
101 TOTAL		27824730	9628601	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		27824730		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL (15-0167)	SUB I	SUB II	SUB III	SUB IV	
DRG AMOUNT						
1 OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1	4293813					1
1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1	1431271					1.01
1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS						1.02
1.03 PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1	2118760					1.03
1.04 PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1	706253					1.04
1.05 PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1						1.05
1.06 ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED						1.06
1.07 PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.07
1.08 SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.08
2 OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01 OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997 INDIRECT MEDICAL EDUCATION ADJUSTMENT	1397297					2.01
3 BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD	29.49					3
3.01 NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I						3.01
3.02 INDIRECT MEDICAL EDUCATION PERCENTAGE						3.02
3.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.03
3.04 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996						3.04
3.05 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.05
3.06 ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [FOR CR PERIODS ENDING] [ON OR AFTER 7/1/2005] [E-3,PT.VI, LN.15][PLUS LN.3.06]	0.75					3.06
3.07 SUM OF LINES 3.04-3.06		0.00	0.75			3.07
3.08 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	0.53					3.08
3.09 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1						3.09
3.10 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1						3.10
3.11 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09						3.11
3.12 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10						3.12
3.13 FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS						3.13
3.14 CURRENT YEAR ALLOWABLE FTE	0.53					3.14
3.15 TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.15
3.16 TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE.. RES. IN INIT YRS						3.16
3.17 SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO		0.00	0.18			3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL (15-0167)	SUB I	SUB II	SUB III	SUB IV	
3.18	CURRENT YEAR RESIDENT TO BED RATIO	0.006104				3.18
3.19	PRIOR YEAR RESIDENT TO BED RATIO	1.000000				3.19
3.20	FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19	0.006104				3.20
3.21	IME PAYMENTS FOR DSCHGS OCCURRING PRIOR TO OCTOBER 1	21367				3.21
3.22	IME PAYMENTS FOR DSCHGS AFTER SEP 30 BUT BEFORE JAN 1	7122				3.22
3.23	IME PAYMENTS FOR DSCHGS OCCURRING ON OR AFTER JANUARY 1 [SUM OF LINES][PLUS E-3,PT.VI] [3.21-3.23][LINE 23]					3.23
3.24	SUM OF LINES 3.21-3.23 DISPROPORTIONATE SHARE ADJUSTMENT	28489 0	28489			3.24
4	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS					4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS					4.01
4.02	SUM OF 4 AND 4.01					4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE					4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES					4.04
5	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317					5
5.01	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, 316 AND 317					5.01
5.02	DIVIDE LINE 5.01 BY LINE 5					5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs 302, 316 AND 317					5.03
5.04	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK					5.04
5.05	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS					5.05
5.06	TOTAL ADDITIONAL PAYMENT					5.06
6	SUBTOTAL	7150870				6
7	HOSPITAL SPECIFIC PAYMENTS					7
7.01	HOSPITAL SPECIFIC PAYMENTS (1996 HSR)					7.01
8	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS	7150870				8
9	PAYMENT FOR INPATIENT PROGRAM CAPITAL	572896				9
10	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL					10
11	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT	29864				11
11.01	NURSING AND ALLIED HEALTH MANAGED CARE					11.01
11.02	ADD-ON PAYMENT FOR NEW TECHNOLOGIES					11.02
12	NET ORGAN ACQUISITION COST					12
13	COST OF TEACHING PHYSICIANS					13
14	ROUTINE SERVICE OTHER PASS THROUGH COSTS					14
15	ANCILLARY SERVICE OTHER PASS THROUGH COSTS					15
16	TOTAL	7753630				16
17	PRIMARY PAYER PAYMENTS					17
18	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES	7753630				18
19	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	499403				19
20	COINSURANCE BILLED TO PROGRAM BENEFICIARIES					20
21	REIMBURSABLE BAD DEBTS	28405				21
21.01	REDUCED PROGRAM REIMBURSABLE BAD DEBTS	19884				21.01
21.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	26357				21.02
22	SUBTOTAL	7274111				22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL (15-0167)	SUB I	SUB II	SUB III	SUB IV	
23						23
24						24
25						25
26	7274111					26
27						27
28	7135724					28
28.01						28.01
29	138387					29
30						30
50						50
51						51
52						52
53						53
54						54
55						55
56						56

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (15-0167)	HOSPITAL (15-0167)	HOSPITAL (15-0167)	
	1	1.01	1.02	
1 MEDICAL AND OTHER SERVICES				1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000	909350			1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS	948707			1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04 LINE 1.01 TIMES LINE 1.03				1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST				5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES				6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10 TOTAL REASONABLE CHARGES				10
CUSTOMARY CHARGES				
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12 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)				12
13 RATIO OF LINE 11 TO LINE 12				13
14 TOTAL CUSTOMARY CHARGES				14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES				17
17.01 TOTAL PPS PAYMENTS	948707			17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (15-0167) 1	HOSPITAL (15-0167) 1.01	HOSPITAL (15-0167) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES AND COINSURANCE			18
18.01 DEDUCTIBLES AND COINSURANCE RELATING TO LINE 17.01	193498		18.01
19 SUBTOTAL	755209		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	2523		21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	757732		23
24 PRIMARY PAYER PAYMENTS			24
25 SUBTOTAL	757732		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	25110		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	17577		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	25016		27.02
28 SUBTOTAL	775309		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	775309		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	755209		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	20100		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCT			51
52 THE RATE USED TO CALCULATE THE TIME VALUE			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 HOSPITAL (15-0167)

WORKSHEET E-1

DESCRIPTION	INPATIENT PART A		PART B		
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		7135724		748605	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		6604	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM					
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .01				3.01
REVISION OF THE INTERIM RATE FOR THE COST	TO .02				3.02
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .03	NONE		NONE	3.03
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .04				3.04
	.05				3.05
	.50				3.50
	PROVIDER .51				3.51
	TO .52	NONE		NONE	3.52
	PROGRAM .53				3.53
	.54				3.54
SUBTOTAL	.99				3.99
4 TOTAL INTERIM PAYMENTS		7135724		755209	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				5.01
	TO .02				5.02
	PROVIDER .03				5.03
	PROVIDER .50				5.50
	TO .51				5.51
	PROGRAM .52				5.52
SUBTOTAL	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01				6.01
	PROVIDER TO .02				6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY					7

NAME OF INTERMEDIARY: _____
 SIGNATURE OF AUTHORIZED PERSON: _____

INTERMEDIARY NUMBER: _____
 DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
 PART III

	[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX			NF I	
		HOSPITAL (15-0167) (PPS)	SUB I	SUB II	SUB III	SUB IV	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1
1	INPATIENT HOSPITAL/SNF/NF SERVICES						1
2	MEDICAL AND OTHER SERVICES	183196					2
3	INTERNS AND RESIDENTS						3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O						4
5	COST OF TEACHING PHYSICIANS						5
6	SUBTOTAL	183196					6
7	INPATIENT PRIMARY PAYER PAYMENTS						7
8	OUTPATIENT PRIMARY PAYER PAYMENTS						8
9	SUBTOTAL	183196					9
	COMPUTATION OF LESSER OF COST OR CHARGES						
10	ROUTINE SERVICE CHARGES						10
11	ANCILLARY SERVICE CHARGES	1718124					11
12	INTERNS AND RESIDENTS SERVICE CHARGES						12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE						13
14	TEACHING PHYSICIANS						14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION						15
16	TOTAL REASONABLE CHARGES	1718124					16
	CUSTOMARY CHARGES						
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						18
19	RATIO OF LINE 17 TO LINE 18						19
20	TOTAL CUSTOMARY CHARGES	1718124					20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	1534928					21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						22
23	COST OF COVERED SERVICES	183196					23
	PROSPECTIVE PAYMENT AMOUNT						
24	OTHER THAN OUTLIER PAYMENTS						24
25	OUTLIER PAYMENTS						25
26	PROGRAM CAPITAL PAYMENTS						26
27	CAPITAL EXCEPTION PAYMENTS						27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS						28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						29
30	SUBTOTAL	183196					30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED)						31
32	LESSER OF LINES 30 OR 31						32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)						33

CALCULATION OF REIMBURSEMENT SETTLEMENT
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
 PART III

	[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX			
	HOSPITAL (15-0167) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I
	1	1	1	1	1	1
34	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
35	EXCESS OF REASONABLE COST					34
36	SUBTOTAL					35
37	COINSURANCE					36
38	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,					37
38	REIMBURSABLE BAD DEBTS					38
38.01	REDUCED REIMBURSABLE BAD DEBTS					38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)					38.02
39	UTILIZATION REVIEW					39
40	SUBTOTAL					40
41	INPATIENT ROUTINE SERVICE COST					41
42	MEDICARE INPATIENT ROUTINE CHARGES					42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE					43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)					44
45	RATIO OF LINE 43 TO LINE 44					45
46	TOTAL CUSTOMARY CHARGES					46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST					47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES					48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION					49
50	OTHER ADJUSTMENTS					50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS					51
52	SUBTOTAL					52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT					53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS					54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER					55
56	SEQUESTRATION ADJUSTMENT					56
57	INTERIM PAYMENTS					57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					57.01
58	BALANCE DUE PROVIDER/PROGRAM					58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2					59

DIRECT GRADUATE MEDICAL EDUCATION (GME)
 & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3
 PART IV

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT		Col. 0	Col. 1	
1	NUMBER OF FTE RESIDENTS FOR OB/GYN & PRIMARY CARE			1
1.01	NUMBER OF FTE RESIDENTS FOR ALL OTHERS			1.01
2	UPDATED PER RESIDENT AMOUNT FOR OB/GYN & PRIMARY CARE			2
2.01	UPDATED PER RESIDENT AMOUNT FOR ALL OTHERS			2.01
3	AGGREGATE APPROVED AMOUNT			3
3.01	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR CR PERIODS ENDING ON OR BEFORE DEC 31, 1996			3.01
3.02	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(6)			3.02
3.03	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(4) [E-3,PT.VI,LN.4] [PLUS LINE 3.03]			3.03
3.04	FTE ADJUSTMENT CAP			3.04
3.05	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR			3.05
3.06	LESSER OF LINE 3.04 OR LINE 3.05			3.06
3.07	WEIGHTED FTE COUNT FOR PRIMARY CARE PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO			3.07
3.08	WEIGHTED FTE COUNT FOR ALL OTHER PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO		0.53	3.08
3.09	SUM OF LINES 3.07 AND LINE 3.08		0.53	3.09
3.10	SEE INSTRUCTIONS		0.53	3.10
3.11	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO			3.11
3.12	SEE INSTRUCTIONS		0.53	3.12
3.13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR CR YEAR. (SEE INSTRUCTIONS)			3.13
3.14	TOTAL WEIGHTED RESIDENT FTE COUNT FOR PENULTIMATE CR YEAR. (SEE INSTRUCTIONS)	1.00		3.14
3.15	ROLLING AVERAGE FTE COUNT (SEE INSTRUCTIONS)		0.18	3.15
3.16	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.53]		0.71	3.16
3.17	SEE INSTRUCTIONS		86268.66	3.17
3.18	SEE INSTRUCTIONS		61251	3.18

DIRECT GRADUATE MEDICAL EDUCATION (GME)
 & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3
 PART IV
 (CONT)

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

3.19	SEE INSTRUCTIONS			3.19
3.20	SEE INSTRUCTIONS			3.20
3.21	SEE INSTRUCTIONS			3.21
3.22	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.00]	0.00		3.22
3.23	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001	0.00		3.23
3.24	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001			3.24
3.25	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001	61251		3.25
COMPUTATION OF PROGRAM PATIENT LOAD				
4	PROGRAM PART A INPATIENT DAYS		1513	4
5	TOTAL INPATIENT DAYS		4042	5
6	RATIO OF PROGRAM INPATIENT DAYS TO TOTAL INPATIENT DAYS		.374320	6
		[LINE 6 x] [E-3,PART 6]		
		[LINE 3.25] [LINE 11]		
6.01	TOTAL GME PAYMENT FOR NON-MANAGED CARE DAYS 22927	0	22927	6.01
6.02	PROGRAM MANAGED CARE DAYS OCCURRING ON OR AFTER JAN 1 OF THIS COST REPORTING PERIOD		727	6.02
6.03	TOTAL INPATIENT DAYS FROM LINE 5 ABOVE		4042	6.03
6.04	APPROPRIATE PERCENTAGE FOR INCLUSION OF MANAGED CARE DAYS		100.00	6.04
6.05	GRADUATE MEDICAL EDUCATION PAYMENT FOR MANAGED CARE DAYS ON OR AFTER JAN 1 THROUGH THE END OF THE COST REPORTING PERIOD		9460	6.05
6.06	PROGRAM MANAGED CARE DAYS OCCURRING BEFORE JAN 1 OF THIS COST REPORTING YEAR			6.06
6.07	APPROPRIATE PERCENTAGE USING THE CRITERIA IDENTIFIED ON LINE 6.04 ABOVE		100.00	6.07
		[PRIOR TO] [E-3,PART 6]		
		[422] [LINE 12]		
6.08	GRAD.MED.ED.PAYMENT FOR MANAGED CARE DAYS PRIOR TO JAN 1 OF THIS COST REPORTING PERIOD	0	0	6.08
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
7	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS			7
8	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES			8
9	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES			9
10	MEDICARE O/P ESRD CHARGES			10
11	MEDICARE O/P ESRD DIRECT MEDICAL EDUCATION COSTS			11

PROVIDER NO. 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVI
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KPMG LLP COMPU-MAX MICRO SYSTEM
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DIRECT GRADUATE MEDICAL EDUCATION (GME)
& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3
PART IV
(CONT)

[] TITLE V

[XX] TITLE XVIII

[] TITLE XIX

APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY
PART A REASONABLE COST

12	REASONABLE COST	10761369	12
13	ORGAN ACQUISITION COSTS		13
14	COST OF TEACHING PHYSICIANS		14
15	PRIMARY PAYER PAYMENTS		15
16	TOTAL PART A REASONABLE COST	10761369	16
PART B REASONABLE COST			
17	REASONABLE COST	909350	17
18	PRIMARY PAYER PAYMENTS		18
19	TOTAL PART B REASONABLE COST	909350	19
20	TOTAL REASONABLE COST	11670719	20
21	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST	.922083	21
22	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST	.077917	22

ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B

23	TOTAL PROGRAM GME PAYMENT		23
23.01	FOR COST REPORTING PERIODS ENDING ON OR AFTER JAN 1, 1998	32387	23.01
24	PART A MEDICARE GME PAYMENT - TITLE XVIII ONLY	29864	24
25	PART B MEDICARE GME PAYMENT - TITLE XVIII ONLY	2523	25

DIRECT GRADUATE MEDICAL EDUCATION (GME)
 & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3
 PART IV

[] TITLE V [] TITLE XVIII [XX] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT		Col. 0	Col. 1	
1	NUMBER OF FTE RESIDENTS FOR OB/GYN & PRIMARY CARE			1
1.01	NUMBER OF FTE RESIDENTS FOR ALL OTHERS			1.01
2	UPDATED PER RESIDENT AMOUNT FOR OB/GYN & PRIMARY CARE			2
2.01	UPDATED PER RESIDENT AMOUNT FOR ALL OTHERS			2.01
3	AGGREGATE APPROVED AMOUNT			3
3.01	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR CR PERIODS ENDING ON OR BEFORE DEC 31, 1996			3.01
3.02	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(6)			3.02
3.03	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(4) [E-3,PT.VI,LN.4] [PLUS LINE 3.03]			3.03
3.04	FTE ADJUSTMENT CAP			3.04
3.05	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR			3.05
3.06	LESSER OF LINE 3.04 OR LINE 3.05			3.06
3.07	WEIGHTED FTE COUNT FOR PRIMARY CARE PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO			3.07
3.08	WEIGHTED FTE COUNT FOR ALL OTHER PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO			3.08
3.09	SUM OF LINES 3.07 AND LINE 3.08			3.09
3.10	SEE INSTRUCTIONS			3.10
3.11	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO			3.11
3.12	SEE INSTRUCTIONS			3.12
3.13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR CR YEAR. (SEE INSTRUCTIONS)			3.13
3.14	TOTAL WEIGHTED RESIDENT FTE COUNT FOR PENULTIMATE CR YEAR. (SEE INSTRUCTIONS)			3.14
3.15	ROLLING AVERAGE FTE COUNT (SEE INSTRUCTIONS)			3.15
3.16	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.00]			3.16
3.17	SEE INSTRUCTIONS			3.17
3.18	SEE INSTRUCTIONS			3.18

DIRECT GRADUATE MEDICAL EDUCATION (GME)
 & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3
 PART IV
 (CONT)

[] TITLE V [] TITLE XVIII [XX] TITLE XIX

3.19	SEE INSTRUCTIONS		3.19
3.20	SEE INSTRUCTIONS		3.20
3.21	SEE INSTRUCTIONS		3.21
3.22	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.00]	0.00	3.22
3.23	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001	0.00	3.23
3.24	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001		3.24
3.25	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001		3.25
COMPUTATION OF PROGRAM PATIENT LOAD			
4	PROGRAM PART A INPATIENT DAYS	47	4
5	TOTAL INPATIENT DAYS	4042	5
6	RATIO OF PROGRAM INPATIENT DAYS TO TOTAL INPATIENT DAYS [LINE 6 x] [E-3,PART 6] [LINE 3.25] [LINE 11]	.011628	6
6.01	TOTAL GME PAYMENT FOR NON-MANAGED CARE DAYS 0 0		6.01
6.02	PROGRAM MANAGED CARE DAYS OCCURRING ON OR AFTER JAN 1 OF THIS COST REPORTING PERIOD		6.02
6.03	TOTAL INPATIENT DAYS FROM LINE 5 ABOVE	4042	6.03
6.04	APPROPRIATE PERCENTAGE FOR INCLUSION OF MANAGED CARE DAYS	100.00	6.04
6.05	GRADUATE MEDICAL EDUCATION PAYMENT FOR MANAGED CARE DAYS ON OR AFTER JAN 1 THROUGH THE END OF THE COST REPORTING PERIOD		6.05
6.06	PROGRAM MANAGED CARE DAYS OCCURRING BEFORE JAN 1 OF THIS COST REPORTING YEAR		6.06
6.07	APPROPRIATE PERCENTAGE USING THE CRITERIA IDENTIFIED ON LINE 6.04 ABOVE	100.00	6.07
6.08	GRAD.MED.ED.PAYMENT FOR MANAGED CARE DAYS PRIOR TO JAN 1 OF THIS COST REPORTING PERIOD [PRIOR TO] [E-3,PART 6] [422] [LINE 12]	0 0	6.08
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
7	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS		7
8	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES		8
9	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES		9
10	MEDICARE O/P ESRD CHARGES		10
11	MEDICARE O/P ESRD DIRECT MEDICAL EDUCATION COSTS		11

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DIRECT GRADUATE MEDICAL EDUCATION (GME)
& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3
PART IV
(CONT)

[] TITLE V

[] TITLE XVIII

[XX] TITLE XIX

APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY

PART A REASONABLE COST

12	REASONABLE COST	12
13	ORGAN ACQUISITION COSTS	13
14	COST OF TEACHING PHYSICIANS	14
15	PRIMARY PAYER PAYMENTS	15
16	TOTAL PART A REASONABLE COST	16

PART B REASONABLE COST

17	REASONABLE COST	17
18	PRIMARY PAYER PAYMENTS	18
19	TOTAL PART B REASONABLE COST	19
20	TOTAL REASONABLE COST	20
21	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST	21
22	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST	22

ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B

23	TOTAL PROGRAM GME PAYMENT	23
23.01	FOR COST REPORTING PERIODS ENDING ON OR AFTER JAN 1, 1998	23.01
24	PART A MEDICARE GME PAYMENT - TITLE XVIII ONLY	24
25	PART B MEDICARE GME PAYMENT - TITLE XVIII ONLY	25

CALCULATION OF GME AND IME PAYMENTS FOR
REDISTRIBUTION OF UNUSED RESIDENCY SLOTS

WORKSHEET E-3
PART VI

[] TITLE V

[XX] TITLE XVIII

[] TITLE XIX

1	CALCULATION OF REDUCED DIRECT GME CAP UNDER SECTION 422 OF MMA		
1	RATIO OF DAYS OCCURRING ON OR AFTER 7/1/2005 TO TOTAL DAYS IN THE COST REPORTING PERIOD	1.000000	1
2	REDUCED DIRECT GME FTE CAP (SEE INSTRUCTIONS)		2
3	UNADJUSTED DIRECT GME FTE CAP		3
4	PRORATED REDUCED DIRECT GME FTE CAP (SEE INSTRUCTIONS)		4
5	CALCULATION OF ADDITIONAL DIRECT GME PAYMENT ATTRIBUTABLE TO SECTION 422 OF MMA		
5	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC.413.79(c)(4)		5
5.01	PRORATED ADDITIONAL UNWEIGHTED DIRECT GME FTE RESIDENT CAP SLOTS		5.01
6	GME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		6
7	ALLOWABLE DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)		7
8	LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)		8
9	LINE 7 TIMES LINE 8		9
10	MEDICARE PGM PATIENT LOAD FROM WKST E-3, PART IV, LINE 6		10
11	DIRECT GME PAYMENT FOR NON-MANAGED CARE DAYS		11
12	DIRECT GME PAYMENT FOR MANAGED CARE DAYS		12
13	CALCULATION OF REDUCED IME CAP UNDER SECTION 422 OF MMA		
13	REDUCED IME FTE CAP (SEE INSTRUCTIONS)		13
14	UNADJUSTED IME FTE CAP		14
15	PRORATED REDUCED ALLOWABLE FTE CAP		15
16	CALCULATION OF ADDITIONAL IME PAYMENTS ATTRIBUTABLE TO SECTION 422 OF MMA		
16	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC.412.105(f)(1)(iv)(C)		16
17	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		17
18	SEE INSTRUCTIONS		18
19	RESIDENT TO BED COUNT		19
20	IME ADJUSTMENT FACTOR (SEE INSTRUCTIONS)		20
21	DRG OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES ON OR AFTER JULY 1, 2005		21
22	SIMULATED MEDICARE MANAGED CARE PAYMENTS FOR DISCHARGES ON OR AFTER JULY 1, 2005		22
23	ADDITIONAL IME PAYMENTS ATTRIBUTABLE TO SECTION 422 OF MMA		23

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	6266982			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	9482874			4
5	OTHER RECEIVABLES	58000			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	46154			7
8	PREPAID EXPENSES	415178			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS	16269188			11
FIXED ASSETS					
12	LAND				12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS				13
13.01	ACCUMULATED DEPRECIATION				13.01
14	BUILDINGS				14
14.01	ACCUMULATED DEPRECIATION				14.01
15	LEASEHOLD IMPROVEMENTS				15
15.01	ACCUMULATED AMORTIZATION				15.01
16	FIXED EQUIPMENT				16
16.01	ACCUMULATED DEPRECIATION				16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT	2476907			18
18.01	ACCUMULATED DEPRECIATION	-1131032			18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	1345875			21
OTHER ASSETS					
22	INVESTMENTS				22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	24570770			25
26	TOTAL OTHER ASSETS	24570770			26
27	TOTAL ASSETS	42185833			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	4178597			28
29	SALARIES, WAGES & FEES PAYABLE				29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)				31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS				34
35	OTHER CURRENT LIABILITIES	153566			35
36	TOTAL CURRENT LIABILITIES	4332163			36
LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE				37
38	NOTES PAYABLE	899983			38
39	UNSECURED LOANS				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41	OTHER LONG TERM LIABILITIES	30056			41
42	TOTAL LONG TERM LIABILITIES	930039			42
43	TOTAL LIABILITIES	5262202			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	36923631			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES	36923631			51
52	TOTAL LIABILITIES AND FUND BALANCES	42185833			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	31281704			1
2 NET INCOME (LOSS)	18831368			2
3 TOTAL	50113072			3
4 ADDITIONS (CREDIT ADJUSTMENTS)	5274201			4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS	5274201			10
11 SUBTOTAL	55387273			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13 TRANSFERS	18463642			13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS	18463642			18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	36923631			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	4604094		4604094	2
4 SUBPROVIDER I				4
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	4604094		4604094	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE	4604094		4604094	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES	84624483	22780950	107405433	18
18.50 ANCILLARY SERVICES				18.50
18.60 OUTPATIENT SERVICES				18.60
19 RHC				19
20 FQHC				20
21 HOME HEALTH AGENCY				21
22 AMBULANCE				22
23 CORF				23
24 ASC				24
25 HOSPICE				25
TOTAL PATIENT REVENUES	89228577	22780950	112009527	

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		37970225	26
27 **ADD (SPECIFY)**			27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS			33
34 **DEDUCT (SPECIFY)** ROUNDING			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		37970225	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	112009527	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	56352108	2
3	NET PATIENT REVENUES	55657419	3
4	LESS - TOTAL OPERATING EXPENSES	37970225	4
5	NET INCOME FROM SERVICE TO PATIENTS	17687194	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	170507	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		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	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)		24
24.02	OTHER OPERATING INCOME	997152	24.02
24.06	ROUNDING	3	24.06
25	TOTAL OTHER INCOME	1167662	25
26	TOTAL	18854856	26
27			27
28	INTEREST EXPENSE	23488	28
29			29
30	TOTAL OTHER EXPENSES	23488	30
31	NET INCOME (OR LOSS) FOR THE PERIOD	18831368	31

CALCULATION OF CAPITAL PAYMENT - TITLE XVIII - FULLY PROSPECTIVE METHOD

WORKSHEET L

	HOSPITAL (15-0167)	HOSPITAL (15-0167)	SUB I	SUB II	SUB III
	1	1.01			
PART I - FULLY PROSPECTIVE METHOD					
1					1
CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS					
CAPITAL FEDERAL AMOUNT					
2	477674				2
CAPITAL DRG OTHER THAN OUTLIER					
3					3
CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997					
3.01	93072				3.01
CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1997					
INDIRECT MEDICAL EDUCATION ADJUSTMENT					
4	11.34				4
TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD [E-3,PT VI, LN.18]					
4.01	0.18	0.00	0.18		4.01
NO. OF INTERNS & RESIDENTS					
4.02			0.45		4.02
INDIRECT MEDICAL EDUCATION PERCENTAGE					
4.03			2150		4.03
INDIRECT MEDICAL EDUCATION ADJUSTMENT DISPROPORTIONATE SHARE ADJUSTMENT					
5					5
% OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS					
5.01					5.01
% OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I					
5.02					5.02
SUM OF LINES 5 AND 5.01					
5.03					5.03
ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE					
5.04					5.04
DISPROPORTIONATE SHARE ADJUSTMENT					
6	572896				6
TOTAL PROSPECTIVE CAPITAL PAYMENTS					
PART II - HOLD HARMLESS METHOD					
1					1
NEW CAPITAL					
2					2
OLD CAPITAL					
3					3
TOTAL CAPITAL					
4					4
RATIO OF NEW CAPITAL TO TOTAL CAPITAL					
5					5
TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE					
6					6
REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT					
7					7
REDUCED OLD CAPITAL AMOUNT					
8					8
HOLD HARMLESS PAYMENT FOR NEW CAPITAL					
9					9
SUBTOTAL					
10					10
PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)					
PART III - PAYMENT UNDER REASONABLE COST					
1					1
PROGRAM INPATIENT ROUTINE CAPITAL COST					
2					2
PROGRAM INPATIENT ANCILLARY CAPITAL COST					
3					3
TOTAL INPATIENT PROGRAM CAPITAL					
4					4
CAPITAL COST PAYMENT FACTOR					
5					5
TOTAL INPATIENT PROGRAM CAPITAL COST					
PART IV - COMPUTATION OF EXCEPTION PAYMENTS					
1					1
PROGRAM INPATIENT CAPITAL COSTS					
2					2
PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES					
3					3
NET PROGRAM INPATIENT CAPITAL COSTS					
4					4
APPLICABLE EXCEPTION PERCENTAGE					
5					5
CAPITAL COST FOR COMPARISON TO PAYMENTS					
6					6
PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES					
7					7
ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES					
8					8
CAPITAL MINIMUM PAYMENT LEVEL					
9					9
CURRENT YEAR CAPITAL PAYMENTS					
10					10
CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS					
11					11
CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT					
12					12
NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS					
13					13
CURRENT YEAR EXCEPTION PAYMENT					
14					14
CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD					
15					15
CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)					
16					16
CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)					
17					17
CURRENT YEAR EXCEPTION OFFSET AMOUNT					

CALCULATION OF CAPITAL PAYMENT - TITLE XIX - COST METHOD

WORKSHEET L

	HOSPITAL (15-0167)	HOSPITAL (15-0167)	SUB I	SUB II	SUB III
	1	1.01			
PART I - FULLY PROSPECTIVE METHOD					
1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS				1
	CAPITAL FEDERAL AMOUNT				
2	CAPITAL DRG OTHER THAN OUTLIER				2
3	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997				3
3.01	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1997				3.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT				
4	TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD				4
4.01	NUMBER OF INTERNS AND RESIDENTS FROM WORKSHEET S-3, PART I				4.01
4.02	INDIRECT MEDICAL EDUCATION PERCENTAGE				4.02
4.03	INDIRECT MEDICAL EDUCATION ADJUSTMENT DISPROPORTIONATE SHARE ADJUSTMENT				4.03
5	% OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS				5
5.01	% OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I				5.01
5.02	SUM OF LINES 5 AND 5.01				5.02
5.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE				5.03
5.04	DISPROPORTIONATE SHARE ADJUSTMENT				5.04
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS				6
PART II - HOLD HARMLESS METHOD					
1	NEW CAPITAL				1
2	OLD CAPITAL				2
3	TOTAL CAPITAL				3
4	RATIO OF NEW CAPITAL TO TOTAL CAPITAL				4
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE				5
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT				6
7	REDUCED OLD CAPITAL AMOUNT				7
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL				8
9	SUBTOTAL				9
10	PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)				10
PART III - PAYMENT UNDER REASONABLE COST					
1	PROGRAM INPATIENT ROUTINE CAPITAL COST				1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST				2
3	TOTAL INPATIENT PROGRAM CAPITAL				3
4	CAPITAL COST PAYMENT FACTOR				4
5	TOTAL INPATIENT PROGRAM CAPITAL COST				5
PART IV - COMPUTATION OF EXCEPTION PAYMENTS					
1	PROGRAM INPATIENT CAPITAL COSTS				1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES				2
3	NET PROGRAM INPATIENT CAPITAL COSTS				3
4	APPLICABLE EXCEPTION PERCENTAGE				4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS				5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES				6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES				7
8	CAPITAL MINIMUM PAYMENT LEVEL				8
9	CURRENT YEAR CAPITAL PAYMENTS				9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS				10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT				11
12	NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS				12
13	CURRENT YEAR EXCEPTION PAYMENT				13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD				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				17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	4A	25	26	27
GENERAL SERVICE COST CENTERS					
1 OLD CAP REL COSTS-BLDG & FIXT					1
2 OLD CAP REL COSTS-MVBLE EQUIP					2
3 NEW CAP REL COSTS-BLDG & FIXT					3
4 NEW CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6 ADMINISTRATIVE & GENERAL					6
7 MAINTENANCE & REPAIRS					7
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING					10
11 DIETARY					11
12 CAFETERIA					12
13 MAINTENANCE OF PERSONNEL					13
14 NURSING ADMINISTRATION					14
15 CENTRAL SERVICES & SUPPLY					15
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY					17
18 SOCIAL SERVICE					18
20 NONPHYSICIAN ANESTHETISTS					20
21 NURSING SCHOOL					21
22 I&R SERVICES-SALARY & FRINGES					22
23 I&R SERVICES-OTHER PRGM COSTS					23
24 PARAMED ED PRGM-(SPECIFY)					24
INPATIENT ROUTINE SERV COST CENTERS					
25 ADULTS & PEDIATRICS					25
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46 WHOLE BLOOD & PACKED RED BLOOD					46
46.30 BLOOD CLOTTING FACTORS ADMIN C					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
55 MEDICAL SUPPLIES CHARGED TO PA					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
62 OBSERVATION BEDS (NON-DISTINCT					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
69.10 CMHC					69.10
69.20 OUTPATIENT PHYSICAL THERAPY					69.20
69.30 OUTPATIENT OCCUPATIONAL THERAP					69.30
69.40 OUTPATIENT SPEECH PATHOLOGY					69.40
71 HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS					
85.01 PANCREAS ACQUISITION					85.01
85.02 INTESTINAL ACQUISITION					85.02
85.03 ISLET CELL ACQUISITION					85.03
95 SUBTOTALS					95
NONREIMBURSABLE COST CENTERS					
100 STUDENT NURSE PROGRAM					100
101 CROSS FOOT ADJUSTMENTS					101
102 NEGATIVE COST CENTER					102
103 TOTAL					103
104 TOTAL STATISTICAL BASIS					104
105 UNIT COST MULTIPLIER					105
105 UNIT COST MULTIPLIER					105

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
25 ADULTS & PEDIATRICS	34.83		1.08				35.91 25
UTILIZATION PERCENTAGES BASED ON CHARGES							
37 OPERATING ROOM	19.85	5.46	3.70	1.92			30.93 37
40 ANESTHESIOLOGY	18.31	6.93	0.62	1.31			27.17 40
41 RADIOLOGY-DIAGNOSTIC	26.96	4.74	1.00	0.70			33.40 41
44 LABORATORY	32.67	0.65	1.05	0.32			34.69 44
46 WHOLE BLOOD & PACKED RED BLOOD	53.79		0.76				54.55 46
49 RESPIRATORY THERAPY	36.83	0.62	1.07	0.04			38.56 49
50 PHYSICAL THERAPY	36.93		1.12				38.05 50
55 MEDICAL SUPPLIES CHARGED TO PAT	29.26	1.10	0.19	0.20			30.75 55
56 DRUGS CHARGED TO PATIENTS	25.93	20.46	0.72	0.61			47.72 56
60 CLINIC	66.72						66.72 60
62 OBSERVATION BEDS (NON-DISTINCT		17.19		4.04			21.23 62
101 TOTAL CHARGES	25.78	2.98	0.98	0.61			30.35 101

COST CENTER		--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
71	HOME HEALTH AGENCY							71
	SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION							85.01
85.02	INTESTINAL ACQUISITION							85.02
85.03	ISLET CELL ACQUISITION							85.03
	NONREIMBURSABLE COST CENTERS							
100	STUDENT NURSE PROGRAM	78300	.21	18504	.17	96804	.25	100
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	38109787	100.00	0	.00	38109787	100.00	103

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	1919918	22612746	.084904	4489047	381138	37
40 ANESTHESIOLOGY	30786	2141410	.014377	392061	5637	40
41 RADIOLOGY-DIAGNOSTIC	22919	1080700	.021208	291363	6179	41
44 LABORATORY	11127	1118389	.009949	365326	3635	44
46 WHOLE BLOOD & PACKED RED BLOOD	2023	79880	.025325	42970	1088	46
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	5364	284011	.018887	104589	1975	49
50 PHYSICAL THERAPY	48763	1523001	.032018	562442	18008	50
55 MEDICAL SUPPLIES CHARGED TO PAT	775372	69625538	.011136	20374804	226894	55
56 DRUGS CHARGED TO PATIENTS	30103	4634018	.006496	1201673	7806	56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	14	682	.020528	455	9	60
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	41359	337745	.122456			62
63.50 RHC						63.50
63.60 FQHC						63.60
101 TOTAL	2887748	103438120		27824730	652369	101

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION		CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	TOTAL COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7
INPATIENT ROUTINE SERVICE COST CENTERS								
25	ADULTS & PEDIATRICS	594909		594909	4344	136.95	1513	207205 25
101	TOTAL	594909		594909			1513	207205 101
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS							207205	
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS							652369	
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS							859574	
MEDICARE DISCHARGES (WORKSHEET S-3, LINE 12, COLUMN 13)							520	
MEDICARE PATIENT DAYS (WORKSHEET S-3, LINE 12, COLUMN 4)							1513	
PER DISCHARGE CAPITAL COSTS							1653.03	
PER DIEM CAPITAL COSTS							568.13	

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	9901795
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-4 FOR HOSPITAL TITLE XVIII COMPONENT)	29508902
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.336

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 25-30, COLS 10 & 12 + WKST D PART II, LINE 101, COLS 6 & 8)	859574
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	.029

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	909350
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	3214403
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.283