

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 05-31-2012 TIME: 10:03
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY COMMUNITY HOSPT. OF LAGRANGE CTY IN (15-1323) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2011 AND ENDING 12/31/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		-183,643	28,448		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF		-79,986			5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC					10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-263,629	28,448		200

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 207 NORTH TOWNLINE ROAD

2 CITY: LAGRANGE

STATE: IN

P.O.BOX:

ZIP CODE: 46761-1325 COUNTY: LAGRANGE

1

2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			3
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	15-1323	99915	1	05/01/2005	N	O	P	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF	15-2323	99915		05/01/2005	N	O	N	7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA								12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC								15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2011			TO: 12/31/2011				20
21	TYPE OF CONTROL								21

INPATIENT PPS INFORMATION

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

		IN-STATE	IN-STATE	OUT-OF	OUT-OF	MEDICAID	OTHER	
		MEDICAID	MEDICAID	STATE	STATE			
		PAID	ELIGIBLE	PAID	ELIGIBLE	HMO	MEDICAID	
		DAYS	DAYS	DAYS	DAYS	DAYS	DAYS	
		1	2	3	4	5	6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:		ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:		ENDING:	38

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2
 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY
 CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-
 PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY
 CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5
 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE
 INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1 / (COL.3 + COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER?			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			N N 107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		250,000 5,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	15H032	140
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IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME: PARKVIEW HEALTH SYSTEM, INC. CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICES CONTRACTOR'S NUMBER: 8			141
142	STREET: 10501 CORPORATE DRIVE P.O. BOX: 5600			142
143	CITY: FORT WAYNE STATE: IN ZIP CODE: 46845			143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	Y	01/23/2012	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

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

MULTICAMPUS

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(m)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.			169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1	
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	N		4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N	Y/N		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
			Y/N		
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		N	12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N	15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

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

HOME OFFICE COSTS

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

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
	1	2	3	4	5	6
SALARIES						
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	12,063,543	-2,260,331		1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A					4
4.01	PHYSICIANS-PART A - DIRECT TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)					7.01
8	HOME OFFICE PERSONNEL					8
9	SNF	44				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		797,676	63,391		10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)					11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A					15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)					16
WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)					17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS					19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A					22
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)					25
OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS		903,335	-905,051		26
27	ADMINISTRATIVE & GENERAL		4,952,062	-2,168,939		27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT		239,160	19,425		30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING		136,480	11,085		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY		297,244	-152,821		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA			174,890		36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION		164,506	13,361		38
39	CENTRAL SERVICES AND SUPPLY		22,148	146,918		39
40	PHARMACY		378,041	30,705		40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY			165,704		41
42	SOCIAL SERVICE					42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	12,063,543	-2,260,331	9,803,212		1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	797,676	63,391	861,067		2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	11,265,867	-2,323,722	8,942,145		3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)					4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)					5
6	TOTAL (SUM OF LINES 3 THRU 5)	11,265,867	-2,323,722	8,942,145		6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	7,092,976	-2,664,723	4,428,253		7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS		1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	209,754	2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	610,533	3
4 PRIOR YEAR PENSION SERVICE COST		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	25,953	7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	1,228,313	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN		10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	14,845	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	33,123	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	22,351	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES		
17 FICA-EMPLOYERS PORTION ONLY	727,847	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE		19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION	18,736	21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	18,598	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,910,053	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE				
		1	2				
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR REST OF THIS WORKSHEET.	N		1			
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N		2			
							TOTAL (COLS. 2 + 3)
	GROUP				SNF DAYS	SWING BED	
	1				2	3	4
3	RUX						3
4	RUL						4
5	RVX						5
6	RVL						6
7	RHX						7
8	RHL						8
9	RMX						9
10	RML						10
11	RLX						11
12	RUC						12
13	RUB						13
14	RUA						14
15	RVC						15
16	RVB						16
17	RVA						17
18	RHC						18
19	RHB						19
20	RHA						20
21	RMC						21
22	RMB						22
23	RMA						23
24	RLB						24
25	RLA						25
26	ES3						26
27	ES2						27
28	ES1						28
29	HE2						29
30	HE1						30
31	HD2						31
32	HD1						32
33	HC2						33
34	HC1						34
35	HB2						35
36	HB1						36
37	LE2						37
38	LE1						38
39	LD2						39
40	LD1						40
41	LC2						41
42	LC1						42
43	LB2						43
44	LB1						44
45	CE2						45
46	CE1						46
47	CD2						47
48	CD1						48
49	CC2						49
50	CC1						50
51	CB2						51
52	CB1						52
53	CA2						53
54	CA1						54
55	SE3						55
56	SE2						56
57	SE1						57
58	SSC						58
59	SSB						59
60	SSA						60
61	IB2						61
62	IB1						62
63	IA1						63
64	IA2						64
65	BB2						65
66	BB1						66
67	BA2						67
68	BA1						68

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		SNF	SWING BED	TOTAL
		DAYS	SNF DAYS	(COLS.
GROUP		2	3	2 + 3)
1				4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL			200

CBSA
 CBSA AT ON/AFTER
 BEGINNING OF THE COST
 OF COST REPORTING
 REPORTING PERIOD (IF
 PERIOD APPLICABLE)
 1 2

SNF SERVICES

201 ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY,
 IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN
 EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE). 201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 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. FOR LINES 202 THROUGH 207:
 ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY
 TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS
 INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

		EXPENSES	PERCENTAGE	ASSOCIATED
		1	2	WITH
				DIRECT
				PATIENT
				CARE AND
				RELATED
				EXPENSES? 3
202	STAFFING			202
203	RECRUITMENT			203
204	RETENTION OF EMPLOYEES			204
205	TRAINING			205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)			207

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)		0.411207	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)				
2	NET REVENUE FROM MEDICAID		776,424	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?			4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID			5
6	MEDICAID CHARGES		6,182,490	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)		2,542,283	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)		1,765,859	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)				
9	NET REVENUE FROM STAND-ALONE SCHIP			9
10	STAND-ALONE SCHIP CHARGES			10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)			11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)			12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)				
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)			13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)			14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)			15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)			16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)				
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS			18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)		1,765,859	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	928,259	676,894	1,605,153	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	381,707	278,344	660,051	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	1,448	5,244	6,692	22
23	COST OF CHARITY CARE	380,259	273,100	653,359	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM				N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)				25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			3,150,424	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			306,936	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			2,843,488	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,169,262	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,822,621	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			3,588,480	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		1,886,550	1,886,550	-534,491	1
1.01	00101				16,040	1.01
2	00200				836,451	2
2.01	00201				24,881	2.01
3	00300					3
4	00400	903,335	2,418,239	3,321,574	-905,051	4
5	00500	4,952,062	1,766,981	6,719,043	388,020	5
6	00600					6
7	00700	239,160	579,011	818,171	1,356	7
8	00800		75,532	75,532		8
9	00900	136,480	38,649	175,129	11,075	9
10	01000	297,244	190,230	487,474	-257,520	10
11	01100				279,081	11
12	01200					12
13	01300	164,506	1,088	165,594	13,361	13
14	01400	22,148	708	22,856	1,744	14
15	01500	378,041	750,797	1,128,838	-672,803	15
16	01600					16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,662,510	219,803	1,882,313	-375,980	30
43	04300				174,685	43
ANCILLARY SERVICE COST CENTERS						
50	05000	539,236	348,283	887,519	16,436	50
52	05200				329,895	52
53	05300		390,613	390,613		53
54	05400	502,645	520,693	1,023,338	-399	54
60	06000	207	682,897	683,104	-606	60
62.30	06250					62.30
65	06500	293,544	21,465	315,009	22,335	65
66	06600	559,478	16,525	576,003	-171,498	66
67	06700				126,486	67
68	06800				73,244	68
69	06900		46,535	46,535	-74	69
71	07100		602,090	602,090	-205,328	71
72	07200				204,385	72
73	07300				707,541	73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	33,455	314	33,769	4,790	90
91	09100	581,816	1,430,720	2,012,536	4,945	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	697,081	150,615	847,696	56,317	95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
113	11300		273,381	273,381	-269,830	113
118		11,962,948	12,411,719	24,374,667	-100,512	118
NONREIMBURSABLE COST CENTERS						
190	19000		8,422	8,422		190
192	19200		5,651	5,651	-635	192
194	07950		-99,459	-99,459	99,459	194
194.01	07951	18,099	7,049	25,148	1,470	194.01
194.03	07952	65,254	72,271	137,525	5,227	194.03
194.04	07954					194.04
194.06	07953	17,242	5,224	22,466	-5,009	194.06
200		12,063,543	12,410,877	24,474,420		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	1,352,059	46,929	1,398,988	1
1.01	00101	EMS WEST STATION	16,040		16,040	1.01
2	00200	CAP REL COSTS-MVBLE EQUIP	836,451	633,745	1,470,196	2
2.01	00201	EMS WEST STATION EQUIP.	24,881		24,881	2.01
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	2,416,523	186,634	2,603,157	4
5	00500	ADMINISTRATIVE & GENERAL	7,107,063	-2,817,579	4,289,484	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	819,527	-3,609	815,918	7
8	00800	LAUNDRY & LINEN SERVICE	75,532		75,532	8
9	00900	HOUSEKEEPING	186,204	-20	186,184	9
10	01000	DIETARY	229,954		229,954	10
11	01100	CAFETERIA	279,081	-154,363	124,718	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	178,955		178,955	13
14	01400	CENTRAL SERVICES & SUPPLY	24,600	181,977	206,577	14
15	01500	PHARMACY	456,035		456,035	15
16	01600	MEDICAL RECORDS & LIBRARY		261,321	261,321	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,506,333		1,506,333	30
43	04300	NURSERY	174,685		174,685	43
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	903,955		903,955	50
52	05200	DELIVERY ROOM & LABOR ROOM	329,895		329,895	52
53	05300	ANESTHESIOLOGY	390,613	-329,183	61,430	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,022,939	-1,557	1,021,382	54
60	06000	LABORATORY	682,498		682,498	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	337,344		337,344	65
66	06600	PHYSICAL THERAPY	404,505	-40,228	364,277	66
67	06700	OCCUPATIONAL THERAPY	126,486		126,486	67
68	06800	SPEECH PATHOLOGY	73,244	-12,036	61,208	68
69	06900	ELECTROCARDIOLOGY	46,461	-29,735	16,726	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	396,762		396,762	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	204,385		204,385	72
73	07300	DRUGS CHARGED TO PATIENTS	707,541	-226,578	480,963	73
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	CLINIC	38,559		38,559	90
91	09100	EMERGENCY	2,017,481	-683,602	1,333,879	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
95	09500	AMBULANCE SERVICES	904,013	-300	903,713	95
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE	3,551	-3,551		113
118		SUBTOTALS (SUM OF LINES 1-117)	24,274,155	-2,991,735	21,282,420	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,422		8,422	190
192	19200	PHYSICIANS' PRIVATE OFFICES	5,016		5,016	192
194	07950	OCCUPATIONAL HEALTH				194
194.01	07951	FOUNDATION	26,618		26,618	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	142,752		142,752	194.03
194.04	07954	ER PHYSICIAN				194.04
194.06	07953	SHIPSHAWANA RADIOLOGY AND LAB	17,457		17,457	194.06
200		TOTAL (SUM OF LINES 118-199)	24,474,420	-2,991,735	21,482,685	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER	
		COST CENTER	LINE #			
	1	2	3	4	5	
1 REHAB THERAPY RECLASS	A	OCCUPATIONAL THERAPY	67	115,363	3,551	1
2		SPEECH PATHOLOGY	68	65,559	2,018	2
500 TOTAL RECLASSIFICATIONS				180,922	5,569	500
CODE LETTER - A						
1 OB RECLASS	B	NURSERY	43	148,712	13,894	1
2		DELIVERY ROOM & LABOR ROOM	52	280,846	26,239	2
500 TOTAL RECLASSIFICATIONS				429,558	40,133	500
CODE LETTER - B						
1 CLINIC DIETICIAN	C	CLINIC	90	2,073		1
500 TOTAL RECLASSIFICATIONS				2,073		500
CODE LETTER - C						
1 EMPLOYEE SALARY BENEFITS	D	ADMINISTRATIVE & GENERAL	5	887		1
2		OPERATION OF PLANT	7	43		2
3		HOUSEKEEPING	9	24		3
4		DIETARY	10	53		4
5		NURSING ADMINISTRATION	13	29		5
6		CENTRAL SERVICES & SUPPLY	14	4		6
7		PHARMACY	15	68		7
8		ADULTS & PEDIATRICS	30	221		8
9		NURSERY	43	27		9
10		OPERATING ROOM	50	97		10
11		DELIVERY ROOM & LABOR ROOM	52	50		11
12		RADIOLOGY-DIAGNOSTIC	54	90		12
13		RESPIRATORY THERAPY	65	53		13
14		PHYSICAL THERAPY	66	66		14
15		OCCUPATIONAL THERAPY	67	22		15
16		SPEECH PATHOLOGY	68	13		16
17		CLINIC	90	6		17
18		EMERGENCY	91	104		18
19		AMBULANCE SERVICES	95	125		19
20		FOUNDATION	194.01	3		20
21		COMMUNITY & VOLUNTEER SVCS	194.03	12		21
22		SHIPSHEWANA RADIOLOGY AND LAB	194.06	3		22
500 TOTAL RECLASSIFICATIONS				2,000		500
CODE LETTER - D						
1 EMPLOYEE SALARY BENEFITS	E	ADMINISTRATIVE & GENERAL	5	401,328		1
2		OPERATION OF PLANT	7	19,382		2
3		HOUSEKEEPING	9	11,061		3
4		DIETARY	10	24,089		4
5		NURSING ADMINISTRATION	13	13,332		5
6		CENTRAL SERVICES & SUPPLY	14	1,795		6
7		PHARMACY	15	30,637		7
8		ADULTS & PEDIATRICS	30	99,921		8
9		NURSERY	43	12,052		9
10		OPERATING ROOM	50	43,701		10
11		DELIVERY ROOM & LABOR ROOM	52	22,760		11
12		RADIOLOGY-DIAGNOSTIC	54	40,735		12
13		LABORATORY	60	17		13
14		RESPIRATORY THERAPY	65	23,789		14
15		PHYSICAL THERAPY	66	29,739		15
16		OCCUPATIONAL THERAPY	67	9,948		16
17		SPEECH PATHOLOGY	68	5,654		17
18		CLINIC	90	2,711		18
19		EMERGENCY	91	47,152		19
20		AMBULANCE SERVICES	95	56,493		20
21		FOUNDATION	194.01	1,467		21
22		COMMUNITY & VOLUNTEER SVCS	194.03	5,288		22
500 TOTAL RECLASSIFICATIONS				903,051		500
CODE LETTER - E						
1 CAFETERIA RECLASS	F	CAFETERIA	11	174,890	104,191	1
500 TOTAL RECLASSIFICATIONS				174,890	104,191	500
CODE LETTER - F						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	-----		INCREASE	-----	
		COST CENTER	LINE #		SALARY	OTHER
	1	2	3	4	5	
1 INSURANCE RECLASS	G	CAP REL COSTS-BLDG & FIXT	1		6,257	1
2		CAP REL COSTS-MVBLE EQUIP	2		2,069	2
500 TOTAL RECLASSIFICATIONS					8,326	500
CODE LETTER - G						
1 DRUGS CHARGED TO PATIENTS	H	DRUGS CHARGED TO PATIENTS	73		710,371	1
2						2
3						3
4						4
5						5
6						6
7						7
500 TOTAL RECLASSIFICATIONS					710,371	500
CODE LETTER - H						
1 SALARY RECLASS	I	ADMINISTRATIVE & GENERAL	5		2,571,154	1
2		CENTRAL SERVICES & SUPPLY	14	145,119		2
3		MEDICAL RECORDS & LIBRARY	16	165,704		3
500 TOTAL RECLASSIFICATIONS				310,823	2,571,154	500
CODE LETTER - I						
1 OCCUPATIONAL HEALTH	J	OCCUPATIONAL HEALTH	194		99,459	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
500 TOTAL RECLASSIFICATIONS					99,459	500
CODE LETTER - J						
1 DEPRECIATION RECLASS	K	CAP REL COSTS-MVBLE EQUIP	2		780,913	1
2		EMS WEST STATION	1.01		16,040	2
3		EMS WEST STATION EQUIP.	2.01		24,881	3
4		ADMINISTRATIVE & GENERAL	5		6,744	4
500 TOTAL RECLASSIFICATIONS					828,578	500
CODE LETTER - K						
1 EQUIP & BUILDING LEASE	L	CAP REL COSTS-BLDG & FIXT	1		18,000	1
2		CAP REL COSTS-MVBLE EQUIP	2		53,469	2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
500 TOTAL RECLASSIFICATIONS					71,469	500
CODE LETTER - L						
1 INTEREST EXPENSE	M	CAP REL COSTS-BLDG & FIXT	1		269,830	1
500 TOTAL RECLASSIFICATIONS					269,830	500
CODE LETTER - M						
1 INPLANTABLE MEDICAL SUP	N	IMPL. DEV. CHARGED TO PATIENT	72		204,385	1
500 TOTAL RECLASSIFICATIONS					204,385	500
CODE LETTER - N						
GRAND TOTAL (INCREASES)				2,003,317	4,913,465	

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 REHAB THERAPY RECLASS	A	PHYSICAL THERAPY	66	180,922	5,569	1
2						2
500 TOTAL RECLASSIFICATIONS CODE LETTER - A				180,922	5,569	500
1 OB RECLASS	B	ADULTS & PEDIATRICS	30	429,558	40,133	1
2						2
500 TOTAL RECLASSIFICATIONS CODE LETTER - B				429,558	40,133	500
1 CLINIC DIETICIAN	C	DIETARY	10	2,073		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C				2,073		500
1 EMPLOYEE SALARY BENEFITS	D	EMPLOYEE BENEFITS	4	2,000		1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
500 TOTAL RECLASSIFICATIONS CODE LETTER - D				2,000		500
1 EMPLOYEE SALARY BENEFITS	E	EMPLOYEE BENEFITS	4	903,051		1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
500 TOTAL RECLASSIFICATIONS CODE LETTER - E				903,051		500
1 CAFETERIA RECLASS	F	DIETARY	10	174,890	104,191	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - F				174,890	104,191	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 INSURANCE RECLASS	G	ADMINISTRATIVE & GENERAL	5		8,326	12 1
2						12 2
500 TOTAL RECLASSIFICATIONS					8,326	500
CODE LETTER - G						
1 DRUGS CHARGED TO PATIENTS	H	PHARMACY	15		703,271	1
2		ADULTS & PEDIATRICS	30		2,776	2
3		OPERATING ROOM	50		653	3
4		RADIOLOGY-DIAGNOSTIC	54		1,856	4
5		EMERGENCY	91		1,441	5
6		AMBULANCE SERVICES	95		301	6
7		COMMUNITY & VOLUNTEER SVCS	194.03		73	7
500 TOTAL RECLASSIFICATIONS					710,371	500
CODE LETTER - H						
1 SALARY RECLASS	I	ADMINISTRATIVE & GENERAL	5	2,571,154		1
2		CENTRAL SERVICES & SUPPLY	14		145,119	2
3		MEDICAL RECORDS & LIBRARY	16		165,704	3
500 TOTAL RECLASSIFICATIONS				2,571,154	310,823	500
CODE LETTER - I						
1 OCCUPATIONAL HEALTH	J	RADIOLOGY-DIAGNOSTIC	54		39,297	1
2		LABORATORY	60		623	2
3		RESPIRATORY THERAPY	65		28	3
4		PHYSICAL THERAPY	66		13,505	4
5		OCCUPATIONAL THERAPY	67		2,398	5
6		ELECTROCARDIOLOGY	69		74	6
7		MEDICAL SUPPLIES CHRGED TO PA	71		943	7
8		DRUGS CHARGED TO PATIENTS	73		2,830	8
9		EMERGENCY	91		23,935	9
10		EMERGENCY	91		15,826	10
500 TOTAL RECLASSIFICATIONS					99,459	500
CODE LETTER - J						
1 DEPRECIATION RECLASS	K	CAP REL COSTS-BLDG & FIXT	1		828,578	9 1
2						9 2
3						9 3
4						4
500 TOTAL RECLASSIFICATIONS					828,578	500
CODE LETTER - K						
1 EQUIP & BUILDING LEASE	L	OPERATION OF PLANT	7		18,000	10 1
2		ADMINISTRATIVE & GENERAL	5		12,613	10 2
3		OPERATION OF PLANT	7		69	3
4		HOUSEKEEPING	9		10	4
5		DIETARY	10		508	5
6		CENTRAL SERVICES & SUPPLY	14		55	6
7		PHARMACY	15		237	7
8		ADULTS & PEDIATRICS	30		3,655	8
9		OPERATING ROOM	50		26,709	9
10		RADIOLOGY-DIAGNOSTIC	54		71	10
11		RESPIRATORY THERAPY	65		1,479	11
12		PHYSICAL THERAPY	66		1,307	12
13		EMERGENCY	91		1,109	13
14		PHYSICIANS' PRIVATE OFFICES	192		635	14
15		SHIPSHAWANA RADIOLOGY AND LAB	194.06		5,012	15
500 TOTAL RECLASSIFICATIONS					71,469	500
CODE LETTER - L						
1 INTEREST EXPENSE	M	INTEREST EXPENSE	113		269,830	11 1
500 TOTAL RECLASSIFICATIONS					269,830	500
CODE LETTER - M						
1 INPLANTABLE MEDICAL SUP	N	MEDICAL SUPPLIES CHRGED TO PA	71		204,385	1
500 TOTAL RECLASSIFICATIONS					204,385	500
CODE LETTER - N						
GRAND TOTAL (DECREASES)				4,263,648	2,653,134	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND RETIREMENTS	BALANCE	DEPRECIATED ASSETS
	1	2	3	4	5	6	7
1 LAND	265,000					265,000	1
2 LAND IMPROVEMENTS	1,891,141	25,975		25,975		1,917,116	2
3 BUILDINGS AND FIXTURES	13,230,046	15,172		15,172		13,245,218	3
4 BUILDING IMPROVEMENTS	29,098					29,098	4
5 FIXED EQUIPMENT	7,627,345					7,627,345	5
6 MOVABLE EQUIPMENT	6,936,180	447,287		447,287	472,053	6,911,414	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	29,978,810	488,434		488,434	472,053	29,995,191	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	29,978,810	488,434		488,434	472,053	29,995,191	1,607,545 10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL(1)
						CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	(SEE INSTR.)	(SEE INSTR.)	14	15
1 CAP REL COSTS-BLDG & FIXT	1,879,439				7,111		1,886,550 1
1.01 EMS WEST STATION							1.01
2 CAP REL COSTS-MVBLE EQUIP							2
2.01 EMS WEST STATION EQUIP.							2.01
3 TOTAL (SUM OF LINES 1-2)	1,879,439				7,111		1,886,550 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	OF RATIOS		INSURANCE	TAXES	OTHER	TOTAL
			(COL. 1 - COL. 2)	RATIO (SEE INSTR.)			CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 5-7)
	1	2	3	4	5	6	7	8
1 CAP REL COSTS-BLDG & FIXT	22,762,969		22,762,969	0.766696				1
1.01 EMS WEST STATION	320,808		320,808	0.010805				1.01
2 CAP REL COSTS-MVBLE EQUIP	6,765,097	305,459	6,459,638	0.217571				2
2.01 EMS WEST STATION EQUIP.	146,317		146,317	0.004928				2.01
3 TOTAL (SUM OF LINES 1-2)	29,995,191	305,459	29,689,732	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL(2)
						CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	(SEE INSTR.)	(SEE INSTR.)	14	15
1 CAP REL COSTS-BLDG & FIXT	1,098,478	18,000	269,142	6,257	7,111		1,398,988 1
1.01 EMS WEST STATION	16,040						16,040 1.01
2 CAP REL COSTS-MVBLE EQUIP	1,414,658	53,469		2,069			1,470,196 2
2.01 EMS WEST STATION EQUIP.	24,881						24,881 2.01
3 TOTAL	2,554,057	71,469	269,142	8,326	7,111		2,910,105 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-688	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2 3
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					4
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					5
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					6
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					7
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					8
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-3,609	OPERATION OF PLANT	7	9
9 PARKING LOT (CHAPTER 21)					10
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-969,337			11
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					12
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	97,701			13
13 LAUNDRY AND LINEN SERVICE					14
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-154,363	CAFETERIA	11	15
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					16
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					17
17 SALE OF DRUGS TO OTHER THAN PATIENTS					18
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					19
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					20
20 VENDING MACHINES					21
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					22
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					23
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				25
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	26
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	27
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	28
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	29
29 PHYSICIANS' ASSISTANT					30
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				32
32 CAH HIT ADJ FOR DEPRECIATION AND					33
33 TELEVISION SERVICES	A	-5,050	CAP REL COSTS-MVBLE EQUIP	2	34
34 MISCELLANEOUS REVENUE	B	-2,559	ADMINISTRATIVE & GENERAL	5	35
35 SPEECH THERAPY CONTRACTED	B	-12,036	SPEECH PATHOLOGY	68	36
36 NON-PATIENT EMS REVENUE	B	-300	AMBULANCE SERVICES	95	37
37 HOUSEKEEPING SUPPLIES	B	-20	HOUSEKEEPING	9	38
38 PHARMACY EMPLOYEE RX PURCHASES	B	-226,578	DRUGS CHARGED TO PATIENTS	73	39
39 RELATED PARTY INTEREST EXP	A	-3,551	INTEREST EXPENSE	113	40
40 SELF INSURANCE	A	-529,460	EMPLOYEE BENEFITS	4	41
41 LOBBY % OF DUES & SUBSCRIPTIONS	A	-3,023	ADMINISTRATIVE & GENERAL	5	42
42 EKG INTERPRETATION COSTS	A	-29,735	ELECTROCARDIOLOGY	69	43
43 TRANSCRIPTION EXPENSE	A	15,252	EMERGENCY	91	44
44 MARKETING	A	-339	PHYSICAL THERAPY	66	45
45 SUBSIDY ADJUSTMENT	A	-1,043,222	ADMINISTRATIVE & GENERAL	5	46
46 ADD-BACK OF DEMOLISHED ASSET DEPREE	A	17,940	CAP REL COSTS-BLDG & FIXT	1	47
47 ADD-BACK OF DEMOLITION COSTS	A	4,125	ADMINISTRATIVE & GENERAL	5	48
48 NOT RELATED TO PATIENT CARE	A	-39,889	PHYSICAL THERAPY	66	49
49 RPS IMAGING RECEIPTS	A	-1,557	RADIOLOGY-DIAGNOSTIC	54	49.01
49.01 PHYSICIAN RECRUITMENT	A	-42,737	ADMINISTRATIVE & GENERAL	5	49.02
49.02 ON-CALL PROF TIME	A	-199,272	ANESTHESIOLOGY	53	49.03
49.03 GROSS-UP ANESTHESIA EXP FOR A/R CO	A	140,572	ANESTHESIOLOGY	53	50
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,991,735			
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7	
1	14	CENTRAL SERVICES & SUPPLY	HOME OFFICE ALLOCATION	181,977	181,977	1	
2	4	EMPLOYEE BENEFITS	HOME OFFICE ALLOCATION	39,334	39,334	2	
3	16	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	261,321	261,321	3	
4	4	EMPLOYEE BENEFITS	HOME OFFICE ALLOCATION	53,290	53,290	4	
4.01	5	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	2,701,837	4,432,000	-1,730,163	4.01
4.02	4	EMPLOYEE BENEFITS	HOME OFFICE ALLOCATION	623,470	623,470	4.02	
4.03	1	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	29,677	29,677	9	4.03
4.04	2	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	638,795	638,795	9	4.04
5		TOTALS (SUM OF LINES 1-4)		4,529,701	4,432,000	97,701	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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

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

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

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----		TYPE OF BUSINESS	
		PERCENT OF OWNERSHIP	PERCENT OF OWNERSHIP		
1	2	3	4	5	6
6	B		PARKVIEW HEALTH SYSTEM, INC.	100.00	HOME OFFICE
7					
8					
9					
10					

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE NO.	1	2	3	4	5	6	7	8	9
1	53	ANESTHESIOLOGY	DR A	331,839	270,483	61,356			1
2	91	EMERGENCY	DR B	30,000		30,000			2
3	91	EMERGENCY	DR C	1,314,000	698,854	615,146			3
4	30	ADULTS & PEDIATRICS	DR D	8,652		8,652			4
200		TOTAL		1,684,491	969,337	715,154			200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	NEW CAP RE COSTS-BLDG & FIXT 1.01	CAP MOVABLE EQUIPMENT 2	NEW CAP RE COSTS-MOV EQUIP 2.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,398,988	1,398,988				1
1.01 EMS WEST STATION	16,040		16,040			1.01
2 CAP REL COSTS-MVBLE EQUIP	1,470,196			1,470,196		2
2.01 EMS WEST STATION EQUIP.	24,881				24,881	2.01
4 EMPLOYEE BENEFITS	2,603,157					4
5 ADMINISTRATIVE & GENERAL	4,289,484	256,988		270,069		5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	815,918	79,461		83,506		7
8 LAUNDRY & LINEN SERVICE	75,532	4,543		4,774		8
9 HOUSEKEEPING	186,184	14,869		15,626		9
10 DIETARY	229,954	52,328		54,991		10
11 CAFETERIA	124,718					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	178,955					13
14 CENTRAL SERVICES & SUPPLY	206,577	35,663		37,479		14
15 PHARMACY	456,035	24,386		25,627		15
16 MEDICAL RECORDS & LIBRARY	261,321	16,341		17,173		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,506,333	314,866		330,891		30
43 NURSERY	174,685	4,741		4,982		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	903,955	179,466		188,601		50
52 DELIVERY ROOM & LABOR ROOM	329,895	22,411		23,552		52
53 ANESTHESIOLOGY	61,430					53
54 RADIOLOGY-DIAGNOSTIC	1,021,382	88,943		93,470		54
60 LABORATORY	682,498	35,484		37,290		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	337,344	19,232		20,211		65
66 PHYSICAL THERAPY	364,277	59,475		62,502		66
67 OCCUPATIONAL THERAPY	126,486					67
68 SPEECH PATHOLOGY	61,208					68
69 ELECTROCARDIOLOGY	16,726	1,670		1,755		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	396,762					71
72 IMPL. DEV. CHARGED TO PATIENT	204,385					72
73 DRUGS CHARGED TO PATIENTS	480,963					73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	38,559					90
91 EMERGENCY	1,333,879	124,283		130,609		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	903,713		16,040		24,881	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	21,282,420	1,335,150	16,040	1,403,108	24,881	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,422	4,004		4,208		190
192 PHYSICIANS' PRIVATE OFFICES	5,016	59,834		62,880		192
194 OCCUPATIONAL HEALTH						194
194.01 FOUNDATION	26,618					194.01
194.03 COMMUNITY & VOLUNTEER SVCS	142,752					194.03
194.04 ER PHYSICIAN						194.04
194.06 SHIPSHEWANA RADIOLOGY AND LAB	17,457					194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	21,482,685	1,398,988	16,040	1,470,196	24,881	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 EMS WEST STATION						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 EMS WEST STATION EQUIP.						2.01
4 EMPLOYEE BENEFITS	2,603,157					4
5 ADMINISTRATIVE & GENERAL	738,904	5,555,445	5,555,445			5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	68,653	1,047,538	365,382	1,412,920		7
8 LAUNDRY & LINEN SERVICE		84,849	29,595	6,041	120,485	8
9 HOUSEKEEPING	39,178	255,857	89,243	19,772		9
10 DIETARY	38,344	375,617	131,016	69,583	341	10
11 CAFETERIA	46,432	171,150	59,697			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	47,223	226,178	78,891			13
14 CENTRAL SERVICES & SUPPLY	44,886	324,605	113,223	47,424		14
15 PHARMACY	108,520	614,568	214,362	32,428		15
16 MEDICAL RECORDS & LIBRARY	43,994	338,829	118,184	21,730		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	353,930	2,506,020	874,111	418,693	48,696	30
43 NURSERY	42,689	227,097	79,212	6,304	2,250	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	154,793	1,426,815	497,674	238,647	15,674	50
52 DELIVERY ROOM & LABOR ROOM	80,619	456,477	159,220	29,801	4,258	52
53 ANESTHESIOLOGY		61,430	21,427			53
54 RADIOLOGY-DIAGNOSTIC	144,289	1,348,084	470,213	118,273	9,920	54
60 LABORATORY	59	755,331	263,460	47,185		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	84,264	461,051	160,815	25,574	1,135	65
66 PHYSICAL THERAPY	108,418	594,672	207,422	79,087	5,511	66
67 OCCUPATIONAL THERAPY	33,275	159,761	55,725		1,850	67
68 SPEECH PATHOLOGY	18,910	80,118	27,945		1,037	68
69 ELECTROCARDIOLOGY		20,151	7,029	2,221		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		396,762	138,391			71
72 IMPL. DEV. CHARGED TO PATIENT		204,385	71,290			72
73 DRUGS CHARGED TO PATIENTS		480,963	167,760			73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	10,154	48,713	16,991			90
91 EMERGENCY	167,015	1,755,786	612,420	165,267	23,075	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	200,103	1,144,737	399,285		4,796	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	2,574,652	21,122,989	5,429,983	1,328,030	118,543	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		16,634	5,802	5,325		190
192 PHYSICIANS' PRIVATE OFFICES		127,730	44,552	79,565	1,942	192
194 OCCUPATIONAL HEALTH						194
194.01 FOUNDATION	5,195	31,813	11,096			194.01
194.03 COMMUNITY & VOLUNTEER SVCS	18,732	161,484	56,326			194.03
194.04 ER PHYSICIAN						194.04
194.06 SHIPSHAWANA RADIOLOGY AND LAB	4,578	22,035	7,686			194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,603,157	21,482,685	5,555,445	1,412,920	120,485	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	HOUSE-KEEPING 9	DIETARY 10	CAFETERIA 11	NURSING ADMINIS-TRATION 13	CENTRAL SERVICES & SUPPLY 14	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 EMS WEST STATION						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 EMS WEST STATION EQUIP.						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	364,872					9
10 DIETARY	18,304	594,861				10
11 CAFETERIA			230,847			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION				6,798	311,867	13
14 CENTRAL SERVICES & SUPPLY	12,475				497,727	14
15 PHARMACY	8,530		10,822		20,616	15
16 MEDICAL RECORDS & LIBRARY	5,716					16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	110,134	594,861	70,971	146,051	37,739	30
43 NURSERY	1,658			14,622	4,339	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	62,775		23,227	61,638	90,011	50
52 DELIVERY ROOM & LABOR ROOM	7,839			27,615	8,194	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	31,111		20,199		15,730	54
60 LABORATORY	12,412		20			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	6,727		12,385		7,294	65
66 PHYSICAL THERAPY	20,804		20,903		2,604	66
67 OCCUPATIONAL THERAPY					871	67
68 SPEECH PATHOLOGY					495	68
69 ELECTROCARDIOLOGY	584					69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					171,410	71
72 IMPL. DEV. CHARGED TO PATIENT					87,780	72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC			1,446		52	90
91 EMERGENCY	43,473		23,345	61,941	19,913	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES			35,281		28,351	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	342,542	594,861	225,397	311,867	495,399	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,401				270	190
192 PHYSICIANS' PRIVATE OFFICES	20,929				1,420	192
194 OCCUPATIONAL HEALTH						194
194.01 FOUNDATION			879		469	194.01
194.03 COMMUNITY & VOLUNTEER SVCS			4,571		169	194.03
194.04 ER PHYSICIAN						194.04
194.06 SHIPSHEWANA RADIOLOGY AND LAB						194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	364,872	594,861	230,847	311,867	497,727	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 EMS WEST STATION						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 EMS WEST STATION EQUIP.						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	901,326					15
16 MEDICAL RECORDS & LIBRARY		484,459				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	237	133,662	4,941,175		4,941,175	30
43 NURSERY	77	23,254	358,813		358,813	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,648	45,491	2,464,600		2,464,600	50
52 DELIVERY ROOM & LABOR ROOM	145		693,549		693,549	52
53 ANESTHESIOLOGY			82,857		82,857	53
54 RADIOLOGY-DIAGNOSTIC	4,960	46,944	2,065,434		2,065,434	54
60 LABORATORY			1,078,408		1,078,408	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			674,981		674,981	65
66 PHYSICAL THERAPY	587	52,370	983,960		983,960	66
67 OCCUPATIONAL THERAPY	197	11,966	230,370		230,370	67
68 SPEECH PATHOLOGY	112	1,163	110,870		110,870	68
69 ELECTROCARDIOLOGY			29,985		29,985	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			706,563		706,563	71
72 IMPL. DEV. CHARGED TO PATIENT			363,455		363,455	72
73 DRUGS CHARGED TO PATIENTS	880,997		1,529,720		1,529,720	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC			67,202		67,202	90
91 EMERGENCY	1,410	169,609	2,876,239		2,876,239	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	9,956		1,622,406		1,622,406	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	901,326	484,459	20,880,587		20,880,587	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			29,432		29,432	190
192 PHYSICIANS' PRIVATE OFFICES			276,138		276,138	192
194 OCCUPATIONAL HEALTH						194
194.01 FOUNDATION			44,257		44,257	194.01
194.03 COMMUNITY & VOLUNTEER SVCS			222,550		222,550	194.03
194.04 ER PHYSICIAN						194.04
194.06 SHIPSEWANA RADIOLOGY AND LAB			29,721		29,721	194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	901,326	484,459	21,482,685		21,482,685	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	NEW CAP RE COSTS-BLDG & FIXT 1.01	CAP MOVABLE EQUIPMENT 2	NEW CAP RE COSTS-MOV EQUIP 2.01
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
1.01 EMS WEST STATION					1.01
2 CAP REL COSTS-MVBLE EQUIP					2
2.01 EMS WEST STATION EQUIP.					2.01
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL		256,988		270,069	5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT		79,461		83,506	7
8 LAUNDRY & LINEN SERVICE		4,543		4,774	8
9 HOUSEKEEPING		14,869		15,626	9
10 DIETARY		52,328		54,991	10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY		35,663		37,479	14
15 PHARMACY		24,386		25,627	15
16 MEDICAL RECORDS & LIBRARY		16,341		17,173	16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS		314,866		330,891	30
43 NURSERY		4,741		4,982	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		179,466		188,601	50
52 DELIVERY ROOM & LABOR ROOM		22,411		23,552	52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC		88,943		93,470	54
60 LABORATORY		35,484		37,290	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		19,232		20,211	65
66 PHYSICAL THERAPY		59,475		62,502	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY		1,670		1,755	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY		124,283		130,609	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES			16,040		24,881 95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)		1,335,150	16,040	1,403,108	24,881 118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		4,004		4,208	190
192 PHYSICIANS' PRIVATE OFFICES		59,834		62,880	192
194 OCCUPATIONAL HEALTH					194
194.01 FOUNDATION					194.01
194.03 COMMUNITY & VOLUNTEER SVCS					194.03
194.04 ER PHYSICIAN					194.04
194.06 SHIPSHEWANA RADIOLOGY AND LAB					194.06
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)		1,398,988	16,040	1,470,196	24,881 202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 EMS WEST STATION						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 EMS WEST STATION EQUIP.						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	527,057	527,057				5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	162,967	34,665	197,632			7
8 LAUNDRY & LINEN SERVICE	9,317	2,808	845	12,970		8
9 HOUSEKEEPING	30,495	8,467	2,766		41,728	9
10 DIETARY	107,319	12,430	9,733	37	2,093	10
11 CAFETERIA		5,664				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		7,485				13
14 CENTRAL SERVICES & SUPPLY	73,142	10,742	6,633		1,427	14
15 PHARMACY	50,013	20,337	4,536		976	15
16 MEDICAL RECORDS & LIBRARY	33,514	11,213	3,039		654	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	645,757	82,920	58,565	5,243	12,595	30
43 NURSERY	9,723	7,515	882	242	190	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	368,067	47,216	33,381	1,687	7,179	50
52 DELIVERY ROOM & LABOR ROOM	45,963	15,106	4,168	458	896	52
53 ANESTHESIOLOGY		2,033				53
54 RADIOLOGY-DIAGNOSTIC	182,413	44,611	16,543	1,068	3,558	54
60 LABORATORY	72,774	24,995	6,600		1,419	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	39,443	15,257	3,577	122	769	65
66 PHYSICAL THERAPY	121,977	19,679	11,062	593	2,379	66
67 OCCUPATIONAL THERAPY		5,287		199		67
68 SPEECH PATHOLOGY		2,651		112		68
69 ELECTROCARDIOLOGY	3,425	667	311		67	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		13,130				71
72 IMPL. DEV. CHARGED TO PATIENT		6,764				72
73 DRUGS CHARGED TO PATIENTS		15,916				73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		1,612				90
91 EMERGENCY	254,892	58,102	23,117	2,484	4,972	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	40,921	37,882		516		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	2,779,179	515,154	185,758	12,761	39,174	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,212	550	745		160	190
192 PHYSICIANS' PRIVATE OFFICES	122,714	4,227	11,129	209	2,394	192
194 OCCUPATIONAL HEALTH						194
194.01 FOUNDATION		1,053				194.01
194.03 COMMUNITY & VOLUNTEER SVCS		5,344				194.03
194.04 ER PHYSICIAN						194.04
194.06 SHIPSEWANA RADIOLOGY AND LAB		729				194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,910,105	527,057	197,632	12,970	41,728	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 EMS WEST STATION						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 EMS WEST STATION EQUIP.						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	131,612					10
11 CAFETERIA		5,664				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		167	7,652			13
14 CENTRAL SERVICES & SUPPLY				91,944		14
15 PHARMACY		266		3,808	79,936	15
16 MEDICAL RECORDS & LIBRARY						16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	131,612	1,740	3,583	6,971	21	30
43 NURSERY			359	801	7	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		570	1,512	16,628	235	50
52 DELIVERY ROOM & LABOR ROOM			678	1,514	13	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		496		2,906	440	54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		304		1,347		65
66 PHYSICAL THERAPY		513		481	52	66
67 OCCUPATIONAL THERAPY				161	18	67
68 SPEECH PATHOLOGY				91	10	68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				31,666		71
72 IMPL. DEV. CHARGED TO PATIENT				16,215		72
73 DRUGS CHARGED TO PATIENTS					78,132	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		35		10		90
91 EMERGENCY		573	1,520	3,678	125	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		866		5,237	883	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	131,612	5,530	7,652	91,514	79,936	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				50		190
192 PHYSICIANS' PRIVATE OFFICES				262		192
194 OCCUPATIONAL HEALTH						194
194.01 FOUNDATION		22		87		194.01
194.03 COMMUNITY & VOLUNTEER SVCS		112		31		194.03
194.04 ER PHYSICIAN						194.04
194.06 SHIPSEWANA RADIOLOGY AND LAB						194.06
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	131,612	5,664	7,652	91,944	79,936	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
1.01 EMS WEST STATION					1.01
2 CAP REL COSTS-MVBLE EQUIP					2
2.01 EMS WEST STATION EQUIP.					2.01
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	48,420				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	13,359	962,366		962,366	30
43 NURSERY	2,324	22,043		22,043	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	4,547	481,022		481,022	50
52 DELIVERY ROOM & LABOR ROOM		68,796		68,796	52
53 ANESTHESIOLOGY		2,033		2,033	53
54 RADIOLOGY-DIAGNOSTIC	4,692	256,727		256,727	54
60 LABORATORY		105,788		105,788	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		60,819		60,819	65
66 PHYSICAL THERAPY	5,234	161,970		161,970	66
67 OCCUPATIONAL THERAPY	1,196	6,861		6,861	67
68 SPEECH PATHOLOGY	116	2,980		2,980	68
69 ELECTROCARDIOLOGY		4,470		4,470	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		44,796		44,796	71
72 IMPL. DEV. CHARGED TO PATIENT		22,979		22,979	72
73 DRUGS CHARGED TO PATIENTS		94,048		94,048	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		1,657		1,657	90
91 EMERGENCY	16,952	366,415		366,415	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		86,305		86,305	95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	48,420	2,752,075		2,752,075	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		9,717		9,717	190
192 PHYSICIANS' PRIVATE OFFICES		140,935		140,935	192
194 OCCUPATIONAL HEALTH					194
194.01 FOUNDATION		1,162		1,162	194.01
194.03 COMMUNITY & VOLUNTEER SVCS		5,487		5,487	194.03
194.04 ER PHYSICIAN					194.04
194.06 SHIPSHEWANA RADIOLOGY AND LAB		729		729	194.06
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	48,420	2,910,105		2,910,105	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET	NEW CAP RE COSTS-BLDG & FIXT SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	NEW CAP RE COSTS-MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS	GROSS SALARIES	
		1	1.01	2	2.01		4	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	77,906						1
1.01	EMS WEST STATION		9,760					1.01
2	CAP REL COSTS-MVBLE EQUIP			77,906				2
2.01	EMS WEST STATION EQUIP.				9,760			2.01
4	EMPLOYEE BENEFITS					9,804,928		4
5	ADMINISTRATIVE & GENERAL	14,311		14,311		2,783,123		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	4,425		4,425		258,585		7
8	LAUNDRY & LINEN SERVICE	253		253				8
9	HOUSEKEEPING	828		828		147,565		9
10	DIETARY	2,914		2,914		144,423		10
11	CAFETERIA					174,890		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					177,867		13
14	CENTRAL SERVICES & SUPPLY	1,986		1,986		169,066		14
15	PHARMACY	1,358		1,358		408,746		15
16	MEDICAL RECORDS & LIBRARY	910		910		165,704		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SRVCES-SALARY & FRINGES APPRVD							21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	17,534		17,534		1,333,094		30
43	NURSERY	264		264		160,791		43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	9,994		9,994		583,034		50
52	DELIVERY ROOM & LABOR ROOM	1,248		1,248		303,656		52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	4,953		4,953		543,470		54
60	LABORATORY	1,976		1,976		224		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,071		1,071		317,386		65
66	PHYSICAL THERAPY	3,312		3,312		408,361		66
67	OCCUPATIONAL THERAPY					125,333		67
68	SPEECH PATHOLOGY					71,226		68
69	ELECTROCARDIOLOGY	93		93				69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC					38,245		90
91	EMERGENCY	6,921		6,921		629,072		91
92	OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES		9,760		9,760	753,699		95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (SUM OF LINES 1-117)	74,351	9,760	74,351	9,760	9,697,560		118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223		223				190
192	PHYSICIANS' PRIVATE OFFICES	3,332		3,332				192
194	OCCUPATIONAL HEALTH							194
194.01	FOUNDATION					19,569		194.01
194.03	COMMUNITY & VOLUNTEER SVCS					70,554		194.03
194.04	ER PHYSICIAN							194.04
194.06	SHIPSHEWANA RADIOLOGY AND LAB					17,245		194.06

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	NEW CAP RE COSTS-BLDG & FIXT SQUARE FEET 1.01	CAP MOVABLE EQUIPMENT SQUARE FEET 2	NEW CAP RE COSTS-MOV EQUIP SQUARE FEET 2.01	EMPLOYEE BENEFITS GROSS SALARIES 4	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,398,988	16,040	1,470,196	24,881	2,603,157	202
203	UNIT COST MULT-WS B PT I	17.957385	1.643443	18.871409	2.549283	0.265495	203
204	COST TO BE ALLOC PER B PT II						204
205	UNIT COST MULT-WS B PT II						205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	RECON-	ADMINIS-	OPERATION	LAUNDRY	HOUSE-	
	CILIAATION	TRATIVE & GENERAL ACCUM COST	OF PLANT	& LINEN SERVICE POUNDS OF LAUNDRY	KEEPING	
	5A	5	SQUARE FEET 7	8	SQUARE FEET 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 EMS WEST STATION						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
2.01 EMS WEST STATION EQUIP.						2.01
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	-5,555,445	15,927,240				5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		1,047,538	59,170			7
8 LAUNDRY & LINEN SERVICE		84,849	253	18,364		8
9 HOUSEKEEPING		255,857	828		58,089	9
10 DIETARY		375,617	2,914	52	2,914	10
11 CAFETERIA		171,150				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		226,178				13
14 CENTRAL SERVICES & SUPPLY		324,605	1,986		1,986	14
15 PHARMACY		614,568	1,358		1,358	15
16 MEDICAL RECORDS & LIBRARY		338,829	910		910	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		2,506,020	17,534	7,422	17,534	30
43 NURSERY		227,097	264	343	264	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		1,426,815	9,994	2,389	9,994	50
52 DELIVERY ROOM & LABOR ROOM		456,477	1,248	649	1,248	52
53 ANESTHESIOLOGY		61,430				53
54 RADIOLOGY-DIAGNOSTIC		1,348,084	4,953	1,512	4,953	54
60 LABORATORY		755,331	1,976		1,976	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		461,051	1,071	173	1,071	65
66 PHYSICAL THERAPY		594,672	3,312	840	3,312	66
67 OCCUPATIONAL THERAPY		159,761		282		67
68 SPEECH PATHOLOGY		80,118		158		68
69 ELECTROCARDIOLOGY		20,151	93		93	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		396,762				71
72 IMPL. DEV. CHARGED TO PATIENT		204,385				72
73 DRUGS CHARGED TO PATIENTS		480,963				73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		48,713				90
91 EMERGENCY		1,755,786	6,921	3,517	6,921	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		1,144,737		731		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	-5,555,445	15,567,544	55,615	18,068	54,534	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		16,634	223		223	190
192 PHYSICIANS' PRIVATE OFFICES		127,730	3,332	296	3,332	192
194 OCCUPATIONAL HEALTH						194
194.01 FOUNDATION		31,813				194.01
194.03 COMMUNITY & VOLUNTEER SVCS		161,484				194.03
194.04 ER PHYSICIAN						194.04
194.06 SHIPSEWANA RADIOLOGY AND LAB		22,035				194.06

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	
		5A	5	7	8	9	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I		5,555,445	1,412,920	120,485	364,872	202
203	UNIT COST MULT-WS B PT I		0.348801	23.878993	6.560934	6.281258	203
204	COST TO BE ALLOC PER B PT II		527,057	197,632	12,970	41,728	204
205	UNIT COST MULT-WS B PT II		0.033092	3.340071	0.706273	0.718346	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING	CENTRAL	PHARMACY
	MEALS SERVED	FTE	ADMINIS- TRATION DIRECT NRSNG HRS	SERVICES & SUPPLY COSTED REQUIS.	COSTED REQUIS.
	10	11	13	14	15
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
1.01 EMS WEST STATION					1.01
2 CAP REL COSTS-MVBLE EQUIP					2
2.01 EMS WEST STATION EQUIP.					2.01
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY	25,319				10
11 CAFETERIA		11,817			11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION		348	125,515		13
14 CENTRAL SERVICES & SUPPLY				1,158,902	14
15 PHARMACY		554		48,002	703,242
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	25,319	3,633	58,780	87,870	185
43 NURSERY			5,885	10,102	60
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		1,189	24,807	209,581	2,066
52 DELIVERY ROOM & LABOR ROOM			11,114	19,079	113
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC		1,034		36,626	3,870
60 LABORATORY		1			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		634		16,983	65
66 PHYSICAL THERAPY		1,070		6,062	458
67 OCCUPATIONAL THERAPY				2,028	154
68 SPEECH PATHOLOGY				1,153	87
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS				399,112	71
72 IMPL. DEV. CHARGED TO PATIENT				204,385	72
73 DRUGS CHARGED TO PATIENTS					687,381
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		74		122	90
91 EMERGENCY		1,195	24,929	46,365	1,100
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		1,806		66,011	7,768
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	25,319	11,538	125,515	1,153,481	703,242
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				629	190
192 PHYSICIANS' PRIVATE OFFICES				3,307	192
194 OCCUPATIONAL HEALTH					194
194.01 FOUNDATION		45		1,092	194.01
194.03 COMMUNITY & VOLUNTEER SVCS		234		393	194.03
194.04 ER PHYSICIAN					194.04
194.06 SHIPSHEWANA RADIOLOGY AND LAB					194.06

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING	CENTRAL	PHARMACY
	MEALS SERVED 10	FTE 11	ADMINIS- TRATION DIRECT NRSING HRS 13	SUPPLY COSTED REQUIS. 14	COSTED REQUIS. 15
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	594,861	230,847	311,867	497,727	901,326 202
203 UNIT COST MULT-WS B PT I	23.494648	19.535161	2.484699	0.429482	1.281673 203
204 COST TO BE ALLOC PER B PT II	131,612	5,664	7,652	91,944	79,936 204
205 UNIT COST MULT-WS B PT II	5.198152	0.479309	0.060965	0.079337	0.113668 205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY TIME SPENT	
	16	
GENERAL SERVICE COST CENTERS		
1 CAP REL COSTS-BLDG & FIXT		1
1.01 EMS WEST STATION		1.01
2 CAP REL COSTS-MVBLE EQUIP		2
2.01 EMS WEST STATION EQUIP.		2.01
4 EMPLOYEE BENEFITS		4
5 ADMINISTRATIVE & GENERAL		5
6 MAINTENANCE & REPAIRS		6
7 OPERATION OF PLANT		7
8 LAUNDRY & LINEN SERVICE		8
9 HOUSEKEEPING		9
10 DIETARY		10
11 CAFETERIA		11
12 MAINTENANCE OF PERSONNEL		12
13 NURSING ADMINISTRATION		13
14 CENTRAL SERVICES & SUPPLY		14
15 PHARMACY		15
16 MEDICAL RECORDS & LIBRARY	10,000	16
17 SOCIAL SERVICE		17
19 NONPHYSICIAN ANESTHETISTS		19
20 NURSING SCHOOL		20
21 I&R SRVCES-SALARY & FRINGES APPRVD		21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23 PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS		
30 ADULTS & PEDIATRICS	2,759	30
43 NURSERY	480	43
ANCILLARY SERVICE COST CENTERS		
50 OPERATING ROOM	939	50
52 DELIVERY ROOM & LABOR ROOM		52
53 ANESTHESIOLOGY		53
54 RADIOLOGY-DIAGNOSTIC	969	54
60 LABORATORY		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65 RESPIRATORY THERAPY		65
66 PHYSICAL THERAPY	1,081	66
67 OCCUPATIONAL THERAPY	247	67
68 SPEECH PATHOLOGY	24	68
69 ELECTROCARDIOLOGY		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		71
72 IMPL. DEV. CHARGED TO PATIENT		72
73 DRUGS CHARGED TO PATIENTS		73
76.97 CARDIAC REHABILITATION		76.97
76.98 HYPERBARIC OXYGEN THERAPY		76.98
76.99 LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS		
90 CLINIC		90
91 EMERGENCY	3,501	91
92 OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS		
95 AMBULANCE SERVICES		95
99.10 CORF		99.10
99.20 OUTPATIENT PHYSICAL THERAPY		99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40 OUTPATIENT SPEECH PATHOLOGY		99.40
SPECIAL PURPOSE COST CENTERS		
118 SUBTOTALS (SUM OF LINES 1-117)	10,000	118
NONREIMBURSABLE COST CENTERS		
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192 PHYSICIANS' PRIVATE OFFICES		192
194 OCCUPATIONAL HEALTH		194
194.01 FOUNDATION		194.01
194.03 COMMUNITY & VOLUNTEER SVCS		194.03
194.04 ER PHYSICIAN		194.04
194.06 SHIPSEWANA RADIOLOGY AND LAB		194.06

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WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY TIME SPENT	
200 CROSS FOOT ADJUSTMENTS		200
201 NEGATIVE COST CENTER		201
202 COST TO BE ALLOC PER B PT I	484,459	202
203 UNIT COST MULT-WS B PT I	48.445900	203
204 COST TO BE ALLOC PER B PT II	48,420	204
205 UNIT COST MULT-WS B PT II	4.842000	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,941,175		4,941,175		4,941,175	30
43 NURSERY	358,813		358,813		358,813	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,464,600		2,464,600		2,464,600	50
52 DELIVERY ROOM & LABOR ROOM	693,549		693,549		693,549	52
53 ANESTHESIOLOGY	82,857		82,857		82,857	53
54 RADIOLOGY-DIAGNOSTIC	2,065,434		2,065,434		2,065,434	54
60 LABORATORY	1,078,408		1,078,408		1,078,408	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	674,981		674,981		674,981	65
66 PHYSICAL THERAPY	983,960		983,960		983,960	66
67 OCCUPATIONAL THERAPY	230,370		230,370		230,370	67
68 SPEECH PATHOLOGY	110,870		110,870		110,870	68
69 ELECTROCARDIOLOGY	29,985		29,985		29,985	69
71 MEDICAL SUPPLIES CHRGED TO	706,563		706,563		706,563	71
72 IMPL. DEV. CHARGED TO PATIE	363,455		363,455		363,455	72
73 DRUGS CHARGED TO PATIENTS	1,529,720		1,529,720		1,529,720	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	67,202		67,202		67,202	90
91 EMERGENCY	2,876,239		2,876,239		2,876,239	91
92 OBSERVATION BEDS	702,086		702,086		702,086	92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,622,406		1,622,406		1,622,406	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	21,582,673		21,582,673		21,582,673	200
201 LESS OBSERVATION BEDS	702,086		702,086		702,086	201
202 TOTAL (SEE INSTRUCTIONS)	20,880,587		20,880,587		20,880,587	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	4,998,414		4,998,414			30
43 NURSERY	491,991		491,991			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,469,512	5,043,662	7,513,174	0.328037	0.328037	0.328037 50
52 DELIVERY ROOM & LABOR ROOM	900,000	29,424	929,424	0.746214	0.746214	0.746214 52
53 ANESTHESIOLOGY	224,995	547,073	772,068	0.107318	0.107318	0.107318 53
54 RADIOLOGY-DIAGNOSTIC	1,047,740	10,976,485	12,024,225	0.171773	0.171773	0.171773 54
60 LABORATORY	1,158,144	2,950,864	4,109,008	0.262450	0.262450	0.262450 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	708,277	1,050,186	1,758,463	0.383847	0.383847	0.383847 65
66 PHYSICAL THERAPY	391,675	1,215,622	1,607,297	0.612183	0.612183	0.612183 66
67 OCCUPATIONAL THERAPY	335,506	281,164	616,670	0.373571	0.373571	0.373571 67
68 SPEECH PATHOLOGY	46,266	81,115	127,381	0.870381	0.870381	0.870381 68
69 ELECTROCARDIOLOGY	172,703	228,714	401,417	0.074698	0.074698	0.074698 69
71 MEDICAL SUPPLIES CHRGD TO	483,156	1,366,556	1,849,712	0.381985	0.381985	0.381985 71
72 IMPL. DEV. CHARGED TO PATIE	842,318	275,727	1,118,045	0.325081	0.325081	0.325081 72
73 DRUGS CHARGED TO PATIENTS	2,153,138	2,309,515	4,462,653	0.342783	0.342783	0.342783 73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	26,738	183,372	210,110	0.319842	0.319842	0.319842 90
91 EMERGENCY	245,975	5,713,138	5,959,113	0.482662	0.482662	0.482662 91
92 OBSERVATION BEDS		859,889	859,889	0.816484	0.816484	0.816484 92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		2,677,064	2,677,064	0.606039	0.606039	0.606039 95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	16,696,548	35,789,570	52,486,118			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	16,696,548	35,789,570	52,486,118			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-1323) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.328037		720,894			236,480	50
52 DELIVERY ROOM & LABOR ROOM	0.746214						52
53 ANESTHESIOLOGY	0.107318		69,984			7,511	53
54 RADIOLOGY-DIAGNOSTIC	0.171773		2,600,527			446,700	54
60 LABORATORY	0.262450		848,155			222,598	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.383847		317,494			121,869	65
66 PHYSICAL THERAPY	0.612183		343,647			210,375	66
67 OCCUPATIONAL THERAPY	0.373571		66,629			24,891	67
68 SPEECH PATHOLOGY	0.870381		26,963			23,468	68
69 ELECTROCARDIOLOGY	0.074698		84,654			6,323	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.381985		127,272			48,616	71
72 IMPL. DEV. CHARGED TO PATIENT	0.325081		52,221			16,976	72
73 DRUGS CHARGED TO PATIENTS	0.342783		715,169			245,148	73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.319842		1,183			378	90
91 EMERGENCY	0.482662		1,343,606			648,508	91
92 OBSERVATION BEDS	0.816484		302,034			246,606	92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.606039						95
200 SUBTOTAL (SEE INSTRUCTIONS)			7,620,432			2,506,447	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)			7,620,432			2,506,447	202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (15-Z323)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.328037						50
52 DELIVERY ROOM & LABOR ROOM	0.746214						52
53 ANESTHESIOLOGY	0.107318						53
54 RADIOLOGY-DIAGNOSTIC	0.171773						54
60 LABORATORY	0.262450						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.383847						65
66 PHYSICAL THERAPY	0.612183						66
67 OCCUPATIONAL THERAPY	0.373571						67
68 SPEECH PATHOLOGY	0.870381						68
69 ELECTROCARDIOLOGY	0.074698						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.381985						71
72 IMPL. DEV. CHARGED TO PATIENT	0.325081						72
73 DRUGS CHARGED TO PATIENTS	0.342783						73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.319842						90
91 EMERGENCY	0.482662						91
92 OBSERVATION BEDS	0.816484						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.606039						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

PROVIDER CCN: 15-1323 COMMUNITY HOSPT. OF LAGRANGE C
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/31/2012 10:03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED ADJUSTMENT	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)		(COL.1 MINUS COL.2)		(COL.3 + COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	962,366		962,366	3,872	248.54	94	23,363	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY	22,043		22,043	584	37.74	39	1,472	43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	984,409		984,409	4,456		133	24,835	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (15-1323) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	481,022	7,513,174	0.064024	20,461	1,310	50
52	DELIVERY ROOM & LABOR ROOM	68,796	929,424	0.074020	34,102	2,524	52
53	ANESTHESIOLOGY	2,033	772,068	0.002633	1,753	5	53
54	RADIOLOGY-DIAGNOSTIC	256,727	12,024,225	0.021351	45,072	962	54
60	LABORATORY	105,788	4,109,008	0.025745	43,425	1,118	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	60,819	1,758,463	0.034586	32,800	1,134	65
66	PHYSICAL THERAPY	161,970	1,607,297	0.100772	3,766	380	66
67	OCCUPATIONAL THERAPY	6,861	616,670	0.011126	4,793	53	67
68	SPEECH PATHOLOGY	2,980	127,381	0.023394	2,226	52	68
69	ELECTROCARDIOLOGY	4,470	401,417	0.011136	10,807	120	69
71	MEDICAL SUPPLIES CHRGD TO PA	44,796	1,849,712	0.024218	3,350	81	71
72	IMPL. DEV. CHARGED TO PATIENT	22,979	1,118,045	0.020553			72
73	DRUGS CHARGED TO PATIENTS	94,048	4,462,653	0.021074	59,682	1,258	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,657	210,110	0.007886	28		90
91	EMERGENCY	366,415	5,959,113	0.061488	39,638	2,437	91
92	OBSERVATION BEDS	167,520	859,889	0.194816			92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	1,848,881	44,318,649	44,318,649	301,903	11,434	200

PROVIDER CCN: 15-1323 COMMUNITY HOSPT. OF LAGRANGE C
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/31/2012 10:03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

PROVIDER CCN: 15-1323 COMMUNITY HOSPT. OF LAGRANGE C
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	3,872		94		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY	584		39		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	4,456		133		200

PROVIDER CCN: 15-1323 COMMUNITY HOSPT. OF LAGRANGE C
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/31/2012 10:03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-1323) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (15-1323)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	IRF	[]	NF			[]	OTHER
COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT	INPAT PGM	O/P PGM	O/P PGM			
	CHARGES	COST TO	OF COST TO		PASS-THRU		PASS-THRU			
	(FROM WKST	CHARGES	CHARGES	PGM	COSTS	CHARGES	COSTS			
	C, PT. I,	(COL. 5 +	(COL. 6 +	CHARGES	(COL. 8 x		(COL. 9 x			
	COL. 8)	COL. 7)	COL. 7)		COL. 10)		COL. 12)			
	7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS										
50	OPERATING ROOM	7,513,174		20,461			50			
52	DELIVERY ROOM & LABOR ROOM	929,424		34,102			52			
53	ANESTHESIOLOGY	772,068		1,753			53			
54	RADIOLOGY-DIAGNOSTIC	12,024,225		45,072			54			
60	LABORATORY	4,109,008		43,425			60			
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30			
65	RESPIRATORY THERAPY	1,758,463		32,800			65			
66	PHYSICAL THERAPY	1,607,297		3,766			66			
67	OCCUPATIONAL THERAPY	616,670		4,793			67			
68	SPEECH PATHOLOGY	127,381		2,226			68			
69	ELECTROCARDIOLOGY	401,417		10,807			69			
71	MEDICAL SUPPLIES CHRGED TO P	1,849,712		3,350			71			
72	IMPL. DEV. CHARGED TO PATIEN	1,118,045					72			
73	DRUGS CHARGED TO PATIENTS	4,462,653		59,682			73			
76.97	CARDIAC REHABILITATION						76.97			
76.98	HYPERBARIC OXYGEN THERAPY						76.98			
76.99	LITHOTRIPSY						76.99			
OUTPATIENT SERVICE COST CENTERS										
90	CLINIC	210,110		28			90			
91	EMERGENCY	5,959,113		39,638			91			
92	OBSERVATION BEDS	859,889					92			
OTHER REIMBURSABLE COST CENTERS										
95	AMBULANCE SERVICES	2,677,064					95			
200	TOTAL (SUM OF LINES 50-199)	44,318,649		301,903			200			

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-1323) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE FROM WKST C, PT I, COL. 9 1	RATIO	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	COST SERVICES SUBJECT TO DED & COINS 5	COST SVCS NOT SUBJECT TO DED & COINS 6	7
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.328037			161,049		52,830	50	
52 DELIVERY ROOM & LABOR ROOM	0.746214			1,728		1,289	52	
53 ANESTHESIOLOGY	0.107318			18,322		1,966	53	
54 RADIOLOGY-DIAGNOSTIC	0.171773			446,723		76,735	54	
60 LABORATORY	0.262450			158,151		41,507	60	
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
65 RESPIRATORY THERAPY	0.383847			68,474		26,284	65	
66 PHYSICAL THERAPY	0.612183			33,601		20,570	66	
67 OCCUPATIONAL THERAPY	0.373571			13,420		5,013	67	
68 SPEECH PATHOLOGY	0.870381			2,387		2,078	68	
69 ELECTROCARDIOLOGY	0.074698						69	
71 MEDICAL SUPPLIES CHRGED TO PATI	0.381985			35,388		13,518	71	
72 IMPL. DEV. CHARGED TO PATIENT	0.325081			19,217		6,247	72	
73 DRUGS CHARGED TO PATIENTS	0.342783			78,185		26,800	73	
76.97 CARDIAC REHABILITATION							76.97	
76.98 HYPERBARIC OXYGEN THERAPY							76.98	
76.99 LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	0.319842			3,425		1,095	90	
91 EMERGENCY	0.482662			438,981		211,879	91	
92 OBSERVATION BEDS	0.816484			34,495		28,165	92	
OTHER REIMBURSABLE COST CENTERS								
95 AMBULANCE SERVICES	0.606039						95	
200 SUBTOTAL (SEE INSTRUCTIONS)				1,513,546		515,976	200	
201 LESS PBP CLINIC LAB SERVICES							201	
202 NET CHARGES (LINE 200 - LINE 201)				1,513,546		515,976	202	

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-1323) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,001	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,872	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,872	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	826	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	303	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,128	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	826	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	156.51	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,941,175	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	47,423	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	907,842	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,033,333	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	4,998,414	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,998,414	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.806923	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,290.91	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	4,033,333	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-1323) [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,041.67 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,175,004 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,175,004 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					844,849 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,019,853 49

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

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

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 860,419 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 860,419 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 674 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,041.67 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 702,086 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					(SEE INSTR.)
90 CAPITAL-RELATED COST	962,366	4,033,333	0.238603	702,086	167,520 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-1323) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,001	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,872	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,872	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	826	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	303	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	94	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	584	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	39	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	156.51	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,941,175	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	47,423	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	907,842	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,033,333	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	4,998,414	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,998,414	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.806923	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,290.91	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	4,033,333	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-1323) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,041.67 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 97,917 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 97,917 41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	358,813	584	614.41	39	23,962 42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS

43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					111,795 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					233,674 49

PASS-THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					24,835 50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					11,434 51
52 TOTAL PROGRAM EXCLUDABLE COST					36,269 52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					197,405 53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)					674 87
88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)					88
89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)					89

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-1323) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		1,575,030		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.328037	390,387	128,061	50
52 DELIVERY ROOM & LABOR ROOM	0.746214			52
53 ANESTHESIOLOGY	0.107318	39,998	4,293	53
54 RADIOLOGY-DIAGNOSTIC	0.171773	369,341	63,443	54
60 LABORATORY	0.262450	289,196	75,899	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.383847	251,416	96,505	65
66 PHYSICAL THERAPY	0.612183	69,912	42,799	66
67 OCCUPATIONAL THERAPY	0.373571	58,216	21,748	67
68 SPEECH PATHOLOGY	0.870381	9,815	8,543	68
69 ELECTROCARDIOLOGY	0.074698	85,807	6,410	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.381985	119,516	45,653	71
72 IMPL. DEV. CHARGED TO PATIENT	0.325081	445,303	144,760	72
73 DRUGS CHARGED TO PATIENTS	0.342783	586,404	201,009	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.319842	4,006	1,281	90
91 EMERGENCY	0.482662	9,210	4,445	91
92 OBSERVATION BEDS	0.816484			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,728,527	844,849	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,728,527		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (15-Z323) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.328037	17,489	5,737	50
52 DELIVERY ROOM & LABOR ROOM	0.746214			52
53 ANESTHESIOLOGY	0.107318	639	69	53
54 RADIOLOGY-DIAGNOSTIC	0.171773	41,487	7,126	54
60 LABORATORY	0.262450	102,440	26,885	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.383847	75,208	28,868	65
66 PHYSICAL THERAPY	0.612183	195,337	119,582	66
67 OCCUPATIONAL THERAPY	0.373571	176,122	65,794	67
68 SPEECH PATHOLOGY	0.870381	15,776	13,731	68
69 ELECTROCARDIOLOGY	0.074698	1,787	133	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.381985	10,813	4,130	71
72 IMPL. DEV. CHARGED TO PATIENT	0.325081			72
73 DRUGS CHARGED TO PATIENTS	0.342783	247,977	85,002	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.319842	6,580	2,105	90
91 EMERGENCY	0.482662			91
92 OBSERVATION BEDS	0.816484			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		891,655	359,162	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		891,655		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-1323) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		146,713			30
43 NURSERY		18,052			43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.328037	20,461	6,712		50
52 DELIVERY ROOM & LABOR ROOM	0.746214	34,102	25,447		52
53 ANESTHESIOLOGY	0.107318	1,753	188		53
54 RADIOLOGY-DIAGNOSTIC	0.171773	45,072	7,742		54
60 LABORATORY	0.262450	43,425	11,397		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.383847	32,800	12,590		65
66 PHYSICAL THERAPY	0.612183	3,766	2,305		66
67 OCCUPATIONAL THERAPY	0.373571	4,793	1,791		67
68 SPEECH PATHOLOGY	0.870381	2,226	1,937		68
69 ELECTROCARDIOLOGY	0.074698	10,807	807		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.381985	3,350	1,280		71
72 IMPL. DEV. CHARGED TO PATIENT	0.325081				72
73 DRUGS CHARGED TO PATIENTS	0.342783	59,682	20,458		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	0.319842	28	9		90
91 EMERGENCY	0.482662	39,638	19,132		91
92 OBSERVATION BEDS	0.816484				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		301,903	111,795		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		301,903			202

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (15-1323) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	INPATIENT PART A		PART B		
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,995,342		1,570,903	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 12/05/2011	32,593	09/20/2011	22,081	3.01
	.02				3.02
	.03				3.03
	.04				3.04
	.05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50				3.50
	.51 09/20/2011	20,754	12/05/2011	193,674	3.51
	.52				3.52
	.53				3.53
	.54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		11,839		-171,593	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		2,007,181		1,399,310	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50				5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01				6.01
	TO .02				6.02
	PROVIDER .03				6.03
	PROVIDER .04				6.04
	TO .05				6.05
	PROGRAM .06				6.06
	.07				6.07
	.08				6.08
	.09				6.09
	PROVIDER .50				6.50
	TO .51				6.51
	PROGRAM .52				6.52
	.53				6.53
	.54				6.54
	.55				6.55
	.56				6.56
	.57				6.57
	.58				6.58
	.59				6.59
	.99				6.99
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL [] IPF [] IRF	[] SUB (OTHER) [] SNF [XX] SWING BED SNF (15-Z323)	INPATIENT PART A	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	PART B	AMOUNT 4	
DESCRIPTION									
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,230,518				1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE			NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .10 .11 .12 .13 .14 .15 .16 .17 .18 .19 .20 .21 .22 .23 .24 .25 .26 .27 .28 .29 .30 .31 .32 .33 .34 .35 .36 .37 .38 .39 .40 .41 .42 .43 .44 .45 .46 .47 .48 .49 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99		12/05/2011	79,152			NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				59,313				
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				1,289,831				4
TO BE COMPLETED BY CONTRACTOR									
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .10 .11 .12 .13 .14 .15 .16 .17 .18 .19 .20 .21 .22 .23 .24 .25 .26 .27 .28 .29 .30 .31 .32 .33 .34 .35 .36 .37 .38 .39 .40 .41 .42 .43 .44 .45 .46 .47 .48 .49 .99							5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)								
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	.01 .02							6.01 6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)								7
8	NAME OF CONTRACTOR:				CONTRACTOR NUMBER:			DATE:	

PROVIDER CCN: 15-1323 COMMUNITY HOSPT. OF LAGRANGE C
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/31/2012 10:03

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK
APPLICABLE BOX

HOSPITAL (15-1323) CAH

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,187	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,128	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	323	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,198	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	52,486,118	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	1,605,153	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

PROVIDER CCN: 15-1323 COMMUNITY HOSPT. OF LAGRANGE C
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/31/2012 10:03

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (15-Z323)
APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	869,023	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	362,754	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	826	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	1,231,777	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	1,231,777	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	1,231,777	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	21,932	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	1,209,845	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	1,209,845	19
20 INTERIM PAYMENTS	1,289,831	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	-79,986	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

CHECK [XX] HOSPITAL (15-1323)
APPLICABLE BOX: [] SUB (OTHER)

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)

1	INPATIENT SERVICES	2,019,853	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	2,019,853	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	2,040,052	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		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 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6, 17 AND 18)	2,040,052	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	250,172	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,789,880	22
23	COINSURANCE	1,132	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,788,748	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	34,790	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	34,790	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	30,525	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,823,538	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,823,538	30
31	INTERIM PAYMENTS	2,007,181	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	-183,643	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (15-1323) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	1
2	MEDICAL AND OTHER SERVICES	515,976 2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	515,976 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	515,976 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	1,815,449 9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	515,976 21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	515,976 29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	515,976 31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	515,976 36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	515,976 38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	515,976 40
41	INTERIM PAYMENTS	515,976 41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	-16,676			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	3,461,147			4
5 OTHER RECEIVABLES	32,787			5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7 INVENTORY	164,459			7
8 PREPAID EXPENSES	173,643			8
9 OTHER CURRENT ASSETS				9
10 DUE FROM OTHER FUNDS	778,861			10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	4,594,221			11
FIXED ASSETS				
12 LAND	265,000			12
13 LAND IMPROVEMENTS	1,917,116			13
14 ACCUMULATED DEPRECIATION	-544,165			14
15 BUILDINGS	13,245,217			15
16 ACCUMULATED DEPRECIATION	-1,340,470			16
17 LEASEHOLD IMPROVEMENTS	29,098			17
18 ACCUMULATED AMORTIZATION	-18,885			18
19 FIXED EQUIPMENT	7,627,345			19
20 ACCUMULATED DEPRECIATION	-2,004,239			20
21 AUTOMOBILES AND TRUCKS	42,445			21
22 ACCUMULATED DEPRECIATION	-33,026			22
23 MAJOR MOVABLE EQUIPMENT	6,858,338			23
24 ACCUMULATED DEPRECIATION	-3,831,915			24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS				27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	22,211,859			30
OTHER ASSETS				
31 INVESTMENTS				31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	5,013,487			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	5,013,487			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	31,819,567			36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	262,267			37
38 SALARIES, WAGES & FEES PAYABLE	492,150			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	675,000			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	225,907			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,655,324			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	90,339			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	32,356,916			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	32,447,255			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	34,102,579			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	-2,283,012			52
53 SPECIFIC PURPOSE FUND BALANCE				53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57 PLANT FUND BALANCE - INVESTED IN PLANT				57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)	-2,283,012			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	31,819,567			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		-2,232,956							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		818,777							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		-1,414,179							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 UNRESTRICTED FUND - FOUNDATI	71,441								5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		71,441							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		-1,342,738							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 ASSET TRANSFERS	939,496								13
14 UNRESTRICTED FUND - VOLUNTEE	778								14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		940,274							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		-2,283,012							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	4,950,927		4,950,927	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	653,080		653,080	6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY				8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	5,604,007		5,604,007	11
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	5,604,007		5,604,007	17
18 ANCILLARY SERVICES	11,178,995		11,178,995	18
19 OUTPATIENT SERVICES		37,316,472	37,316,472	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE		2,686,071	2,686,071	23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	16,783,002	40,002,543	56,785,545	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		24,474,420	29
30 **ADD (SPECIFY)** BAD DEBTS	2,926,895		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		2,926,895	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		27,401,315	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	56,785,545	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	29,365,392	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	27,420,153	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	27,401,315	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	18,838	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	106,672	6
7	INCOME FROM INVESTMENTS	-1,318	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	154,363	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	19	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	225,865	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	12,644	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	52,972	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GAIN ON DISPOSAL OF ASSETS)	3,267	24
24.01	OTHER (COUNTY REIMBURSEMENT OF AMBULANCE S)	219,600	24.01
24.02	OTHER (MISCELLANEOUS)	25,855	24.02
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	799,939	25
26	TOTAL (LINE 5 PLUS LINE 25)	818,777	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	818,777	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-132) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL (COLS.0-4)	SUBTOTAL 24	I&R COST &	TOTAL 26
	NARY CAP- REL COSTS 0			POST STEP- DOWN ADJS 25	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
1.01 EMS WEST STATION					1.01
2 CAP REL COSTS-MVBLE EQUIP					2
2.01 EMS WEST STATION EQUIP.					2.01
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
194 OCCUPATIONAL HEALTH					194
194.01 FOUNDATION					194.01
194.03 COMMUNITY & VOLUNTEER SVCS					194.03
194.04 ER PHYSICIAN					194.04
194.06 SHIPSHAWANA RADIOLOGY AND LAB					194.06
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204