DUKKE ME	DICAL CENTER								12-22
<b>APPORTIO</b>	NMENT OF INPATIENT ROUTINE			PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE C	CAPITAL COSTS					FROM: 06/01/2020		PART I	
				11-0113		TO: 05/31/2021			
Check	[[] Title V	[X] Hospital		[X]PPS					
Applicable	[X ] Title XVIII	[] PARHM Demon	stration	[]TEFRA					
Boxes:	[] Title XIX	[] Chart Model							
	1			Reduced				Inpatient	
				Capital				Program	
		Capital		Related		Per		Capital	
		Related Cost	Swing	Cost	Total	Diem	Inpatient	Cost	l
		(from Wkst. B,	Bed	(col. 1 minus	Patient	(col. 3 /	Program	(col. 5	l
		Part II, col. 26)	Adjustment	col. 2)	Days	col. 4)	Days	x col. 6)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	
-	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults and Pediatrics (General Routine Care)	318,634	842	317,792	1,229	259	225	58,181	30
	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
	Other Special Care (specify)								35
	Subprovider - IPF								40
41	Subprovider - IRF								41
	Subprovider (specify)								42
43	Nursery								43
44	,								44
	Nursing Facility								45
	Other Long Term Care								46
200	Total	318,634		317,792	1,229		225	58,181	200

	EDICAL CENTER						12-22
APPORTI	ONMENT OF INPATIENT ANCILLARY	PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE	CAPITAL COSTS			FROM: 06/01/2020		PART II	
		11-0113		TO: 05/31/2021			
Check	[] Title V	[ X ] Hospital		[X]PPS			
Applicable	[X] Title XVIII	[] PARHM Demon	stration	[]TEFRA			
Boxes:	[] Title XIX	[] Chart Model					
		Capital					
		Related Cost	Total Charges	Ratio of Cost	Inpatient		
		(from Wkst. B,	(from Wkst. C,	to Charges	Program	Capital Costs	
		Part II, col. 26)	Pt I, col 8)	(col. 1 / col. 2)	Charges	(col.3 x col. 4)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	65,318	565,508	0	6,235	720	50
53	Anesthesiology	1,230	75,661	0	409	7	53
54	Radiology-Diagnostic	38,644	2,738,521	0	31,797	449	54
57	Computed Tomography (CT) Scan	27,088	2,913,276	0	48,802	454	57
58	Magnetic Resonance Imaging (MRI)	7,622	557,557	0	4,019	55	58
60	Laboratory	53,703	3,063,302	0	135,770	2,380	60
62	Whole Blood & Packed Red Blood Cells	7,025	268,387	0	38,440	1,006	62
65	Respiratory Therapy	20,722	2,872,042	0	318,724	2,300	65
66	Physical Therapy	40,518	3,801,966	0	12,481	133	66
68	Speech Pathology	3,913	117,645	0	738	25	68
71	Medical Supplies Charged to Patients	8,579	426,182	0	90,339	1,819	71
73	Drugs Charged to Patients	21,571	3,613,829	0	257,937	1,540	73
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	148,461	7,756,491	0	73,107	1,399	91
92	Observation Beds	121,014	478,210	0	18,447	4,668	92
200	Total (sum of lines 50 through 199)	565,408	29,248,577		1,037,245	16,955	200

BURKE ME	DICAL CENTER												12-22
APPORTIO	NMENT OF INPATIENT ROUTINE							PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE O	THER PASS-THROUGH COSTS									FROM: 06/01/2020		PART III	
								11-0113		TO: 05/31/2021			
Check	[] Title V	[X] Hospital		[X]PPS									
Applicable	[X ] Title XVIII	[] PARHM Demon	stration	[] TEFRA									
Boxes:	[] Title XIX	[] Chart Model											
	•	Nursing		Allied		All	Swing-Bed					Inpatient	
		Program		Health		Other	Adjustment	Total Costs		Per		Program	
		Post-		Post-		Medical	Amount	(sum of cols.	Total	Diem	Inpatient	Pass-Through	
		Stepdown	Nursing	Stepdown	Allied Health	Education	(see	1, 2, and 3,	Patient	(col. 3 /	Program	Cost	
		Adjustments	Program	Adjustments	Cost	Cost	instructions)	minus col. 4)	Days	col. 4)	Days	(col. 7 x col. 8)	
	COST CENTER DESCRIPTIONS	1A	1	2A	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)								1,229		225		30
31	Intensive Care Unit												31
33	Burn Intensive Care Unit												33
35	Other Special Care (specify)												35
41	Subprovider - IRF												41
43	Nursery												43
200	Total								1,229		225		200

	EDICAL CENTER				I nnovenne oov		Lacaion		Lucanionies a	12-2
	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY				PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE	OTHER PASS-THROUGH COSTS				14 0440		FROM: 06/01/2020	J	PART IV	
Observi	In Tale V	[[V]]]]===#=	LIONE		11-0113		TO: 05/31/2021			
	[] Title V	[X] Hospital	[]SNF		[] PARHM Demons		[X]PPS			
	[X] Title XVIII, PART A	[] IPF	[] NF		[] PARHM CAH SV	wing-Bea SNF	[]TEFRA			
Boxes:	[] Title XIX	[] IRF	[]ICF/IID		[] Chart Model		[] Other			
		[] Subprovider (Other)	[] Swing-Bed SNF	1	[] Chart CAH Swin	g-Bed SNF		1		1
			Nursing		Allied		All		Total	
		Non	Program		Health		Other		Outpatient	
		Physician	Post-		Post-		Medical	Total Cost	Cost	
		Anesthetist	Stepdown	Nursing	Stepdown	Allied	Education	(sum of cols. 1, 2		
		Cost	Adjustments	Program	Adjustments	Health	Cost	3 and 4)	3, and 4)	
	COST CENTER DESCRIPTIONS	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									5
52	Labor Room and Delivery Room									52
53										53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									5
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									5
59	Cardiac Catheterization									5
60	Laboratory									6
61	PBP Clinical Laboratory Services-Program Only									6
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									6
64	Intravenous Therapy									64
65	1									6
66	Physical Therapy									66
67	Occupational Therapy									6
68	Speech Pathology									68
69	Electrocardiology									69
70	. 0 . ,									7
71	Medical Supplies Charged to Patients									7
72										7:
73										7:
74	,									74
75	,									7:
76	Other Ancillary (specify)		-					+	-	76.0
76.01	OUTPATIENT SERVICE COST CENTERS									76.0
	1									88
88	Rural Health Clinic (RHC) Federally Qualified Health Center (FQHC)		1					+	-	89
90	Clinic		1					+		9(
90.01	Cillio		1					+	-	90.0
	Emergency		1		1		-	+	-	90.0
91	Emergency Observation Beds							+	-	9:
92			1					+	-	9.
93	Other Outpatient Service (specify) Total (sum of lines 50 through 199)							+		200

	EDICAL CENTER									12-2
	NMENT OF INPATIENT/OUTPATIENT ANCILLARY				PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE (	OTHER PASS-THROUGH COSTS						FROM: 06/01/2020		PART IV	
					11-0113		TO: 05/31/2021			
Check	[] Title V	[ X ] Hospital	[]SNF		[X] Hospital		[X]PPS			
Applicable	[X] Title XVIII, PART A	[] IPF	[]NF		[] PARHM Demon	nstration	[]TEFRA			
Boxes:	[] Title XIX	[] IRF	[]ICF/IID		[] Chart Model		[] Other			
		[] Subprovider (Other)	[] Swing-Bed SNF		[] Chart CAH Swir	ng-Bed SNF				
		, , ,	T T		Ī	Ĭ	Inpatient		Outpatient	
				Ratio	Outpatient		Program		Program	
				of Cost	Ratio		Pass-		Pass-	
			Total Charges	to Charges	of Cost	Inpatient	Through	Outpatient	Through	
			(from Wkst. C,	(col. 5 / col. 7)	to Charges	Program	Costs	Program	Costs	
			Pt I, col 8)	(see instructions	-	Charges	(col. 8 x col 10)	Charges	(col. 9 x col. 12)	
			7	8	9	10	11	12	13	ł
	ANCILLARY SERVICE COST CENTERS		,		<u> </u>	10	11	12	10	$\vdash$
50	Operating Room		565,508			6,235		71,519		50
51	Recovery Room		1			.,		,		51
52	Labor Room and Delivery Room		+		+					52
53	Anesthesiology		75,661			409		10,053		53
54	Radiology-Diagnostic		2,738,521		<del> </del>	31,797		232,809		54
55	Radiology-Therapeutic		_,,,,,,,,,,,		+	2.,.01				55
56	Radioisotope		+		+					56
57	Computed Tomography (CT) Scan		2,913,276			48,802		423,720		5
58	Magnetic Resonance Imaging (MRI)		557,557			4,019		79,126		5
59	Cardiac Catheterization		551,551		+	.,				5
60	Laboratory		3,063,302			135,770		250,654		6
61	PBP Clinical Laboratory Services-Program Only		0,000,002			100,110		200,001		6
62	Whole Blood & Packed Red Blood Cells		268,387		+	38,440		48,017		6:
63	Blood Storing, Processing, & Trans.									6
64	Intravenous Therapy									6
65	Respiratory Therapy		2,872,042			318,724		299,256		65
66	Physical Therapy		3,801,966			12,481		3,242		66
67	Occupational Therapy		1,000,000			1, 1		5,2 .2		6
68	Speech Pathology		117,645		+	738				6
69	Electrocardiology		,							6
70	Electroencephalography									70
71	Medical Supplies Charged to Patients		426,182			90,339		19,441		7
72	Implantable Devices Charged to Patients		1.23,102		+	11,500		,		72
73	Drugs Charged to Patients		3,613,829			257,937		371,786		7:
74	Renal Dialysis		1,1 7,000		<b>+</b>	. ,		. ,,		74
75	ASC (Non-Distinct Part)									7:
76	Other Ancillary (specify)		+		<del> </del>					7
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									8
89	Federally Qualified Health Center (FQHC)		1							89
90	Clinic		+							9(
91	Emergency		7,756,491			73,107		719,019		9
92	Observation Beds		478,210		<del> </del>	18,447		104,886		9:
93	Other Outpatient Service (specify)		1,210			-,		. ,		9:
	Total (sum of lines 50 through 199)		29,248,577		+	1,037,245		2,633,528		200

BURKE M	EDICAL CENTER								12-22
APPORTI	ONMENT OF MEDICAL AND OTHER			PROVIDER CCN:		PERIOD:		WORKSHEET D	
HEALTH S	SERVICES COSTS					FROM: 06/01/2020		PART V	
				11-0113		TO: 05/31/2021			
Check	[ ] Title V - O/P	[ X ] Hospital	[] Subprovider (Other)	[] Swing-Bed SNF	[] PARHM Demons	stration			
Applicable	[X] Title XVIII, PART B	[] IPF	[]SNF	[] Swing-Bed NF	[] PARHM CAH Sw	ing-Bed SNF			
Boxes:	[] Title XIX - O/P	[] IRF	[]NF	[] ICF/IID	[] Chart Model				
					[] Chart CAH Swing	g-Bed SNF			
				Program Charges			Program Cost		
		Cost		Cost	Cost		Cost	Cost	ı
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	ı
		Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
		Pt. I, col. 9	(see inst.)	(see inst.)	(see inst.)	inst)	(see inst.)	(see inst.)	ı
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	ĺ
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.584464	71,519			41,800			50
52	Labor Room and Delivery Room								52
	Anesthesiology	0.063771	10,053			641			53
	Radiology-Diagnostic	0.276041	232,809			64,265			54
57	Computed Tomography (CT) Scan	0.237073	423,720			100,453			57
58	Magnetic Resonance Imaging (MRI)	0.237142	-, -			18,764			58
60	Laboratory	0.475361	250,654			119,151			60
62	Whole Blood & Packed Red Blood Cells	0.402203	48,017			19,313			62
	Respiratory Therapy	0.195961	299,256			58,643			65
	Physical Therapy	0.344278	,			1,116			66
	Medical Supplies Charged to Patients	0.435572	19,441			8,468			71
73	Drugs Charged to Patients	0.161883	371,786			60,186			73
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.316658	,			227,683			91
92	Observation Beds	2.251383	104,886			236,139			92
200	Subtotal (see instructions)		2,633,528			956,622			200
	Less PBP Clinic Lab. Services - Program Only Charges								201
202	Net Charges (line 200 - line 201)		2,633,528			956,622			202

BURKE M	EDICAL CENTER								12-22
APPORTIC	DNMENT OF MEDICAL AND OTHER			PROVIDER CCN:		PERIOD:		WORKSHEET D	
HEALTH S	SERVICES COSTS					FROM: 06/01/2020		PART V	
				11-0113		TO: 05/31/2021			
Check	[] Title V - O/P	[ X ] Hospital	[] Subprovider (Other)	[] Swing-Bed SNF	[] PARHM Demons	stration			
Applicable	[] Title XVIII, PART B	[] IPF	[]SNF	[] Swing-Bed NF	[] PARHM CAH Sw	ving-Bed SNF			
Boxes:	[X] Title XIX - O/P	[] IRF	[] NF	[]ICF/IID	[] Chart Model				
					[] Chart CAH Swing	g-Bed SNF			
				Program Charges			Program Cost		
		Cost		Cost	Cost		Cost	Cost	
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
		Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
		Pt. I, col. 9	(see inst.)	(see inst.)	(see inst.)	inst)	(see inst.)	(see inst.)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.584464		6,259			3,658		50
	Anesthesiology	0.063771		2,381			152		53
	Radiology-Diagnostic	0.276041		81,633			22,534		54
57	Computed Tomography (CT) Scan	0.237073		101,269			24,008		57
58	Magnetic Resonance Imaging (MRI)	0.237142		12,910			3,062		58
60	Laboratory	0.475361		5,738	1		2,728		60
	Whole Blood & Packed Red Blood Cells	0.402203		6,650			2,675		62
	Respiratory Therapy	0.195961		39,478			7,736		65
	Physical Therapy	0.344278		442			152		66
	Medical Supplies Charged to Patients	0.435572		2,972			1,295		71
73	Drugs Charged to Patients	0.161883		93,947			15,208		73
	OUTPATIENT SERVICE COST CENTERS								
	Emergency	0.316658		373,042			118,127		91
	Observation Beds	2.251383		8,402			18,916		92
	Subtotal (see instructions)			735,123			220,251		200
	Less PBP Clinic Lab. Services - Program Only Charges								201
202	Net Charges (line 200 - line 201)			735,123			220,251		202

**BURKE MEDICAL CENTER** 12-22 COMPUTATION OF INPATIENT PROVIDER CCN: PERIOD: WORKSHEET D-1. OPERATING COST FROM: 06/01/2020 PART I 11-0113 TO: 05/31/2021 Check Title V - O/P [X]PPS X ] Hospital [] NF X ] Title XVIII, PART A []ICF/IID []TEFRA [] IPF Applicable [] Title XIX - I/P []NF 1 IRF [] Other Boxes: [] PARHM Demonstration 1 Subprovider (Other) 1 SNF [] Chart Model PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS I Inpatient days (including private room days and swing-bed days, excluding newborn) 1.560 2 Inpatient days (including private room days, excluding swing-bed and newborn days) 1,229 3 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4 Semi-private room days (excluding swing-bed and observation bed days) 761 4 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 263 5 6 6 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if 6 calendar year, enter 0 on this line) 29 7 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 27 7 8 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if 8 calendar year, enter 0 on this line) 12 8 9 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 225 9 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the 10 cost reporting period (see 109 10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the 11 cost reporting period (if calendar 11 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 12 the cost reporting period. 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the 13 cost reporting period (if calendar 13 year, enter 0 on this line) 13 14 Medically necessary private room days applicable to the Program (excluding swing-bed days) 14 15 Total nursery days (title V or XIX only) 15 16 Nursery days (title V or XIX only) 16 SWING BED ADJUSTMENT 17 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 17 18 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18 19 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 19 20 20 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 2,834,811 21 21 Total general inpatient routine service cost (see instructions) 22 22 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24 25 24 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 5,156 25 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 2.340 26 27 7,496 26 Total swing-bed cost (see instructions) 2,827,315 27 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29 29 Private room charges (excluding swing-bed charges) 30 Semi-private room charges (excluding swing-bed charges) 30 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31 32 32 Average private room per diem charge (line 29 ÷ line 3)

33 Average semi-private room per diem charge (line 30 ÷ line 4)

36 Private room cost differential adjustment (line 3 x line 35)

35 Average per diem private room cost differential (line 34 x line 31)

34 Average per diem private room charge differential (line 32 minus line 33) (see instructions)

37 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)

33

34

35

36

37

2,827,315

COMPUTATION OF INPATENT	BURKE ME	DICAL CENTER							12-22
Title V - OIP	COMPUTA	TION OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,	
Check   Time V - Oil	OPERATING	G COST						PART II	
Applicable (X) Title XVIII. PART A [] IPF [] ISCARIO [] IPAREM DEPOSE: [] ISABOPOVICER ON [] ISABOPOVICER ON [] IPAREM DEPOSE ON [] ISABOPOVICER O									
				• •					
PART II - HOSPITAL AND SUBPROVIDERS ONLY	Boxes:	[] Title XIX - I/P				[] Otner			
PART II. HOSPITAL AND SUBPROVIDERS ONLY PROCRAM INPATENT DEPRATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  38) Adjusted general inpatient routine service cost per diem (see instructions)  49) Program general inpatient routine service cost (time 9 x ine 38)  40) Medically necessary private norm cost applicable to the Program (line 14 x ine 35)  41) Total Program general inpatient routine service cost (time 30 + ine 40)  517,613  41) Total Program general inpatient routine service cost (time 30 + ine 40)  Total Total Program general inpatient routine service cost (time 30 + ine 40)  Total Total Program (cost (col. 1,7 col. 2) Days (col. 3 x col. 4)  42 (Nursery (title V & XIX only)  1 2 3 4 5 4 5  42 (Nursery (title V & XIX only)  1 2 3 4 5 4 5  43 (Nursery (title V & XIX only)  44 (Nursery (title V & XIX only)  45 (Nursery (title V & XIX only)  46 (Surgical Internsive Care Unit  47 (Surgical Internsive Care Unit  48 (Surgical Internsive Care Unit  49 (Surgical Internsive Care Unit  40 (Surgical Internsive Care Unit  41 (Surgical Internsive Care Unit  42 (Surgical Internsive Care Unit  43 (Surgical Internsive Care Unit  44 (Surgical Internsive Care Unit  45 (Surgical Internsive Care Unit  46 (Surgical Internsive Care Unit  47 (Dither Special Care Unit (specify)  48 (Surgical Internsive Care Unit  48 (Surgical Internsive Care Unit)  48 (Surgical Internsive Care Unit)  49 (Surgical Internsive Care Unit)  40 (Surgical Internsive Care Unit)  40 (Surgical Internsive Care Unit)  40 (Surgical Internsive Care Unit)  41 (Surgical Internsive Care Unit)  42 (Surgical Internsive Care Unit)  43 (Surgical Internsive Care Unit)  44 (Surgical Internsive Care Unit)  45 (Surgical Internsive Care Unit)  46 (Surgical Internsive Care Unit)  47 (Surgical Internsive Care Unit)  48 (Surgical Internsive Care Unit)  49 (Surgical Internsive Care Unit)  40 (Surgical Internsive Care Unit)  40 (Surgical Internsive Care Unit)  41 (Surgic					ion				
Signature   Section   Se	DADT II III	DEDITAL AND SUBDED VIDEDS ON		[] Chart Model					
38 Adjusted general inpatient routine service cost per dient (see instructions) 39 Program general inpatient routine service cost (line 39 line 35) 40 Medically recessary private room cost applicable to the Program (line 14 kine 35) 41 Total Program general inpatient routine service cost (line 39 + line 40)  Total Program general inpatient routine service cost (line 39 + line 40)  Total Program general inpatient routine service cost (line 39 + line 40)  Total Program general inpatient routine service cost (line 39 + line 40)  Total Inpatient Days (cot 1 / cot 12) Days (cot 3 x cot 4)  42 Nursery (lite V & XIX orby)  1 2 3 4 5 42  Intensive Care Type Inpatient 43 Intensive Care Type Inpatient 43 Intensive Care Type Inpatient 44 Corcovary Care Unit 45 Burn Intensive Care Unit 46 Surgical Intensive Care Unit 47 Other Special Care Unit (specify) 48 Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)  48 Program inpatient ancillary service cost (Worksheet D-5, column 3, line 200)  48 Program inpatient costs (sum of lines 41 through 4601) (see instructions)  PASS THROUGH Costs ADJUSTMENTS 50 Pass Brough costs applicable to Program inpatient notes (sum of lines 41 through 4601) (see instructions)  TARGET AMOUNT AND LIMIT COMPUTATION  51 Pass Brough costs applicable to Program inpatient ancillary service cost (Worksheet D, sum of Parts I and III) 51 Pass Through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts I and III) 52 Total Program inpatient costs (sum of lines 50 and 51) 53 Total Program inpatient costs (sum of lines 50 and 51) 54 Target amount per discharge 55 Total Program inpatient costs (sum of lines 50 and 51) 55 Total Program inpatient costs (sum of lines 50 and 51) 55 Total Program inpatient costs (sum of lines 50 and 51) 56 Total Program inpatient costs (sum of lines 50 and 51) 57 Total Inpatient ancillary services (from Worksheet D, sum of Parts I and III) 58 Total Program inpatient costs (sum of lines 50 and 51) 57 Total Inpatient (substa	PARTII-H								
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41 Total Program general inpatient routine service cost ((ine 39 + line 40))  Total   Total   Per   Per   Per   Program   Program Cost (co.1 / col. 2)   Days   Co.1 x col. 4)    1								517,613	
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Total paperent Cost Inpatient Days (col. 1 / col. 2) Days (col. 3 x col. 4)  42 Nursery (title V & XIX only)  1 2 3 4 5  42 Intensive Care Type Inpatient Hospital Units  43 Intensive Care Unit	41	Total Program general inpatient rout	tine service cost (line 39 +	line 40)				517,613	41
Inpatient Cost									
42 Nursery (title V & XIX only)  42 Intensive Care Type Inpatient Hospital Units  43 Intensive Care Unit  43 Intensive Care Unit  44 Coronary Care Unit  45 Burn Intensive Care Unit  46 Surgical Intensive Care Unit  47 Other Special Care Unit (specify)  48 Program inpatient acciliary service cost (Worksheet D.3, column 3, line 200)  48 Program inpatient acciliary service cost (Worksheet D.3, column 3, line 200)  48 Program inpatient colliary service cost (Worksheet D.3, column 3, line 200)  48 Program inpatient colliary service cost (Worksheet D.4, Part III, line 10, column 1)  49 Total Program inpatient colliary service ost (Worksheet D.4, Part III, line 10, column 1)  PASS-THROUGH COST ADJUSTMENTS  50 Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and IV)  51 Plass through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts I and IV)  52 Total Program excludable cost (sum of lines 50 and 51)  53 Total Program excludable cost (sum of lines 50 and 51)  54 Program excludable cost (sum of lines 50 and 51)  55 Transe through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts I and IV)  55 Total Program excludable cost (sum of lines 50 and 51)  56 Transe through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts I and IV)  57 Total Program excludable cost (sum of lines 50 and 51)  58 Transe through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts II and IV)  59 Transe through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts II and IV)  50 Transe through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts II and IV)  50 Transe through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts II and IV)  51 Transe through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Part									
42   Nursery (title V & XIX only)   42   Intensive Care Upit   43   44   Coronary Care Unit   43   44   Coronary Care Unit   44   45   Burn Intensive Care Unit   44   45   Burn Intensive Care Unit   44   45   Burn Intensive Care Unit   45   46   Surgical Intensive Care Unit   46   47   Other Special Care Unit (specify)   47   48   Program Inpatient anciliary service cost (Worksheet D-3, column 3, line 200)   1   48   Program Inpatient anciliary service cost (Worksheet D-8, Part III, line 10, column 1)   48   48   19   19   19   19   19   19   19   1				Inpatient Cost		(col. 1 / col. 2)	Days		1
Intensive Care Type Inpatient Hoppital Units 43. Intensive Care Unit 43. Intensive Care Unit 44. As Intensive Care Unit 45. Burn Intensive Care Unit 46. Burgoral Intensive Care Unit 47. Other Special Care Unit (specify) 47. Other Special Care Unit (specify) 48. Program inpatient ancillary service cost (Worksheet D.3, column 3, line 200) 48. Program inpatient ancillary service cost (Worksheet D.3, column 3, line 200) 48. Program inpatient collister therapy exceptisition cost (Worksheet D.4, Part III, line 10, column 1) 49. Total Program inpatient collist therapy exceptisition cost (Worksheet D.4, Part III, line 10, column 1) 49. Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions)  PASS-THROUGH COST ADJUSTMENTS  50. Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts I and III) 50. Firess through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts I and III) 51. Strong Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts I and III) 52. Total Program excludable cost (sum of lines 50 and 51) 53. Total Program excludable cost (sum of lines 50 and 51) 54. Program indenting the partial protein partial resided, nonphysician anesthetist, and medical education costs (line 49 minus line 52) 55. Total Program indenting personal partial resided, nonphysician anesthetist, and medical education costs (line 49 minus line 52) 56. Transpart amount per discharge 55. Stranger amount per discharge 55. Stranger amount per discharge 55. Stranger amount per discharge (contractor use only) 56. Transpart (line 54 x sum of lines 55 and 15 x stranger and 15 x stranger amount (line 54 x sum of lines 55 x stranger and 15 x stranger amount (line 54 x sum of lines 55 x stranger and 15 x stranger amount (line 56 x stranger amount per discharge (contractor use only) 56. Transpart amount per discharge (contractor use only) 57. Stranger amount per discharge (contractor use only) 58. T				1	2	3	4	5	
Hospital Units 4.3 Intensive Care Unit 4.4 (Coronary Care Unit 4.5 Burn Intensive Care Unit 4.5 Burn Intensive Care Unit 4.5 Burn Intensive Care Unit 4.6 (Surgical Intensive Care Unit 4.7 Other Special Care Unit (specify) 4.6 (Surgical Intensive Care Unit 4.7 Other Special Care Unit (specify) 4.7 Other Special Care Unit (specify) 4.8 (Program Inpatient ancillary service cost (Worksheet D-3, column 3, line 200) 4.8 (Program Inpatient ancillary service cost (Worksheet D-3, column 3, line 200) 4.8 (Program Inpatient cellular Therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 4.9 (Program Inpatient cellular Therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 4.9 (Program Inpatient cellular Therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 4.9 (Program Inpatient cellular Therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 4.9 (Program Inpatient cellular Therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 4.9 (Program Inpatient Cellular Therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 4.9 (Program Inpatient Cellular Therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 4.9 (Program Inpatient Cellular Therapy acquisition cost (Worksheet D-7, Sum of Parts I and III) 5.0 (Pass Through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts I and III) 5.0 (Pass Through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts I and III) 5.0 (Pass Through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts I and III) 5.0 (Pass Through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts I and III) 5.0 (Pass Through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts I and III) 5.0 (Pass Through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts I and III) 5.0 (Pass Through Costs applica	42								42
43   Intensive Care Unit   43   44   Coronary Care Unit   44   45   Burn Intensive Care Unit   44   45   Burn Intensive Care Unit   45   46   Surgical Intensive Care Unit   45   46   Surgical Intensive Care Unit   45   46   Surgical Intensive Care Unit   46   47   Other Special Care Unit (specify)   47   47   48   Program inpatient acililary service cost (Worksheet D-3, column 3, line 200)   1   47   48   Program inpatient cellular therapy acquisition cost (Worksheet D-5, column 3, line 200)   1   48   71   71   72   72   73   73   73   73   73   73									
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46) Surgical Intensive Care Unit ( 47) Other Special Care Unit (specify)									
47 Other Special Care Unit (specify)  48 Program inpatient anciliary service cost (Worksheet D-3, column 3, line 200)  48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)  49 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions)  50 Pass ThroUGH COST ADJUSTMENTS  501 Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)  51 Pass through costs applicable to Program inpatient raciliary services (from Worksheet D, sum of Parts II and IV)  51 Pass through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts II and IV)  52 Total Program recitudable cost (sum of lines 50 and 51)  53 Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)  54 Program discharges  55 Target amount per discharge  55 Target amount general adjustment amount per discharge  55 Target amount (line 54 x sum of lines 55, 501, and 55.02)  56 Target amount (line 54 x sum of lines 55, 550, 1, and 55.02)  57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58 Bonus payment (see instructions)  59 Tended costs (lesser of line 53 * line 54, or line 55 from prior year cost report, updated by the market basket)  Continuous improvement bonus payment (if line 53 * line 54 to line 55 from prior year cost report, updated by the market basket)  Continuous improvement bonus payment (if line 53 * line 54 to line 55 from prior year cost report, updated by the market basket)  Continuous improvement bonus payment (if line 53 * line 54 to line 55 from prior year cost report, updated by the market basket)  Continuous improvement bonus payment (if line 53 * line 54 to line 55 from prior year cost report, updated by the market basket)  Continuous improvement bonus payment									
48 Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200) 323,028 48 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 49 Total Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48.01 49 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions)  840.641 49  PASS-THROUGH COST ADJUSTMENTS 50 Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III) 51 Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV) 52 Total Program excludable cost (sum of lines 50 and 51) 53 Total Program excludable cost (sum of lines 50 and 51) 54 Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION 54 Program discharges 55 Target amount per discharge (contractor use only) 55 Cold Agilustment amount per discharge (contractor use only) 55 Cold Pargustment adjustment amount per discharge (contractor use only) 55 Day Demanent adjustment adjustment per discharge (contractor use only) 55 Day Demanent adjustment per discharge (contractor use only) 55 Day Demanent (line 54 x sum of lines 55, 55.01, and 55.02) 56 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 57 Difference between adjusted injustment operating cost and target amount (line 56 minus line 53) 58 Drous payment (see instructions) 59 Tended costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 50 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 50 Continuous improvement borus payment (fi line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the 161 al amount by which operating costs (line 54) are less than expected costs (li		<u> </u>							
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48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 49 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions)  840,641 49  PASS-THROUGH COST ADJUSTMENTS  50 Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III) 51 Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and III) 52 Total Program excludable cost (sum of lines 50 and 51) 53 Total Program excludable cost (sum of lines 50 and 51) 53 Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION 54 Program discharges 55 Target amount per discharge 55 Target amount per discharge 55 Jarget amount per discharge 55 Jarget amount per discharge (contractor use only) 56 Target amount per discharge (contractor use only) 57 Jifference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58 Bonus payment (see instructions) 59 Trended costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 50 Expected costs (lesser of line 53 + line 54, or line 55 ine 54, or line 55 from prior year cost report, updated by the market basket) 50 Expected costs (lesser of line 53 + line 54, or line 55 ine for prior year cost report, updated by the market basket) 50 Expected costs (lesser of line 53 + line 54, or line 55 ine for prior year cost report, updated by the market basket) 50 Expected costs (lesser of line 53 + line 54, or line 55 ine for prior year cost report, updated by the market basket) 51 Continuous improvement bonus payment (16 lie less than the lowest of lines 55 55.01, or line 59, or line 60, otherwise enter zero. (see 61 Amount by which operating costs (line 53 ine 64 lie less than the lowest of lines 55 55.01, or line 59, or line 60, otherwise enter zero. (see 61 Ca Relief payment (see i								1	
PASS-THROUGH COST ADJUSTMENTS  50 Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)  51 Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)  15 Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)  16,955  51 Total Program excludable cost (sum of lines 50 and 51)  75,136  52 Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)  765,505  78 TARGET AMOUNT AND LIMIT COMPUTATION  54 Program discharges  55 Target amount per discharge  55 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58 Bonus payment (see instructions)  59 Trended costs (lesser of line 53 + line 54, or line 55 from prior year cost reporting period ending 1996, updated and compounded by the market basket)  59 Continuous improvement bonus payment (fine 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  59 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated with the water of the cost reporting period (see instructions)  60 Expected costs (lesser of line 53 + line 64, or line 55 from prior year cost report, updated with the lowest of line 59, or line 60, enter the lesser of 50% of the 61 amount by which operating costs (line 63) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see  61 Allowable Inpatient cost plus incentive payment (see instructions)  62 Relief payment (see instructions)  63 Allowable Inpatient cost plus incentive payment (see instructions)  64 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting								323,028	
PASS-THROUGH COST ADJUSTMENTS  50 Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)  51 Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)  52 Total Program excludable cost (sum of lines 50 and 51)  53 Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)  765,505 53  TARGET AMOUNT AND LIMIT COMPUTATION  54 Program discharges  55 Target amount per discharge  55 S1 Target amount per discharge  55 S5,01 Permanent adjustment amount per discharge  55 S5,02 Adjustment amount per discharge  55 S5,01 Permanent adjustment amount per discharge  56 S5,02 Adjustment amount per discharge (contractor use only)  56 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58 Bosus payment (line 54 x sum of lines 55, 55.01, sum of 56 from the cost reporting period ending 1996, updated and compounded by the market basket)  59 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  60 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  60 Continuous improvement bonus payment (line 54 is less than the lowest of lines 55 pits 55.01, or line 59, or line 60, enter the lesser of 50% of the 61 fl amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see  61 Allowable Inpatient cost plus incentive payment (see instructions)  63 Allowable Inpatient cost plus incentive payment (see instructions)  64 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)  65 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost rep					nn 1)				
50 Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)  51 Pass through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts II and IV)  52 Total Program excludable cost (sum of lines 50 and 51)  53 Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)  765,505 53  TARGET AMOUNT AND LIMIT COMPUTATION  54 Program discharges  54 Target amount per discharge  55 Target amount per discharge  55 Target amount per discharge  55 Jarget amount per discharge (contractor use only)  55 Jarget amount per discharge (contractor use only)  55 Jarget amount (line 54 x sum of lines 55, 55.01, and 55.02)  56 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58 Bonus payment (see instructions)  59 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  60 Expected costs (lesser of line 53 + line 54 in les 54 line 5	49	Total Program inpatient costs (sum	of lines 41 through 48.01)	(see instructions)				840,641	49
50 Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)  51 Pass through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts II and IV)  52 Total Program excludable cost (sum of lines 50 and 51)  53 Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)  765,505 53  TARGET AMOUNT AND LIMIT COMPUTATION  54 Program discharges  54 Target amount per discharge  55 Target amount per discharge  55 Target amount per discharge  55 Jarget amount per discharge (contractor use only)  55 Jarget amount per discharge (contractor use only)  55 Jarget amount (line 54 x sum of lines 55, 55.01, and 55.02)  56 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58 Bonus payment (see instructions)  59 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  60 Expected costs (lesser of line 53 + line 54 in les 54 line 5									
51 Pass through costs applicable to Program inpatient anciliary services (from Worksheet D, sum of Parts II and IV)  52 Total Program excludable cost (sum of lines 50 and 51)  53 Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54 Program discharges  55 Target amount per discharge  55 So 10 Permanent adjustment amount per discharge  55 So 10 Permanent adjustment amount per discharge  55 So 20 Adjustment amount per discharge (contractor use only)  56 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58 Bonus payment (see instructions)  59 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  60 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  Continuous improvement bonus payment (if I line 53 + line 54 ine 55 ine 54 ine 55 ine									
52 Total Program excludable cost (sum of lines 50 and 51)  53 Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)  75,136 52  765,505 53  TARGET AMOUNT AND LIMIT COMPUTATION  54 Program discharges  55 55 13 Target amount per discharge  55 55 10 Permanent adjustment amount per discharge  55 50.1 Permanent adjustment amount per discharge  55 50.2 Adjustment amount per discharge (contractor use only)  56 Target amount (line 54 x sum of lines 55, 50.1, and 55.02)  57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  59 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  58 Bonus payment (see instructions)  59 Trended costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  60 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  60 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the did amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see  61 62 Relief payment (see instructions)  63 Allowable Inpatient cost plus incentive payment (see instructions)  64 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)  64 Medicare swing-bed SNF inpatient routine costs dire December 31 of the cost reporting period (line 12 x line 19)  65 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  66 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 13 x line 20)									
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TARGET AMOUNT AND LIMIT COMPUTATION  54 Program discharges  55 Target amount per discharge  55.01 Permanent adjustment amount per discharge  55.02 Adjustment amount per discharge  55.02 Adjustment amount per discharge  55.01 Secondary amount per discharge (contractor use only)  55.02 56 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  56 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58 Bonus payment (see instructions)  58 Bonus payment (see instructions)  59 Trended costs (lesser of line 53 + line 54, or line 55 from prior year cost reporting period ending 1996, updated and compounded by the market basket)  59 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  60 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  61 Continuous improvement bonus payment (if line 53 + line 54 is less than the loses of lines 59, or line 60, enter the lesser of 50% of the 61 amount by which operating costs (line 53) are less than the obsert of lines 59 to line 59, or line 60, enter the lesser of 50% of the 62 Relief payment (see instructions)  62 Relief payment (see instructions)  63 Allowable Inpatient cost plus incentive payment (see instructions)  64 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)  65 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  66 Total Medicare swing-bed NF inpatient routine costs fline 64 plus line 65) (title XVIII only) (or CAH, see instructions)  67 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  68 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  68 Title V or						1 (1) 10 : 11 50			
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67 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  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	65	Medicare swing-bed SNF inpatient r	outine costs after December	er 31 of the cost reporting	period (see instructions) (ti	tle XVIII only)			65
67 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  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	66	Total Medicare swing-bed SNF inpa	tient routine costs (line 64	plus line 65) (title XVIII only	y; for CAH, see instructions	3)			
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69 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)									68
	69	Total title V or XIX swing-bed NF inp	patient routine costs (line 67	7 + line 68)		<u> </u>			69

BURKE MEI	DICAL CENTER							12-22			
COMPUTAT	ION OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,				
OPERATING	COST				FROM: 06/01/2020		PARTS III & IV				
			11-0113		TO: 05/31/2021						
Check	[] Title V - O/P	[ X ] Hospital	[] NF		[X]PPS						
Applicable	[ X ] Title XVIII, PART A	[] IPF	[] ICF/IID		[]TEFRA						
Boxes:	[] Title XIX - I/P	[] IRF	[] NF		[] Other						
		[] Subprovider (Other)	[] PARHM Demons	tration							
		[]SNF	[] Chart Model								
	NF, NF, AND ICF/IID ONLY										
	SNF / NF / ICF/IID routine service of							70			
	Adjusted general inpatient routine s		÷ line 2)					71			
	Program routine service cost (line 9							72 73			
	73 Medically necessary private room cost applicable to Program (line 14 x line 35)										
	74 Total Program general inpatient routine service costs (line 72 + line 73)										
75	Capital-related cost allocated to inpa	atient routine service costs (f	from Worksheet B, Pa	rt II, column 26, line 45)				75 76			
	76 Per diem capital-related costs (line 75 ÷ line 2)										
77	77 Program capital-related costs (line 9 x line 76)										
	78 Inpatient routine service cost (line 74 minus line 77)										
	Aggregate charges to beneficiaries							79			
	Total Program routine service costs		imitation (line 78 minu	s line 79)				80			
	Inpatient routine service cost per die							81			
	Inpatient routine service cost limitat							82			
	Reasonable inpatient routine servic							83			
	Program inpatient ancillary services							84			
	Utilization review - physician compe							85			
86	Total Program inpatient operating c	osts (sum of lines 83 through	า 85)					86			
	-						-				
	OMPUTATION OF OBSERVATION		ST								
	Total observation bed days (see ins						468	87			
	Adjusted general inpatient routine c		)				2,301	88			
89	Observation bed cost (line 87 x line	88) (see instructions)					1,076,634	89			
	COMPLITATION OF ODDEDWATE	N DED DAGG TUDOUGU G	.007								
	COMPUTATION OF OBSERVATION	IN BED PASS THROUGH C	1081			T +	I 01 B 1	ı			
						Total	Observation Bed				
				Routine	1	Observation	Pass-Through Cost				
				Cost	column 1 /	Bed Cost	(col. 3 x col. 4)				
			Cost	(from line 21)	column 2	(from line 89)	(see instructions)				
	In the second		1	2	3	4	5				
	Capital-related cost		-				318,634	90			
	Nursing Program cost							91			
	Allied Health cost All other Medical Education							92			
93		93									

COMPLITAT	DICAL CENTER TION OF INPATIENT		PROVIDER CCN:	PERIOD:	WORKSHEET D-1.	12-22
OPERATING			I NOVIDEN GON.	FROM: 06/01/2020	PART I	
OI LIVATIIV	0 0001		11-0113	TO: 05/31/2021	ACCIT	
Check	[] Title V - O/P	[X] Hospital	[]NF	[X]PPS		
Applicable	[] Title XVIII, PART A	[] IPF	[] ICF/IID	[]TEFRA		
Boxes:	[X] Title XIX - I/P	[] IRF	[] NF	[] Other		
DOXES.	[X] THE XIX - W	[] Subprovider (Other)	[] PARHM Demonstration	[] Other		
		[] Subprovider (Other)	[] Chart Model			
ΡΔΡΤΙ- ΔΙ	L PROVIDER COMPONENTS	L J	[] Chart Model			
ANTI-AL	INPATIENT DAYS				1	
1		ate room days and swing-bed da	vs excluding newhorn)		1,560	
		ate room days and swing-bed da ate room days, excluding swing-b			1,229	:
			days). If you have only private room days.	do not complete this line	1,220	
		uding swing-bed and observatio		, do not complete uno mie.	761	-
			om days) through December 31 of the cos	t reporting period	263	
				porting period (if 6 calendar year, enter 0 on this	200	<u> </u>
6	line)	,- ( ,	···· <b>,</b> -, -···· · · · · · · · · · · ·	F ( ),	29	
7		tient days (including private roon	n days) through December 31 of the cost r	reporting period	27	
	,,,,,,,	<i>y</i> , <i>y</i> ,	,, ,			
8	Total swing-bed NF type inpa	tient days (including private roon	n days) after December 31 of the cost repo	orting period (if 8 calendar year, enter 0 on this line)	12	
9			the Program (excluding swing-bed and ne		48	
				ecember 31 of the 10 cost reporting period (see		
10	instructions).	t days applicable to the XVIII offi	y (molading private room days) through be	soomber of or the 10 occurreporting period (see		1
- 10		t days applicable to title XVIII onl	v (including private room days) after Dece	mber 31 of the 11 cost reporting period (if calendar		<u> </u>
11	year, enter 0 on this line)	t days approads to the fitting on	y (including private reem daye) and Beec	inser or or the fire each operating period (in edicinada		1
		days applicable to titles V or XIX	only (including private room days) through	December 31 of 12 the cost reporting period.		1:
				ecember 31 of the 13 cost reporting period (if		
13	calendar year, enter 0 on this		only (moldaring private room days) after be	soomber of or the 10 oost reporting period (ii		13
		oom days applicable to the Prog	ram (excluding swing-bed days)			14
	Total nursery days (title V or )		(			15
	Nursery days (title V or XIX or					10
	SWING BED ADJUSTMENT	,,				
17		SNF services applicable to service	es through December 31 of the cost repo	rting period		1
			es after December 31 of the cost reporting			18
			s through December 31 of the cost reporti		191	19
			s after December 31 of the cost reporting		195	2
		e service cost (see instructions)	1 3	1	2,834,811	2
			ember 31 of the cost reporting period (line	5 x line 17)	, , , , ,	2
			er 31 of the cost reporting period (line 6 x			2
			nber 31 of the cost reporting period (line 7		5,156	24
			r 31 of the cost reporting period (line 8 x li		2,340	2
	Total swing-bed cost (see ins			,	7,496	20
27	General inpatient routine serv	rice cost net of swing-bed cost (li	ne 21 minus line 26)		2,827,315	2
	PRIVATE ROOM DIFFEREN	TIAL ADJUSTMENT	•			
28	General inpatient routine serv	rice charges (excluding swing-be	d and observation bed charges)			28
	Private room charges (exclud		- ,			29
30	Semi-private room charges (	excluding swing-bed charges)				30
31	General inpatient routine serv	vice cost/charge ratio (line 27 ÷ li	ne 28)			3
32	Average private room per die	m charge (line 29 ÷ line 3)				32
33	Average semi-private room p	er diem charge (line 30 ÷ line 4)				3
34	Average per diem private roo	m charge differential (line 32 mir	nus line 33) (see instructions)			34
		m cost differential (line 34 x line				35
	Private room cost differential					3(
			nd private room cost differential (line 27 m	inus line 36)	2,827,315	3

**BURKE MEDICAL CENTER** 12-22 WORKSHEET D-1 COMPUTATION OF INPATIENT PROVIDER CCN: DEBIUD. OPERATING COST FROM: 06/01/2020 PART II 11-0113 TO: 05/31/2021 Title V - O/P [X]PPS Check X | Hospital [] NF [] Title XVIII, PART A Applicable [] ICF/IID []TEFRA [ ] IPF [X] Title XIX - I/P [] IRF [] NF [] Other ] Subprovider (Other) [] PARHM Demonstration []SNF [] Chart Model PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS 38 38 Adjusted general inpatient routine service cost per diem (see instructions) 2 301 39 Program general inpatient routine service cost (line 9 x line 38) 110.424 39 40 40 Medically necessary private room cost applicable to the Program (line 14 x line 35) 110,424 41 41 Total Program general inpatient routine service cost (line 39 + line 40) Average Per Diem Total Total Program Program Cost Inpatient Cost Inpatient Days (col. 1 / col. 2) Days (col. 3 x col. 4) 42 Nursery (title V & XIX only) 42 Intensive Care Type Inpatient Hospital Units Intensive Care Unit 43 44 44 Coronary Care Unit 45 Burn Intensive Care Unit 45 46 Surgical Intensive Care Unit 46 47 47 Other Special Care Unit (specify) 48 48 Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200) 65 999 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48.01 176,423 49 49 Total Program inpatient costs (sum of lines 41 through 48.01 ) (see instructions) PASS-THROUGH COST ADJUSTMENTS 50 Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III) 50 51 52 51 Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV) Total Program excludable cost (sum of lines 50 and 51) 53 53 Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION 54 Program discharges 54 55 Target amount per discharge 55 55.01 Permanent adjustment amount per discharge 55.01 55.02 Adjustment amount per discharge (contractor use only) 55.02 56 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56 57 57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58 59 58 Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 60 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket) 60 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of 61 the 61 amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero 61 62 Relief payment (see instructions) 62 63 63 Allowable Inpatient cost plus incentive payment (see instructions)

64

65 66 67

68

69

PROGRAM INPATIENT ROUTINE SWING BED COST

69 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)

64 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)

65 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)

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

BURKE MED	DICAL CENTER							12-22
	ON OF INPATIENT		PROVIDER CCN:		PERIOD: FROM: 06/01/2020 TO: 05/31/2021		WORKSHEET D-1, PARTS III & IV	
Applicable	[] Title V - O/P [] Title XVIII, PART A [X] Title XIX - I/P	[X] Hospital [] IPF [] IRF [] Subprovider (Other) [] SNF	[] NF [] ICF/IID [] NF [] PARHM Demons [] Chart Model	tration	[X] PPS [] TEFRA [] Other			
PART III - SN	IF, NF, AND ICF/IID ONLY	15.7	.,					
70	SNF / NF / ICF/IID routine service of	ost (line 37)						70
71	Adjusted general inpatient routine s	service cost per diem (line 70	0 ÷ line 2)					71
72	Program routine service cost (line 9	x line 71)	·					72
73	Medically necessary private room c	ost applicable to Program (l	ine 14 x line 35)					73
74	Total Program general inpatient rou	ıtine service costs (line 72 +	line 73)					74 75
75	Capital-related cost allocated to inp	atient routine service costs	(from Worksheet B, P	art II, column 26, line 45)				75
	Per diem capital-related costs (line							76 77
	Program capital-related costs (line			77				
	Inpatient routine service cost (line 7			78				
	Aggregate charges to beneficiaries			79				
	Total Program routine service costs		limitation (line 78 minເ	us line 79)				80
	Inpatient routine service cost per di							81
	Inpatient routine service cost limitat							82
	Reasonable inpatient routine service							83
	Program inpatient ancillary services							84
	Utilization review - physician compe							85
86	Total Program inpatient operating of	osts (sum of lines 83 throug	h 85)					86
	OMPUTATION OF OBSERVATION		ST					
	Total observation bed days (see ins						468	87
	Adjusted general inpatient routine of		2)				2,301	88
89	Observation bed cost (line 87 x line	88) (see instructions)					1,076,634	89
	COMPUTATION OF OBSERVATIO	N BED PASS THROUGH C	COST					
				Routine		Total Observation	Observation Bed Pass-Through Cost	
				Cost	column 1 /	Bed Cost	(col. 3 x col. 4)	
			Cost	(from line 21)	column 2	(from line 89)	(see instructions)	
			1	2	3	4	5	
90	Capital-related cost						318,634	90
91	Nursing Program cost							91
	Allied Health cost							92
93	All other Medical Education			93				

BURKE MEDICA	AL CENTER				12-				
	OF INPATIENT			PROVIDER CCN:	PERIOD:		WORKSHEET D-3		
OPERATING CO	OST				FROM: 06/01/20				
		-		11-0113	TO: 05/31/2021				
Check	[] Title V - O/P		] SNF	[] ICF/IID	[X]PPS				
Applicable Boxes	[X] Title XVIII, PART A [] Title XIX - I/P		NF 1 Swing Rod SNE	[] PARHM Demonstration [] PARHM CAH Swing-Bed SNF	[]TEFRA []Other				
Boxes:	[] Title XIX - I/P	[] Subprovider (Other) [	] Swing-Bed SNF	[] Chart Model	[ ] Other				
		[] Gubpiovider (Guier) [	1 Owing Dea 141	[] Chart CAH Swing-Bed SNF					
		1		[] Great Gray Swing Bod Gra	Ratio of Cost	Inpatient	Inpatient Program Costs		
	COST CENTER DESCRIPTION	ON			to Charges	Program Charges	(col. 1 x col. 2)		
(A)					1	2	3		
	INPATIENT ROUTINE SERVI								
30	Adults and Pediatrics (Gener	al Routine Care)				135,000		30	
31	Intensive Care Unit							31	
32 33	Coronary Care Unit Burn Intensive Care Unit							32	
34	Surgical Intensive Care Unit							34	
35	Other Special Care (specify)							35	
40	Subprovider - IPF							40	
41	Subprovider - IRF							41	
42	Subprovider (specify)							42	
43	Nursery							43	
FO	ANCILLARY SERVICE COS	SICENTERS			0.504464	6.005	2 644	F0	
50 51	Operating Room Recovery Room				0.584464	6,235	3,644	50 51	
	Labor Room and Delivery Ro	nom						52	
53	Anesthesiology				0.063771	409	26	53	
54	Radiology-Diagnostic				0.276041	31,797	8,777	54	
55	Radiology-Therapeutic							55	
56	Radioisotope							56	
57	Computed Tomography (CT)				0.237073	48,802	11,570	57	
58	Magnetic Resonance Imagin	g (MRI)			0.237142	4,019	953	58	
59	Cardiac Catheterization				0.475004	405 770	04.540	59 60	
60 61	Laboratory PBP Clinical Laboratory Serv	vices-Program Only			0.475361	135,770	64,540	61	
62	Whole Blood & Packed Red				0.402203	38,440	15,461	62	
63	Blood Storing, Processing, &				0		,	63	
64	Intravenous Therapy							64	
65	Respiratory Therapy				0.195961	318,724	62,457	65	
66	Physical Therapy				0.344278	12,481	4,297	66	
67	Occupational Therapy				2 222222	700	500	67	
68	Speech Pathology				0.809920	738	598	68	
69 70	Electrocardiology Electroencephalography							69 70	
71	Medical Supplies Charged to	Patients			0.435572	90,339	39,349	71	
72	Implantable Devices Charged						00,010	72	
73	Drugs Charged to Patients				0.161883	257,937	41,756	73	
74	Renal Dialysis							74	
75	ASC (Non-Distinct Part)							75	
76	Other Ancillary (specify)	OOT OFNITEDO						76	
88	OUTPATIENT SERVICE CO Rural Health Clinic (RHC)	JST CENTERS						88	
89	Federally Qualified Health Co	enter (EOHC)						89	
90	Clinic	sitter (i Qi io)						90	
91	Emergency				0.383949	73,107	28,069	91	
92	Observation Beds				2.251383	18,447	41,531	92	
93	Other Outpatient Service (sp	ecify)						93	
	OTHER REIMBURSABLE (	COST CENTERS							
94	Home Program Dialysis							94	
95	Ambulance Services	Dantad						95	
96 97	Durable Medical Equipment-							96 97	
98	Durable Medical Equipment-S Other Reimbursable (specify							98	
99	Outpatient Rehabilitation Pro							99	
100	Intern-Resident Service (not							100	
101	Home Health Agency							101	
200	Total (sum of lines 50 through 94 and 96 through 98)					1,037,245	323,028	200	
201	Less PBP Clinic Laboratory S		arges (line 61)			,		201	
202	Net charges (line 200 minus li	ine 201)				1,037,245		202	

BURKE MEDIC	AL CENTER							12-22
	N OF INPATIENT			PROVIDER CCN:	PERIOD:		WORKSHEET D-3	
OPERATING C	OST		FROM: 06/01/20	020				
		11-0113	TO: 05/31/202	1				
Check	[] Title V - O/P [X] Hospital [] SNF			[] ICF/IID	[X]PPS			
Applicable	[] Title XVIII, PART A [] IPF [] NF [] PARHM Demonstr				[] TEFRA			
Boxes:	[X] Title XIX - I/P [] IRF [] Swing-Bed SNF [] PARHM CAH Swing-Bed SN				[] Other			
		[] Subprovider (Other)	[] Swing-Bed NF	[] Chart Model				
	[] Chart CAH Swing-Bed SNF							
	COST CENTED DESCRIPTION		Ratio of Cost	Inpatient	Inpatient Program Costs	ı		
COST CENTER DESCRIPTION (A)					to Charges	Program Charges 2	(col. 1 x col. 2) 3	ı
(A)	INPATIENT ROUTINE SERV	ICE COST CENTERS			'		3	
30						28,800		30
31								31
32								32
33	Burn Intensive Care Unit							33
34								34
35								35
40								40
41								41
42								42
43		CT CENTEDS						43
50	ANCILLARY SERVICE COST CENTERS  Operating Room				0.584464			50
	Recovery Room				0.304404			51
	Labor Room and Delivery Room							52
53	Anesthesiology				0.063771			53
54						5,999	1,656	54
55								55
56	Radioisotope							56
57					0.237073 0.237142	14,716	3,489	57
58	0 0 7							58
59					0.475361			59
	Laboratory					26,834	12,756	60
61								61
	Whole Blood & Packed Red Blood Cells Blood Storing, Processing, & Trans.							62 63
64								64
65						94,927	18,602	65
66						482	166	66
67	Occupational Therapy							67
68								68
	Electrocardiology							69
	Electroencephalography							70
	Medical Supplies Charged to Patients					19,685	8,574	71
72					0.404000	20.404	10.750	72
73					0.161883	66,464	10,759	73 74
74 75	ASC (Non-Distinct Part)					75		
76								76
	OUTPATIENT SERVICE C	OST CENTERS						
88					1			88
89		enter (FQHC)					89	
	Clinic							90
91					0.316658	23,395	7,408	91
92					2.251383	1,150	2,589	92
93	3 Other Outpatient Service (specify)							93
	OTHER REIMBURSABLE	COST CENTERS						
94								94
95 96								95 96
97								97
98	Other Reimbursable (specify)							98
99	Outpatient Rehabilitation Provider (specify)							99
100								100
101								101
200	Total (sum of lines 50 through 94 and 96 through 98)					253,652	65,999	200
201	Less PBP Clinic Laboratory Services - Program only charges (line 61)							201
202	Net charges (line 200 minus line 201)					253,652		202