THE UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

MEDICARE REIMBURSEMENT AND AN EVALUATION OF ALTERNATIVE REIMBURSEMENT PROPOSALS

A DISSERTATION

SUBMITTED TO THE GRADUATE COLLEGE

in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

BY

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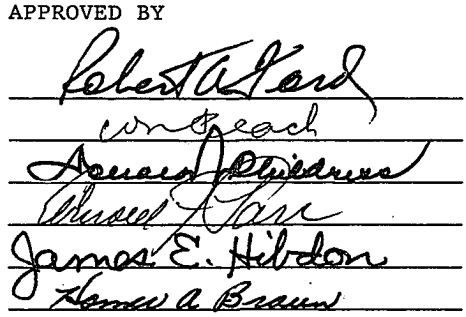
Norman, Oklahoma

1977

MEDICARE REIMBURSEMENT AND AN EVALUATION
OF ALTERNATIVE REIMBURSEMENT PROPOSALS

APPROVED BY



DISSERTATION COMMITTEE

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ACKNOWLEDGMENTS

To the members of my dissertation committee, Dr. Donald Childress, Dr. Arnold Parr, Dr. Robert Ford, Dr. James Hibdon, Dr. Homer Brown, and Dr. Nelson Peach I extend my sincere thanks and appreciation for their constructive criticism, encouragement, and assistance.

To Helen Jordan, who worked so closely with me in the preparation of the manuscript, I also express my sincere thanks and appreciation.

MEDICARE REIMBURSEMENT AND AN EVALUATION OF ALTERNATIVE REIMBURSEMENT PROPOSALS

CHAPTER I

INTRODUCTION

The history of the Medicare program is replete with controversy concerning the system whereby institutional providers of medical care to eligible Medicare program participants are reimbursed for services rendered. In general, the contention is made that institutional providers are reimbursed less than the cost of providing care to Medicare program participants. As a consequence, the level and range of services offered by the provider institution to the community is alleged to be inhibited in the present and future periods. The fundamental purpose of this study is to review the Medicare reimbursement mechanism, and to empirically evaluate alternative systems of reimbursement and their applicability to Medicare certified provider institutions.

Approach Followed in the Study

The research for this dissertation was conducted in three separate phases. The first phase involved a thorough review of the literature concerning Medicare reimbursement.

Such a review was essential in order to determine that a controversial issue exists, to define the practical limits within which the study could be conducted, and to obtain information about existing relevant research and analyses. This phase of the research provided the basis for much of the discussion which follows, particularly that segment concerning the Medicare reimbursement system, and the review of relevant literature. In addition, this phase of the research provided the conceptual foundation for the development of alternative reimbursement proposals.

The second phase of research for this dissertation concerned the collection of six years of reimbursement information from each of five metropolitan Oklahoma hospitals which agreed to participate in the study. All of the reimbursement information obtained, with the exception of that pertaining to the year 1972, had been audited by the fiscal intermediary. Information for the year 1972 was "as submitted" to the fiscal intermediary by the provider institution.

The third phase of research for this dissertation concerned the hypothecation and empirical evaluation of alternatively proposed methods of provider reimbursement. A detailed discussion of the methodology, application, and findings is presented in subsequent chapters.

Scope of the Study

Although there are many different forms of institu-

tions certified for the provision of medical care under Medicare, such as General Medical and Surgical hospitals, specialized institutions such as Tuberculosis or Orthopedic hospitals, proprietorships, partnerships, and corporations operated for a profit, church related non-profit hospitals, etc., the reimbursement regulations whereby all are compensated for services rendered to Medicare program participants are of one body. To be sure, deviations from the general body of regulations do, in practice, exist. However, the fact remains that the present reimbursement regulations have been generated in such a manner as to be generally applicable to all provider institutions. The research in this dissertation, therefore, concerns the general body of regulations as they apply to hospitals and the hypothecation of alternative reimbursement proposals capable of application to all Medicare certified hospital units.

Sources of Data

The data used in the empirical evaluation of the hypothecated alternative reimbursement proposals was collected from five metropolitan Oklahoma hospitals, agreeing to participate in the study on an individual basis. All participating hospitals were asked to supply the following information for the years 1967 through 1972:

Form SSA-1562	Reimbursable Cost on the Departmental RCC Method or Combination Method (computed with cost finding)

Schedule A	Reclassification of Trial Balance Expenses (and all supporting subschedules A-1 through A-5)
Worksheet B	Cost Apportionment- General Services
Worksheet B-1	Statistical Basis - Cost Apportionment
Schedule C	Departmental Cost Allocation
Schedule C-1	Departmental Charges
Schedule D	Cost Per Unit of Service
Schedule E	Computation of Hospital Inpatient Routine Service Cost for Title XVIII (Medicare)
Form SSA-1563	Hospital Statement of Reimbursable Cost
Form SSA-1992	Hospital Statement of Reimbursable Cost
Exhibit A	Statistical Data
Exhibit B	Calculation of Reimbursement Settlement - Inpatient Services Excluding Title XVIII, Part B
Exhibit E	Calculation of Reimbursement Settlement - Title XVIII Part B and Part A, Outpatient
Exhibit F	Computation of Inpatient Hospital Ancillary Services Covered by Supplementary Medical Insurance (Title XVIII, Part B only)
Exhibit H	Apportionment of Remuneration for Professional Services Rendered by Hospital-Based Physicians
Exhibit H-1	Summary of Remuneration for Professional Services Rendered by Hospital-Based Physicians Applicable to the Health Care Programs
Exhibit J	Supplementary Cost Form

Form SSA-1564	Combination Method (Estimated Percentage Basis)
Form SSA-1564A	Gross RCC Method

Although the first reporting year for provider institutions participating in the Medicare program was 1966, preliminary investigations, corroborated by the financial officers of the five participating metropolitan Oklahoma hospitals, indicated that data for that year was very incomplete and could not be meaningfully incorporated in the research. Furthermore, in two cases the data available in Form SSA-1564, for the year 1967, was inconsistent with regulations and necessitated minor revisions. Every attempt, however, was made to use material audited by the fiscal intermediary. In the instances where revisions were necessitated, they were made in concert with the chief financial officer of the hospital in question, in accordance with his recommendation, and based on supporting work papers as provided by the institution.

In addition to the operating data supplied by individual participating institutions, as delineated above, hospital expense, inpatient days and outpatient occasions of service data, on a time series basis for the years 1962 through 1973, and on a cross-sectional basis was used in the evaluation of one of the hypothesized alternative reimbursement proposals. This data was secured from Hospital Statistics 1974 Edition, the most recent publication of such information by the American Hospital Association.

Participating Institutions

Five metropolitan Oklahoma hospitals have agreed to participate in this study. Each hospital has supplied financial and statistical data for the six year period 1967 through 1972. Three of the participating hospitals are church operated, not for profit, general medical and surgical hospitals. One hospital is a corporation, operated for a profit, and is a specialized service institution. One hospital is a non-governmental, not for profit, general medical and surgical institution. All five hospitals are short stay.

For proprietary reasons all participating hospitals will be identified only by means of a number in this study.

Organization of the Dissertation

This dissertation is composed of five chapters.

Chapter I contains a statement as to the purpose of the study and major problem to be investigated. The approach used in the study, scope of the study, sources of data, and organization of the dissertation are delineated.

Chapter II presents a summary, using a numerical example, of the reimbursement system applicable to the period in question. In addition, the number and types of hospitals participating in the Medicare program, the medical needs of Medicare type patients, and operational characteristics of Medicare certified Oklahoma hospitals is noted. Furthermore, both terms and literature basic to an understanding of the Medicare reimbursement system, and the benefits, eligibility,

and financing and administration of both the Hospital Insurance Program (Part A of Medicare), and Supplementary Medical Insurance Program (Part B of Medicare) are reviewed.

Chapter III presents alternative reimbursement proposals. The first proposal presented concerns primarily the allocation of the expenses of non-revenue producing departments to revenue producing departments on the basis of the results obtained from regressing the individual departmental expenses with such indices of patient activity as patient days and outpatient occasions of service. The second proposal focuses primarily on the allocation of non-revenue producing department, support-related expenses on the basis of the weighted average impact of the Medicare program relative to all hospital programs. This proposal draws a fundamental distinction between the expenses of non-revenue producing, support-related departments and the expenses of non-revenue producing, patient-related departments.

Chapter IV presents the results of an application of the two hypothecated alternative methods of Medicare reimbursement as applied to five metropolitan Oklahoma hospitals.

Chapter V provides a summary of the dissertation and the major findings of the study.

Appendix I presents the financial and statistical data for five metropolitan Oklahoma hospitals.

Appendix II presents the results of the reimbursement settlement for Medicare programs using the weighted average impact reimbursement proposal.

Appendix III presents the results of multiple linear regression and correlation analysis of non-revenue producing department expenses versus patient days and outpatient occasions of service.

CHAPTER II

THE PRESENT SYSTEM OF REIMBURSEMENT

The system of reimbursement whereby institutional providers of medical care are paid for the services rendered eligible Medicare program participants is very complex.

At the time of its implementation the Medicare program was structured to serve approximately 19 million people.[1] Never before in the history of our country had a program of such scale, designed specifically to service the medical needs of a particular segment of the national population been undertaken. Today the Medicare program serves more than 20.3 million people[2] through more than 5,500 short-stay general medical and surgical hospitals, 342 psychiatric institutions, 53 tuberculosis and respiratory disease hospitals, 128 long-term general hospitals, and numerous other authorized health related institutions as indicated in Table 1.[3]

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[1]Martin Ruther, "Health Insurance for the Aged: Persons Insured, Mid-1966 to Mid-1970," Social Security Bulletin, Vol. 35, No. 9 (September, 1972), p. 13.

[2]Howard West, "Five Years of Medicare - A Statisti- Review," Social Security Bulletin, Vol. 34 (December, 1971), p. 18.

[3]American Hospital Association, Hospital Statistics, 1974 Edition (Chicago, Illinois: The Association), p. 196.

TABLE 1

MEDICARE CERTIFIED HOSPITALS, NON-FEDERAL
FOR THE YEAR 1973

Type	Total	Psychiatric	Tuberculosis and Other Resp. Disease	Long-Term General	Short-Stay General and Other Special
Total	6,102	342	53	128	5,579
For Profit	747	65	0	3	679
Non-Govt. Not For Profit	3,312	54	4	56	3,198
State and Local Govt.	2,043	223	49	69	1,702

SOURCE: American Hospital Association, Hospital Statistics, 1974 Edition (Chicago, Illinois: The Association, 1974), p. 196.

Complexity of the System

Adding to the complexity of the program is the fact that not only is the program designed to serve a very special segment of the population which historically was less capable of paying for its medical assistance, but also the needs of this segment of the population were themselves quite different and varied. For example, according to information released by the Department of Health, Education, and Welfare, presented in Tables 2 and 3, those persons aged 65 and over, as a class, suffer from different ailments, with dissimilar frequencies, necessitating hospitalization stays of a different average duration than non-Medicare qualified patients.

From a provider point of view the system is further complicated. As indicated earlier, more than 6,000 hospitals are currently authorized to provide medical care to Medicare program participants.[4] While these institutions possess the common feature of participating in the Medicare program they exhibit a wide variety of operational characteristics. For example, an examination of the characteristics of Medicare certified short-stay general medical and surgical community hospitals in the state of Oklahoma for the year 1973, as presented in Tables 4 and 5, indicates a wide range of bed capacity, percent of occupancy, overall per diem cost of hospitalization, and labor intensity.

While the aforementioned items indicate the complexity

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[4]Ibid.

TABLE 2

NUMBER AND PERCENT DISTRIBUTION OF DISCHARGES FROM SHORT-STAY HOSPITALS, BY CONDITION FOR WHICH HOSPITALIZED ACCORDING TO AGE: UNITED STATES, JULY 1963-JUNE 1965

Condition for which hospitalized	All ages	Under 45 years	45-64 years	65+ years	All ages	Under 45 years	45-64 years	65+ years
	Number of discharges in thousands				Percent distribution			
All conditions	24,012	15,210	5,606	3,196	100.0	100.0	100.0	100.0
Infective and parasitic diseases	485	358	92	35	2.0	2.4	1.6	1.1
Malignant neoplasms	435	89	203	143	1.8	0.6	3.6	4.5
Benign and unspecified neoplasms	1,184	703	373	107	4.9	4.6	6.7	3.3
Diabetes mellitus	233	82	71	80	1.0	0.5	1.3	2.5
Other endocrine, allergic, and metabolic disorders	520	308	138	75	2.2	2.0	2.5	2.3
Mental, personality disorders, and deficiences	527	308	163	57	2.2	2.0	2.9	1.8
Vascular lesions of the central nervous system	217	*	85	120	0.9	*	1.5	3.8
Diseases of the eye and visual impairments	355	128	72	155	1.5	0.8	1.3	4.8
Other diseases of nervous system and sense organs	466	280	122	64	1.9	1.8	2.2	2.0
Diseases of the heart, NEC	976	142	475	358	4.1	0.9	8.5	11.2
Hypertension without heart involvement	236	50	109	78	1.0	0.3	1.9	2.4
Varicose veins (excluding hemorrhoids)	150	80	63	*	0.6	0.5	1.1	*
Hemorrhoids	310	152	139	19	1.3	1.0	2.5	0.6
Other circulatory diseases	360	136	124	100	1.5	0.9	2.2	3.1
Upper respiratory conditions	1,474	1,373	71	31	6.1	9.0	1.3	1.0
Other respiratory conditions	1,418	819	361	238	5.9	5.4	6.4	7.4
Ulcer of stomach and duodenum	616	258	263	96	2.6	1.7	4.7	3.0
Appendicitis	395	342	42	*	1.6	2.2	0.7	*
Hernia	633	291	232	109	2.6	1.9	4.1	3.4
Diseases of the gallbladder	507	161	211	135	2.1	1.1	3.8	4.2
Other digestive system conditions	1,238	614	393	231	5.2	4.0	7.0	7.2
Male genital disorders	269	61	75	133	1.1	0.4	1.3	4.2
Female breast and genital disorders	850	550	258	42	3.5	3.6	4.6	1.3
Other genitourinary system conditions	958	540	277	141	4.0	3.6	4.9	4.4
Deliveries	3,727	3,722	*	...	15.5	24.5	*	...
Complications of pregnancy and the puerperium	606	601	*	...	2.5	4.0	*	...
Diseases of the skin	258	163	69	*	1.1	1.1	1.2	*
Arthritis, all forms	206	43	91	72	0.9	0.3	1.6	2.3
Conditions of bones and joints, NEC	415	232	149	33	1.7	1.5	2.7	1.0
Other conditions of the musculoskeletal system	417	272	108	37	1.7	1.8	1.9	1.2
Fractures and dislocations	909	509	223	177	3.8	3.3	4.0	5.5
Other current injuries	1,327	939	275	113	5.5	6.2	4.9	3.5
All other conditions and observations	1,334	893	270	172	5.6	5.9	4.8	5.4

SOURCE: U.S. Department of Health, Education, and Welfare, Vital and Health Statistics, "Age Patterns in Medical Care, Illness, and Disability, United States-July 1963-June 1965," Series 10, Number 32 (June, 1966), p. 30.

TABLE 3

NUMBER OF HOSPITAL DAYS AND AVERAGE LENGTH OF STAY IN SHORT-STAY HOSPITALS FOR DISCHARGES, BY AGE AND CONDITION FOR WHICH HOSPITALIZED: UNITED STATES, JULY 1963-JUNE 1965

Condition for which hospitalized	All ages	Under 45 years	45-64 years	65+ years	All ages	Under 45 years	45-64 years	65+ years
	Number of hospital days in thousands				Average length of stay in days			
All conditions	198,539	96,698	61,407	40,434	8.3	6.4	11.0	12.7
Infective and parasitic diseases	4,856	2,596	1,886	374	10.0	7.3	20.5	10.7
Malignant neoplasms	5,415	682	2,846	1,887	12.4	7.7	14.0	13.2
Benign and unspecified neoplasms	9,310	4,976	3,198	1,136	7.9	7.1	8.6	10.6
Diabetes mellitus	3,098	865	1,039	1,194	13.3	10.5	14.6	14.9
Other endocrine, allergic, and metabolic disorders	4,475	2,553	1,157	765	8.6	8.3	8.4	10.2
Mental, personality disorders, and deficiences	6,045	3,557	2,047	442	11.5	11.5	12.6	7.8
Vascular lesions of the central nervous system	5,418	242	2,705	2,471	25.0	18.6	31.8	20.6
Diseases of the eye and visual impairments	2,501	677	553	1,271	7.0	5.3	7.7	8.2
Other diseases of nervous system and sense organs	4,334	2,249	1,428	657	9.3	8.0	11.7	10.3
Diseases of the heart, NEC	14,652	2,048	7,037	5,568	15.0	14.4	14.8	15.6
Hypertension without heart involvement	1,922	394	788	740	8.1	7.9	7.2	9.5
Varicose veins (excluding hemorrhoids)	1,136	489	565	*	7.6	6.1	9.0	*
Hemorrhoids	2,499	1,140	1,166	193	8.1	7.5	8.4	10.2
Other circulatory diseases	4,152	1,575	1,472	1,106	11.5	11.6	11.9	11.1
Upper respiratory conditions	3,634	3,063	392	179	2.5	2.2	5.5	5.8
Other respiratory conditions	12,532	5,967	3,682	2,883	8.8	7.3	10.2	12.1
Ulcer of stomach and duodenum	6,812	2,600	2,848	1,364	11.1	10.1	10.8	14.2
Appendicitis	2,652	2,058	450	144	6.7	6.0	10.7	13.1
Hernia	4,904	1,712	2,034	1,158	7.7	5.9	8.8	10.6
Diseases of the gallbladder	5,473	1,523	2,318	1,631	10.8	9.5	11.0	12.1
Other digestive system conditions	9,599	3,864	3,232	2,502	7.8	6.3	8.2	10.8
Male genital disorders	2,957	250	738	1,968	11.0	4.1	9.8	14.8
Female breast and genital disorders	5,374	2,966	2,005	403	6.3	5.4	7.8	9.6
Other genitourinary system conditions	7,339	3,360	2,488	1,491	7.7	6.2	9.0	10.6
Deliveries	15,557	15,528	*	...	4.2	4.2	*	...
Complications of pregnancy and the puerperium	2,024	2,012	*	...	3.3	3.3	*	...
Diseases of the skin	2,064	1,132	500	431	8.0	6.9	7.2	16.6
Arthritis, all forms	2,291	312	1,219	760	11.1	7.3	13.4	10.6
Conditions of bones and joints, NEC	5,143	2,318	2,495	330	12.4	10.0	16.7	10.0
Other conditions of the musculoskeletal system	3,583	2,499	810	275	8.6	9.2	7.5	7.4
Fractures and dislocations	14,574	6,855	3,431	4,288	16.0	13.5	15.4	24.2
Other current injuries	9,867	5,885	2,647	1,336	7.4	6.3	9.6	11.8
All other conditions and observations	12,346	8,749	2,190	1,407	9.3	9.8	8.1	8.2

SOURCE: U.S. Department of Health, Education, and Welfare, Vital and Health Statistics," Age Patterns in Medical Care, Illness and Disability, United States-July 1963-June 1965," Series 10, Number 32 (June, 1966), p. 31.

TABLE 4

AVERAGE BED CAPACITY, OCCUPANCY, AND PER DIEM COST, FOR MEDICARE CERTIFIED SHORT-STAY, GENERAL MEDICAL AND SURGICAL COMMUNITY HOSPITALS: OKLAHOMA 1973

Type	Hospitals	Average Bed Capacity	Occupancy	Per Diem Cost
6-24 beds	9	20	45.1	$ 78.47
25-49 beds	44	35	57.0	66.74
50-99 beds	36	65	62.3	75.89
100-199 beds	19	151	74.0	86.19
200-299 beds	4	239	75.3	83.95
300-399 beds	2	346	79.6	78.85
400-499 beds	1	407	75.7	117.75
500 & Over	4	559	78.8	106.87
Total	119	94[a]	70.2	$ 87.34

[a]Calculated value.

SOURCES: James E. Perry, "The Cost of Hospitalization - Oklahoma Hospitals," The Journal of the Oklahoma State Medical Association (November, 1975), p. 425.

American Hospital Association, Hospital Statistics 1974 Edition (Chicago, Illinois: 1974), p. 128.

TABLE 5

LABOR INTENSITY AND EMPLOYEES PER BED, MEDICARE CERTIFIED SHORT-STAY, GENERAL MEDICAL AND SURGICAL COMMUNITY HOSPITALS: OKLAHOMA 1973

Type	Hospitals	Average Labor Intensity (% of Tot.Cost)	Average Employees Per Bed
6-24 beds	9	.545	1.74
25-49 beds	44	.525	1.59
50-99 beds	36	.527	1.80
100-199 beds	19	.531	2.31
200-299 beds	4	.540	2.21
300-399 beds	2	.543	2.56
400-499 beds	1	.547	2.81
500 & Over	4	.527	2.68
Total	119	.531	2.20

SOURCE: James E. Perry, "The Cost of Hospitalization - Oklahoma Hospitals," The Journal of the Oklahoma State Medical Association (November, 1975), p. 425.

that pervades the administration of the Medicare program, the situation is further complicated by the legislation itself, that brought the program into being.

Medicare

The Hospital Insurance Program

The Medicare program, as we know it, came about as a result of the 1965 amendments to the Social Security Act.[5] Formally, the program is called Title XVIII of the Social Security Act and consists of two fundamentally separate yet coordinated plans, namely Hospital Insurance, commonly referred to as Part A, and Supplementary Medical Insurance referred to as Part B.

Eligibility

Generally speaking, Hospital Insurance program benefits are available to all persons entitled to receive monthly cash benefits under the Old Age, Survivors, and Disability Insurance program or Railroad Retirement system program.[6]

> The term entitled (italicized) when used in connection with OASDI and RR benefits has a technical meaning that is important to understand. Entitlement merely means attainment of the required age, possession of either the necessary insured status conditions or relationship to a person who meets such conditions, and filing of a claim. Thus, it is not necessary that the entitled individual actually receive the monthly benefits in order to be eligible for HI benefits.[7]

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[5]The Medicare program enacted on July 30, 1965 is officially titled Public Law 89-97.

[6]Robert J. Myers, Medicare (Homewood, Illinois: Richard D. Irwin, Inc., 1970), p. 89.

[7]Ibid.

Benefits are also available to persons not insured under the Old Age, Survivors, and Disability Insurance program or Railroad Retirement system program who had attained the age of 65 prior to 1968 or will attain the age of 65 after 1967, providing specified minimum amounts of coverage under OASDI or RR have been met, even though the minimum required coverage is insufficient to qualify a person for monthly cash benefits.[8] In this way, the 3 million plus people who were not eligible for OASDI or RR cash benefits at the time of the implementation of the program were "blanketed in," while at the same time the basic principle that benefits under Medicare "should be an earned right, and not a dole" was preserved.[9] The cost of the benefits for these non-insured people as well as the administrative expenses incurred in the rendering of such benefits is paid out of the general revenues of the Federal government.[10]

While persons included in the above categories are indeed eligible to receive benefits under the Hospital Insurance program, there are four specific classes of people who are ineligible for benefit participation. Aliens, such as employees of embassies or diplomats who have not been law-

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[8]U.S. Department of Health, Education, and Welfare, Medicare 1968 (Washington, D.C.: U.S. Government Printing Office, 1972), p. xxiv.

[9]Herman M. Somers and Anne R. Somers, Medicare and the Hospitals: Issues and Prospects (Washington, D.C.: Brookings Institution, 1967), P. 20.

[10]Myers, Medicare, p. 92.

fully admitted for permanent residence in the United States are ineligible for benefits.[11] Also, aliens who have been lawfully admitted, yet have not been residents of the United States or its possessions for a five-year period immediately preceding application for benefit protection, are ineligible, as well as persons convicted of subversive activity.[12] Finally, active and retired employees of the Federal government who are, or could have been, covered under the Federal Employees Health Benefits Act of 1959 are ineligible for Hospital Insurance benefits.[13] Due to the fact the Federal Employees Health Benefits Act of 1959 did not cover existing retirants, however, Hospital Insurance benefits were made available to this group in exactly similar fashion as they were made available to transitional non-insured persons.[14]

Benefits

> The basic benefit principle under the HI system is to provide hospital and post-hospital services to the beneficiaries after certain deductible and cost-sharing amounts are paid by them, rather than providing specified indemnity benefits and leaving it up to the beneficiary to pay the difference between charges and the benefits. In this respect, HI is patterned along the lines of Blue Cross benefits, instead of those found in the more usual insurance company plans.[15]

Essentially, the benefits of the Hospital Insurance program can be categorized as inpatient hospital benefits, post-hospital home health care benefits, and post-hospital

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[11] Ibid., p. 93. [12] Ibid., p. 94. [13] Ibid.
[14] Ibid. [15] Ibid., p. 101.

extended care facility benefits, with the latter two types of benefits, according to Robert J. Myers, author of Medicare, being designed specifically to reduce hospital utilization.

Inpatient hospital services are covered under the Hospital Insurance program in relation to spells of illness.

> The term spell of illness (italicized) is not defined on the basis of the duration of the particular ailment that the beneficiary has. Instead, it is defined as the period beginning on the first day for which he receives these and terminating after he has had a period of 60 consecutive days during which he has not been an inpatient in a hospital or an extended care facility.[16]

> Covered hospital services include hospital room and board in accommodations containing from two to four beds, nursing services except for private duty nursing, drugs and biologicals, and all those services ordinarily furnished by a hospital to its inpatients. Coverage under the Hospital Insurance program does not include the services of physicians (including radiologists, anesthesiologists, pathologists, and physiatrists) except for those services provided by interns or residents in training under approved teaching programs in a hospital.[17]

The cost of all of these services as determined consistent with Medicare regulations are paid in full for the first 60 days relating to a spell of illness after a deductible of $60 has been paid by the insured. Expenses for the 61st to 90th days are shared by the insured and Hospital Insurance program wherein the insured pays a coinsurance provision equal to 25% per day of the initial deductible.[18]

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[16] Ibid., p. 102. [17] Medicare 1968, p. xxxii.

[18] Beneficiaries of the Hospital Insurance program also have a lifetime reserve of 60 days which can be used at any time after the exhaustion of the 90 days in a spell of illness.

Costs specifically excluded from coverage under the Hospital Insurance program include, among other items, those arising from the operation of a gift shop, the maintenance of religious personnel, and the cost of facilities not medically necessary. The former examples of the operation of a gift shop and the maintenance of religious personnel are non-allowable since they do not relate to patient care, while the latter example of room charge is non-allowed since it is not medically necessary although it is related to patient care. The law states explicitly:

> Where a patient occupies a private room in an institution which offers semi-private accommodations, and the private room is not considered medically necessary, the Medicare program will pay only the cost of the most prevalent semi-private room. The difference between the private room charge and the semi-private room charge may be billed to the patient, providing the patient requested the private room with the knowledge that he would be charged the differential.[19]

In a related manner,

> The cost of the first three pints of blood (or equivalent amounts of packed red blood cells) furnished a patient during a benefit period is a deductible amount unless the patient arranges for replacement. Charges for additional blood are covered under the program.[20]

Also within the framework of inpatient hospital benefits, the Hospital Insurance program extends coverage for a maximum of 190 days of inpatient care rendered in a psychia-

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[19] U.S. Department of Health, Education, and Welfare, Health Insurance for the Aged Provider Reimbursement Manual (Washington, D.C.: 1972), Section 2104.2.

[20] Medicare 1968, p. xxiii.

tric or tuberculosis hospital.[21] However,

> Where an individual is a patient in a participating psychiatric hospital at the time he becomes entitled to hospital insurance, the number of days he was such a patient in the 150 day period immediately prior to his eligibility are deducted from his days of entitlement in that benefit period, but not from the lifetime limitation.[22]

Post-hospital home health care benefits

> cover the cost of visiting nurse services and related home health services for as many as 100 visits for up to a year following the patient's most recent discharge from a hospital or participating extended care facility, provided he has been confined for at least 3 consecutive days in a hospital. A home health plan must be developed by a physician, and implemented within 14 days after the patient's discharge from the hospital or extended care facility. The home health care must be for further treatment of a condition for which he received services as an inpatient in the hospital or extended care facility.[23]

Relevant post-hospital extended care facility benefits relate to

> the reasonable cost of all covered inpatient services in a participating extended care facility for up to 100 days of such care in any benefit period, following discharge from a hospital after a stay of 3 consecutive days or more, and the admission to an extended care facility within 14 days of discharge.[24]

Financing and Administration

Part A of Title XVIII is financed by "compulsory contributions of employers and employees through the Social Security System, with a separately earmarked payroll tax and trust fund."[25]

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[21] Ibid. [22] Ibid. [23] Ibid., p. xxiv. [24] Ibid.

[25] Somers and Somers, Medicare and the Hospital, p. 15.

> The proceeds of this tax and that collected from the railroad retirement system are placed in a Hospital Insurance Trust Fund from which reimbursements for all benefits and administrative expenses incurred under the hospital insurance program are paid. The Hospital Insurance Trust Fund is reimbursed from general tax revenues for the cost of providing coverage for the almost 2 million persons who qualify for Hospital Insurance but who are not entitled to monthly social security or railroad retirement benefits, that is, those "deemed insured."[26]

The agency or fiscal intermediary through which provider claims are serviced and reimbursement is made is chosen, usually, by the membership of the hospital association in a given state or region, in concert with the Social Security Administration with whom overall responsibility for the program rests.[27]

> A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee, if approved by the Secretary (Health, Education, and Welfare), and agreeable to the intermediary selected. In addition, a provider may deal directly with the Social Security Administration.[28]

Basically, the responsibility of the intermediary is to reimburse providers on the basis of reasonable costs for services rendered to eligible Medicare program participants and to assist in the application of safeguards against indiscriminate use of covered services.[29]

> In addition, the fiscal intermediary obtains from the providers, and transmits to the SSA, data on individual bills so that proper records can be maintained on the utilization of services and on the meeting of

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[26] Medicare 1968, p. xxv. [27] Myers, Medicare, p. 178.

[28] Medicare 1968, p. xxvi. [29] Ibid.

> cost-sharing provisions, and so that adequate statistical and actuarial analysis of the experience may be made.[30]

Furthermore, the intermediary may provide consultative services to both potential providers and existing providers such that proper fiscal records relative to the Hospital Insurance program will be maintained, it serves as a communicating center with providers disseminating information on changes concerning the program, and it audits provider records.[31]

Medicare

The Supplementary Medical Insurance Program

The best way to describe the Supplementary Medical Insurange program is to

> call it a voluntary individual insurance program with government subsidy that is underwritten and administered by the government using private carriers to assist with the administration. SMI is a program under which each eligible individual elects, during specified enrollment periods, whether he wishes to participate and pay a premium in partial financial support of the program.[32]

Eligibility

Supplementary Medical Insurance benefits are available to all persons 65 years of age or older who elect to participate in the program and pay the required premium. Aliens, however, who have not been lawfully admitted to the

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[30]Myers, Medicare, p. 178.

[31]Medicare 1968, p. xxvi. [32]Myers, Medicare, p. 87.

United States for residence, such as diplomats, or who have not been in residence for at least five years immediately prior to their application for benefits are ineligible for benefit participation.[33]

Benefits

Generally speaking, the Supplementary Medical Insurance program pays for 80% of the allowed reasonable charges for any covered physician services and other medical services, after the enrollee has paid a $60 deductible, during a calendar year.[34]

> Covered under the program are such benefits as physicians' services, including home, health, hospital and office visits; services and supplies, including drugs and biologicals that cannot be self-administered, that are furnished as part of a physician's professional service, most commonly in his office, and either rendered without charge or included in the physician's bills; diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests; X-ray; radium, and radioactive isotope therapy, including materials and the services of technicians; surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations; purchase or rental of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home); ambulance service in cases where the use of other methods of transportation is contraindicated by the individual's condition; prosthetic devices (other than dental) that replace all or part of an internal organ, including replacement of such devices; leg, arm, back, and neck braces, and artificial legs, arms, eyes, including replacement if required because of a change in the patient's physical condition; and 100 home health visits during a calendar year--these visits being independent of those provided under the Hospital Insurance program.[35]

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[33]Ibid., p. 95. [34]Medicare 1968, p. xxiv. [35]Ibid.

> . . . . Also covered are hospital services, incident to physicians' services rendered to outpatients, including services beginning April 1, 1963 which were previously covered under the Hospital Insurance program, and outpatient physical therapy services beginning July 1, 1968.[36]

Financing and Administration

As mentioned earlier the SMI program is supported by contributions from both the individual enrollees and the Federal government. In fact, the program is "financed in equal amount from premiums paid by the insured and a contribution from general Federal revenues."[37]

Under the Supplementary Medical Insurance program, "the Secretary of Health, Education, and Welfare may enter into contracts with carriers for the performance of specified administrative functions."[38] The primary function of the SMI carrier, however similar to the nominated fiscal intermediary for the Hospital Insurance program, is to determine the reasonableness of charges for covered services, and to make reimbursements for the same. In addition, of course, the carrier also has the obligation of reviewing claims for their allowability, and of assisting in the application of safeguards so as to prevent unnecessary or indiscriminate use of covered services.[39]

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[36]Ibid.

[37]Somers and Somers, Medicare and the Hospitals, p. 15.

[38]Medicare 1968, p. xxvi.

[39]Ibid., p. xxvii.

Realizing the forces of pressure that are brought to bear due to the particular characteristics of the population that the Medicare program was designed to serve, the nature of the legislation itself, and the wide range of operational characteristics of the institutions through which the program is implemented, the reimbursement system applicable can most easily be understood by examining the two fundamentally separate yet interrelated processes of which it is composed. These processes and their indigenous component parts are illustrated in Figure 1.

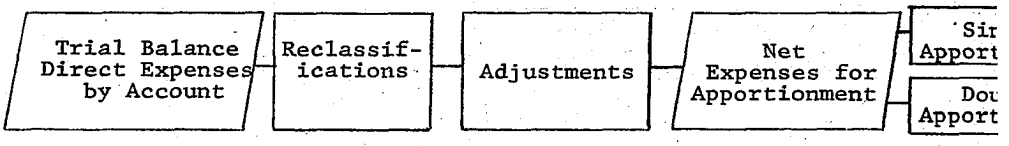
While the steps of the reimbursement process are clearly indicated in Figure 1, it is essential to understand that the entire reimbursement system whereby institutional providers of medical care to eligible Medicare program participants are paid, is founded on the concept of reasonable cost. Furthermore, it is essential to an understanding of the reimbursement process that certain terms be defined as in the Health Insurance for the Aged Provider Reimbursement Manual.

Definition of Terms

(Section 2100) PRINCIPLE
All payments to providers of services must be based on the "reasonable cost" of services covered under Title XVIII of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to the principles relating to specific items of revenue and cost.

FIGURE 1

PREPARATION OF COST DA



REIMBURSEMENT SETTLEMEN

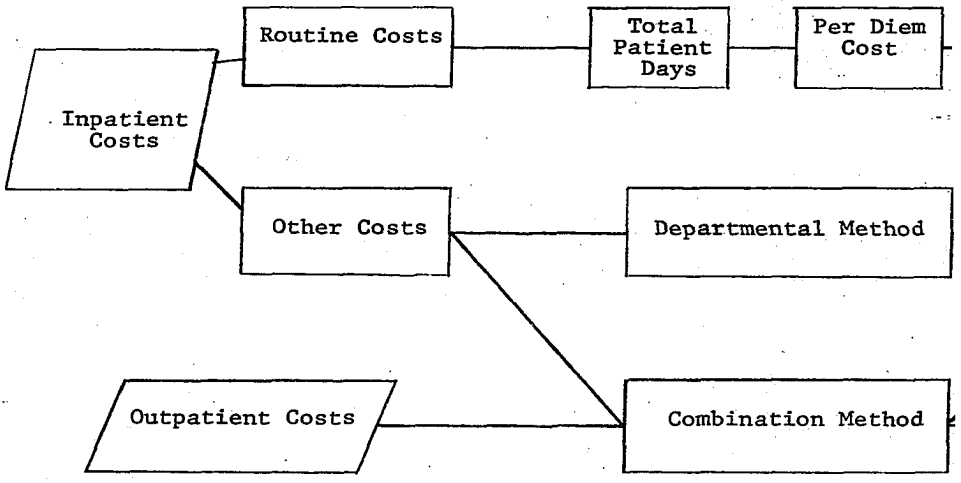
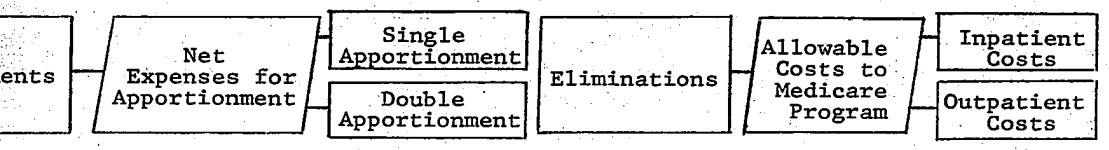
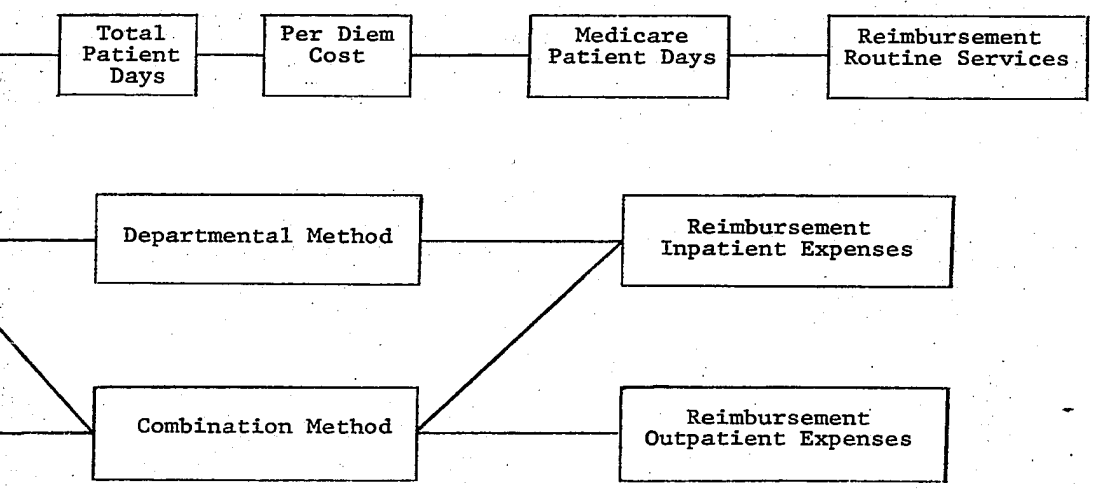


FIGURE 1

PREPARATION OF COST DATA



REIMBURSEMENT SETTLEMENT



(Section 2102.1) REASONABLE COSTS

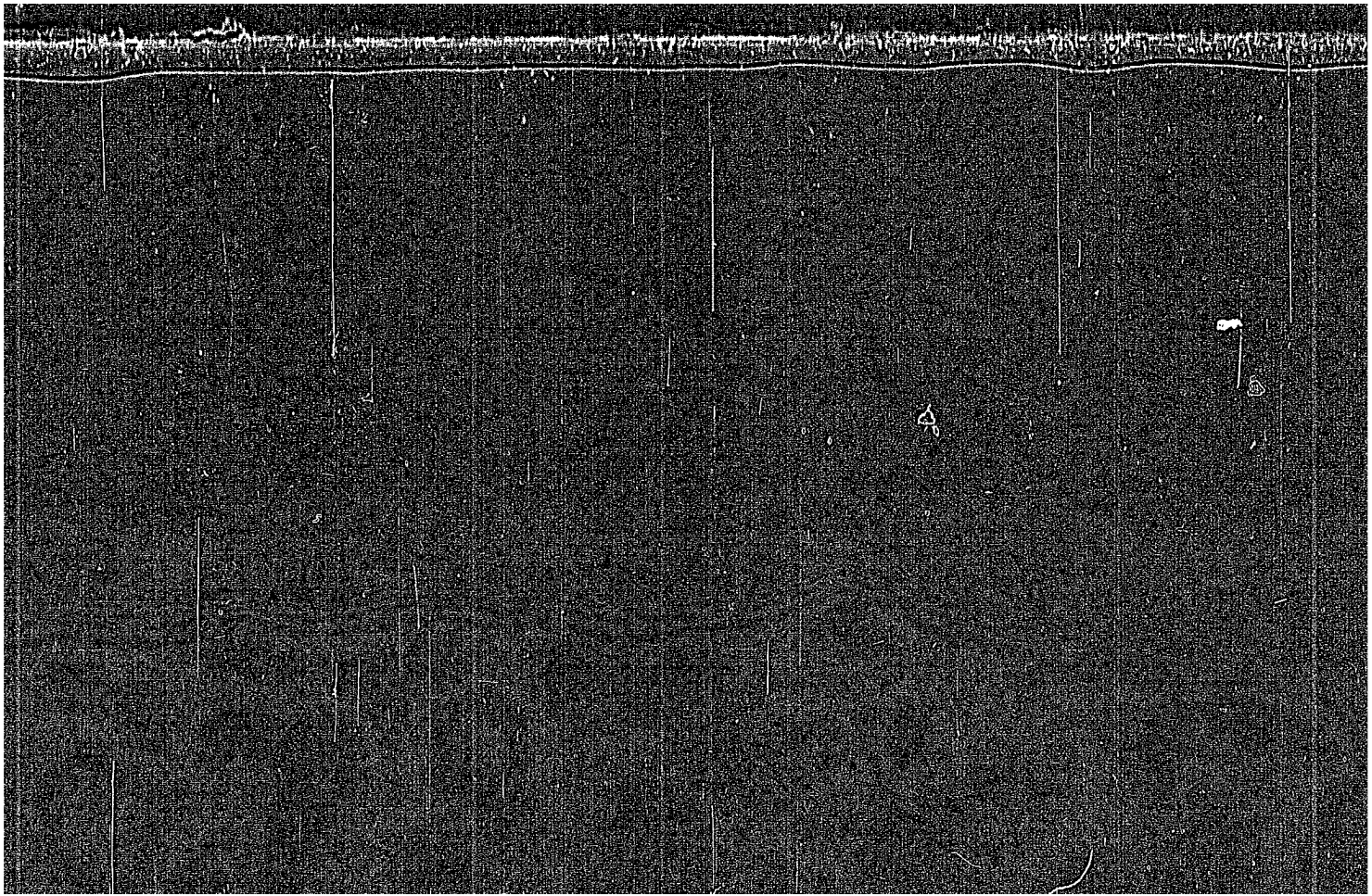
Reasonable costs of any services are determined in accordance with regulations establishing the method or methods to be used and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by others not so covered, and the costs with respect to individuals not so covered will not be borne by the program. Costs may vary from one institution to another because of scope of services, level of services, location, and utilization. It is the intent that providers will be reimbursed the costs incurred in providing high quality care, regardless of how these costs may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors. "Utilization" for this purpose refers not to the provider's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., its patient mix--age of patients, type of illness, etc.).

Implicit in the intention that actual costs be paid to the extent they are reasonable, is the expectation that the provider seeks to minimize its costs and that its actual

costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service (see Section 2103). If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher cost were unavoidable, the excess costs are not reimbursable under the program.

(Section 2102.2) COSTS RELATED TO PATIENT CARE
These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs, and others. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

(Section 2102.3) COSTS NOT RELATED TO PATIENT CARE
Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, costs of meals sold to visitors or employees, costs of drugs sold to other than patients, cost of operation of a gift shop, and similar item



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(Section 2103) PRUDENT BUYER
The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, but he also seeks to economize by minimizing cost. This is especially so when the buyer is an institution or organization which makes bulk purchases and can, therefore, gain economies because of the size of its purchases. It is quite common that discounts are given in these instances. In addition, bulk purchase of items or services often gives the buyer leverage in bargaining with suppliers for other items or services. These are advantages which any alert and cost-conscious buyer seeks, and it is to be expected that providers of services under the Medicare program will also seek them.

For example, reimbursement will not be based on costs arising from a provider paying at individual rates for physical therapy which is provided by a single therapist to groups of patients simultaneously. Nor will reimbursement be based on costs arising from the purchase of drugs at prices above the prices commonly charged in the area. Moreover, where a supplier of drugs "rents" space from an extended care facility to store drugs for use in the facility, the rental paid by the supplier to the provider would generally constitute an indirect discount on the cost of drugs which must be reflected as a reduction of the cost of drugs supplied. Where a provider chooses to pay above the going price for a supply or service, in the absence of clear justifica-

tion for the premium, the intermediary will exclude costs in determining allowable costs under Medicare.

Intermediaries may employ various means of detecting and investigating situations in which costs seem excessive. They may include such techniques as comparing the prices paid by providers with the prices paid for similar items or services by comparable purchasers and spotchecking and querying the provider about indirect, as well as direct, discounts. In addition, where a group of institutions have a joint purchasing arrangement which seems to result in participating members getting very favorable prices because of the advantages gained from bulk purchasing, any potentially eligible providers in the area which do not participate in the group may be called upon to justify any higher prices paid. Also, when most of the costs of a service are reimbursed by Medicare, the costs may be examined with particular care.

(Section 2300) PRINCIPLE
Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

(Section 2302.1) ACCRUAL BASIS OF ACCOUNTING
Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

(Section 2302.4) ALLOWABLE COSTS
An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

(Section 2302.5) APPLICABLE CREDITS
Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs. In some instances the amounts received from the Federal Government to finance hospital activities or service operations should be treated as applicable credits.

(Section 2302.6) CHARGES
Charges refers to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.

(Section 2302.7) COST FINDING
A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of the direct costs and the proration of indirect costs.

(Section 2304) ADEQUACY OF COST INFORMATION
Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records, and original evidence of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost, capable of being audited.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures provided that full disclosure of significant changes is made to the intermediary.

(Section 2306) COST FINDING METHODS
One of the methods of cost finding described in Section 2306.1-2310 must be used to determine the actual costs of services rendered during the provider's initial Medicare cost reporting period. Having elected one of these methods, the provider may not change methods unless the intermediary,

based on knowledge of the provider's accounting capability, approves the provider's request to change methods.

(Section 2306.1) STEP-DOWN METHOD
This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers. All costs of nonrevenue-producing centers are allocated to centers which they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(Section 2306.2) THE DOUBLE-APPORTIONMENT METHOD
The double-apportionment method may be used by a provider upon approval of the intermediary. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of nonrevenue-producing centers is made. These centers

or departments are not "closed" after this preliminary allocation. Instead, they remain "open" accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers.

(Section 2302.8) COST CENTER
A division, a department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

(Section 2302.9) GENERAL SERVICE COST CENTER
Those divisions, departments, or subdivisions thereof, etc., which are operated for the benefit of the institution as a whole. Each of these may render services to other general service areas as well as to special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

(Section 2302.10) SPECIAL SERVICE COST CENTER
Commonly referred to as ancillary cost centers. Such centers

usually provide direct identifiable services to individual patients, and include departments such as the operating room, radiology, laboratory, etc.

(Section 2302.11) INPATIENT COST CENTERS
Cost centers established to accumulate costs applicable to providing routine and ancillary services of inpatients for the purposes of cost assignment and allocation.

(Section 2302.12) OUTPATIENT COST CENTERS
Cost centers established to accumulate cost applicable to the care and treatment of outpatients.

(Section 2302.13) OUTPATIENT OCCASIONS OF SERVICE
Each examination, consultation or treatment received by an outpatient in any service department of a hospital. Such occasions of service should be recorded by individual departments and classified as to emergency room, clinics, or private ambulatory.

(Section 2302.15) RCC
The ratio of charges to charges. The bases, or charges, used in the RCC formula varies as to the costs to be allocated. The ratios may be expressed as follows:

a) ratio of beneficiary charges to total charges on a departmental basis;

b) ratio of beneficiary charges for ancillary services to total charges for ancillary services;

c) ratio of total patient charges by patient care centers to the total of charges of all patient care centers.

(Section 2310) MORE SOPHISTICATED METHODS
A more sophisticated method designed to allocate cost more accurately may be used by the provider upon approval of the intermediary.

The Medicare System of Reimbursement

Preparation of Cost Data

After the close of the reporting period all providers of medical care prepare a trial balance of direct expenses, per the hospital's general books, as in Exhibit 1, using Form SSA-1562, Schedule A. This schedule provides for the classification of expenses in terms of two components--salary and other (Columns 1 through 3), and their categorization by cost center (Lines 1 through 32). Column 4 of Form SSA-1562, Schedule A provides for the reclassification of expenses per the Medicare regulations. This process is essential at the present time in order to effect what is presently regarded as a proper distribution of General Service cost center expenses to revenue producing areas.

For example, an examination of Exhibit 1 indicates that $102,766 classified as Employee Health and Welfare Benefits (Column 4, Line 2), was removed from the Administration and General cost center (Line 1), and that $273 of Interest Expense (Column 3, Line 33) was added to this cost center.

EXHIBIT 1

STEP-DOWN METHOD

PROVIDER NO. 00-0000

RECLASSIFICATION OF TRIAL BALANCE OF EXPENSES

PERIOD 7/1/66 - 12/31/66

Schedule A

LINE NO.	ACCOUNT	TRIAL BALANCE OF DIRECT EXPENSES			TRIAL BALANCE RECLASSIFIED FOR COST APPORTIONMENT	ADJUSTMENTS TO EXPENSES Increases and (Decreases) (See Sch. A-5)	NET EXPENSES FOR COST APPORTIONMENT
		SALARIES	OTHER	TOTAL	TOTAL		
		1	2	3	4	5	6
1	Administration and General	$ 120,893	$ 207,223	$ 328,116	$ 225,623	$ (2,782)	$ 222,841
2	Employee Health & Welfare Bene.	-	-	-	102,766	-	102,766
3	Dietary – Raw Food	-	127,543	127,543	68,440	-	68,440
4	Dietary – Other Expense	41,676	3,137	44,813	25,096	-	25,096
5	Cafeteria	-	-	-	73,147	(18,149)	54,998
6	Housekeeping	63,013	11,120	74,133	74,133	-	74,133
7	Laundry and Linen	23,959	12,901	36,860	36,860	-	36,860
8	Maintenance of Personnel	3,745	936	4,681	4,681	(1,637)	3,044
9	Operation of Plant	9,207	34,636	43,843	43,843	-	43,843
10	Maintenance of Plant	24,129	22,273	46,402	46,402	-	46,402
11	Nursing Service	437,750	38,065	475,815	475,815	-	475,815
12	Nursing School	24,765	4,717	29,482	29,482	(5,428)	24,054
13	Medical-Surgical Expense	57,722	11,637	69,359	-	-	-
14	Intern-Resident Service	-	-	-	50,000	-	50,000
15	Oxygen Therapy	-	-	-	-	-	-
16	Medical Supplies and Expense	-	-	-	19,359	(2,386)	16,973
17	Pharmacy	8,936	46,914	55,850	55,850	-	55,850
18	Medical Records	23,101	2,855	25,956	25,956	(1,297)	24,659
19	Social Service	3,116	300	3,416	3,416	-	3,416
20	Operating Rooms	52,533	27,042	79,575	79,575	-	79,575
21	Delivery Rooms	6,869	3,539	10,408	10,408	-	10,408
22	Anesthesia	2,698	4,797	7,495	7,495	-	7,495
23	X-Ray	38,170	50,598	88,768	88,768	(24,608)	64,160
24	Laboratory	70,639	29,960	100,599	93,704	(19,482)	74,222
25	Blood Bank	-	-	-	6,895	-	6,895
26	Research - Organized	4,320	1,080	5,400	5,400	-	5,400
27	Physical Therapy	48,734	12,183	60,917	60,917	-	60,917
28	Nursery	-	-	-	5,673	-	5,673
29	Fund Raising	12,994	3,413	16,407	16,407	-	16,407
30	Emergency Service	1,030	226	1,256	1,256	-	1,256
31	Depreciation–Buildings, etc.	-	42,257	42,257	42,257	-	42,257
32	Depreciation–Movable Equipment	-	35,823	35,823	35,823	-	35,823
33	Interest Expense	-	273	273	-	-	-
34	Total Expenses	$ 1,079,999	$ 735,448	$ 1,815,447	$ 1,815,447	$ (75,769)	$ 1,739,678
35	2% Allowance (Column 6) (A)						34,788 (2)
36	Total Net Expenses						$ 1,774,466 (3)

*NOTE: Transfer the amounts on lines 1 through 34, Column 6, above, to Column 1, Worksheet B. (1)
If hospital practice provides for combining certain of the above amounts this will be acceptable. The prevailing basis for allocation for the center in which combined should be used.

Form SSA-1562 10-66 (A) Show computation on Form SSA-1563A

(1) From Schedule A-5
(2) Form SSA-1563A
(3) To Worksheet B

Original Balance, Administration and General per Col. 3, Line 1	$328,116
Less	
Employee Health and Welfare Benefits	102,766
Sub-Total:	225,350
Add	
Interest Expense	273
Ending Balance, Administration and General	$225,623

A detailed breakdown of the composition of these reclassification entries is given in Exhibit 2, Form SSA-1562, Schedule A-1.

Similarly, $59,103 was removed from the Dietary - Raw Food department (Line 3), with $53,430 of this total being reclassified as Cafeteria expenses (Line 5), and the balance of $5,673 being reclassified as Nursery expense (Line 28).

Original Balance, Dietary - Raw Food per Col. 3, Line 3		$127.543
Less		
Cafeteria Raw Food	$53,430	
Nursery	5,673	59,103
Ending Balance, Dietary - Raw Food		$ 68,440

The Dietary - Other Expense account was reduced by $19,717 owing to the reclassification of Cafeteria Salaries in the amount of $18,337, and Other Cafeteria Expenses in the amount of $1,380. Thus, as a result of the foregoing reclassifications, the Dietary - Other Expense account has a balance before adjustment of $25,096 (Column 4, Line 4), and

EXHIBIT 2

STEP-DOWN METHOD

ADMINISTRATION AND GENERAL EXPENSE ANALYSIS		PERIOD 7/1/66 - 12/31/66		Schedule A-1
LINE NO.	ITEM	SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Total *(from line 1, Columns 1, 2 and 3, Schedule A)*	$ 120,893	$ 207,223	$ 328,116
2.	Personnel Department	9,506	635	10,141
3.	Employee Health Service	10,867	2,152	13,019
4.	Hospitalization Insurance		5,755	5,755
5.	Workmen's Compensation		10,550	10,550
6.	Employee Group Insurance		2,877	2,877
7.	Social Security Taxes		36,446	36,446
8.	Annuity Premiums, Past Service Benefits, and Pensions voted by Governing Board		23,978	23,978
9.	Total Employee Health and Welfare *(lines 2 thru 8; to Sch. A. line 2. Column 4)*	$ 20,373	$ 82,393	$ 102,766
10.	Remaining Administration and General	$ 100,520	$ 124,830	$ 225,350
11.	Interest *(from Schedule A Column 3, line 33)* and Other Expense to be added to Administration and General for cost allocation		273	273
12.	Interest expense and remaining administration and general expenses and other expenses *(line 10 +11; to Schedule A. line 1. Column 4)*	$ 100,520	$ 125,103	$ 225,623

correspondingly the Cafeteria account balance before adjustment is $73,147 (Column 4, Line 5).

Original Balance, Dietary - Other Expense per Col. 3, Line 4		$44,813
Less		
Cafeteria Salaries	$18,337	
Other Cafeteria Expenses	1,380	19,717
Ending Balance, Dietary - Other Expense per Col. 4, Line 4		$25,096
Original Balance, Cafeteria per Col. 3, Line 5		$ -0-
Add		
Cafeteria Salaries		18,337
Cafeteria - Raw Food	$53,430	
Other	1,380	54,810
Ending Balance, Cafeteria per Col. 4, Line 5		$73,147

A detailed breakdown of the composition of these reclassification entries is given in Exhibit 3, Form SSA-1562, Schedule A-2.

The remaining two reclassifications illustrated in Exhibit 1, concern Medical and Surgical Expense (Line 13), and Laboratory expense (Line 24). The original balance of the Medical and Surgical Expense account, namely $69,359 was reclassified into its component parts, Intern-Resident expense of $50,000 (Column 4, Line 14), and Medical Supplies and Expense of $19,359 (Column 4, Line 16). The original balance in the Laboratory account of $100,599 (Column 3,

EXHIBIT 3

DIETARY EXPENSE ANALYSIS	PERIOD 7/1/66 - 12/31/66	Schedule A-2
A. Analysis of Dietary–Raw Food: Value of Raw Food (From line 3, column 2, Schedule A)		$ 127,543
Issued to or prepared for use in:		
1 Cafeteria	$ 53,430	
2 Nursery	5,673	
3 Dietary–Raw Food	68,440	
4 TOTAL (Same as line A)		$ 127,543

B. Analysis of Dietary–Other (from [illegible] Schedule A)

LINE NO.		SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Cafeteria	18,337	$ 1,380	$ 19,717
2.	Dietary	23,339	1,757	25,096
3.	TOTAL	1,67[illegible]	$ 3,137	$ 44,813

C. Summary of Analysis:

Dietary–Raw Food (from A, line 3 above) (to appear on line 3 [illegible])		$ 68,440
Dietary–Other–Salaries		$ 23,339
Other expense (from B, [illegible])		1,757
Total–Other (to line 4, [illegible])		$ 25,096
Cafeteria Salaries (from B, column 1, line 1 [illegible])		$ 18,337
Raw food (from A, line 1 above)	$ 53,430	
Other (from B, column 2, line 1 above)	1,380	
Total Other		54,810
Total Salaries and Other (to Line 5, Column 4, Schedule A)		$ 73,147
Nursery (from A, line 2 above) (to line 2B, Column 4, Schedule A)		$ 5,673

FORM SSA-1562 (6-66)

EXHIBIT 3

DIETARY EXPENSE ANALYSIS	PERIOD 7/1/66 - 12/31/66	Schedule A-2
A. Analysis of Dietary–Raw Food: Value of Raw Food *(From line 3, column 2, Schedule A)*		$ 127,543
Issued to or prepared for use in:		
1 Cafeteria	$ 53,430	
2 Nursery	5,673	
3 Dietary–Raw Food	68,440	
4 TOTAL *(Same as line A)*		$ 127,543

B. Analysis of Dietary–Other *(from line 4, Columns 1, 2 and 3, Schedule A)*

LINE NO.	ITEM	SALARIES 1	OTHER EXPENSE 2	TOTAL 3
1.	Cafeteria	$ 18,337	$ 1,380	$ 19,717
2.	Dietary	23,339	1,757	25,096
3.	TOTAL	$ 41,67	$ 3,137	$ 44,813

C. Summary of Analysis:

Dietary–Raw Food *(from A, line 3 above) (to appear on line 3 in Column 4, Schedule A)*		$ 68,440
Dietary–Other–Salaries *(from B, line 2, column 1 above)* Salaries		$ 23,339
Other expense *(from B, column 2, line 2 above)*		1,757
Total–Other *(to line 4, Column 4, Schedule A)*		$ 25,096
Cafeteria Salaries *(from B, column 1, line 1 above)*		$ 18,337
Raw food *(from A, line 1, above)*	$ 53,430	
Other *(from B, column 2, line 1 above)*	1,380	
Total Other		54,810
Total Salaries and Other *(to Line 5, Column 4, Schedule A)*		$ 73,147
Nursery *(from A, line 2 above) (to line 2R, Column 4, Schedule A)*		$ 5,673

FORM SSA-1562 (6-66)

Line 24) was adjusted downward to reflect the removal and reclassification of Blood Bank expenses in the amount of $6,895 (Column 4, Line 25). A detailed breakdown of the component parts of these reclassifications is contained in Exhibits 4 and 5, Form SSA-1562, Schedules A-3, and A-4, respectively.

While the nature of the reclassification entry, per the example utilized, appears to be hard and fast, it should be pointed out that reasonable flexibility within the reclassification process existed at the time the Medicare program was implemented. Thus, through judicious reclassifications the ultimate amount actually reimbursed to the provider could be increased.[40] For example, after reclassifications and adjustments are made relative to the Administration and General cost center, the total cost within this center is distributed to other service cost centers and revenue producing centers on the basis of "accumulated cost," In other words, just as square feet is often used as the basis for assigning depreciation costs to various departments within any given operation, "accumulated cost" or more precisely, the summation of all costs from all cost centers less the amount in the Administration and General cost center, is the basis upon which the amount in the Administration and General cost center is allocated. If the dollar value of the Administration and

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[40]Russell Caruana, "How to Maximize Reimbursement Through Reclassification Entries," Hospital Financial Management (November, 1971), p. 4.

EXHIBIT 4

STEP-DOWN METHOD

EXHIBIT I-2

PROVIDER NO. 00-0000

MEDICAL-SURGICAL EXPENSE ANALYSIS

PERIOD 7/1/66 - 12/31/66

Schedule A-3

LINE NO.	ITEM	SALARIES	OTHER EXPENSE	TOTAL
		1	2	3
1.	Total *(from line 13, Columns 1, 2 and 3, Schedule A)*	$ 57,722	$ 11,637	$ 69,359
2.	Intern-Resident Service *(to line 14, Column 4, Schedule A)*	$ 50,000	$	$ 50,000
3.	Oxygen Therapy *(to line 15, Column 4, Schedule A)*	-		-
4.	Medical Supplies and Expense *(to line 16, Column 4, Schedule A)*	7,722	11,637	19,359
5.				
6.	Total Transferred *(Same as line 1 above)*	$ 57,722	$ 11,637	$ 69,359

EXHIBIT 5

LABORATORY EXPENSE ANALYSIS

PERIOD 7/1/66 - 12/31/66

Schedule A-4

LINE NO.	ITEM	SALARIES 1	OTHER EXPENSE 2	TOTAL 3
1.	Total *(from line 24, Columns 1, 2 and 3, Schedule A)*	$ 70,639	$ 29,960	$ 100,599
2.	Blood Bank *(to line 25, Column 4, Schedule A)*	$ 3,172	$ 3,723	$ 6,895
3.				
4.	Remaining Laboratory *(to line 24, Column 4, Schedule A)*	67,467	26,237	93,704
5.	Total Transferred *(same as line 1 above)*	$ 70,639	$ 29,960	$ 100,599

FORM SSA-1562 (5-66)

General cost center included such items, as it typically did, as Admitting expenses and Hospital Professional Liability Insurance, the former relating to inpatient service totally, and the latter relating to inpatient service primarily, then not reclassifying these values so as to ensure that they are regarded as allowable and reimbursable via the Hospital Insurance program was equivalent to not attempting to seek maximum reimbursement.[41] In other words the failure to reclassify these values gave rise to an inappropriate cost distribution. Instead of the Hospital Insurance program reimbursing the provider 100% for its share of Admitting costs it would be allowed to reimburse far less than its fair share.[42]

Having reclassified the relevant direct expenses to conform with applicable Medicare regulations the various expense items within the trial balance are then adjusted. This adjustment process is essential to the system insofar as upon completion of the process only the net costs allowable to the Medicare program by regulation remain. In essence, the expenses contained in Exhibit 1, Column 4, would be adjusted to recognize:

1) an allowable expense hitherto not on the provider institution's general books

2) to remove from the trial balance costs specifically designated as unallowable

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[41] Ibid., pp. 4-5.

[42] Ibid., p. 4.

3) to reduce costs by revenues arising from activity not indigenous to the personality of the institution (i.e., rental of rooms to personnel)

4) to remove a portion of provider based physician compensation expense not considered to be an administrative expense.[43]

Exhibit 6 identifies specifically the adjustments shown on Exhibit 1, Column 5, Lines 1, 5, 8, 12, 16, 18, 23, and 24. For example, the adjustment to Administration and General expenses of $2,782, was composed of revenues arising from the sale of scrap in the amount of $1,484, revenues of $704 arising from the rental of telephone equipment, and $594 from the rental of television equipment. In fact, as designated in Exhibit 6 all of the adjustments with the exception of those made to Radiology and Pathology, in the amounts of $24,608 and $19,482, respectively, were reductions in costs based on revenues received. The Radiology and Pathology adjustments, however, represent the cost of services applicable only to the Supplementary Medical Insurance program.

While the impact of the adjustment process on reimbursement as a result of the non-allowed status of specific items received widespread attention, so too, the flexibility within the adjustment process itself was proclaimed as a possible lever in increasing the amounts reimbursed.

For example, Hans M. Link and Jerry G. Plaster in an

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[43] Health Insurance for the Aged Provider Reimbursement Manual, Section 2322.7.

EXHIBIT 6

STEP-DOWN METHOD

PROVIDER NO. 00-0000

PERIOD 7/1/66 - 12/31/66

Schedule A-5

ADJUSTMENTS TO EXPENSES

LINE	DESCRIPTION	BASIS FOR ADJUSTMENT	AMOUNT	EXPENSE CLASSIFICATION ON SCHEDULE A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED	
				NAME	LINE NO.
			1	2	3
1.	Telephone service *(pay stations excluded)*	B	$ (704)	Admin & Gen	1
2.	Radio and television service	B	(594)	Admin & Gen	1
3.	Laundry and Linen Service				7
4.	Vending Machines Commission				9
5.	Employee and guest meals	B	(18,149)	Dietary	5
6.	Sale of drugs to other than patients				17
7.	Sale of medical and surgical supplies to other than patients				16
8.	Sale of medical records and abstracts	B	(1,297)	Medical Records	18
9.	Sale of scrap, waste, etc.	B	(1,484)	Admin & Gen	1
10.	Rental of quarters to employees and others	B	(1,637)	Maint. of Personnel	8
11.	Rental of hospital space				9
12.	Payments received from specialists				1
13.	Trade, quantity, time, and other discounts on purchases	B	(2,386)	Medical Supplies and Expense	16
14.	Rebates and refunds of expenses				Various
15.	Gift, flower, and coffee shops				Various
16.	Interest on unrestricted funds				1
17.	Nursing School *(tuition, fees, textbooks, uniforms, etc.)*	B	(5,428)	Nursing School	12
18.	Grants, gifts, and income designated by the donor for specific expenses				Various
19.	Recovery of insured loss				Various
20.	Amount applicable to Part B for hospital based physicians	A	(24,608) (19,482)	Radiologist Pathologist	23 24
21.	Fund raising expenses				Various
22.	Depreciation				31/32
23.	Other *(Specify)*				
24.	Other *(Specify)*				
25.	TOTAL		$ (75,769)		

FORM SSA-1562 (10-66) *BASIS FOR ADJUSTMENT: A – Cost B – Amount Received To Sch A

3) to reduce costs by revenues arising from activity not indigenous to the personality of the institution (i.e., rental of rooms to personnel)

4) to remove a portion of provider based physician compensation expense not considered to be an administrative expense.[43]

Exhibit 6 identifies specifically the adjustments shown on Exhibit 1, Column 5, Lines 1, 5, 8, 12, 16, 18, 23, and 24. For example, the adjustment to Administration and General expenses of $2,782, was composed of revenues arising from the sale of scrap in the amount of $1,484, revenues of $704 arising from the rental of telephone equipment, and $594 from the rental of television equipment. In fact, as designated in Exhibit 6 all of the adjustments with the exception of those made to Radiology and Pathology, in the amounts of $24,608 and $19,482, respectively, were reductions in costs based on revenues received. The Radiology and Pathology adjustments, however, represent the cost of services applicable only to the Supplementary Medical Insurance program.

While the impact of the adjustment process on reimbursement as a result of the non-allowed status of specific items received widespread attention, so too, the flexibility within the adjustment process itself was proclaimed as a possible lever in increasing the amounts reimbursed.

For example, Hans M. Link and Jerry G. Plaster in an

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[43] Health Insurance for the Aged Provider Reimbursement Manual, Section 2322.7.

EXHIBIT 6

STEP-DOWN METHOD

PROVIDER NO. 00-0000

PERIOD 7/1/66 - 12/31/66

Schedule A-5

ADJUSTMENTS TO EXPENSES

LINE	DESCRIPTION	BASIS FOR ADJUSTMENT	AMOUNT	EXPENSE CLASSIFICATION ON SCHEDULE A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED	
				NAME	LINE NO.
			1	2	3
1.	Telephone service *(pay stations excluded)*	B	$ (704)	Admin & Gen	1
2.	Radio and television service	B	(594)	Admin & Gen	1
3.	Laundry and Linen Service				7
4.	Vending Machines Commission				9
5.	Employee and guest meals	B	(18,149)	Dietary	5
6.	Sale of drugs to other than patients				17
7.	Sale of medical and surgical supplies to other than patients				16
8.	Sale of medical records and abstracts			Medical Records	18
9.	Sale of scrap, waste, etc.			in & Gen	1
10.	Rental of quarters to employe			of Personnel	8
11.	Rental of hospital space				9
12.	Payments received from spe				1
13.	Trade, quantity, time, and ot discounts on purchases			al Supplies and se	16
14.	Rebates and refunds of expense				Various
15.	Gift, flower, and coffee shops				Various
16.	Interest on unrestricted funds				1
17.	Nursing School *(tuition, fees, textbooks, uniforms, etc.)*	B	(5,428)	ursing School	12
18.	Grants, gifts, and income designated by the donor for specific expenses				Various
19.	Recovery of insured loss				Various
20.	Amount applicable to Part B for hospital based physicians	A	(24,608) (19,482)	Radiologist Pathologist	23 24
21.	Fund raising expenses				Various
22.	Depreciation				31/32
23.	Other *(Specify)*				
24.	Other *(Specify)*				
25.	TOTAL		$ (75,769)		

FORM SSA-1562 (5-68) *BASIS FOR ADJUSTMENT: A – Cost B – Amount Received To Sch A

article entitled, "How to Maximize Medicare Reimbursement," stated that since Medicare will pay reasonable costs, irrespective of how questionably defined that term might be, it was incumbent on every hospital to refine its accounting techniques such that the maximum of all possible items was included in allowable costs for Medicare.[44] Link and Plaster indicated that items such as telephone service, radio and television, employee and guest meals, and the sale of drugs, medical supplies, and medical records should be adjusted via cost not revenue.[45] Also, provider institutions, at the time, were advised to take care and recognize the cost of volunteer help and the revaluation of depreciated facilities.[46] Finally, they indicated that institutions, at the time, should take care in classifying the cost of student nursing services rendered as an educational cost and not a charity allowance, which was not reimbursable.[47] In other words, hospitals could obtain maximum reimbursement for services rendered to Medicare patients within the established principles of reimbursement for provider costs. However, the achievement of this goal required a close scrutiny of the principles of reimbursement for provider costs together with all interpretations and regulations.[48] To obtain less

[44]Hans M. Link and Jerry G. Plaster, "How to Maximize Medicare Reimbursement," Hospital Accounting (Sept., 1967), pp. 3-4.

[45]Ibid., p. 4. [46]Ibid. [47]Ibid., p. 5.

[48]Lawrence LeBlanc, "Maximizing Medicare Reimbursement," Hospital Financial Management (November, 1968), p. 9.

than maximum reimbursement as a result of not investigating to determine the lesser of cost or revenue for adjustment purposes would then be a violation of the responsibility of the provider.[49]

After having reclassified and adjusted the trial balance of direct expenses the next step in the reimbursement process is to allocate the General Service cost center expense balances as shown in Column 6 of Exhibit 1, to revenue producing areas.[50] This step in the reimbursement process is critical, for in order to bring about a proper allocation of support costs, the most efficient statistical base for each support cost classification must be utilized, and since the apportionment dollar values for all support cost centers is what may be characterized as an "accumulative value," the order in which the service cost center expenses are allocated must be carefully studied.

The above considerations, however, while very important, must also be evaluated from an implementation point of view in accordance with the guidelines of the Medicare regulations. In other words, the statistical bases chosen must

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[49]Ibid.

[50]Line 35, Column 6, of Exhibit 1, which is in addition to the reclassified and adjusted expenses represents a 2% allowance in lieu of specific recognition of other costs. The basis for this calculation is Total Allowable Costs (Exhibit 1, Column 6, Line 34), less Interest Expense (Exhibit 1, Column 6, Line 33), or $1,739,678 - $273 = $1,739,405. This allowance in lieu of specific recognition of other costs has since been eliminated from the Medicare program.

lead to an equitable distribution of costs rather than simply ensuring that the Hospital Insurance and/or Supplementary Medical Insurance programs are assigned the majority of costs.[51] Recommended bases by cost classification are shown in Exhibit 7. In addition, the order in which the various support cost center expenses are apportioned must be consistent with the following:

> All costs of nonrevenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first.[52]

Realizing the intent of law, providers could select either the Step-Down (single apportionment), or Double Apportionment method of cost finding (previously defined), as a means of allocating support costs. Hence, the balances in Column 6, Exhibit 1 are transferred to Form SSA-1562, Worksheet B, Column 1, herein labeled as Exhibit 8.

The statistical bases utilized for the allocation of support costs for the purposes of this chapter are consistent with those illustrated in Exhibit 7. Furthermore, the order in which support costs are allocated is shown on both Exhibits 8 and 9, with the detailed breakdown of all statistical bases also being shown in Exhibit 9. For example, Line 1a,

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[51] Health Insurance for the Aged Provider Reimbursement Manual, Section 2102.1.

[52] Ibid., Section 2306.1.

EXHIBIT 7

RECOMMENDED STATISTICAL BASES, BY COST CENTER

Cost Center	Base
Depreciation	Dollar Value or Square Feet
Administration and General	Accumulated Cost
Employee Health and Welfare	Gross Salaries
Operation of Plant	Square Feet
Maintenance of Plant	Square Feet
Laundry	Pounds of Laundry
Housekeeping	Hours of Service
Dietary - Raw Food	Weighted - Meals Served
Dietary - Other	Weighted - Meals Served
Cafeteria	Sales Value of Meals
Maintenance of Personnel	Number Housed
Nursing Service	Hours of Service
Medical Supplies and Expense	Costed Requisitions
Pharmacy	Costed Requisitions
Medical Records	Percent of Time Spent
Social Service	Time Spent
Nursing School	Assigned Time
Intern-Resident Service	Assigned Time

EXHIBIT 8

COST APPORTIONMENT – GENERAL SERVICES

LINE NO.	COST CENTER (Omit cents)	TOTAL DIRECT EXPENSES FOR APPORTIONMENT (from Sched. A, Col. 6, Lines 1-33)	PROVISION FOR DEPRECIATION		SUBTOTAL (Col. 1, 2a, and 2b)	ADMINISTRATION AND GENERAL	EMPLOYEE HEALTH AND WELFARE	OPERATION OF PLANT	MAINTENANCE OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING	DIETARY RAW FOOD	DIETARY OTHER
			BLDG. AND FIXTURES, ETC.	MOVABLE EQUIPMENT									
		1	2(a)	2(b)	3	5	6	8	9	7	10	11	12
	General Service Cost Centers												
1a	Provision for Depreciation — Bldg. & Fixtures	$ 42,257	$ 42,257										
1b	Provision for Depreciation — Movable Equip.	35,823		$35,823									
2	Administration & General	257,629	2,887	2,006	$ 262,522	$262,522							
3	Employee Health & Welfare	102,766	297	106	103,169	17,913	$121,082						
4	Operation of Plant	43,843	494	680	45,017	7,816	1,162	$ 53,995					
5	Maintenance of Plant	46,402	249	574	47,225	8,200	1,046	369	$ 58,820				
6	Laundry and Linen Service	36,860	1,139	541	38,540	6,692	3,025	1,594	1,748	$ 51,599			
7	Housekeeping	76,132	71	513	76,717	12,973	7,955	100	110	124	$ 95,979		
8	Dietary—Raw Food	68,440	-	-	68,440	11,883	-	-	-	-	-	$ 80,323	
9	—Other	25,096	1,298	291	26,685	4,633	2,946	1,817	1,992	519	-	594	$ 39,186
10	Cafeteria	54,998	1,354	1,248	57,600	10,001	2,315	1,895	2,078	372	-	660	32
11	Maintenance of Personnel	3,044	7,695	485	11,224	1,949	473	10,769	11,808	1,533	11,627	137	61
12	Nursing Service	425,815	462	481	426,758	82,779	55,262	647	709	420	-	14,545	7,16
13	Medical Supplies & Expense	16,973	266	895	18,134	3,149	975	372	408	100	730	248	12
14	Pharmacy	55,850	197	493	56,540	9,817	1,128	276	302	22	730	302	14
15	Medical Records	24,659	262	462	25,383	4,407	2,916	367	403	16	2,944	770	37
16	Social Service	3,416	138	200	3,754	652	393	193	211	143	730	110	5
17	Nursing School	26,054	1,169	2,091	27,314	4,743	3,126	1,636	1,793	758	4,501	825	40
18	Intern-Resident Service	50,000	852	269	51,121	8,876	6,312	1,193	1,308	885	-	1,650	81
19	Organized Research	5,400	40	9	5,449	948	545	55	61	24	167	-	-
20	Fund Raising Activities	16,407	138	355	16,900	2,936	1,640	194	213	72	405	-	-
	Special Service Cost Centers												
21	Operating Rooms	79,575	1,979	6,430	87,984	15,277	6,632	2,770	3,037	11,220	357	1,760	86
22	Delivery Rooms	10,408	853	710	11,971	2,079	867	1,194	1,309	1,223	1,657	220	10
23	Anesthesia	7,495	11	469	7,975	1,385	941	16	17	169	-	81	41
24	X-Ray	64,160	941	1,729	66,830	11,604	4,819	1,317	1,444	915	2,944	1,265	62
25	Laboratory	76,222	1,114	875	76,211	13,233	8,517	1,559	1,710	23	2,351	2,255	1,10
26	Blood Bank	6,895	173	450	7,518	1,305	400	242	266	18	338	110	5
27	Oxygen Therapy												
28	Physical Therapy	60,917	537	786	62,240	10,809	6,157	752	824	1,328	2,757	1,622	79
29	Cost of Medical Supplies Sold												
30	Cost of Drugs Sold												
	Inpatient Cost Centers												
32	Inpatients		13,141	11,094	24,235	4,208		18,388	20,162	26,849	56,736	51,107	26,10
33	Nursery	5,673	1,301	282	7,256	1,260		1,821	1,997	3,413	1,118	33	1
	Outpatient Cost Centers												
34	Outpatients		2,780	405	3,185	553		3,692	4,267	842	4,594		
35	Emergency	1,256	419	894	2,569	446	130	587	643	201	1,293	27	1
36	Private Ambulatory												
37	TOTAL	$ 1,774,466	$ 42,257	$35,823	$ 1,774,466	$262,522	$ 121,082	$ 53,995	$ 58,820	$ 51,599	$ 95,979	$ 80,323	$ 39,186

FORM SSA-1562 (10-65) From Sch A Page 1 — From Worksheet S-1-1 — From S-

EXHIBIT 8

PERIOD: 7/1/66 - 12/31/66 — Worksheet B

ION NT	MAINTENANCE OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING	DIETARY RAW FOOD	DIETARY OTHER	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING SERVICE	MEDICAL SUPPLIES AND EXPENSE	PHARMACY	MEDICAL RECORDS	SOCIAL SERVICE	NURSING SCHOOL	INTERN-RESIDENT SERVICE	TOTAL (Cols. Form IV, Lines 31-37) (To Sched. C)	LINE NO.
	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
																1a
																1b
25																2
9	$ 58,820															3
6	1,748	$ 51,599														4
0	110	124	$ 95,979													5
	-	-	-	$ 80,323												6
7	1,992	519	-	594	$ 39,186											7
5	2,078	372	-	660	324	$ 75,245										8
9	11,808	1,533	11,622	137	68	376	$ 49,964									9
7	709	420	-	14,545	7,149	42,212	5,047	$685,528								10
2	408	100	210	248	122	677	-	7,541	$ 32,456							11
6	302	22	210	302	149	903	-	-	-	$ 70,169						12
7	403	16	2,944	770	378	2,257	-	7,541	-	-	$47,382					13
3	211	143	210	110	54	301	505	-	-	-	-	$ 7,046				14
6	1,793	738	4,501	825	405	2,408	17,664	32,219	-	-	-	-	$ 97,392			15
3	1,308	885	-	1,650	811	4,816	25,739	-	-	-	-	-	-	$102,711		16
5	61	24	162	-	-	-	-	-	-	-	-	-	-	-	$ 7,247	17 (1)
4	213	72	405	-	-	-	-	-	-	-	-	-	-	-	22,358	18 (1)
0	3,037	11,220	357	1,760	865	5,117	-	54,157	4,055	8,521	-	-	10,323	18,850	230,975	21 (2)
4	1,709	3,223	1,657	220	108	602	-	23,308	3,052	3,780	-	-	9,034	13,432	75,836	22 (2)
6	17	169	-	83	41	226	-	-	-	9,611	-	-	-	-	20,086	23 (2)
7	1,444	915	2,944	1,265	622	3,687	-	26,050	-	2,581	-	-	-	-	124,078	24 (2)
9	1,710	23	2,351	2,255	1,108	6,546	-	30,869	-	1,454	-	-	-	-	146,026	25 (2)
2	266	18	338	110	54	301	-	4,799	-	-	-	-	-	-	15,351	26 (2)
																27
2	824	1,328	2,757	1,622	797	4,741	1,009	15,082	1,656	-	-	-	-	-	109,774	28 (2)
																29
																30
3	20,162	24,849	56,736	52,107	26,102	-	-	361,275	20,805	35,873	38,853	7,046	65,975	67,940	825,362	32 (2)
1	1,997	3,613	1,118	33	16	-	-	35,646	1,070	2,897	474	-	7,411	2,481	66,893	33 (2)
2	4,267	842	4,594					76,093	97	2,186	6,634	-	4,201	-	106,544	34 (2)
7	643	201	1,293	27	13	75		10,968	1,721	3,244	1,421	-	448	-	23,786	35 (2)
																36
	$ 58,820	$ 51,599	$ 95,979	$ 80,323	$ 39,186	$ 75,245	$ 49,964	$685,528	$ 32,456	$ 70,169	$47,382	$ 7,046	$ 97,392	$102,711	$1,774,466	37
															29,605	(1)
															$1,744,861	(2)

(1) Worksheet B-1-1 — (2) From Worksheet B-1-2 — (2) To Sch C — Exclusions

EXHIBIT 9

STEP-DOWN METHOD EXHIBIT I-5

COST APPORTIONMENT – STATISTICAL BASIS

LINE NO.	COST CENTER (Statistical Basis)	PROVISION FOR DEPRECIATION: BUILDING AND FIXTURES (Square Feet)	PROVISION FOR DEPRECIATION: MOVABLE EQUIPMENT (Dollar Value or Square Feet)		ADMINISTRATION AND GENERAL (Accumulated Costs*)	EMPLOYEE HEALTH AND WELFARE (Gross Salaries)	OPERATION OF PLANT (Square Feet)	MAINTENANCE OF PLANT (Square Feet)	LAUNDRY AND LINEN SERVICE (Pounds of Laundry)	HOUSEKEEPING (Hours of Service)	DIETARY RAW FOOD Weighted (Meals Served)	DIETAR OTHE Weight (Meals Se
		(a)	(a)		b	c	d	e	f	g	h	w
	General Service Cost Centers											
1a	Provision for Bldg. & Fixtures	213,150										
1b	Depreciation Movable Equip.		414,063									
2	Administration and General	14,564	23,182		1,511,946							
3	Employee Health and Welfare	1,500	1,220		103,169	959,106						
4	Operation of Plant	2,490	7,860		45,017	9,207	194,596					
5	Maintenance of Plant	1,256	6,639		47,225	24,129	1,256	193,340				
6	Laundry and Linen Service	5,746	6,252		38,540	23,959	5,746	5,746	647,100			
7	Housekeeping	360	5,925		74,717	63,013	360	360	1,556	63,115		
8	Dietary—Raw Food				68,440						1,143,476	
9	—Other	6,569	3,360		26,685	23,339	6,569	6,569	6,510		$ 8,636	1,13
10	Cafeteria	6,830	14,427		57,600	18,337	6,830	6,830	4,666		9,395	
11	Maintenance of Personnel	38,813	5,610		11,224	3,765	38,813	38,813	19,224	7,648	1,955	
12	Nursing Service	2,332	5,559		476,758	437,750	2,332	2,332	5,268		207,080	2
13	Medical Supplies and Expense	1,341	10,342		18,134	7,722	1,341	1,341	1,254	480	3,525	
14	Pharmacy	993	5,696		56,560	8,936	993	993	270	480	4,305	
15	Medical Records	1,324	5,340		25,383	23,101	1,324	1,324	200	1,938	10,960	
16	Social Service	695	2,316		3,754	3,116	695	695	1,792	480	1,555	
17	Nursing School	5,895	24,175		27,314	24,765	5,895	5,895	9,504	2,980	11,765	
18	Intern-Resident Service	4,300	3,105		51,121	50,000	4,300	4,300	12,103		23,685	
19	Organized Research	200	100		5,449	4,320	200	200	300	110		
20	Fund Raising Activities	700	4,100		16,900	12,994	700	700	900	266		
	Special Service Cost Centers											
21	Operating Rooms	9,983	74,314		87,984	52,533	9,983	9,983	140,707	235	25,030	
22	Delivery Rooms	4,302	8,704		11,971	6,869	4,302	4,302	40,425	1,090	3,130	
23	Anesthesia	56	5,421		7,975	2,698	56	56	4,625		1,175	
24	X-Ray	4,748	19,985		66,830	38,170	4,748	4,748	11,472	1,930	18,005	
25	Laboratory	5,620	10,109		76,211	67,467	5,620	5,620	2,921	1,546	17,095	
26	Blood Bank	873	5,202		7,518	3,172	873	873	227	222	1,565	
27	Oxygen Therapy											
28	Physical Therapy	2,709	9,083		62,240	48,734	2,709	2,709	16,660	1,813	23,095	
29	Cost of Medical Supplies Sold											
30	Cost of Drugs Sold											
	Inpatient Cost Centers											
32	Inpatients	66,267	126,233		24,235		66,267	66,267	311,628	37,312	756,010	
33	Nursery	6,564	3,265		7,256		6,564	6,564	42,802	735	470	
	Outpatient Cost Centers											
34	Outpatients	14,025	4,689		3,185		14,025	14,025	10,564	3,021		
35	Emergency	2,115	10,332		2,569	1,030	2,115	2,115	2,522	850	390	
36	Private Ambulatory											
37	Costs to be apportioned (per W/S B)	$ 42,257	$ 35,823	$	$ 262,322	$ 121,082	$ 53,993	$ 58,820	$ 51,599	$ 95,975	$ 80,323	$
38	Unit Cost Multiplier	.19825	.08652		.17363	.12624	.27747	.30623	.07976	1.32063	.07025	

*Total Accumulated Costs of all other cost centers, per cent. 2, lines 1 thru 36, Worksheet B.

NOTE: Bases shown at top of each column are the usually recommended bases.
Other bases will be acceptable when they result in more appropriate and more accurate allocations.

FORM SSA-1542 10-66

EXHIBIT 9

PROVIDER NUMBER: 00 - 0000 EXHIBIT I-5

PERIOD: 7/1/66 - 12/31/66 Worksheet B-1

MAINTENANCE OF PLANT (Square Feet)	LAUNDRY AND LINEN SERVICE (Pounds of Laundry)	HOUSEKEEPING (Hours of Service)	DIETARY RAW FOOD Weighted (Meals Served)	DIETARY OTHER Weighted (Meals Served)	CAFETERIA (Sales Value of Meals)	MAINTENANCE OF PERSONNEL (Number Housed)	NURSING SERVICE (Hours of Service)	MEDICAL SUPPLIES AND EXPENSE (Costed Req'n)	PHARMACY (Costed Req'n)	MEDICAL RECORDS (% Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING SCHOOL (Assigned Time)	INTERN-RESIDENT SERVICE (Assigned Time)	LINE NO.
6	7	8	9	10	11	12	13	14	15	16	17	18	19	
														1a
														1b
														2
193,340														3
5,746	647,100													4
360	1,556	61,115												5
			1,143,476											6
6,549	6,510		8,456	1,135,020										7
6,830	4,666		9,395	9,395	93,394									8
38,813	19,224	7,648	1,955	1,955	467	99								9
2,332	5,268		207,050	207,050	52,393	10	413,263							10
1,341	1,254	480	3,525	3,525	840		6,546	18,071						11
993	270	480	4,305	4,305	1,121				53,387					12
1,324	200	1,936	10,960	10,960	2,801		4,546			100%				13
695	1,792	480	1,565	1,565	374	1								14
5,895	9,504	2,960	11,745	11,745	2,989	35	19,423					88,982		15
4,300	11,103		23,485	23,485	5,978	51							61,175	16
200	300	110												17
700	900	266												18
														19
9,983	140,707	235	25,050	25,050	6,351		32,648	2,258	6,483			9,432	11,227	20
4,302	40,425	1,090	3,130	3,130	747		14,051	1,699	2,876			8,254	8,000	21
56	4,625		1,175	1,175	281				7,329					22
4,748	11,472	1,936	18,005	18,005	4,576		15,704		1,964					23
5,620	2,921	1,568	32,095	32,095	8,125		18,597		1,106					24
873	227	222	1,565	1,565	374		2,893							25
														26
														27
2,709	16,660	1,813	23,095	23,095	5,885	2	9,092	922						28
														29
														30
66,267	311,628	37,312	756,050	756,050			217,790	11,584	27,294	82%	100%	60,278	40,470	31
6,564	42,802	735	470	470			21,489	596	2,204	1%		6,771	1,478	32
														33
14,025	10,564	3,021					45,872	54	1,663	14%		3,838		34
2,115	2,522	850	390	390	92		6,612	958	2,468	3%		409		35
														36
$ 58,820	$ 51,599	$ 95,975	$ 80,323	$ 39,186	$ 75,245	$ 49,964	$ 685,528	$ 32,456	$ 70,169	$ 47,382	$ 7,046	$ 97,392	$ 102,711	37
.30423	.07974	1.32065	.07025	.034524	.80567	504.68687	1.65882	1.79603	1.31435	47,382	7,046	1.09451	1.67897	38

Column 1a of Exhibit 9 indicates that the provider has facilities encompassing 213,150 square feet of space, with a detailed breakdown of this total given on Lines 2 through 36, Column 1a. Since the total depreciation expense for Buildings and Fixtures per Exhibit 8, Line 1a, Column 1, is $42,257, then depreciation in the amount of $.19825 per square foot ($42,257/$213,150) is assigned to each department. The actual assignment of depreciation, by department, is shown in Column 1a, Lines 2 through 36, of Exhibit 8. Depreciation of Movable Equipment in the amount of $35,823 (Exhibit 8, Column 1, Line 16), is assigned to each department on the basis of the dollar value of the Movable Equipment in each department, as illustrated in Exhibit 9, Column 1b, Lines 2 through 36. Since the total value of all Movable Equipment, per Exhibit 9, Column 1b, Line 1b, is $414,043, then depreciation in the amount of $.08625 per dollar of value $35,823/$414,043) is assigned to each department.

In similar fashion the expenses of all remaining support departments are allocated consistent with the appropriate statistical basis as shown in Exhibit 9. If the Step-Down or single apportionment method was used then each department is considered closed as its costs are allocated. In other words, irrespective of the fact that one department may have received services from another department, the value of such services cannot be allocated to the receiving department if its expenses have themselves already been allocated. Thus,

in spite of the fact that the Housekeeping department (in Exhibit 8) may have spent many hours rendering a service to the Administration and General cost center, the fact that Housekeeping expense is allocated, subsequently, to Administration and General expenses necessitates that no Housekeeping costs can be assigned to the Administration and General cost center.[53]

Furthermore, the dollar value of each cost center to be apportioned is, as mentioned previously, an accumulative value. In other words, the dollar of the Housekeeping department to be apportioned was not $74,133, as shown in Exhibit 1, Column 6, Line 6, but was rather $95,979, determined as follows:

---

[53]If the Double Apportionment method of cost finding had been used, it would have been possible to assign Housekeeping costs to the Administration and General cost center. Such a situation is possible because under the Double Apportionment method all cost centers remain open and, therefore, can receive costs from centers subsequently distributed, on the first distribution. On the second distribution, however, cost centers again close as they are allocated. Therefore, since the Double Apportionment method is really the Step-Down method applied twice it allows for costs, only on the initial distribution to be apportioned to previously distributed cost centers.

Original Balance, Housekeeping per Exhibit 1, Column 6, Line 6	$74,133
Add	
Apportionments from previously distributed cost centers:	
Depreciation - Buildings and Fixtures	71
Depreciation - Movable Equipment	513
Administration and General	12,973
Employee Health and Welfare	7,955
Operation of Plant	100
Maintenance of Plant	110
Laundry	124
Housekeeping Balance to be Apportioned:	$95,979

When all General Service cost center expenses have been apportioned the allowable accumulative totals, as shown in Exhibit 8, Column 20, Lines 21 through 36, are transferred to Form SSA-1562, Schedule C, Column 1, herein labeled as Exhibit 10, for segregation into inpatient, nursery, outpatient, emergency and private ambulatory categories. The unallowed values, per Exhibit 8, of $7,247 and $22,358 representing the direct and indirect costs of the disallowed activities of Organized Research and Fund Raising, respectively, are deleted.

The basis for the segregation of the accumulative costs listed in Exhibit 10, Column 1, into the aforementioned categories is the ratio of charges to charges, by department, as delineated in Exhibit 11. In other words, of the total charges for Operating Room services, per Exhibit 11, Column 1, Line 1, namely, $201,074, all inpatients accounted for

EXHIBIT 10

STEP-DOWN METHOD

EXHIBIT I-8

PROVIDER NO. 00-0000

DEPARTMENTAL COST ALLOCATION (Unit Costs)
(For Basis see Worksheet C-1 – Page 10)

PERIOD 7/1/66 12/31/66

Schedule C

DISTRIBUTION BASIS: [X] RATIO OF CHARGES TO CHARGES APPLIED TO COST [ ] STATISTICAL (OCCASIONS OF SERVICE) IF CHECKED, FURNISH DETAIL SCHEDULES [ ] OTHER

LINE NO.	COST CENTER	ACCUMULATED COSTS (from Column 20, Lines 31 to 37 of Worksheet B)	INPATIENTS	NURSERY	OUTPATIENTS	EMERGENCY	PRIVATE AMBULATORY
		1	2	3	4	5	6
1	SPECIAL COST CENTERS Operating Rooms	$ 230,925	$ 227,579	$	$ 670	$	$ 2,676
2	Delivery Rooms	75,836	75,836				
3	Anesthesia	20,086	17,899	379	362		1,446
4	X-Ray	124,078	89,518	1,756	6,561		26,243
5	Laboratory	146,026	132,611		2,682		10,733
6	Blood Bank	15,351	14,345		201		805
7	Oxygen Therapy						
8	Physical Therapy	109,774	98,725		2,210		8,839
9	Cost of Medical Supplies Sold						
10	Cost of Drugs Sold						
	INPATIENT COST CENTERS						
11	Inpatients	825,562	825,562				
12	Nursery	66,893		66,893			
	OUTPATIENT COST CENTERS						
13	Outpatients	106,544			89,497		17,047
14	Emergency	23,786				23,786	
15	Private Ambulatory	-	-	-	-	-	-
16	TOTAL	$ 1,744,861	$ 1,482,075	$ 69,028	$ 102,183	$ 23,786	$ 67,789

FORM SSA-1562 (9-66)

Form SSA 1563 Page 2

Sum to Form SSA-1563 Page 3, line 4

EXHIBIT 11

STEP-DOWN METHOD

PROVIDER NO. 00-0000

DEPARTMENTAL COST ALLOCATION (Unit Costs)
TOTAL GROSS CHARGES TO CHARGES BASIS (Applied on Schedule C)

PERIOD 7/1/66 - 12/31/66

Schedule C-1

LINE NO.	COST CENTER	TOTAL GROSS CHARGES (All Patients)	TOTAL GROSS CHARGES (All Inpatients)	TOTAL GROSS CHARGES (All Nursery)	TOTAL GROSS CHARGES (All Outpatients)	TOTAL GROSS CHARGES (All Emergency)	TOTAL GROSS CHARGES (All Private Ambulatory)
		1	2	3	4	5	6
	SPECIAL COST CENTERS		$ 198,160	$	$ 583	$	$ 2,331
1	Operating Rooms	201,074	% 98.551	%	% 00.290	%	% 01.159
			$ 27,360	$	$	$	$
2	Delivery Rooms	27,360	% 100.0	%	%	%	%
			$ 18,892	$ 400	$ 382	$	$ 1,526
3	Anesthesia	21,200	% 89.113	% 1.887	% 01.802	%	% 07.198
			$ 127,728	$ 2,505	$ 9,361	$	$ 37,445
4	X-Ray	177,039	% 72.147	% 1.415	% 05.288	%	% 21.150
			$ 165,763	$	$ 3,354	$	$ 13,416
5	Laboratory	182,533	% 90.813	%	% 01.837	%	% 07.350
			$ 15,782	$	$ 221	$	$ 886
6	Blood Bank	16,889	% 93.445	%	% 01.309	%	% 05.246
			$	$	$	$	$
7	Oxygen Therapy		%	%	%	%	%
			$ 106,583	$	$ 2,386	$	$ 9,543
8	Physical Therapy	118,512	% 89.935	%	% 02.013	%	% 08.052
			$	$	$	$	$
9	Cost of Medical Supplies Sold		%	%	%	%	%
			$	$	$	$	$
10	Cost of Drugs Sold		%	%	%	%	%
	INPATIENT COST CENTERS		$ 904,248				
11	Inpatients	904,248	% 100.00	—	—	—	—
				$ 60,000			
12	Nursery	60,000	—	% 100.00	—	—	—
	OUTPATIENT COST CENTERS				$ 103,616	$	$ 19,736
13	Outpatients	123,352	—	—	% 84.000	%	% 16.000
					$	$ 26,015	$
14	Emergency	26,015	—	—	%	% 100.00	%
					$	$	$
15	Private Ambulatory		—	—	%	%	%
16	TOTAL	$ 1,858,222	$ 1,564,516	$ 62,905	$ 119,903	$ 26,015	$ 84,883

FORM SSA-1562 (5-66) *Ambulance 9,649
1,867,871

Sources: Charges - Form SSA-1563 Page 2 and 3

*Ambulance is covered by a separate set of reimbursement schedules

only $583 or .29% (Column 4, Line 1), and Private Ambulatory patients accounted for $2,331 or 1.159% (Column 6, Line 1). Therefore, assuming a consistency between cost and charge 98.551% of the total Operating Room cost or $227,579 (Exhibit 10, Column 2, Line 2) is assigned to the inpatient category. Similarly, .29% of total Operating Room cost or $670 (Exhibit 10, Column 4, Line 1) is assigned to outpatients, and 1.159% or $2,676 (Exhibit 10, Column 6, Line 1) is assigned the private ambulatory category. Thus, in the case of Operating Room expense, as well as all other departmental expenses listed, total cost is assigned to various patient subclassifications such as inpatients, outpatients and nursery, on the basis of the ratio of subclassification charges to total departmental charges.[54]

With the completion of this step all applicable cost data has been prepared consistent with Medicare regulations. That is, the original trial balance of direct expenses has been reclassified and adjusted. The adjusted costs have been apportioned using either the Step-Down or Double Apportionment method of cost finding. The expenses of any unallowed cost centers have been eliminated; and the remaining allowable expenses have been segregated into inpatient, outpatient, nursery, and private ambulatory categories.

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[54]Health Insurance for the Aged Provider Reimbursement Manual, Section 2302.6.

With these steps having been completed only the actual reimbursement settlement process remains.

Reimbursement Settlement

The first step in the applicable reimbursement process is to calculate a reimbursement settlement for inpatient services excluding Title XVIII, Part B. In order to complete this objective either the Combination or Departmental method of reimbursement may be used.[55] Essentially, the Combination method uses the ratio of total Hospital Insurance program charges for all ancillary services rendered to total charges for all ancillary services times, the aggregate costs of such services for determining the amount reimbursable to the provider. The Departmental method uses the ratio of Medicare program charges to total charges, however, this ratio is calculated by department, and is used to allocate the cost of each separate department. The summation of the reimbursable portions from each ancillary department then represents the total amount reimbursable to the provider for the provision of ancillary services. With either the Combination or Departmental method, inpatient routine costs are allocated on an adjusted per diem basis. Thus, the essential difference between methodologies is that the Combination

---

[55]Subsection A, Title XVIII - Medicare, now provides that, for cost reporting periods starting after December 31, 1971, hospitals having less than 100 beds and all ECF's must use the Combination Method of cost apportionment. Hospitals having 100 or more beds must use the Departmental Method of apportionment.

method utilizes aggregate values of cost and charge while the Departmental method utilizes cost and charges by department.

For simplicity, using the Combination method, the total billed inpatient charges for all patients per Exhibit 11, Column 2, Line 16, namely $1,564,516 is broken into two component parts. The first part $904,248 (Column 2, Line 11) represents charges levied for routine inpatient services, such as room and board. This total is entered in Column 1, Line 16, Exhibit B of Form SSA-1992, herein labeled as Exhibit 12. The second part $660,268 which is actually the remainder of all inpatient charges, per Exhibit 11, Column 2, Lines 1 through 10, is entered in Column 1, Line 15 of Exhibit 12. In Column 2, Line 15 of Exhibit 12, the value of all billed inpatient charges for services such as Operating Room, Anesthesia, X-ray, etc., for health care program patients excluding Title XVIII, Part B, is entered. When the ratio of health care program participant charges to total charges for ancillary services, namely .34 ($224,491/$660,268), is multiplied by the sum of all inpatient costs for corresponding services, $656,513 per Exhibit 12, Column 4, Line 15, the resulting figure $223,214 represents an amount reimbursable to the provider institution from the Medicare program for costs incurred in the rendering of ancillary services to eligible Medicare program participants.

Rather than use the ratio of charges to charges as

EXHIBIT 12

EXHIBIT B

Form Approved
Budget Bureau No. 72-R0646

To be completed only when using the Departmental RCCAC or Combination Method (with cost finding)

TITLE _____ PROVIDER NO.

CALCULATION OF REIMBURSEMENT SETTLEMENT--INPATIENT SERVICES EXCLUDING TITLE XVIII, PART B (Omit Cents)

PERIOD

LINE NO.	COST CENTER	TOTAL BILLED INPATIENT CHARGES (Gross) ALL PATIENTS	TOTAL BILLED INPATIENT CHARGES (Gross) HEALTH CARE PROGRAM PATIENTS (Excl. Title XVIII, Part B)	PERCENT PROGRAM CHARGES TO TOTAL CHARGES (Col. 2 ÷ Col. 1)	TOTAL INPATIENT EXPENSES From Col. 2 and 3, Schedule C, Form SSA-1562)	INPATIENT EXPENSES APPLICABLE TO HEALTH CARE PROGRAM (Col. 3 × Col. 4)	COMBINATION METHOD (Computed with Cost Finding)
		1	2	3	4	5	6
	SPECIAL SERVICE COST CENTERS					Dept. RCCAC	
1.	Operating Rooms	$	$	%	$	$	
2.	Delivery Rooms						
3.	Anesthesia						
4.	X-Ray						
5.	Laboratory						
6.	Blood Bank						
7.	Oxygen Therapy						
8.	Physical Therapy						
9.	Cost of Medical Supplies Sold						
10.	Cost of Drugs Sold						
11.							
12.							
13.							
14.	Outpatient Costs *(Inpatient Services) (See Inst.)*						
15.	SUB-TOTALS	$660,268	$224,491	.34	$656,513	$	(A) 223,214
16.	Inpatient Routine Services	904,248			567,699	$	
17.	Newborn Routine Services					$	
18.	Total Inpatient Days *(Excl. Newborn) (1563, pg. 1, line 4 or Exh. A, line 4)*				16,511		
19.	Average Per Diem Cost---Routine Services *(line 16 ÷ 18)*				34.38		
20.	Health Care Program Patient Days (B) 4900 × line 19, Col. 4						257,863
21.	Total Newborn Days *(1563, pg. 1, line 10 or Exh. A, line 9)*						
22.	Average Per Diem Cost---Newborn Routine Services						

11.							
12.							
13.							
14.	Outpatient Costs *(Inpatient Services) (See Inst.)*						
15.	SUB-TOTALS	$ 660,268	$ 224,491	.34	$ 656,513	$	(A) 223,21
16.	Inpatient Routine Services	904,248			567,699	$	
17.	Newborn Routine Services					$	
18.	Total Inpatient Days *(Excl. Newborn) (1563, pg. 1, line 4 or Exh. A, line 4)*				16,511		
19.	Average Per Diem Cost—Routine Services *(line 16 ÷ 18)*				34.38		
20.	Health Care Program Patient Days (B) 4900 × line 19, Col. 4						257,863
21.	Total Newborn Days *(1563, pg. 1, line 10 or Exh. A, line 9)*						
22.	Average Per Diem Cost—Newborn Routine Services *(line 17 ÷ line 21)*						
23.	(C) Program Newborn Patient Days _____ × line 22						
24.	SUB-TOTALS	$	$			$	$ 481,077
25.	OTHER SERVICES INCLUDED HERE FOR TITLES V AND XIX ONLY—See Note below Ambulance—Inpatients *(From Exh. I, col. 3, line 3.a or 3.b)*						
26.	Radiologists and Pathologists Inpatient Services *(From Exh. H-1, line 3, Col. 1 or 3)*						
27.	Interns & Residents—Not in Approved Training Programs—Inpatients *(From Exh. J, line 10)*						
28.	SUB-TOTALS *(Sum of lines 24 thru 27)*					$	$ 481,077
29.	Subtract: Amounts paid and payable by Workmen's Compensation, etc. *(See Instructions)*						
30.	SUB-TOTALS *(line 28 minus line 29)*					$	$ 481,077
31.	Deductibles and coinsurance billed to Health Care Program patients					$	$ 35,000
32.	Subtract: Bad debts for deductibles and coinsurance, net of bad debt recoveries						
33.	Net deductibles and coinsurance billed to Health Care Program patients *(line 31 minus line 32)*					$	$ 35,000
34.	Differential in charges between semi-private accommodations and less than semi-private accommodations						
35.	Net cost of covered services to Program inpatients *(Excl. return on equity capital) (line 30 minus 33 & 34)*					$	$ 446,077
36.	Reimbursable return on equity capital						
37.	Total cost reimbursable to hospital *(line 35 plus 36)*					$	$ 446,077
38.	Amount received and receivable from Intermediary or Social Security Administration (Excl. current financing)						
39.	Balance due hospital/Health Care Program *(line 37 minus 38)*					$	$

(A) Line 15, column 4 multipled by Line 15, Column 3.
(B) From Exhibit A, line 10.a.
(C) From Exhibit A, line 10.c.
Note: Lines 17, 21, 22 and 23 do not apply to Title XVIII. Reimbursement for the services shown on lines 25, 26 and 27 are included here for Titles V and XIX only. For Title XVIII—the services shown on lines 25 and 26 are reimbursable on Exhibit E; the services shown on line 27 are reimbursable on Exhibit J.

FORM SSA-1992 (9-69) THIS EXHIBIT SHOULD BE USED IN LIEU OF FORM SSA-1563, PAGE 2

the basis for assigning routine inpatient costs to the Medicare program, however, an adjusted per diem basis, as mentioned earlier, is utilized.

In essence, the cost of routine inpatient services, as shown in Exhibit 13, Line 9 is adjusted by 8½% to reflect an allowed nursing service cost differential factor. This adjusted value, shown in Exhibit 13, Line 24 is transferred to Form SSA-1992, Line 20, herein labeled Exhibit 12, and represents the total amount reimbursable to the provider for the provision of routine inpatient services to Medicare program participants. (The total of health care program patient days is shown on Form SSA-1992, Exhibit A, Line 10a, herein labeled Exhibit 14.)

The total amount to be reimbursed to the provider for the provision of ancillary services and routine inpatient services, namely $481,077 ($223,214 + $257,863) is shown in Exhibit 13, Column 6, Line 24. This value, after being adjusted for deductible and coinsurance amounts which are the primary responsibility of the individual Medicare program participants, as well as any bad debts, bad debt recoveries per the Medicare program, and differentials in charges between semi-private accommodations and less than semi-private accommodations, represents the amount due to the hospital for rendering inpatient services excluding Title XVIII, Part B.[56]

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[56]If the Medicare enrollee defaults on the payment of either the deductible and/or coinsurance amounts, these amounts are recoverable in succeeding periods from the Medicare program.

EXHIBIT 13

Form Approved.
OMB No. 72-R0763

PART I – COMPUTATION OF HOSPITAL INPATIENT ROUTINE SERVICE COST FOR TITLE XVIII (MEDICARE)	PERIOD	Schedule E PROVIDER NO.
INPATIENT DAYS		
1. Total Inpatient days – all patients *(excluding nursery) (from Form SSA-1992, Exhibit A, line 4)*		16,511
2. Total inpatient days – aged, pediatric, and maternity		6,000
3. Total inpatient days – other *(line 1 minus line 2)*		10,511
4. Inpatient days applicable to Title XVIII (Medicare) *(from Form SSA-1992, Exhibit A, column 2, line 10.a)*		4,900
5. Inpatient days – aged, pediatric, and maternity plus 8½% *(line 2 x 1.085)*		6,510
6. Total adjusted inpatient days *(line 3 plus line 5)*		17,021
INPATIENT ROUTINE COSTS		
7. Total inpatient routine nursing salary cost *(excluding nursery)*		$ 825,562
8. Total inpatient routine service costs excluding inpatient routine nursing salary cost on line 7		-
9. Total inpatient routine service costs *(line 7 plus line 8) (Must agree with Form SSA-1562, Sch. C, Col. 2, line 11)*		$ 825,562
10. Inpatient routine nursing salary cost plus 8½% *(line 7 x 1.085)*		$ 895,735
COMPUTATION OF INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)		
11. Adjusted average per diem inpatient routine nursing salary cost *(line 10 ÷ line 6)*		$ 52.625
12. Average per diem inpatient routine nursing salary cost – unadjusted *(line 7 ÷ line 1)*		50.001
13. Average per diem inpatient routine nursing salary cost differential adjustment factor *(line 11 minus line 12)*		$ 2.624
14. Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare *(line 4 x line 13) (see instructions)*		$ 12,858
APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE), AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE (INCLUDING THE INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL ADJUSTMENT FACTOR) (COMPLETE LINES 15–19 OR 20–22, WHICHEVER ARE APPLICABLE)		
DEPARTMENTAL RCCAC		
15. Total billed inpatient charges (gross) for routine services – all patients *(excluding nursery) (from Form SSA-1562, Sch. C-1, Col. 2, line 11)*		$
16. Total billed inpatient charges (gross) for routine services – Medicare patients		$
17. Percent Medicare patient charges to total charges – all patients *(line 16 ÷ line 15)*		%
18. Inpatient routine service cost applicable to Medicare – Does not include inpatient routine nursing salary cost differential adjustment factor *(line 9 x line 17)*		$
19. Total inpatient routine service cost applicable to Medicare including nursing cost differential adjustment factor *(line 14 plus line 18) (Transfer this amount to Form SSA-1992, Exhibit B, Column 5, line 16)*		$
COMBINATION METHOD (WITH COST FINDING)		
20. Inpatient routine average per diem cost *(line 9 ÷ line 1)*		$ 50.001
21. Inpatient routine service cost applicable to Medicare – Does not include inpatient routine nursing salary cost differential adjustment factor *(line 4 x line 20)*		$ 245,005
22. Total inpatient routine service cost applicable to Medicare including nursing cost differential adjustment factor *(line 14 plus line 21) (Transfer this amount to Form SSA-1992, Exhibit B, Column 6, line 20)*		$ 257,863
PART II – COMPUTATION OF ALLOWABLE INPATIENT ROUTINE SERVICE COST SUBJECT TO COST APPORTIONMENT UNDER TITLES V AND XIX		
23. Total inpatient routine service costs *(from line 9)*		$ 825,562
24. Total inpatient routine service cost applicable to Medicare including nursing cost differential adjustment factor *(from line 19 or line 22, whichever is appropriate)*		257,863
25. Allowable inpatient routine service cost subject to cost apportionment under Titles V and XIX *(line 23 minus line 24) (Transfer this amount to Form SSA-1992, Exhibit B, Col. 4, line 16 for Titles V and XIX)*		$ 567,699

FORM SSA-1562E (11-71)

EXHIBIT 14

EXHIBIT A

Form Approved
Budget Bureau No. 72-R0846

PROVIDER NO.

HOSPITAL STATEMENT OF REIMBURSABLE COST

READ INSTRUCTIONS BEFORE FILLING IN FORM

DATE

(Intermediary Use Only)
☐ DESK REVIEWED ☐ NOT AUDITED
☐ AUDITED
INTERMEDIARY NO.

NAME OF HOSPITAL

ADDRESS

TYPE OF CONTROL[1]

VOLUNTARY NONPROFIT	PROPRIETARY	GOVERNMENT		
☐ CHURCH	☐ INDIVIDUAL OR PARTNERSHIP	(NON-FEDERAL)	☐ STATE	☐ CITY
☐ OTHER (Specify)	☐ CORPORATION		☐ COUNTY	☐ CITY-COUNTY
				☐ HOSPITAL DISTRICT

TYPE OF HOSPITAL[2]

			HEALTH CARE PROGRAMS
☐ GENERAL—SHORT TERM	☐ PSYCHIATRIC	☐ SPECIALTY—LONG TERM	☐ TITLE V
☐ GENERAL—LONG TERM	☐ CHRONIC DISEASE	☐ OTHER (Specify)	☐ TITLE XVIII
☐ TUBERCULOSIS	☐ SPECIALTY—SHORT TERM		☐ TITLE XIX

PERIOD COVERED BY STATEMENT[3]	FROM	TO

STATISTICAL DATA

INPATIENT STATISTICS—ALL PATIENTS

1. Beds (exclusive of bassinets) available at beginning of period		56
Adult beds *(included in line 1)*	56	
2. Beds (exclusive of bassinets) available at end of period		56
Adults beds *(included in line 2)*	56	
3. Total bed days available (excluding newborn)[4]		20,640
Adult days *(included in line 3)*	20,640	
4. Total inpatient days (excluding newborn)[5]		16,511
Adult days *(included in line 4)*	16,511	
5. Percent occupancy *(line 4 divided by line 3)*		80.0
6. Discharges, including deaths (excluding newborn infants)		3,070
7. Average length of stay—inpatients (excluding newborn) (line 4 divided by line 6)		5.9
8. Number of admissions		3,075
9. Total newborn inpatient days		-

10. Health Care Programs	TITLE V	TITLE XVIII	TITLE XIX
a. Total inpatient days		4,900	
b. Number of discharges		514	

1. Beds (exclusive of bassinets) available at beginning of period		56
Adult beds *(included in line 1)*	56	
2. Beds (exclusive of bassinets) available at end of period		56
Adults beds *(included in line 2)*	56	
3. Total bed days available (excluding newborn)[1]		20,640
Adult days *(included in line 3)*	20,640	
4. Total inpatient days (excluding newborn)[2]		16,511
Adult days *(included in line 4)*	16,511	
5. Percent occupancy *(line 4 divided by line 3)*		80.0
6. Discharges, including deaths (excluding newborn infants)		3,070
7. Average length of stay—inpatients (excluding newborn) (line 4 divided by line 6)		5.9
8. Number of admissions		3,075
9. Total newborn inpatient days		-

10. Health Care Programs	TITLE V	TITLE XVIII	TITLE XIX
a. Total inpatient days		4,900	
b. Number of discharges		514	
c. Average length of stay *(line 10a ÷ line 10b)*		8.5	
d. Number of admissions		600	
e. Newborn inpatient days			

OUTPATIENT STATISTICS—ALL PATIENTS

11. Total number of occasions of service[3]	
a. Emergency room occasions of service	
b. Clinic occasions of service	
c. Private referred outpatients occasions of service	
d. Total outpatient occasions of service	
e. Total outpatient occasions of service—Title XVIII	

OTHER STATISTICS

12. Cost Apportionment Method Used. *(Check one)*

☐ DEPARTMENTAL RCC ☐ COMBINATION METHOD *(with cost finding)*

☐ OTHER *(specify)* ☐ COMBINATION METHOD *(estimated percentage basis)*

13. a. Amount of current financing outstanding as of the end of the cost reporting period—All Health Care Programs	$
b. Amount of accelerated payments outstanding as of the end of the cost reporting period—All Health Care Programs	$
14. a. Average number of employees on payroll for the period (full-time equivalent)—Excludes nonpaid workers	
b. Average number of nonpaid workers for the period for which reimbursement is claimed (full-time equivalent)	

FORM SSA-1992 (6-70)

This total is shown in Exhibit 13, Column 6, Line 37.

The next step in the reimbursement process is to determine the reimbursement applicable to Title XVIII, Part B and Part A outpatient. In order to complete this step, the sum of the total charges for outpatients, emergency, and private ambulatory subclassifications, per Exhibit 11, Columns 4, 5, and 6, Line 16, is entered on Form SSA-1992, Exhibit E, Column 2, Line 1, labeled here as Exhibit 15.

On Line 2, Column 2, of Exhibit 15, the total amount of outpatient charges for Health Insurance program outpatients, namely $19,618, is entered. Since the basis for allocating costs is the ratio of charges to charges the ratio of the amount on Line 2, Exhibit 15, to the amount on Line 1, Exhibit 15, namely .085 ($19,618/$230,801), represents that portion of the applicable costs to be borne by the Medicare program. Therefore, when the sum of the applicable costs, as shown in Exhibit 15 (Column 2, Line 4) is multiplied by .085%, the resulting figure of $16,469, appearing on Line 5 of Exhibit 15, represents the actual gross amount of outpatient expenses applicable to the Supplementary Medical Insurance program.

Before the total amount to be reimbursed to the provider under Title XVIII, Part B and Part A outpatient can be determined, this value must be adjusted by such items as:

1) the cost of inpatient ancillary services covered by Supplementary Medical Insurance

EXHIBIT 15

EXHIBIT E

Form Approved
Budget Bureau No. 72-R0846

PROVIDER NO.

CALCULATION OF REIMBURSEMENT SETTLEMENT—TITLE XVIII, PART B AND PART A OUTPATIENT (Omit Cents)	PERIOD	
RATIO OF CHARGES TO CHARGES (Gross) APPLIED TO COST	HOSPITAL PLAN (Part A) OUTPATIENT SERVICES (thru 3/31/68)	MEDICAL PLAN (Part B)
*1. Total amount of outpatient charges (gross) all outpatients	$	$ 230,801
2. Total amount of outpatient charges (gross) Health Insurance Program outpatients	$	$ 19,618
3. Percent Health Insurance Program outpatient charges to total gross charges (line 2 ÷ line 1)	%	% 8.5
*4. Total amount of hospital expenses for outpatient services from (Sch. C, Form SSA-1562—cols. 4 plus 5 and 6, line 16) or (page 1a, Form SSA-1564 line 50, col. 5) or (page 1b, Form SSA-1564A, line 50, col. 5)	$	$ 193,758
5. Outpatient expenses applicable to Health Insurance Program (excl. bad debts) (line 4 multiplied by line 3)	$	$ 16,469
6. Add:		
a) Cost of inpatient ancillary services covered by Supplementary Medical Insurance (from Exhibit F, col. 5, line 7 or Exhibit G, line 5, Part I or Part II, whichever is applicable)		1,400
b) Outpatient services rendered by hospital-based physicians (from Exhibit H-1, col. 2, line 9)		483
c) Cost of ambulance services (from Exhibit I, col. 3, line 3.c)		-0-
7. SUB-TOTAL (Sum of lines 5 through 6c)	$	$ 18,352
8. Subtract: Amounts paid and payable by Workmen's Compensation, etc. (See Instructions)		-0-
9. SUB-TOTAL (line 7 minus line 8)	$	$ 18,352
10. Less: Deductibles billed to Health Insurance Program outpatients		8,852
11. Net cost (line 9 minus line 10)	$	$ 9,500
12. 80% of net cost (line 11)—Reimbursable Expenses—HI Program	$	$ 7,600
13. Add: Reimbursable return on equity capital (Exclude amounts applicable to line 6b)		-
14. SUB-TOTAL (Sum of lines 12 and 13)		7,600
15. Amount received and receivables from Intermediary or Social Security Administration (excluding current financing)		
16. Balance due hospital/health insurance program (exclusive of bad debts) (line 14 minus line 15)	$	$

		-0-
7. SUB-TOTAL *(Sum of lines 5 through 6c)*	$	$ 18,352
8. Subtract: Amounts paid and payable by Workmen's Compensation, etc. *(See Instructions)*		-0-
9. SUB-TOTAL *(line 7 minus line 8)*	$	$ 18,352
10. Less: Deductibles billed to Health Insurance Program outpatients		8,852
11. Net cost *(line 9 minus line 10)*	$	$ 9,500
12. 80% of net cost *(line 11)*—Reimbursable Expenses—HI Program	$	$ 7,600
13. Add: Reimbursable return on equity capital *(Exclude amounts applicable to line 6b)*		-
14. SUB-TOTAL *(Sum of lines 12 and 13)*		7,600
15. Amount received and receivables from Intermediary or Social Security Administration *(excluding current financing)*		
16. Balance due hospital/health insurance program *(exclusive of bad debts)* *(line 14 minus line 15)*	$	$
REIMBURSABLE BAD DEBTS		
17. Total outpatient expenses applicable to health insurance program *(line 9 above)*	$	$
18. Add: Return on equity capital *(Apportioned on basis of line 17)*		
19. Total expenses applicable to health insurance program *(line 17 plus line 18)*	$	$
20. Amount received and to be received from Intermediary or Social Security Administration *(ine 15 plus line 16)*		
21. Balance to be recovered from HI program outpatients *(line 19 minus line 20)*	$	$
22. Deductibles and coinsurance billed to HI program outpatients	$	$
23. Less: Bad debts for deductibles and coinsurance, net of bad debt recoveries		
24. Net deductibles and coinsurance billed to HI program outpatients *(line 22 minus line 23)*	$	$
**25. Unrecovered from HI program patients *(line 21 minus line 24. If line 24 is greater than line 21 enter zero and do not complete lines 26, 27 and 28)* *(See Instructions for Exhibit E)*	$	$
26. Gross bad debts *(line 23 or line 25 whichever is lower)*	$	$
27. Bad debts applicable to professional component and unallowable under Title XVIII (____% [*From E-1, line 3*] × *line 26*)		
28. Reimbursable bad debts *(col 1—amount on line 26)* *(col. 2—line 26 minus line 27)*	$	$
29. Inpatient services rendered by hospital-based radiologists and pathologists *(From Exhibit H-1, col. 2, line 3)*		
30. Total balance due hospital/Health Insurance Program *(Sum of lines 16, 28 and 29)*	$	$

* Use same amount in both columns.
** Complete this line only when line 21 exceeds line 24.

THIS EXHIBIT SHOULD BE USED IN LIEU OF FORM SSA-1563, PAGE 3; FORM SSA-1564, PAGE 4a; OR FORM SSA-1564A, PAGE 4b

2) outpatient services rendered by hospital based physicians

3) the cost of ambulance services

4) amounts paid and payable by Workman's compensation

5) that portion of outpatient charges billed to Health Insurance program outpatients.

For the purposes of the example given in this chapter, as well as for simplicity, we will assume only Items 1, 2, and 5 are applicable.

Therefore, in order to determine the adjustment value for the cost of inpatient ancillary services covered by Supplementary Medical Insurance, the total billed inpatient charges for all patients and total billed inpatient charges relating to Part B, Title XVIII, for the applicable cost centers are entered in Columns 1 and 2 respectively of Form SSA-1992 Exhibit F, labeled for the purposes of this paper as Exhibit 16. Using the Combination method, the percent of the total charges appearing in Column 2, Line 7 versus the total charges in Column 1, Line 7, namely .5% is multiplied by the total inpatient expenses for the applicable cost centers, per Column 4, Line 7. The resulting value is entered in Column 5, Line 7 of Exhibit 16, and also on Line 6 of Exhibit 15. It represents an addition to outpatient expenses applicable to the Health Insurance program.

In similar fashion that portion of the remuneration for professional services rendered by hospital-based physicians for departments such as Electroencephalography, Electro-

EXHIBIT 16

EXHIBIT F

Form Approved
Budget Bureau No. 72-R0846

COMPUTATION OF INPATIENT HOSPITAL ANCILLARY SERVICES COVERED BY SUPPLEMENTARY MEDICAL INSURANCE (*TITLE XVIII, PART B ONLY*)

LINE NO.	COST CENTER	TOTAL BILLED INPATIENT CHARGES (*Gross*) ALL PATIENTS (*from Exhibit B, Col. 1*)	TOTAL BILLED INPATIENT CHARGES (*Gross*) PART B—TITLE XVIII	PERCENT INPATIENT CHARGES PART B—TITLE XVIII TO TOTAL INPATIENT CHARGES (*col. 2 ÷ col. 1*)	TOTAL INPATIENT EXPENSES (*From Exhibit B, col. 4*)	INPATIENT EXPENSES APPLICABLE TO PART B—TITLE XVIII (A)
		1	2	3	4	5
1.	X-Ray	$	$	%	$	$
2.	Laboratory					
3.	Medical Supplies					
4.						
5.						
6.						
7.	Totals (*Transfer col. 5, line 7 to Exh. E; col. 2, line 6.a)*	$ 293,400	$ 1467	% .5	$ 280,000	$ 1400

To be completed only by providers using the *Departmental RCCAC* or *Combination Method (Computed With Cost Finding)*.

(A) If Dept RCCAC Method is used the amounts in col. 5 are obtained by multiplying col. 3 by col. 4 for lines 1-6. If Combination Method *(with cost finding)* is used, the amount in col. 5, line 7 is obtained by multiplying line 7—col. 3 × col. 4.

This exhibit pertains to beneficiaries enrolled under Part B of Title XVIII who are inpatients of participating hospitals and who are not eligible to receive such ancillary services under Part A of Title XVIII.

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cardiology, and Pathology are determined using Exhibit H, Form SSA-1992, shown here as Exhibits 17 and 18, using the ratio of charges to charges.

The sum of the reimbursable portions of remuneration for professional services rendered by hospital-based physicians, per Exhibits 17 and 18, Column 3, Line 7, is entered also as an addition to outpatient expenses applicable to the Health Insurance program.

With the addition of these items outpatient expenses applicable to the Health Insurance program need only be adjusted for the deductible billed to Health Insurance program outpatients, per Exhibit 15, Line 10, to arrive at the net cost of providing service under Title XVIII, Part B and Part A outpatient. Medicare, according to the regulations, reimburses all provider institutions 80% of this net cost, which is entered on Exhibit 15, Line 12.

Thus, the total amount reimbursed for all programs under Medicare, per the example in this chapter is:

Reimbursement Settlement Inpatient Services, excluding Title XVIII, Part B	$446,077
Reimbursement Settlement Title XVIII, Part B and Part A outpatient	7,600
TOTAL REIMBURSEMENT SETTLEMENT:	$453,677

EXHIBIT 17

EXHIBIT H

Form Approved
Budget Bureau No. 72-R0846

PROVIDER NO.

PERIOD

APPORTIONMENT OF REMUNERATION FOR PROFESSIONAL SERVICES RENDERED BY HOSPITAL-BASED PHYSICIANS

LINE NO.

1. Remuneration applicable to hospital-based EEG (A) for professional services rendered during period 4/1/68 through end of cost reporting period $7,430

LINE NO.	DESCRIPTION	CHARGES (B)	RATIO TO TOTAL CHARGES	COSTS APPLICABLE TO HEALTH CARE PROGRAMS (col. 2, lines 3-8 × line 1) (C)
		1	2	3
2.	Total Charges—All Patients	$	100%	
	INPATIENT			
3.	Title V	$	%	$
4.	Title XVIII		%	
5.	Title XIX		%	
6.	All Other	17,543	58.68 %	4,360
	OUTPATIENT			
7.	Title XVIII	515	1.72 %	128
8.	All Other	11,839	39.60 %	2,942
9.	TOTALS *(Col. 1 should equal line 2)* *(Col. 3 should equal line 1)*	$29,897		$7,430

(A) This form must be completed for each hospital-based physician department under which combined billing is being used (e.g., Pathology, Radiology, Cardiology, etc.). Insert on this line the department to which this form pertains.

(B) If gross combined charges for professional and hospital component are used on line 2, column 1, then combined charges must be used on lines 3 thru 8. If gross charges for professional component only are used on line 2, column 1, then gross charges for professional component only must be used on lines 3 thru 8.

(C) The amounts computed in column 3 applicable to each of the health care programs must be summarized for each Exhibit H completed for hospital-based physicians. Transfer the amounts in column 3, lines 3, 4, 5 and 7 to Exhibit H-I for this summarization.

Note: Combined billing may not be used for periods prior to 4/1/68. Remuneration on line 1 and charges on lines 2 thru 9 must not apply to any period prior to 4/1/68. If combined billing began after 4/1/68, indicate the appropriate date below "4/1/68" in line 1, and include only the remuneration and charges for the period under combined billing.

FORM SSA-1992 (6-70)

EXHIBIT 18

EXHIBIT H

Form Approved
Budget Bureau No. 72-R0846

PROVIDER NO.

PERIOD

APPORTIONMENT OF REMUNERATION FOR PROFESSIONAL SERVICES RENDERED BY HOSPITAL-BASED PHYSICIANS

LINE NO.

1. Remuneration applicable to hospital-based EKG (A)
for professional services rendered during period 4/1/68 through end of cost reporting period $ 29,580

	DESCRIPTION	CHARGES (B)	RATIO TO TOTAL CHARGES	COSTS APPLICABLE TO HEALTH CARE PROGRAMS (col. 2, lines 3-8 × line 1) (C)
		1	2	3
2.	Total Charges—All Patients	$	100%	
	INPATIENT			
3.	Title V	$	%	$
4.	Title XVIII		%	
5.	Title XIX		%	
6.	All Other	84,657	%	26,906
	OUTPATIENT			
7.	Title XVIII	1,115	%	355
8.	All Other	7,300	%	2,319
9.	TOTALS *(Col. 1 should equal line 2)* *(Col. 3 should equal line 1)*	$93,072		$29,580

(A) This form must be completed for each hospital-based physician department under which combined billing is being used (e.g., Pathology, Radiology, Cardiology, etc.). Insert on this line the department to which this form pertains.

(B) If gross combined charges for professional and hospital component are used on line 2, column 1, then combined charges must be used on lines 3 thru 8. If gross charges for professional component only are used on line 2, column 1, then gross charges for professional component only must be used on lines 3 thru 8.

(C) The amounts computed in column 3 applicable to each of the health care programs must be summarized for each Exhibit H completed for hospital-based physicians. Transfer the amounts in column 3, lines 3, 4, 5 and 7 to Exhibit H-I for this summarization.

Note: Combined billing may not be used for periods prior to 4/1/68. Remuneration on line 1 and charges on lines 2 thru 9 must not apply to any period prior to 4/1/68. If combined billing began after 4/1/68, indicate the appropriate date below "4/1/68" in line 1, and include only the remuneration and charges for the period under combined billing.

FORM SSA-1992 (6-70)

CHAPTER III

ALTERNATIVE SYSTEMS OF REIMBURSEMENT

The essence of the current system of reimbursement for institutional providers of medical care to Medicare program participants is the ratio of charges to charges as applied to apportioned costs. While the efficacy of using a charge structure as the ultimate base for reimbursement has been debated, the fact remains that the present system is predicated on charges. Within this framework, however, alternatives obviating the necessity of apportioning costs, either in whole or in part, exist.

The purpose of this chapter is to propose alternatives that may be used to achieve the same end as the present system. The only constraints imposed on alternative proposals is that they be generally applicable to all institutional providers, that they necessitate no greater degree of bookkeeping or recording of statistics than the existent system, and that they be capable of application consistent with statutes governing the operation of the program. In the succeeding chapter the results generated from each of the proposed alternatives will be compared to that generated by existent system, where applicable, for five metropolitan Oklahoma hospitals.

While a wide variety of alternative reimbursement systems could be generated, the two plans that will, in fact, be proposed and evaluated in this work have been suggested for study by general partners of a Certified Public Accounting firm specializing in consulting with and auditing institutions within the health care industry. Short stay, general medical and surgical institutions, as well as extended care facilities through which services relative to both the Medicaid and Medicare programs have been rendered, have been and are at the present time among the clients of the Certified Public Accounting firm. As a result of direct personal work experience with the accounting firm in various health care institutions, as well as a result of discussions with each of the general partners of the accounting firm, the alternative proposals delineated herein were generated.

Support for each alternative system presented in terms of both the merits thereof and an evaluation thereof was also offered by the chief financial officers of the health care institutions which have voluntarily participated in this study and by administrators of the Oklahoma Hospital Association.

First Alternative Reimbursement System

Before the alternative reimbursement systems are offered it is imperative to point out that all health care institutions whether they are involved directly in the provision of health services or are support related have an obligation to those who utilize health services and/or pay for the same, irrespec-

tive of whether such payments are made directly to the health institution by the user, are derived from taxation, or are the result of medical insurance, as well as to society as a whole, to operate in a socially responsible manner. It is important that quality medical care be available to the public. However, it is equally important that the institutional providers of such care utilize their resources in the most efficient manner possible such that not only a full range of services are offered but also that these services are offered at the lowest possible cost.

A social program such as Medicare, whether measured in terms of dollars of cost or utilization of facilities and services, is very significant and, therefore, carries with it a great degree of responsibility from the point of view of the government through which it is administered, and from the point of view of the institutions through which health care is offered. The federal government, in fact, has taken the steps to assess the benefits and costs of the Medicare program to the parties concerned. The basis for such assessment is stated to be equity. It appears reasonable to presume then that provider institutions should themselves be aware of the economics of a program such as Medicare as well as the externalities or costs or benefits arising from their institutional operations but which impact on other entities. A legitimate expectation of the implementation and growth of a program such as Medicare should then be an equitable distribution of both the costs and benefits derived.

The first alternative to be studied concerns an examination of health care costs through the application of multiple regression and correlation analysis. Such applications are being employed on an expanding basis as the issue of health care cost receives greater attention.[57]

In essence, the first alternative centers on the allocation of General Service cost center expenses on the basis of results obtained from regressing the individual General Service cost center expenses with such indices of patient activity as patient days and occasions of service.

The form of the equation to be used is, therefore:

$$Y_i = \alpha + \beta X_i + \gamma W_i + \mu_i$$

$$(i = 1,2,\ldots n)$$

where:

Y_i = Estimated value of the General Service cost center expense in the year i.

X_i = The total number of patient days in the year i.

W_i = The total number of occasions of service rendered in the year i.

α = Y intercept. The estimate of fixed cost.

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[57]Dennis D. Pointer, "Multiple Regression Analysis, A Tool for Examining Health Care Costs," Medical Group Management (January/February, 1974), pp. 16-18, 20.

β = Coefficient of the independent variable, patient days, or the variable cost per patient day.

γ = Coefficient of the independent variable, occasions of service, or the variable cost per occasion of service.

μ_i = Independent random variables, each with a mean zero and variance σ_μ^2.

If a statistically significant relationship is found to exist between the endogenous variable, General Service cost center expense, and the exogenous variables, patient days and occasions of service, then provider reimbursement would be calculated in the following general manner.

1.) Allocate the depreciation expense of Buildings and Fixtures and Movable Equipment consistent with the methodology applicable by regulation for the period under review.

2.) Allocate the costs of Special Service cost centers, Inpatient Cost Centers, and Outpatient Cost Centers also in a manner consistent with applicable regulations. That is, using the ratios of total inpatient charges to total charges and total outpatient charges to total charges, on a departmental basis, segregate the expenses of these cost centers into inpatient and outpatient component parts. Then, utilizing the ratio of aggregate Medicare inpatient charges to aggregate inpatient charges (the Combination Method), or the ratio of Medicare inpatient charges to total inpatient charges by department (the Departmental Method), determine that portion

of the relevant cost center expense applicable to the Hospital Insurance program.

In similar fashion, multiplying the ratio of aggregate Medicare outpatient charges to aggregate outpatient charges by total outpatient costs, as previously calculated, determine that portion of the relevant cost center expense to be borne by the Supplementary Medical Insurance program.

Finally, allocate the cost of Inpatient cost centers where applicable consistent with regulations on the basis of an adjusted per diem allowance.

Thus, the Medicare portion of Special Service and Outpatient cost center expense is:

$$\text{Cost} \times \frac{\text{Total Inpatient Charges}}{\text{Total Charges}} = \text{Inpatient Portion of Cost} \times \frac{\text{Medicare Inpatient Charges}}{\text{Total Inpatient Charges}} = \text{Medicare Inpatient Cost}$$

$$\text{Cost} \times \frac{\text{Total Outpatient Charges}}{\text{Total Charges}} = \text{Outpatient Portion of Cost} \times \frac{\text{Medicare Outpatient Charges}}{\text{Total Outpatient Charges}} = \text{Medicare Outpatient Cost}$$

(If the Combination Method was used the ratio Medicare Inpatient Charges/Total Inpatient Charges represents the aggregate charges for all ancillary departments. If the departmental method is used this ratio represents departmental totals and, therefore, the resulting Medicare Inpatient cost figures would have to be summed for all departments in order to arrive at the total expense to be reimbursed by the Medicare program.)

The Medicare portion of Inpatient cost center expense would be:

Inpatient Routine Service Costs	+	Inpatient Routine Nursing Salary Cost Differential	=	Inpatient Routine Costs Applicable to Medicare

3.) Allocate the cost of each General Service cost center or support area on the basis of the variable cost per inpatient day (β) times the number of Medicare inpatient days, and the variable cost per occasion of service (γ) times the number of Medicare occasions of service. The fixed cost (α) of each General Service cost center can be apportioned using the weighted average impact of Medicare rendered services to all services.

In essence, since the value of α represents the fixed cost, per General Service cost center, for all hospital programs it is essential to determine not only that portion of the fixed cost that must be borne by the Medicare program in total but also to allocate that portion between the Hospital Insurance and Supplementary Medical Insurance programs. Furthermore, while it may be more desirable to use actual indices of patient activity such as days and occasions of service for this purpose, the nonhomogeneity of such data precludes their use. Therefore, in order to accomplish the dual objective stated earlier it is incumbent again to rely on charges.

If the ratio of total inpatient charges to total charges is considered to represent the impact of all inpatient

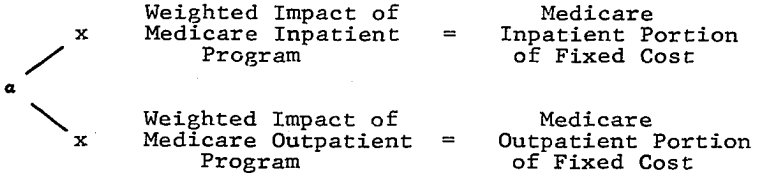
programs then this ratio multiplied by the ratio of Medicare inpatient days to total inpatient days yields the relative impact of the Medicare, Hospital Insurance program.

$$\frac{\text{Total Inpatient Charges}}{\text{Total Charges}} \times \frac{\text{Medicare Inpatient Days}}{\text{Total Inpatient Days}} = \text{Weighted Impact of Medicare Inpatient Program}$$

Similarly, if the ratio of total outpatient charges to total charges is considered to represent the impact of all outpatient programs, then this ratio multiplied by the ratio of total Medicare occasions of service to total occasions of service yields the relative impact of the Medicare, Supplementary Medical Insurance program.

$$\frac{\text{Total Outpatient Charges}}{\text{Total Charges}} \times \frac{\text{Medicare Occasions of Service}}{\text{Total Occasions of Service}} = \text{Weighted Impact of Medicare Outpatient Program}$$

The summation of the relative impacts of the Hospital Insurance program and the Supplementary Medical Insurance program times α, the fixed cost, yields that portion of the total fixed cost which should be borne by the Medicare program in total.



In summary, reimbursement under this proposed alternative consists of a three part operation.

Part I Allocate depreciation and inpatient cost center expenses consistent with specified regulations.

Allocate the cost of Special Service and Outpatient cost centers consistent with the present system, using the ratio of charges applied to cost.

Part II Allocate that portion of the total variable cost per General Service cost center to the Medicare program using the coefficients of the indices of patient activity as determined through regression analysis times the number of either Medicare patient days or Medicare occasions of service whichever is applicable.

Part III Allocate the fixed cost of each General Service cost center to the Medicare program on the basis of the weighted average impact of the Medicare program relative to all hospital programs.

While the above proposal appears quite feasible, its goodness and, therefore, equitability is contingent upon how closely the estimated relationship per the multiple regression equation fits the actual data used, and the fact that both the inpatient and outpatient cost determinations are individually positive. This latter constraint results from the fact that by statute, benefits paid under the Hospital Insurance

Program and Supplementary Medical Insurance Program derive from separate trust funds.

A variation of this proposal which might appear at first glance to be more efficient would involve the use of a base period such that the form of the equation would be:

$$Y_i = a + \beta (X_i - X_b) + \gamma (W_i - W_b) + \mu_i \qquad (i = 1,2,\ldots n)$$

where,

Y_i = Estimated value of the General Service Cost Center expense in the year i.

X_i = The total number of patient days in year i.

X_b = The total number of patient days in the base year.

W_i = The total number of occasions of service rendered in the year i.

W_b = The total number of occasions of service rendered in the base year.

a = Y intercept. The estimate of fixed base period cost.

β = Coefficient of the independent variable, incremental patient days, or the variable cost per incremental patient day.

γ = Coefficient of the independent variable incremental occasions of service, or the variable cost per incremental occasion of service.

μ_i = Independent random variables, each with a mean zero and variance σ_μ^2.

In spite of the fact that the Medicare program was implemented on July 1, 1966, and was introduced into already existing and operating health institutions, the lack of adequate base period data precludes the use of the equation form stated above.

Second Alternative Reimbursement System

While the foregoing proposal obviates the necessity of apportioning General Service cost center expenses entirely, a second alternative taking into consideration the fundamental dicotomy in existence within the expenses of the General Service cost center category may prove to be more workable.

Essentially, the fundamental distinction between patient-related and support-related expenses within the General Service cost center category is made. For example, patient-related expenses are Medical Supplies and Expense, Medical Records, Social Service, Nursing School, and Intern-Resident Service. All of these expenses are clearly assignable via currently utilized bases to revenue producing areas. The remaining, support-related expenses such as Administration and General, Employee Health and Welfare, Operation of Plant, Maintenance of Plant, Laundry and Linen, Housekeeping, Dietary-Raw Food, Dietary-Other, Cafeteria, and Maintenance of Personnel are incapable of being properly assigned to revenue producing areas under the present system unless an order for their assignation is pre-established. Even with a pre-established order for the assignation of these costs, however,

the possibility of an inappropriate distribution of costs to the allowed versus unallowed cost centers still exists due to the fact that as the expenses of a department are apportioned that department becomes closed and cannot, therefore, receive a portion of the cost of a succeeding department. In other words, while the dollar value of a department to be apportioned is an accumulative value, the fact that the statistical base upon which this accumulative value is apportioned, is shrinking, may give rise to an inappropriate distribution of costs.

A reimbursement system eliminating this bias would consist of the following:

1). After assigning depreciation to all cost centers, allocate the patient-related General Service cost center expenses to the revenue producing areas using statistical bases consistent with regulations.

In other words, allocate the cost of Medical Records to Special Service, Inpatient, and Outpatient cost centers on the basis of the percent of time spent rendering a service to the above mentioned cost centers. In similar fashion allocate Nursing School expenses on the basis of assigned time, Intern-Resident expenses on the basis of assigned time, and Medical Supplies and Expenses on the basis of costed requisitions.

2). Allocate the dollar values of Special Service and Outpatient cost centers between inpatients and outpatients and then between the Medicare program and the balance of hospital programs using the ratio of charges consistent with regulations.

Allocate the cost of Inpatient cost centers, where applicable, on an adjusted per diem basis.

3). Adjust the total of General Service cost center support-related expenses for unallowed items such as the operation of a gift shop or the maintenance of religious personnel.

Such adjustments must include not only the direct costs after the distribution of depreciation to the particular unallowed item but also a pro-rata share of the expenses of other departments from which services were received.

For example, an adjustment for the unallowed activity of operating a gift shop should typically include a factor for the cost of the operation of plant, and maintenance of plant, usually based on the square footage occupied, a factor for housekeeping usually based on hours of service, a factor for laundry usually based on pounds of linen used, and a factor for administration and general based on accumulated cost.

The adjusted General Service cost center support-related expenses can then be allocated to the Medicare program on the basis of the weighted average impact of the Medicare program, as previously defined in the first alternative.

Recalling, the weighted average impact of the Hospital Insurance program is determined by multiplying the ratio of total inpatient charges to total charges by the ratio of Medicare inpatient days to total inpatient days. The weighted average impact of the Supplementary Medical Insurance program is found by multiplying the ratio of total outpatient charges to total charges by the ratio of Medicare occasions of service to total occasions of service.

The sum of the impact of the Hospital Insurance program and the Supplementary Insurance program indicates the weighted average impact of the overall Medicare program on total hospital operations.

The foregoing proposals obviate the necessity of apportioning or stepping-down General Service cost center expenses either in whole or in part and will be applied and evaluated in the succeeding chapter.

CHAPTER IV

REIMBURSEMENT SETTLEMENT ON THE BASIS OF ALTERNATIVE PROPOSALS

In the preceding chapter, alternative reimbursement proposals designed to obviate the need, in whole or in part, of allocating General Service cost center expenses were formulated. Both of the proposed alternative reimbursement systems assume a consistency between cost and charge per Medicare regulations. Furthermore, both proposals rely heavily on the use of patient days and occasions of service as indices of patient activity and as partial bases for the assignation of costs to the Medicare program. The purpose of this chapter is to present the results of an application of both alternative reimbursement proposals to five metropolitan Oklahoma hospitals and then to evaluate the goodness of these proposals.

For the sake of an orderly presentation, all of the financial and statistical data submitted by the five metropolitan Oklahoma hospitals participating in this study is presented, by hospital, in Appendix I. The results of the application of both alternative reimbursement proposals offered are presented and discussed in the body of this chapter,

while the data pertaining to the reimbursement settlement itself, for the second alternative, is presented in Appendix II. Appendix III presents the results of multiple regression and correlation analysis of non-revenue producing department expenses versus patient days and occasions of service, by hospital, as generated for the first alternative reimbursement proposal offered.

Participating Institutions

Five metropolitan Oklahoma hospitals agreed to participate in this study, on an individual basis. All five institutions are short-stay hospitals. Three of the five are church operated, not for profit, general medical and surgical institutions. One participating hospital is a specialized institution, organized as a corporation, and seeks to make a profit from the provision of specialized health care services to the community. The remaining participating institution is non-governmental, non-profit, general medical and surgical hospital.

Operational Characteristics of Participating Institutions

While all five hospitals participating in this study possess the common feature of being located in a metropolitan area, and being certified for the provision of health services under Medicare, they exhibit a wide variety of operational characteristics. For example, the specialized institution has 74 total beds available while the general medical and

surgical institutions range from a low of 177 beds to a high of 197 beds. The occupancy rate for participating hospitals ranged from a low of 77.7% to a high of 35.3%. The specialized institution as well as two of the church related, non-profit, general medical and surgical hospitals had occupancy rates ranging from 77.7% to 78.2%. The remaining church related, general medical and surgical unit had an occupancy rate of 85.3%, while the non-governmental, non-profit, general medical and surgical hospital had an occupancy rate of 84.8%.

In terms of employees per bed, the range for participating hospitals was 2.3 to 2.8. The low value of 2.3 employees per bed was exhibited by a church related, general medical and surgical hospital while the high value of 2.8 employees per bed was exhibited by the non-governmental, general medical and surgical institution. The most significant variation among the operational characteristics of the participating hospitals concerned the overall per diem cost of operation. In the latest year surveyed, the specialized institution, for example, exhibited an overall per diem cost of approximately $43.00, while the range for general medical and surgical institutions was $73.87 on the low side to $92.02 on the high side. The lowest overall per diem cost for general medical and surgical hospitals was exhibited by the non-governmental institution while the highest overall per diem cost was exhibited by a church related, non-profit institution.

Regression Based System

On an overall basis, the first alternative reimbursement proposal, wherein the expenses of General Service cost centers are allocated to revenue producing departments on the basis of results obtained from regressing departmental General Service cost center expenses with patient days and occasions of service, appears to be suspect.

The constraints under which each of the alternative reimbursement proposals were offered, were:

1) that they be applicable to all provider institutions
2) that they involve no greater bookkeeping or record keeping effort
3) that they be consistent with statutes governing the program.

It is with this latter constraint that the first alternative reimbursement proposal appears directly discordant.

Table 6 presents a summary of the results of the multiple regression analysis performed for the five metropolitan Oklahoma hospitals participating in the study, as well as the resulting net distribution of provider costs between the Hospital Insurance and Supplementary Medical Insurance programs, for each institution.

Given the fact that the law provides that benefits under the Hospital Insurance program and Supplementary Medical Insurance program be paid from independent trust funds maintained for the respective programs, it is essential that the net cost distribution for any provider institution result

TABLE 6

RESULTS OF MULTIPLE REGRESSION ANALYSIS, AND NET COST DISTRIBUTION, BY PROVIDER INSTITUTION - 1973

Hospital	Fixed Cost	Variable Cost		Cost Distribution	
		Per Patient Day	Per Occasion of Service	HI	SMI
	(α)	(β)	(γ)		
No. 1	$3,753,975	$ (37.27)	$ 37.04	$437,570	$256,472
No. 2	9,591,472	(401.63)	(30.54)	207.051	7,617
No. 3	(306,941)	25.90	77.39	330,060	22,812
No. 4	7,906,401	(111.40)	15.79	578,519	34,653
No. 5	(88,814)	44.95	(25.75)	817,806	(35,831)

in a positive value being assigned to both the Hospital Insurance program and Supplementary Medical Insurance program. As is seen from Table 6, the net cost distribution for one of the participating institutions in this study results in a negative value being assigned to the Supplementary Medical Insurance program.

Supplementary Tests

Given the apparent unacceptability of the first alternative reimbursement proposal, supplemental tests involving the regression of hospital costs against inpatient days and occasions of service, on a time series basis for the years 1962 through 1973 and a cross-sectional basis were performed, using the latest available data as published in Hospital Statistics, 1974 Edition, by the American Hospital Association.

The results of these supplemental tests, which included all American Hospital Association registered hospitals, shown in Table 7, appear to lend further credibility to the conclusions drawn from the study group of five metropolitan Oklahoma hospitals.

With respect to Community hospitals, which account for more than 81% of all American Hospital Association registered hospitals, 78% of the total dollar value of expenses incurred by all American Hospital Association registered hospitals, 57% of the total inpatient days sustained and 74% of all outpatient visits, it appears that a cost distribution predicated on the values of the coefficients derived from multiple

TABLE 7

RESULTS OF MULTIPLE REGRESSION ANALYSIS
HOSPITAL COSTS VERSUS INPATIENT DAYS
AND OCCASIONS OF SERVICE

Analysis	α	β	γ
United States Hospitals-Total, 1962-1973	53,947	(.111623)	.130516
United States Hospitals-Total, Cross Sectional Analysis 1973, by Hospital Bed Size	(387,254)	.032277	.106874
United States Hospitals-Total, Cross Sectional Analysis 1973, by Hospital Type	48,362	.023129	.110565
Community Hospitals Cross Sectional Analysis, 1973, by Hospital Bed Size	(86,093.2)	(.062495)	.257402

regression analysis could result in a negative cost value being assigned to one of the independent trust funds.[58] This possibility would violate then, two of the constraints mentioned earlier, namely, that the alternative proposal be applicable to all provider institutions and that it be consistent with statutes governing the program.

Assessing the Results

The relationship between General Service cost center expenses and indices of patient activity, namely patient days and occasions of service, was determined through stepwise multiple regression. This type of program includes predictor variables, one at a time, in successive stages, with each predictor variable raising the dimensions of the analysis by one. In other words a stepwise multiple regression program selects the most promising independent variable, that is, the independent variable that provides the greatest reduction in the unexplained variation in Y, at each stage. In this manner, the computer performs simple regression separately for each independent variable, printing the results for the best one. In successive stages the computer performs separate multiple regressions, each combining one of the remaining independent variables with the variables selected in previous stages, in such a manner that the variable causing the most significant reduction in the unexplained variation is chosen

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[58] Hospital Statistics, 1974 Edition, p. 34.

to be permanently included in all future stages. The process is continued either until every variable has been included in the multiple regression analysis, or until no further reduction in unexplained variation is possible.

With respect to the application of stepwise multiple regression for the purposes of this study, it should be recalled, that all meaningful data for the period reviewed was used in the analysis for all five participating metropolitan Oklahoma hospitals. Furthermore, the independent variables selected for this study were chosen not with the intent of developing a cost function per se, but rather with the intent of identifying a viable basis for the assignation of costs to the Medicare program. To be sure, other factors probably have an impact on the level of cost incurred by a hospital. The two independent variables selected in this study, however, were chosen not only because of their suspected influence on levels of cost, but also because they are readily available means through which costs can be apportioned to the Medicare program. All provider institutions are required to report separately, patient days and occasions of service utilized by Medicare eligible patients. In assessing the results of and use of regression analysis in this study one must initially confront the problem of multicolinearity. An examination of the results of the multiple regression analysis of General Service cost center expenses with respect to patient days and occasions of service indicates that in a significant number

of instances, the multiple coefficient of determination, which signifies the relative portion of the total variation in the dependent variable explained by the independent variables was in excess of .9. At first glance this appears to indicate a very strong explanatory ability of the independent variables. However, further examination indicates that the tests of significance of the independent variables at the .05 level of significance, in many instances, leads to the acceptance of the null hypothesis. That is, the variables are not significantly different from zero. In addition to the above, the standard errors of the parameters, in many instances, were very high. Thus, the parameter estimates may be insignificant not because the estimates are too small, but because the standard errors are too large.

In summary, therefore, irrespective of the fact that a reimbursement system predicated on the results of regression analysis would apparently be incompatible with statute, the apparent intercorrelation of the independent variables causes the results of the regression analysis, itself, to be considered conjectural.

Results of Weighted Impact Method

On an overall basis, the second alternative reimbursement proposal wherein the expenses of support-related General Service cost centers were allocated to the Medicare program on the basis of the weighted average impact of the Medicare program relative to all hospital programs, generated a greater

total reimbursement for all five metropolitan Oklahoma hospitals studied. Table 8 presents a comparison of the reimbursement results generated from an application of this proposal alternative, in total and by sub-program, with the reimbursement generated under the present system.

The increase in total reimbursement accruing to participating metropolitan Oklahoma hospitals as a result of the application of the second alternative reimbursement proposal ranged from a low of 11.1% to a high of 17.4%. Increments in reimbursement for services covered by the Hospital Insurance program averaged 13.6% and ranged from 10.9% to 17.5%, with all hospitals receiving an increase in reimbursement for services covered under the Hospital Insurance program.

With respect to the Supplementary Medical Insurance program, three hospitals would have received increases in reimbursement, ranging from a low of 6.1% to a high of 10.8%. One of the hospitals would have received an increase in reimbursement for services covered under the Supplementary Medical Insurance program of 116.6%, while the remaining institution would have sustained a reduction in reimbursement for Supplementary Medical Insurance covered services of 1.5%.

While it is apparently reasonable to suspect that the hospital institution sustaining the 116.6% increase would, in fact, receive an increment in reimbursement for services covered under the Supplementary Medical Insurance program, with an application of the second alternative reimbursement proposal, the magnitude of the increase is suspect.

TABLE 8

WEIGHTED AVERAGE IMPACT REIMBURSEMENT
VERSUS ACTUAL REIMBURSEMENT

Hospital		Actual Reimbursement	Weighted Average Impact Reimbursement	% Change
No. 1	Total	$1,263,422	$1,459,065	15.5
	HI	1,221.042	1,367,282	12.0
	SMI	42,380	91,783	116.6
No. 2	Total	652,583	755,487	15.8
	HI	646,714	749,260	15.9
	SMI	5,869	6,227	6.1
No. 3	Total	1,235,022	1,376,872	11.5
	HI	1,200,241	1,342,610	11.9
	SMI	34,781	34,262	(1.5)
No. 4	Total	1,544,558	1,812,919	17.4
	HI	1,525,704	1,792,272	17.5
	SMI	18,854	20,647	9.5
No. 5	Total	1,203,524	1,337,170	11.1
	HI	1,156,334	1,282,886	10.9
	SMI	47,190	52,284	10.8

In the case at hand, this value may possibly be inflated as a result of the use of an estimated number of Medicare occasions of service for the year 1972. This estimate, however questionable, however, was offered by the administration of the hospital studied, and was, therefore, an impacting factor on the reimbursement the institution actually received.

While reimbursement using the Weighted Average Impact proposal does, in fact, result in a larger reimbursement for institutions participating in this study, it is essential to restate that this proposal was offered only insofar as it resulted in an equitable distribution of costs within the health care institution relative to its mix of programs, only one element of which is the Medicare program. To the extent that a relationship between the cost of services rendered and the concomitant charge for services is mandated, a reimbursement system such as the Weighted Average Impact proposal should result in an equitable distribution of costs between both the inpatient and outpatient sectors of institutional provider activity and between the Medicare program and all other programs through which an institution renders a service.

However, if the fundamental relationship between cost and charge either fails to exist or becomes imbalanced a misallocation of costs between inpatient and outpatient activity as well as between the Medicare program and other programs could result.

While comment on the probability of an imbalance between cost and charge for any particular service or mix of services would be speculative, the fact remains that a trend within the outpatient sector of hospital activity could impact negatively on the viability of the Weighted Average Impact proposal as an efficient basis for cost reimbursement. Specifically, it is noteworthy to mention that outpatient volume in hospital institutions has increased continuously since 1962, when the American Hospital Association commenced compilation of these statistics. More important, however, is the fact that in large hospitals, that is, hospitals with bed capacities in excess of 500 beds, the greatest proportion of outpatient visitations were sustained through clinics as opposed to emergency and referred visits.[59] In selected instances, hospitals such as those in the 6 to 24 bed category in the Mid-Atlantic and East North Central census divisions also derive the bulk of outpatient volume from clinic visitations. Proceeding further, it is interesting to note that only in the Pacific census division do all hospitals with bed capacities equal to or in excess of 200 beds, on average, derive the greatest proportion of their outpatient volume

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[59]The Mountain census division, to a great degree, and the East South Central census division, to a lesser degree, are exceptions. Clinic outpatient visits derive through the use of therapeutic and/or diagnostic facilities during the regularly scheduled periods when such services are made available for public consumption and are a function of the patient's individual desire to receive such services.

from clinic visitations rather than emergency or referred visits.[60]

Outpatient visitations for services other than emergency and referred diagnostic or therapeutic purposes have long been a means through which medical services are made available to a community on a low cost basis. Oftentimes outpatient clinics are geared to serving a constituency which has a lesser ability to pay for services rendered. In many instances, therefore, the charge for services rendered is based on the ability to pay or is simply set at a nominal level. To the extent that the fundamental relationship between cost and charge does not exist, costs become incorrectly distributed between inpatient and outpatient sectors and then between the Medicare program and other health related programs conducted by provider institutions.

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[60] James E. Perry and Lanny W. Gallup, "The Economics of Hospitals," Southwestern Society of Economists, Proceedings (March, 1976), p. 5. The above discussion concerns hospitals by bed size categories. The authors recognize that the mix of the sources of outpatient visitations varies greatly among hospitals.

CHAPTER V

FINDINGS

The purpose of this study was to examine the reimbursement system whereby institutional providers of medical care to eligible Medicare program participants are reimbursed for services rendered, and to empirically evaluate alternative systems of reimbursement and their applicability to Medicare certified provider institutions.

Using a numerical example, the applicable Medicare reimbursement system, for the study period, was presented. While this system was defined in terms of reasonable cost and predicated on an assumed relationship between charges and cost, the primary focus of concern was the manner in which the expenses of General Service cost centers were allocated to revenue producing departments.

Given the fact that regulations prescribed that the expenses of the General Service cost center giving service to the greatest number of other cost centers while receiving service from the least, were to be allocated first, and that costs could not be allocated back to a cost center which, itself, had previously been distributed, the resultant alloca-

tion of cost, having been predicated on accumulative values and most importantly, on declining bases, could result in an inappropriate distribution of costs to the Medicare program.

In recognition of the above problem, two alternative reimbursement systems, obviating the need, in whole or in part, of allocating General Service cost center expenses were proposed. Both alternative systems were offered subject to the constraints that they be generally applicable to all provider institutions that they involve no greater degree of bookkeeping or record keeping effort, and that they result in a cost distribution consistent with the regulation that benefits for services rendered under the Hospital Insurance program and Supplementary Medical Insurance program be paid from separately maintained trust funds.

The first alternative reimbursement proposal centered on the allocation of General Service cost center expenses on the basis of the results obtained from regressing individual General Service cost center expenses with indices of patient activity. Empirical evaluation of this proposal, first in terms of its applicability to five metropolitan Oklahoma hospitals which agreed to participate in this study, and then in terms of its applicability to the population of United States hospitals, in total, and Community hospitals, in total, indicates that this proposal would apparently be inconsistent with Medicare reimbursement related statutes and thus be unacceptable.

The second alternative reimbursement proposal, which was predicated on the weighted average impact of the Medicare program relative to all hospital programs appears to be a promising alternative. This method obviates the necessity of apportioning General Service cost center, support related expenses and, therefore, circumvents the problems of dealing with accumulative values and declining bases delineated earlier.

While both alternative reimbursement proposals assumed a consistency between cost and charges, per Medicare regulations, the remaining bases for the assignation of General Service cost center expenses under the weighted average impact proposal, namely patient days and occasions of service, fall directly under the purview of a hospital utilization review committee whose responsibility it is to ensure against the indiscriminate use of hospital services. Furthermore, the weighted average impact proposal appears to be functional for all provider institutions.

An application of this alternative reimbursement proposal on the basis of information submitted by five metropolitan Oklahoma hospitals indicated that all five metropolitan hospitals would have received greater total reimbursement from Medicare under this alternative plan. More specifically, the reimbursement value generated under this proposed alternative would have given rise to an increase in reimbursement for services covered under the Hospital Insurance

program for all five metropolitan Oklahoma hospitals. For services covered under the Supplementary Medical Insurance program, four of the five metropolitan hospitals would have received greater reimbursement. The one metropolitan hospital which would have received a smaller reimbursement for services covered under the Supplementary Medical Insurance program would have sustained a decrease of less than 1.5%.

While the central issue of this study has been Medicare cost reimbursement, and more specifically, the apportionment of General Service cost center expenses to revenue producing cost centers, and then ultimately to the Medicare program, a far broader issue concerning the overall cost of hospitalization remains.

When the Medicare program was first introduced into already operating institutions, great concern was expressed as to the definitions of allowable cost, reasonable cost, relationship of charges to cost, and the lack of incentives for cost control.

The issue of allowable cost had merit then, and still does. Medicare program regulations detail specifically, certain items of cost which are unallowed or not acceptable for reimbursement from the Medicare program. To that extent that definitions of allowable cost do not encompass the full range of costs indigenous to the provision of health care and operation of hospital institutions, the ability of the provider institution to offer health services in future periods is restricted.

With respect to reasonable costs, charges, and incentives, significant strides have been made to make all provider institutions more efficient.

Incentives in the form of plus-factors over and above cost, irrespective of the general level of institutional cost, received much attention in the formative years of Medicare. While arguments for plus-factors went generally unaccepted, the fact remains, that through the increasing role and responsibility of utilization committees and professional standards review organizations, hospital institutions now have implied incentives to be both cost conscious and utilization conscious. To the extent that provider reimbursements become influenced by the average and/or most prevalent costs for similar sized institutions in a given geographical area, hospital institutions will be pressed even more to gain higher degrees of efficiency.

APPENDIX I

FINANCIAL AND STATISTICAL DATA OF METROPOLITAN OKLAHOMA HOSPITALS

HOSPITAL NO. I

FINANCIAL AND STATISTICAL DATA

HOSPITAL NO. I

PATIENT ACTIVITY STATISTICS
BY YEAR, 1967 - 1972

Year	All Patients		Medicare	
	Inpatient Days	Occasions of Service	Inpatient Days	Occasions of Service
1967	68,964	20,107	20,722	2,071
1968	66,584	18,120	20,582	Not Available
1969	65,407	24,209	19,972	
1970	63,168	23,563	18,973	
1971	57,390	15,121	18,225	
1972	52,988	15,571	15,611	4,587

HOSPITAL NO. I

REIMBURSEMENT
BY YEAR, 1967 - 1972

Year	Hospital Insurance Program	Supplementary Medical Insurance Program	Total
1967	$ 911,108	$ 5,705	$ 916,813
1968	$1,053,063	$ 7,567	$1,060,630
1969	$1,086,642	$33,103	$1,119,745
1970	$1,125,429	$40,789	$1,166,218
1971	$1,198,450	$33,120	$1,231,570
1972	$1,221,042	$42,380	$1,263,422

HOSPITAL NO. I

GENERAL SERVICE COST CENTER EXPENSES
AFTER DEPRECIATION DISTRIBUTION
BY YEAR, 1967 - 1972

Cost Center	1967	1968	1969	1970	1971	1972
Administration and General	$ 485,136	$ 551,088	$ 726,985	$ 653,018	$ 742,675	$ 743,588
Employee Health and Welfare	129,074	158,412	175,684	211,013	270,026	345,600
Operation of Plant	184,524	190,422	165,760	181,577	207,382	228,538
Laundry	76,404	77,760	76,584	85,129	65,763	77,329
Housekeeping	135,688	150,367	165,791	151,981	169,870	180,797
Dietary	297,851	293,601	289,109	311,137	265,042	274,887
Medical Supplies and Expense	120,504	89,231	92,663	103,942	94,516	95,806
Pharmacy	197,378	219,903	271,697	300,854	269,795	268,779
Medical Records	56,648	57,073	65,246	82,149	83,550	84,180
Nursing School	102,851	101,616	99,806	7,545	21,577	13,610
Intern-Resident Service	132,440	41,295	129,866	145,122	17,540	24,416
Gift Shop	-	-	15,648	12,884	11,472	12,054
Convent	-	-	-	23,961	1,949	1,926
Total	$1,918,498	$1,930,768	$2,274,839	$2,270,312	$2,221,157	$2,351,510

HOSPITAL NO. I

CHARGES, BY PATIENT CLASSIFIC
1972

Cost Center	Total Gross Charges All Patients	All Inpatient	All Nurser
	1	2	3
Special Service Cost Centers:			
Operating Room	$ 875,729	867,691	
		% 99.802	%
Delivery Room	48,033	48,033	
		% 100	%
Anesthesia	78,297	77,085	
		% 98.452	%
X-Ray	457,797	347,429	
		% 75.891	%
Laboratory	739,160	699,411	
		% 94.622	%
Oxygen Therapy	166,981	165,657	
		% 99.207	%
Physical Therapy	45,044	35,722	
		% 79.305	%
Cost of Medical Supplies Sold	252,561	243,483	
		% 96.406	%
Cost of Drugs Sold	681,432	614,322	
		% 90.152	%
Inpatient Cost Centers:			
Inpatient	2,670,533	2,670,533	
		% 100	%
Nursery	91,587		91,5
		%	% 1
Outpatient Cost Centers:			
Outpatient			
		%	%
Emergency	283,795	29,687	
		% 10.461	%
Private Ambulatory			
		%	%
Total	$6,390,949	$ 5,799,053	$ 91,58

HOSPITAL NO. I

CHARGES, BY PATIENT CLASSIFICATION
1972

Total Gross Charges					
›tal Gross Charges .l Patients	All Inpatient	All Nursery	All Outpatient	All Emergency	All Private Ambulatory
1	2	3	4	5	6
875,729	867,691			8,038	
	% 99.802	%	%	% .918	%
48,033	48,033				
	% 100	%	%	%	%
78,297	77,085			1,212	
	% 98.452	%	%	% 1.548	%
457,797	347,429			110,368	
	% 75.891	%	%	% 24.109	%
739,160	699,411			39,749	
	% 94.622	%	%	5.378	%
166,981	165,657			1,324	
	% 99.207	%	%	% .793	%
45,044	35,722			9,322	
	% 79.305	%	%	% 20.695	%
252,561	243,483			9,078	
	% 96.406	%	%	% 3.594	%
681,432	614,322			67,110	
	% 90.152	%	%	% 9.848	%
670,533	2,670,533				
	% 100	%	%	%	%
91,587		91,587			
	%	% 100	%	%	%
	%	%	%	%	%
283,795	29,687			254,108	
	% 10.461	%	%	% 89.539	%
	%	%	%	%	%
990,949	$ 5,799,053	$ 91,587	$	$ 500,309	$

HOSPITAL NO. I

EXPENSES BY COST CENTER
AFTER DEPRECIATION DISTRIBUTION
1972

Cost Center	Total	Inpatient	Nursery	Outpatient	Emergency	Private Ambulatory
	1	2	3	4	5	6
Special Service Cost Centers:						
Operating Room	$ 521,730	$ 520,697	$ -	$ -	$ 1,033	$ -
Delivery Room	44,055	44,055				
Anesthesia	20,467	20,150			317	
X-Ray	232,311	176,303			56,008	
Laboratory	337,696	319,535			18,161	
Oxygen Therapy	63,552	63,048			504	
Physical Therapy	24,599	19,508			5,091	
Inpatient Cost Centers:						
Inpatient	1,253,377	1,253,377				
Nursery	88,986		88,986			
Outpatient Cost Centers:						
Outpatients						
Emergency	168,327	17,609			150,718	
Private Ambulatory						
Total	$2,755,100	$2,434,282	$ 88,986	$ -	$ 231,832	$ -

HOSPITAL NO. I

EXPENSES BY COST CENTER, AFTER DEPRECIATION DISTRIBUTION
AND PATIENT RELATED GENERAL SERVICE COST CENTER EXPENSES
1972

Cost Center	Total	Inpatient	Nursery	Outpatient	Emergency	Private Ambulatory
	1	2	3	4	5	6
Special Service Cost Centers:						
Operating Room	$ 521,730	$ 520,697	$ -	$ -	$ 1,033	$ -
Delivery Room	44,055	44,055				
Anesthesia	20,467	20,150			317	
X-Ray	232,311	176,303			56,008	
Laboratory	337,696	319,535			18,161	
Oxygen Therapy	63,552	63,048			504	
Physical Therapy	24,599	19,363			5,091	
Cost of Medical Supplies Sold	95,806	92,363			3,443	
Cost of Drugs Sold	268,779	242,310			26,469	
Inpatient Cost Centers:						
Inpatients	1,364,024	1,364,024				
Nursery	96,151		96,151			
Outpatient Cost Centers:						
Outpatient						
Emergency	168,490	17,626			150,864	
Private Ambulatory						
Total	$3,237,660	$2,879,619	$ 96,151	$ -	$ 261,890	$ -

HOSPITAL NO. I

STATISTICAL BASES FOR ALLOCAT
PATIENT RELATED EXPENSES, 19

Cost Center	Inpatient	Nursery	Emergency	Operating Room	Anesthesi
Medical Supplies & Expense					
Pharmacy					
Medical Records	89.78%	5.95%	4.27%		
Nursing School	88.24%	5.88%	5.88%		
Intern-Resident Service	94.45%	5.55%			

HOSPITAL NO. I

STATISTICAL BASES FOR ALLOCATING
PATIENT RELATED EXPENSES, 1972

ry	Emergency	Operating Room	Anesthesia	Laboratory	Cost Of Medical Supplies Sold	Cost Of Drugs Sold	Total
					100%		100%
						100%	100%
%	4.27%						100%
%	5.88%						100%
%							100%

HOSPITAL NO. I

STATISTICAL BASIS
UNALLOWED COST CENTERS - 1972

Cost Center From Which Services Received			Unallowed Cost Center Portion of Base Utilized	
Center	Total Amount	Total Base	Gift Shop	Convent
Employee Health & Welfare	$ 345,600	$2,618,047 salaries	$ 11,329	-0-
Administration & General	$ 735,795	$4,357,528 accumulated cost	$ 12,054	$ 1,926
Operation of Plant	$ 228,538	106,499 square feet	699	4,039
Laundry	$ 77,329	377,798 pounds	-0-	$ 2,494 *
Housekeeping	$ 180,797	106,499 square feet	699	4,039
Cafeteria	$ 95,814	380 employees	-0-	$ 7,359 *

* Direct Allocation

HOSPITAL NO. II

FINANCIAL AND STATISTICAL DATA

HOSPITAL NO. II

PATIENT ACTIVITY STATISTICS
BY YEAR, 1967 - 1972

Year	All Patients		Medicare	
	Inpatient Days	Occasions of Service	Inpatient Days	Occasions of Service
1967	22,199	5,958	5,632	36
1968	21,876	10,657	6,189	75
1969	21,929	5,818	6,604	172
1970	21,937	4,748	7,051	222
1971	21,531	6,002	6,923	283
1972	21,172	6,228	6,776	189

HOSPITAL NO. II

REIMBURSEMENT
BY YEAR, 1967 - 1972

Year	Hospital Insurance Program	Supplementary Medical Insurance Program	Total
1967	$ 293,750	$ -0-	$ 293,750
1968	$ 364,228	$ 87	$ 364,315
1969	$ 421,447	$4,143	$ 425,590
1970	$ 546,035	$4,753	$ 550,788
1971	$ 607,780	$6,482	$ 614,262
1972	$ 646,714	$5,869	$ 652,583

HOSPITAL NO. II

GENERAL SERVICE COST CENTER EXPENSES
AFTER DEPRECIATION DISTRIBUTION
BY YEAR, 1967 - 1972

Cost Center	1967	1968	1969	1970	1971	1972
Administration and General	$ 175,458	$ 188,261	$ 208,527	$ 243,875	$ 264,121	$ 305,034
Maintenance of Plant	20,711	23,581	24,408	36,673	42,355	40,151
Laundry	-	-	543	937	950	846
Housekeeping	16,498	22,455	20,994	11,405	9,590	11,075
Dietary - Raw Food	44,706	48,014	44,838	51,006	54,568	53,792
Dietary - Other	38,244	40,743	46,931	62,134	73,868	73,919
Medical Supplies and Expense	70,184	53,615	74,645	99,604	142,510	136,920
Pharmacy	49,725	76,843	78,912	116,274	125,327	126,572
Medical Records	17,599	22,065	23,217	28,719	35,485	38,884
Total	$ 451,573	$ 497,948	$ 551,394	$ 704,304	$ 815,888	$ 853,306

HOSPITAL NO. II

CHARGES, BY PATIENT CLASSIFIC
1972

Cost Center	Total Gross Charges All Patients	All Inpatient	All Nurse
	1	2	3
Special Service Cost Centers:			
Operating Room	$ 186,963	186,963	
		% 100	%
Delivery Room			
		%	%
Anesthesia	85,464	85,464	
		% 100	%
X-Ray	152,146	120,996	
		% 79.5	%
Laboratory	220,391	220,391	
		% 100	%
Blood Bank			
		%	%
Oxygen Therapy			
		%	%
Physical Therapy	76,309	52,288	
		% 68.5	%
Cost of Medical Supplies Sold	232,233	226,129	
		% 97.4	%
Cost of Drugs Sold	284,711	280,846	
		% 98.6	%
Inpatient Cost Centers:			
Inpatient	837,728	837,728	
		% 100	%
Nursery			
		%	%
Outpatient Cost Centers:			
Outpatient			
		%	%
Emergency	31,816		
		%	%
Private Ambulatory			
		%	%
Total	$2,707,761	$2,010,805	$

HOSPITAL NO. II

CHARGES, BY PATIENT CLASSIFICATION
1972

otal Gross Charges ll Patients	Total Gross Charges All Inpatient	All Nursery	All Outpatient	All Emergency	All Private Amb[illegible]tory
1	2	3	4	5	6
186,963	186,963				
	% 100	%	%	%	%
	%	%	%	%	%
85,464	85,464				
	% 100	%	%	%	%
152,146	120,996			31,150	
	% 79.5	%	%	% 20.5	%
220,391	220,391				
	% 100	%	%	%	%
	%	%	%	%	%
	%	%	%	%	%
76,309	52,288		24,021		
	% 68.5	%	% 31.5	%	%
232,233	226,129			6,104	
	% 97.4	%	%	% 2.6	%
284,711	280,846			3,865	
	% 98.6	%	%	% 1.4	%
837,728	837,728				
	% 100	%	%	%	%
	%	%	%	%	%
	%	%	%	%	%
31,816				31,816	
	%	%	%	% 100	%
	%	%	%	%	%
707,761	$2,010,805	$	$ 24,021	$ 72,935	$

HOSPITAL NO. II

EXPENSES BY COST CENTER
AFTER DEPRECIATION DISTRIBUTION
1972

Cost Center	Total	Inpatient	Nursery	Outpatient	Emergency	Private Ambulatory
	1	2	3	4	5	6
Special Service Cost Centers:						
Operating Room	$ 169,592	$ 169,592	$ -	$ -	$ -	$ -
Delivery Room						
Anesthesia	79,479	79,479				
X-Ray	53,790	42,763			11,027	
Laboratory	187,929	187,929				
Blood Bank						
Oxygen Therapy						
Physical Therapy	57,473	39,369		18,104		
Inpatient Cost Centers:						
Inpatient	630,356	630,356				
Nursery						
Outpatient Cost Centers:						
Outpatients						
Emergency	27,103				27,103	
Private Ambulatory						
Total	$1,205,722	$1,149,488	$ -	$ 18,104	$ 38,130	$ -

HOSPITAL NO. II

EXPENSES BY COST CENTER, AFTER DEPRECIATION DISTRIBUTION
AND PATIENT RELATED GENERAL SERVICE COST CENTER EXPENSES
1972

Cost Center	Total	Inpatient	Nursery	Outpatient	Emergency	Private Ambulatory
	1	2	3	4	5	6
Special Service Cost Centers:						
Operating Room	$ 189,463	$ 189,463	$ -	$ -	$ -	$ -
Delivery Room						
Anesthesia	80,140	80,140				
X-Ray	53,790	42,763			11,027	
Laboratory	190,574	190,574				
Blood Bank						
Oxygen Therapy						
Physical Therapy	57,473	39,369		18,104		
Cost of Medical Supplies Sold	136,920	133,360			3,560	
Cost of Drugs Sold	126,572	124,800			1,772	
Inpatient Cost Centers:						
Inpatients	705,994	705,994				
Nursery						
Outpatient Cost Centers:						
Outpatients						
Emergency	33,286				33,286	
Private Ambulatory						
Total	$1,574,212	$1,506,463	$ -	$ 18,104	$ 49,645	$ -

HOSPITAL NO. II

STATISTICAL BASES FOR ALLOCATI
PATIENT RELATED EXPENSES, 19

Cost Center	Inpatient	Nursery	Emergency	Operating Room	Anesthesia
Medical Supplies & Expense					
Pharmacy					
Medical Records	85%		2%	8%	1%
Social Service					
Nursing School					
Intern-Resident Service	50%		12½%	37½%	

HOSPITAL NO. II

STATISTICAL BASES FOR ALLOCATING
PATIENT RELATED EXPENSES, 1972

Emergency	Operating Room	Anesthesia	Laboratory	Cost Of Medical Supplies Sold	Cost Of Drugs Sold	Total
				100%		100%
					100%	100%
2%	8%	1%	4%			100%
						-
						-
12½%	37½%					100%

HOSPITAL NO. II

STATISTICAL BASIS
UNALLOWED COST CENTERS - 1972

Cost Center From Which Services Received			Unallowed Cost Center Portion of Base Utilized
Center	Total Amount	Total Base	

N O T A P P L I C A B L E

HOSPITAL NO. III

FINANCIAL AND STATISTICAL DATA

HOSPITAL NO. III

PATIENT ACTIVITY STATISTICS
BY YEAR, 1967 - 1972

Year	All Patients		Medicare	
	Inpatient Days	Occasions of Service	Inpatient Days	Occasions of Service
1967	35,008	4,019	10,861	127
1968	37,242	4,368	12,244	192
1969	38,363	4,530	11,501	155
1970	38,139	5,129	10,819	169
1971	50,094	10,571	14,136	231
1972	57,343	13,646	15,909	298

HOSPITAL NO. III

REIMBURSEMENT
BY YEAR, 1967 - 1972

Year	Hospital Insurance Program	Supplementary Medical Insurance Program	Total
1967	$ 495,701	$ -0-	$ 495,701
1968	$ 565,918	$ 1,175	$ 567,093
1969	$ 596,114	$ 2,109	$ 598,223
1970	$ 619,743	$ 2,489	$ 622,232
1971	$ 979,134	$ 11,490	$ 990,624
1972	$1,200,241	$ 34,781	$1,235,022

HOSPITAL NO. III

GENERAL SERVICE COST CENTER EXPENSES
AFTER DEPRECIATION DISTRIBUTION
BY YEAR, 1967 - 1972

Cost Center	1967	1968	1969	1970	1971	1972
Administration and General	$ 258,118	$ 289,069	$ 336,791	$ 355,059	$ 572,614	$ 731,443
Employee Health and Welfare	80,547	90,571	113,496	157,161	233,079	363,645
Maintenance of Plant	93,684	90,414	92,717	104,956	154,626	197,305
Laundry	48,666	28,250	30,628	27,391	37,349	23,553
Housekeeping	75,799	79,434	83,125	102,732	143,653	161,440
Dietary	149,220	174,301	181,489	182,676	258,069	309,563
Medical Supplies and Expense	60,062	56,452	78,487	99,385	133,857	134,206
Pharmacy	84,431	94,869	102,408	113,914	173,104	242,677
Medical Records	22,458	26,347	34,712	41,310	59,592	80,301
Total	$ 872,985	$ 929,707	$1,053,853	$1,184,584	$1,765,943	$2,244,133

HOSPITAL NO. III

CHARGES, BY PATIENT CLASSIFICAT
1972

Cost Center	Total Gross Charges All Patients	All Inpatient	All Nurser
	1	2	3
Special Service Cost Centers:			
Operating Room	$ 681,343	667,608	
		% 97.98	%
Delivery Room	151,111	151,111	
		% 100	%
Anesthesia	67,359	66,138	
		% 98.19	%
X-Ray	244,192	199,117	
		% 81.54	%
Laboratory	533,889	510,306	
		% 95.58	%
Blood Bank	75,869	75,609	
		% 99.66	%
Oxygen Therapy	219,360	218,235	
		% 99.49	%
Physical Therapy	33,578	30,993	
		% 92.3	%
Cost of Medical Supplies Sold	287,552	277,037	
		% 96.34	%
Cost of Drugs Sold	675,792	664,265	
		% 98.29	%
Inpatient Cost Centers:			
Inpatient	2,919,953	2,919,953	
		% 100	%
Nursery	215,310		215,310
		%	% 100
Outpatient Cost Centers			
Outpatient			
		%	%
Emergency	140,991	181,164	
		% 12.88	%
EKG	63,101	60,428	
		% 95.76	%
Total	$6,309,400	$5,858,964	$ 215,310

HOSPITAL NO. III

CHARGES, BY PATIENT CLASSIFICATION
1972

otal Gross Charges ll Patients	Total Gross Charges All Inpatient	All Nursery	All Outpatient	All Emergency	All Private Ambulatory
1	2	3	4	5	6
81,343	667,608			13,735	
	% 97.98	%	%	% 2.02	%
51,111	151,111				
	% 100	%	%	%	%
67,359	66,138			1,221	
	% 98.19	%	%	% 1.81	%
44,192	199,117			45,075	
	% 81.54	%	%	% 18.46	%
33,889	510,306			23,583	
	% 95.58	%	%	% 4.42	%
75,869	75,609			260	
	% 99.66	%	%	% .34	%
19,360	218,235			1,125	
	% 99.49	%	%	% .51	%
33,578	30,993			2,585	
	% 92.3	%	%	% 7.7	%
37,552	277,037			10,515	
	% 96.34	%	%	% 3.66	%
75,792	664,265			11,527	
	% 98.29	%	%	% 1.71	%
19,953	2,919,953				
	% 100	%	%	%	%
15,310		215,310			
	%	% 100	%	%	%
	%	%	%	%	%
10,991	181,164			122,827	
	% 12.88	%	%	% 87.12	%
63,101	60,428			2,673	
	% 95.76	%	%	% 4.24	%
98,400	$5,858,964	$ 215,310	$	$ 235,126	$

HOSPITAL NO. III

EXPENSES BY COST CENTER
AFTER DEPRECIATION DISTRIBUTION
1972

Cost Center	Total	Inpatient	Nursery	Outpatient	Emergency	Private Ambulatory
	1	2	3	4	5	6
Special Service Cost Centers:						
Operating Room	$ 458,392	$ 449,132	$ -	$ -	$ 9,260	$ -
Delivery Room	127,881	127,881				
Anesthesia	15,047	14,775			272	
X-Ray	136,569	111,358			25,211	
Laboratory	362,360	346,344			16,016	
Blood Bank	24,136	24,054			82	
EKG	16,480	15,781			699	
Oxygen Therapy	90,209	89,749			460	
Physical Therapy	22,730	20,980			1,750	
Inpatient Cost Centers:						
Inpatient	1,414,253	1,414,253				
Nursery	149,695		149,695			
Outpatient Cost Centers:						
Outpatient	148,596	19,139			129,457	
Total	$2,966,348	$2,633,446	$ 149,695	$ -	$ 183,207	$ -

HOSPITAL NO. III

EXPENSES BY COST CENTER, AFTER DEPRECIATION DISTRIBUTION
AND PATIENT RELATED GENERAL SERVICE COST CENTER EXPENSES
1972

Cost Center	Total	Inpatient	Nursery	Outpatient	Emergency	Private Ambulatory
	1	2	3	4	5	6
Special Service Cost Centers:						
Operating Room	$ 458,392	$ 449,132	$ -	$ -	$ 9,260	$ -
Delivery Room	127,881	127,881				
Anesthesia	15,047	14,775			272	
X-Ray	136,569	111,358			25,211	
Laboratory	362,360	346,344			16,016	
Blood Bank	24,136	24,054			82	
EKG	16,480	15,781			699	
Oxygen Therapy	90,209	89,749			460	
Physical Therapy	22,730	20,980			1,750	
Cost of Medical Supplies Sold	134,206	129,294			4,912	
Cost of Drugs Sold	242,677	238,527			4,150	
Inpatient Cost Centers:						
Inpatient	1,502,360	1,502,360				
Nursery	155,316		155,316			
Outpatient Cost Centers:						
Emergency	151,808	19,553			132,255	
Total	$3,440,171	$3,089,788	$ 155,316	$ -	$ 195,067	$ -

HOSPITAL NO. III

STATISTICAL BASES FOR ALLOCATI
PATIENT RELATED EXPENSES, 197

Cost Center	Inpatient	Nursery	Emergency	Operating Room	Anesthesia
Medical Supplies & Expense					
Pharmacy					
Medical Records	89%	7%			
Social Service	100%				

HOSPITAL NO. III

STATISTICAL BASES FOR ALLOCATING
PATIENT RELATED EXPENSES, 1972

y	Emergency	Operating Room	Anesthesia	Laboratory	Cost Of Medical Supplies Sold	Cost Of Drugs Sold	Outpatient	Total
					100%			100%
						100%		100%
							4%	100%
								100%

HOSPITAL NO. III

STATISTICAL BASIS
UNALLOWED COST CENTERS - 1972

Cost Center From Which Services Received			Unallowed Cost Center Portion of Base Utilized		
Center	Total Amount	Total Base	Vending Machines	Gift Shop	Mothers Home
Administration & General	$ 731,443	$4,838,454 accumulated cost	$ 10, 469	$ 1,388	$ 13,147
Operation of Plant	$ 197,305	133,710 square feet	298 square feet	691 square feet	
Employee Health & Welfare	$ 363,645	$2,447,124 salaries			$ 3,494
Cafeteria	$ 56,275	$2,447,124 salaries			$ 3,494

HOSPITAL NO. IV

FINANCIAL AND STATISTICAL DATA

HOSPITAL NO. IV

PATIENT ACTIVITY STATISTICS
BY YEAR, 1967 - 1972

Year	All Patients		Medicare	
	Inpatient Days	Occasions of Service	Inpatient Days	Occasions of Service
1967	58,444	17,691	20,429	17,691*
1968	58,715	16,306	21,559	655
1969	57,977	24,207	20,812	633
1970	55,861	19,081	20,303	429
1971	54,636	21,184	19,057	Not Available
1972	52,554	22,545	17,896	1,102

* Number of Occasions of Service as listed on report submitted to fiscal intermediary.

HOSPITAL NO. IV

REIMBURSEMENT
BY YEAR, 1967 - 1972

Year	Hospital Insurance Program	Supplementary Medical Insurance Program	Total
1967	$ 985,935	$ 981	$ 986,916
1968	$1,181,497	$ 3,506	$1,185,003
1969	$1,260,344	$ 7,633	$1,267,977
1970	$1,370,330	$ 7,722	$1,378,052
1971	$1,483,167	$ 7,370	$1,490,537
1972	$1,525,704	$18,854	$1,544,558

HOSPITAL NO. IV

GENERAL SERVICE COST CENTER EXPENSES
AFTER DEPRECIATION DISTRIBUTION
BY YEAR, 1967 - 1972

Cost Center	1967	1968	1969	1970	1971	1972
Administration and General	$ 415,963	$ 466,255	$ 391,228	$ 417,346	$ 443,358	$ 503,182
Employee Health and Welfare	77,940	183,679	116,648	135,537	169,145	261,790
Operation of Plant	38,501	37,783	33,590	37,691	40,008	45,753
Maintenance of Plant	129,685	139,144	148,949	174,215	196,759	209,874
Laundry	102,157	105,898	165,392	113,206	121,142	117,356
Housekeeping	103,851	116,445	131,673	142,987	158,018	167,370
Dietary	290,005	201,126	352,587	352,784	376,650	389,378
Medical Supplies and Expense	73,520	86,052	84,322	116,010	127,718	197,451
Pharmacy	163,019	195,231	228,634	238,534	256,155	294,206
Medical Records	60,536	72,073	68,758	71,102	76,407	93,927
Nursing School	41,494	40,651	42,002	41,545	47,517	48,274
Intern-Resident Service	97,111	85,505	81,840	87,795	100,154	133,668
Total	$1,593,782	$1,729,842	$1,845,622	$1,928,752	$2,113,031	$2,462,229

HOSPITAL NO. IV

CHARGES, BY PATIENT CLASSIFIC
1972

Cost Center	Total Gross Charges All Patients	All Inpatient	All Nurse
	1	2	3
Special Service Cost Centers:			
Operating and Recovery Room	$ 702,824	673,982	22
	%	% 95.81	% .09
Delivery Room	20,535	20,535	
	%	% 100	%
Anesthesia	192,076	187,437	
	%	% 97.58	%
X-Ray	297,364	234,426	388
	%	% 78.84	% .13
Laboratory and Pathology	732,771	709,819	3,705
	%	% 96.87	% .53
EKG and Radioisotope	56,706	43,962	5
	%	% 77.53	% .01
Oxygen Therapy	128,806	128,546	
	%	% 99.80	%
Physical Therapy	47,183	31,440	
	%	% 66.63	%
Cost of Medical Supplies Sold	232,081	218,313	
	%	% 94.07	%
Cost of Drugs Sold	690,554	670,591	
	%	% 97.11	%
Inpatient Cost Centers:			
Inpatient	2,641,303	2,641,303	
	%	% 100	%
Coronary Care	228,578	228,578	
	%	% 100	%
Nursery	44,028		44,028
			% 100
Outpatient Cost Centers:			
Outpatients			
	%	%	%
Emergency	65,997		
	%	%	%
Cobalt Unit	29,239		
	%	%	%
Total	$6,110,045	$5,788,932	$ 48,348

HOSPITAL NO. IV

CHARGES, BY PATIENT CLASSIFICATION
1972

otal Gross Charges ll Patients	Total Gross Charges All Inpatient	All Nursery	All Outpatient	All Emergency	All Private Ambulatory
1	2	3	4	5	6
)2,824	673,982	22	28,820		
	% 95.81	% .09	% 4.10	%	%
20,535	20,535				
	% 100	%	%	%	%
)2,076	187,437		4,639		
	% 97.58	%	% 2.42	%	%
)7,364	234,426	388	62,550		
	% 78.84	% .13	% 21.03	%	%
12,771	709,819	3,705	19,047		
	% 96.87	% .53	% 2.60	%	%
6,706	43,962	5	12,739		
	% 77.53	% .01	% 22.46	%	%
8,806	128,546		260		
	% 99.80	%	% .20		
7,183	31,440		15,743		
	% 66.63	%	% 33.37	%	%
2,081	218,313		13,768		
	% 94.07	%	% 5.93	%	%
0,554	670,591		19,963		
	% 97.11	%	% 2.89	%	%
1,303	2,641,303				
	% 100	%	%	%	%
8,578	228,578				
	% 100	%	%	%	%
4,028		44,028			
		% 100	%	%	%
	%	%	%	%	%
5,997				65,997	
	%	%	%	% 100	%
9,239					29,239
	%	%	%	%	% 100
1,045	$5,788,932	$ 48,348	$ 177,529	$ 65,997	$ 29,239

HOSPITAL NO. IV

EXPENSES BY COST CENTER
AFTER DEPRECIATION DISTRIBUTION
1972

Cost Center	Total	Inpatient	Nursery	Outpatient	Emergency	Private Ambulatory
	1	2	3	4	5	6
Special Service Cost Centers:						
Operating Room	$ 481,501	$ 461,326	$ 433	$ 19,742	$ -	$ -
Delivery Room	29,823	29,823				
Anesthesia	106,471	103,894		2,577		
X-Ray	191,515	150,990	249	40,276		
Laboratory	396,657	384,242	2,102	10,313		
Oxygen Therapy	41,447	41,364		83		
Physical Therapy	21,670	14,439		7,231		
Coronary Care	105,054	105,054				
Radioisotope	20,288	15,729	2	4,557		
Inpatient Cost Centers:						
Inpatient	1,363,809	1,363,809				
Nursery	61,862		61,862			
Outpatient Cost Centers:						
Outpatient						
Emergency	31,258				31,258	
Private Ambulatory						
Cobalt Unit	5,907					5,907
Total	$2,857,262	$2,670,670	$ 64,648	$ 84,779	$ 31,258	$ 5,907

HOSPITAL NO. IV

EXPENSES BY COST CENTER, AFTER DEPRECIATION DISTRIBUTION
AND PATIENT RELATED GENERAL SERVICE COST CENTER EXPENSES
1972

Cost Center	Total	Inpatient	Nursery	Outpatient	Emergency	Private Ambulatory
	1	2	3	4	5	6
Special Service Cost Centers:						
Operating Room	$ 527,652	$ 505,543	$ 475	$ 21,634	$ -	$ -
Delivery Room	50,581	50,581				
Anesthesia	106,471	103,894		2,577		
X-Ray	214,760	169,317	279	45,164		
Laboratory	405,787	393,086	2,151	10,550		
Oxygen Therapy	41,447	41,364		83		
Physical Therapy	21,670	14,439		7,231		
Radioisotope	20,288	15,729	2	4,557		
Cost of Medical Supplies Sold	197,451	185,742		11,709		
Cost of Drugs Sold	294,206	285,703		8,503		
Inpatient Cost Centers:						
Inpatient	1,524,152	1,524,152				
Coronary Care	105,440	105,440				
Nursery	63,271		63,271			
Outpatient Cost Centers:						
Outpatient						
Emergency	45,705				45,705	
Private Ambulatory						
Cobalt Unit	5,907					5,907
Total	$3,624,788	$3,394,990	$ 66,178	$ 112,008	$ 45,705	$ 5,907

HOSPITAL NO. IV

STATISTICAL BASIS FOR ALLOCAT
PATIENT RELATED EXPENSES, 19

Cost Center	Inpatient	Nursery	Emergency	Operating Room	Anesthes
Medical Records	95.5%	1.5%	3.0%		
Nursing School	46.6%			9.6%	
Intern-Resident Service	36.02%		8.7%	31.06%	

HOSPITAL NO. IV

STATISTICAL BASIS FOR ALLOCATING
PATIENT RELATED EXPENSES, 1972

ry	Emergency	Operating Room	Anesthesia	Laboratory	Delivery Room	X-Ray	Coronary Care Unit	Total
%	3.0%							100%
		9.6%			43.0%		.8%	100%
	8.7%	31.06%		6.83%		17.39%		100%

HOSPITAL NO. IV

STATISTICAL BASIS
UNALLOWED COST CENTERS - 1972

Cost Center From Which Services Received			Unallowed Cost Center Portion of Base Utilized
Center	Total Amount	Total Base	

N O T A P P L I C A B L E

HOSPITAL NO. V

FINANCIAL AND STATISTICAL DATA

HOSPITAL NO. V

PATIENT ACTIVITY STATISTICS
BY YEAR, 1967 - 1972

Year	All Patients		Medicare	
	Inpatient Days	Occasions of Service	Inpatient Days	Occasions of Service
1967	27,444	17,883	8,667	592
1968	28,054	18,280	9,216	629
1969	42,760	28,228	13,290	939
1970	56,683	37,484	17,593	1,182
1971	60,993	27,801	18,590	1,478
1972	64,339	29,323	17,701	1,407

HOSPITAL NO. V

REIMBURSEMENT
BY YEAR, 1967 - 1972

Year	Hospital Insurance Program	Supplementary Medical Insurance Program	Total
1967	$ 336,798	$ 648	$ 337,446
1968	$ 423,604	$ 1,655	$ 425,259
1969	$ 671,659	$20,256	$ 691,915
1970	$ 910,892	$36,674	$ 947,566
1971	$1,104,639	$51,771	$1,156,410
1972	$1,156,334	$47,190	$1,203,524

HOSPITAL NO. V

GENERAL SERVICE COST CENTER EXPENSES
AFTER DEPRECIATION DISTRIBUTION
BY YEAR, 1967 - 1972

Cost Center						
Administration and General	$ 216,101	$ 320,301	$ 407,499	$ 443,138	$ 580,810	$ 741,247
Employee Health and Welfare	7,062	10,468	19,026	28,143	42,946	54,961
Operation of Plant	68,887	72,599	114,932	156,533	207,473	216,227
Laundry	26,742	32,758	51,373	71,145	89,111	93,882
Housekeeping	57,201	63,390	99,450	131,890	158,037	177,391
Dietary - Other	109,106	112,610	228,945	282,660	327,035	395,742
Medical Supplies and Expense	50,998	32,160	69,779	94,623	68,769	123,327
Pharmacy	84,690	75,781	137,937	206,223	257,141	308,289
Medical Records	17,186	20,324	27,126	44,842	49,250	84,770
Gift Shop	281	227	327	392	403	394
Total	$ 638,254	$ 740,618	$1,156,394	$1,459,589	$1,780,975	$2,196,230

HOSPITAL NO. V

CHARGES, BY PATIENT CLASSIFICA
1972

Cost Center	Total Gross Charges All Patients	All Inpatient	All Nurser
	1	2	3
Special Service Cost Centers:			
Operating Room	$ 630,220	621,604	
	%	% 98.63	%
Delivery Room	161,898	161,898	
	%	% 100	%
Anesthesia	100,397	99,232	
	%	% 98.84	%
X-Ray and EKG	541,650	344,974	
	%	% 63.69	%
Laboratory	763,485	729,740	
	%	% 95.58	%
Blood Bank	5,106	5,106	
	%	% 100	%
Oxygen Therapy	266,926	265,519	
	%	% 99.47	%
Physical Therapy	82,987	72,404	
	%	% 87.25	%
Cost of Medical Supplies Sold	287,139	232,043	
	%	% 80.81	%
Cost of Drugs Sold	925,143	895,290	
	%	% 96.27	%
Inpatient Cost Centers:			
Inpatient	3,076,391	3,076,391	
	%	% 100	%
Nursery	186,852		186,852
	%	%	% 100
Outpatient Cost Centers:			
Outpatient			
	%	%	
Emergency	397,889	39,586	
	%	% 9.95	%
Private Ambulatory			
	%	%	
Total	$7,426,083	$6,543,787	$ 186,852

HOSPITAL NO. V

CHARGES, BY PATIENT CLASSIFICATION
1972

Total Gross Charges All Patients	All Inpatient	All Nursery	All Outpatient	All Emergency	All Private Ambulatory
1	2	3	4	5	6
530,220	621,604		8,616		
	% 98.63	%	% 1.37	%	%
161,898	161,898				
	% 100	%	%	%	%
100,397	99,232		1,165		
	% 98.84	%	% 1.16	%	%
341,650	344,974		196,676		
	% 63.69	%	% 36.31	%	%
763,485	729,740		33,745		
	% 95.58	%	% 4.42	%	%
5,106	5,106				
	% 100	%	%	%	%
266,926	265,519		1,407		
	% 99.47	%	% .53	%	%
82,987	72,404		10,583		
	% 87.25	%	% 12.75	%	%
287,139	232,043		55,096		
	% 80.81	%	% 19.19	%	%
25,143	895,290		29,853		
	% 96.27	%	% 3.73	%	%
76,391	3,076,391				
	% 100	%	%	%	%
86,852		186,852			
	%	% 100	%	%	%
	%	%	%	%	%
397,889	39,586		358,303		
	% 9.95	%	% 90.05	%	%
	%	%	%	%	%
26,083	$6,543,787	$ 186,852	$ 695,444	$	$

HOSPITAL NO. V

EXPENSES BY COST CENTER
AFTER DEPRECIATION DISTRIBUTION
1972

Cost Center	Total	Inpatient	Nursery	Oupatient	Emergency	Private Ambulatory
	1	2	3	4	5	6
Special Service Cost Centers:						
Operating Room	$ 438,974	$ 432,960	$ -	$ 6,014	$ -	$ -
Delivery Room	109,247	109,247				
Anesthesia	9,165	9,059		106		
X-Ray and EKG	198,515	126,434		72,081		
Laboratory	397,680	380,103		17,577		
Blood Bank	21,616	21,616				
Oxygen Therapy	81,348	80,917		431		
Physical Therapy	29,279	25,546		3,733		
Inpatient Cost Centers:						
Inpatient	$1,469,392	$1,469,392				
Nursery	106,091		106,091			
Outpatient Cost Centers:						
Outpatient	101,216	10,071		91,145		
Emergency						
Private Ambulatory						
Total	$2,962,523	$2,665,345	$ 106,091	$ 191,087	$ -	$ -

HOSPITAL NO. V

EXPENSES BY COST CENTER, AFTER DEPRECIATION DISTRIBUTION
AND PATIENT RELATED GENERAL SERVICE COST CENTER EXPENSES
1972

Cost Center	Total	Inpatient	Nursery	Outpatient	Emergency	Private Ambulatory
	1	2	3	4	5	6
Special Service Cost Centers:						
Operating Room	$ 438,974	$ 432,960	$ -	$ 6,014	$ -	$ -
Delivery Room	109,247	109,247				
Anesthesia	9,165	9,059		106		
X-Ray and EKG	198,515	126,434		72,081		
Laboratory	397,680	380,103		17,577		
Blood Bank	21,616	21,616				
Oxygen Therapy	81,348	80,917		431		
Physical Therapy	29,279	25,546		3,733		
Cost of Medical Supplies Sold	123,327	99,661		23,666		
Cost of Drugs Sold	308,289	296,790		11,499		
Inpatient Cost Centers:						
Inpatient	1,552,721	1,552,721				
Nursery	107,532		107,532			
Outpatient Cost Centers:						
Outpatient	101,216	10,071		91,145		
Emergency						
Private Ambulatory						
Total	$3,478,909	$3,145,125	$ 107,532	$ 226,252	$ -	$ -

HOSPITAL NO. V

STATISTICAL BASES FOR ALLOCATI
PATIENT RELATED EXPENSES, 19

Cost Center	Inpatient	Nursery	Emergency	Operating Room	Anesthesia
Medical Supplies & Expense					
Pharmacy					
Medical Records	98.3%	1.7%			

HOSPITAL NO. V

STATISTICAL BASES FOR ALLOCATING
PATIENT RELATED EXPENSES, 1972

y	Emergency	Operating Room	Anesthesia	Laboratory	Cost Of Medical Supplies Sold	Cost Of Drugs Sold	Total
					100%		100%
						100%	100%
							100%

HOSPITAL NO. V

STATISTICAL BASIS
UNALLOWED COST CENTERS - 1972

Cost Center From Which Services Received			Unallowed Cost Center Portion of Base Utilized
Center	Total Amount	Total Base	Gift Shop
Administration & General	$ 391,073	$4,769,380 accumulated cost	$ 394
Purchasing	$ 30,697	$ 666,229 accumulated cost	$ 99
Patient Accounting	$ 284,016	$3,697,609 accumulated cost	
Admitting	$ 35,461	$3,885,405 accumulated cost	
Operation of Plant	$ 86,677	134,859 square feet	334 square feet

APPENDIX II

REIMBURSEMENT SETTLEMENT

USING THE

WEIGHTED AVERAGE IMPACT PROPOSAL

HOSPITAL NO. I

HOSPITAL NO. I

SUMMARY OF REIMBURSEMENT
WEIGHTED AVERAGE IMPACT PROPOSAL

Total	Hospital Insurance Program	Supplementary Medical Insurance Program
$	$ 744,989	$ 34,593
		4,343
	622,293	52,847
$1,459,065	$1,367,282	$ 91,783

HOSPITAL NO. I

CALCULATION OF REIMBURSEMENT - INPATI
EXCLUDING TITLE XVIII, PART
WEIGHTED AVERAGE IMPACT PROF
1972

Cost Center	Total Billed Inpatient Charges All Patients	Total Billed Inpatient Charges Health Care Program	Per Col. 2
Operating Room			
Delivery Room			
Anesthesia			
X-Ray			
Laboratory			
Blood Bank			
Oxygen Therapy			
Physical Therapy			
Cost of Medical Supplies			
Cost of Drugs Sold			
Subtotals	$3,128,520	$ 843,001	26.94
Inpatient Routine Service	$2,670,533	$ 821,395	
Total Inpatient Days			
Average Per Diem Cost			
Inpatient Routine Service Cost			
Subtotals	$5,799,053	$1,664,396	
Less: Amount Paid by Workman's Compensation			
Subtotals			
Less: Net Deductibles + Coinsurance			
Differential in Room Charge			
Net Cost of Covered Services			
Reimbursable Return on Equity			
Total Cost Reimbursable			

HOSPITAL NO. I

CULATION OF REIMBURSEMENT - INPATIENT SERVICES
EXCLUDING TITLE XVIII, PART B
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

Total Billed Patient Charges All Patients	Total Billed Inpatient Charges Health Care Program	Percent Col. 2 / Col. 1	Total Inpatient Expenses	Inpatient Expenses Applicable To Health Care Program Departmental Method	Combination Method
28,520	$ 843,001	26.9456	$1,515,595		$ 408,386
70,533	$ 821,395		$1,364,024		
			52,988		
			$ 25.7421		
				$ 417,471	
99,053	$1,664,396			$ 825,857	
				-0-	
				$ 825,857	
				$ 80,868	
				-0-	
				$ 744,989	
				-0-	
				$ 744,989	

HOSPITAL NO. I

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII, PART B
AND PART A OUTPATIENT
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

1	Total amount of outpatient charges (gross) all outpatients	$	500,309
2	Total amount of outpatient charges (gross) Health Insurance Program outpatients	$	24,527
3	Percent (Line 2 ÷ Line 1)		4.9023%
4	Total amount of hospital expenses for outpatient services	$	261,890
5	Outpatient expenses applicable to Health Insurance Program	$	12,839
6	Add: Cost of inpatient ancillary services covered by Supplementary Medical Insurance	$	1,312
	Outpatient services rendered by hospital based physicians	$	1,614
	Cost of ambulance services		-0-
7	Subtotal	$	15,765
8	Less: Amounts paid and payable by Workman's Compensation		-0-
9	Subtotal	$	15,765
10	Less: Deductibles billed to HI outpatients	$	12,369
11	Net Cost (Line 9 minus Line 10)	$	3,396
12	80% of Net Cost - reimbursable expenses - HI Program	$	2,717
13	Add: Reimbursable return on equity capital		-0-
14	Subtotal	$	2,717
	REIMBURSABLE BAD DEBTS		
15	Total applicable outpatient expenses (Line 9 above)	$	15,765
16	Add: Return on equity capital (apportioned on basis of Line 15)		-0-
17	Subtotal (Line 15 + Line 16)	$	15,765
18	Amount received and to be received from intermediary	$	7,787
19	Balance to be recovered from HI Program outpatients	$	7,978
20	Deductibles and coinsurance, net of bad debt recoveries	$	14,785
21	Less: Bad debts for deductibles and coinsurance, net of bad debt recoveries	$	478
22	Net deductibles and coinsurance billed to HI Program outpatients	$	14,307
23	Unrecovered from HI Program patients (Line 19 minus Line 22, if line 22 is greater than Line 19 enter zero and do not complete Lines 24, 25, 26)		-0-
24	Gross bad debts (Line 21 or 23 whichever is lower)		
25	Bad debts applicable to professional component and unallowed under Title XVIII		

10	Less: Deductibles billed to HI outpatients	$	12,369
11	Net Cost (Line 9 minus Line 10)	$	3,396
12	80% of Net Cost - reimbursable expenses - HI Program	$	2,717
13	Add: Reimbursable return on equity capital		-0-
14	Subtotal	$	2,717
	REIMBURSABLE BAD DEBTS		
15	Total applicable outpatient expenses (Line 9 above)	$	15,765
16	Add: Return on equity capital (apportioned on basis of Line 15)		-0-
17	Subtotal (Line 15 + Line 16)	$	15,765
18	Amount received and to be received from intermediary	$	7,787
19	Balance to be recovered from HI Program outpatients	$	7,978
20	Deductibles and coinsurance, net of bad debt recoveries	$	14,785
21	Less: Bad debts for deductibles and coinsurance, net of bad debt recoveries	$	478
22	Net deductibles and coinsurance billed to HI Program outpatients	$	14,307
23	Unrecovered from HI Program patients (Line 19 minus Line 22, if line 22 is greater than Line 19 enter zero and do not complete Lines 24, 25, 26)		-0-
24	Gross bad debts (Line 21 or 23 whichever is lower)		
25	Bad debts applicable to professional component and unallowed under Title XVIII		
26	Reimbursable bad debts (Line 24 minus Line 25)		
27	Inpatient services rendered by hospital-based radiologists and pathologists	$	31,876
28	Total (Line 14 + Line 26 + Line 27)	$	34,593

HOSPITAL NO. I

CALCULATION OF REIMBURSEMENT SETTLEMENT, GENERAL SERVICE COST CENTER,
SUPPORT-RELATED EXPENSES
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

1	Administration and General	$ 743,588
2	Employee Health and Welfare	345,600
3	Operation of Plant	228,538
4	Maintenance of Plant	
5	Laundry and Linen	77,329
6	Housekeeping	180,797
7	Dietary - Raw Food	274,887
8	Dietary - Other	
9	Cafeteria	
10	Maintenance of Personnel	
11	Medical Supplies and Expense	95,806
12	Pharmacy	268,779
13	Medical Records	84,180
14	Nursing School	13,610
15	Intern-Resident Service	24,416
16		
17	Total	$ 2,337,530
18	Less: Unallowed Expenses	$ 45,898
19	Net Allowable Expenses	$ 2,291,632
20	Total Charges, All Patients	$ 6,390,949
21	Total Charges, All Inpatients	$ 5,890,640
22	Percent (line 21 to line 20)	92.1717%
23	Total Inpatient Days	52,988
24	Total Inpatient Days, Medicare	15,611
25	Percent (line 24 to line 23)	29.4613%
26	Line 25 times line 22	.271550
27	Total Occasions of Service	15,571
28	Total Occasions of Service, Medicare	4,587
29	Percent (line 28 to line 27)	29.4586%
30	Total Charges, All Outpatients	$ 500,309
31	Percent (line 30 to line 20)	7.8283%
32	Line 31 times line 29	

16	Intern-Resident Service	24,416
17	Total	$ 2,337,530
18	Less: Unallowed Expenses	$ 45,898
19	Net Allowable Expenses	$ 2,291,632
20	Total Charges, All Patients	$ 6,390,949
21	Total Charges, All Inpatients	$ 5,890,640
22	Percent (line 21 to line 20)	92.1717%
23	Total Inpatient Days	52,988
24	Total Inpatient Days, Medicare	15,611
25	Percent (line 24 to line 23)	29.4613%
26	Line 25 times line 22	.271550
27	Total Occasions of Service	15,571
28	Total Occasions of Service, Medicare	4,587
29	Percent (line 28 to line 27)	29.4586%
30	Total Charges, All Outpatients	$ 500,309
31	Percent (line 30 to line 20)	7.8283%
32	Line 31 times line 29	.023061%
33	Line 26 times line 19	$ 622,293
34	Line 32 times line 19	$ 52,847

HOSPITAL NO. I

CALCULATION OF INPATIENT ROUTINE SERVICE COST
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

	INPATIENT DAYS	
1	Total inpatient days - all patients	52,988
2	Total inpatient days - aged, pediatric, maternity	21,030
3	Total inpatient days - other	31,958
4	Inpatient days applicable to Title XVIII (Medicare)	15,611
5	Inpatient days - aged, pediatric, maternity plus 8½%	22,818
6	Total adjusted inpatient days	54,776
	INPATIENT ROUTINE COSTS	
7	Total inpatient routine nursing salary cost (excluding nursery)	$1,060,490
8	Total inpatient routine service costs excluding inpatient routine nursing salary cost on Line 7	303,534
9	Total inpatient routine service costs (Line 7 + Line 8)	$1,364,024
10	Inpatient routine nursing salary cost plus 8½%	$1,150,632
	COMPUTATION OF INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)	
11	Adjusted average per diem inpatient routine nursing salary cost (Line 10 ÷ Line 6)	$ 21.01
12	Average per diem inpatient routine nursing salary cost - unadjusted (line 7 ÷ Line 1)	$ 20.01
13	Average per diem inpatient routine nursing salary cost differential adjustment factor (Line 11 minue Line 12)	$ 1.00
14	Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare (Line 4 x Line 13)	$ 15,611
	APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE) AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE	
	DEPARTMENTAL RCCAC	
15	Total billed inpatient charges (gross) for routine services all patients, excluding nursery	
16	Total billed inpatient charges (gross) for routine services - Medicare	
17	Percent Medicare charges to total charges (Line 16 ÷ Line 15)	
18	Inpatient routine service cost applicable to Medicare	

ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)

11	Adjusted average per diem inpatient routine nursing salary cost (Line 10 ÷ Line 6)	$ 21.01
12	Average per diem inpatient routine nursing salary cost - unadjusted (line 7 ÷ Line 1)	$ 20.01
13	Average per diem inpatient routine nursing salary cost differential adjustment factor (Line 11 minue Line 12)	$ 1.00
14	Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare (Line 4 x Line 13)	$ 15,611

APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE) AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE

DEPARTMENTAL RCCAC

15	Total billed inpatient charges (gross) for routine services all patients, excluding nursery	
16	Total billed inpatient charges (gross) for routine services - Medicare	
17	Percent Medicare charges to total charges (Line 16 ÷ Line 15)	
18	Inpatient routine service cost applicable to Medicare excluding inpatient routine salary cost differential adjustment factor (Line 9 x Line 17)	
19	Total inpatient routine service cost applicable to Medicare (Line 14 + Line 18)	

COMBINATION METHOD

20	Inpatient routine average per diem cost (Line 9 ÷ Line 1)	$ 25.7421
21	Inpatient routine service cost applicable to Medicare excluding inpatient routine nursing salary cost differential adjustment factor (Line 4 x Line 20)	$ 401,860
22	Total inpatient routine service cost applicable to Medicare (Line 14 + Line 21)	$ 417,471

HOSPITAL NO. I

SUPPLEMENTARY COST FORM
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

CALCULATION OF REIMBURSEMENT SETTLEMENT (RESIDENTS AND INTERNS NOT UNDER APPROVED TEACHING PROGRAM) - INPATIENT AND OUTPATIENT SERVICES - MEDICAL PLAN (PART B)

	AMOUNT OF EXPENSES - SUBJECT SERVICES	
1	Salaries	$ 73,506
	ALLOCATION OF TOTAL AMOUNT OF EXPENSES BASIS OF TIME	
2	Inpatient services 10% x Line 1	$ 7,351
3	Outpatient services 90% x Line 1	$ 66,155
4	Total services 100% x Line 1	$ 73,506
	APPORTIONMENT OF EXPENSES - INPATIENT SERVICES	
5	Total inpatient days - all patients (including 1/3 of newborn days)	54,016
6	Average expense for inpatient day (Line 2 ÷ Line 5)	.14
7	Inpatient days - Health Care Program	15,611
8	Expenses - inpatient services - Health Care Program (Line 6 x Line 7)	$ 2,186
	APPORTIONMENT OF EXPENSES - OUTPATIENT SERVICES	
9	Percent - HI Program outpatient services received - sum of HI Program Part A and Part B outpatient charges total outpatient charges - all patients	4.9023%
10	Expenses - outpatient services - HI Program (Line 9 x Line 3)	$ 3,243
	SUMMARY	
11	Total expenses - services - HI Program (Line 8 + Line 10)	$ 5,429
12	Less: deductibles billed to Health Insurance Program patients	-0-
13	Net Cost	$ 5,429
14	80% of net expenses - services - HI Program	$ 4,343
15	Add: bad debts for subject services, net of bad debt recoveries (HI Program - Part B beneficiaries)	-0-
16	Total	$ 4,343

	[illegible] Expense day (Line 2 ÷ Line 3)		.14
7	Inpatient days - Health Care Program		15,611
8	Expenses - inpatient services - Health Care Program (Line 6 x Line 7)	$	2,186
	APPORTIONMENT OF EXPENSES - OUTPATIENT SERVICES		
9	Percent - HI Program outpatient services received - sum of HI Program Part A and Part B outpatient charges / total outpatient charges - all patients		4.9023%
10	Expenses - outpatient services - HI Program (Line 9 x Line 3)	$	3,243
	SUMMARY		
11	Total expenses - services - HI Program (Line 8 + Line 10)	$	5,429
12	Less: deductibles billed to Health Insurance Program patients		-0-
13	Net Cost	$	5,429
14	80% of net expenses - services - HI Program	$	4,343
15	Add: bad debts for subject services, net of bad debt recoveries (HI Program - Part B beneficiaries)		-0-
16	Total	$	4,343

HOSPITAL NO. I

UNALLOWED EXPENSES
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

	Gift Shop	Convent	Total
Unallowed Cost Center Expenses After Depreciation Distribution	$ 12,054	$ 1,926	$
Add:			
Administration & General	2,035	324	
Employee Health & Welfare	1,495	-0-	
Operation of Plant	1,500	8,667	
Housekeeping	1,187	6,857 *	
Laundry	-0-	2,494 *	
Cafetaria	-0-	7,359	
Total Unallowed Expense	$ 18,271	$ 27,627	$ 45,898

*Direct Allocations

HOSPITAL NO. II

HOSPITAL NO. II

SUMMARY OF REIMBURSEMENT
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

Total	Hospital Insurance Program	Supplementary Medical Insurance Program
$	$ 488,726	$ 5,036
	260,534	1,191
$ 755,487	$ 749,260	$ 6,227

HOSPITAL NO. II

CALCULATION OF REIMBURSEMENT - INPATI
EXCLUDING TITLE XVIII, PART
WEIGHTED AVERAGE IMPACT PROP
1972

Cost Center	Total Billed Inpatient Charges All Patients	Total Billed Inpatient Charges Health Care Program	Per Col. 2
Operating Room	$ 186,963	$ 37,046	19.8
Delivery Room			
Anesthesia	85,464	22.901	26.8
X-Ray	120,996	49.844	41.2
Laboratory	220,391	85,004	38.5
Blood Bank			
Oxygen Therapy			
Physical Therapy	52,288	20,207	28.6
Cost of Medical Supplies	226,129	99,419	43.9
Cost of Drugs Sold	280,846	76,113	27.1
Subtotals	$1,173,077	$ 390,534	
Inpatient Routine Service	$ 837,728	$ 280,600	
Total Inpatient Days			
Average Per Diem Cost			
Inpatient Routine Service Cost Subtotals	$2,010,805	$ 671,134	
Less: Amount Paid by Workman's Compensation Subtotals			
Less: Net Deductibles + Coinsurance Differential in Room Charge			
Net Cost of Covered Services			
Reimbursable Return on Equity			
Total Cost Reimbursable			

HOSPITAL NO. II

LCULATION OF REIMBURSEMENT - INPATIENT SERVICES
EXCLUDING TITLE XVIII, PART B
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

Total Billed Inpatient Charges All Patients	Total Billed Inpatient Charges Health Care Program	Percent Col. 2 Col. 1	Total Inpatient Expenses	Inpatient Expenses Applicable To Health Care Program Departmental Method	Combination Method
186,963	$ 37,046	19.81	$ 189,463	$ 37,533	
85,464	22.901	26.8	80,140	21,478	
120,996	49.844	41.19	42,763	17,614	
220,391	85,004	38.57	190,574	73,504	
52,288	20,207	28.65	39,369	11,279	
226,129	99,419	43.97	133,360	58,638	
280,846	76,113	27.10	124,800	33,821	
173,077	$ 390,534		$ 800,469	$ 253,867	
837,728	$ 280,600		$ 705,994	$ 244,707	
			21,172		
			$ 33.3456		
010,805	$ 671,134			$ 498,574	
				-0-	
				$ 498,574	
				35,930	
				-0-	
				$ 462,644	
				26,082	
				$ 488,726	

HOSPITAL NO. II

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII, PART B
AND PART A OUTPATIENT
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

1	Total amount of outpatient charges (gross) all outpatients	$	96,956
2	Total amount of outpatient charges (gross) Health Insurance Program outpatients	$	5,536
3	Percent (Line 2 ÷ Line 1)		5.71%
4	Total amount of hospital expenses for outpatient services	$	67,749
5	Outpatient expenses applicable to Health Insurance Program	$	3,868
6	Add: Cost of inpatient ancillary services covered by Supplementary Medical Insurance		-0-
	Outpatient services rendered by hospital-based physicians	$	143
	Cost of ambulance services		-0-
7	Subtotal	$	4,011
8	Less: Amounts paid and payable by Workman's Compensation		-0-
9	Subtotal	$	4,011
10	Less: Deductibles billed to HI outpatients	$	2,335
11	Net Cost (Line 9 minus Line 10)	$	1,676
12	80% of Net Cost - reimbursable expenses - HI Program	$	1,341
13	Add: Reimbursable return on equity capital	$	201
14	Subtotal	$	1,542
	REIMBURSABLE BAD DEBTS		
15	Total applicable outpatient expenses (Line 9 above)		
16	Add: Return on equity capital (apportioned on basis of Line 15)		
17	Subtotal (Line 15 + Line 16)		
18	Amount received and to be received from intermediary		
19	Balance to be recovered from HI program outpatients		
20	Deductibles and coinsurance billed		
21	Less: Bad debts for deductibles and coinsurance, net of bad debt recoveries		
22	Net deductibles and coinsurance billed to HI program outpatients		
23	Unrecovered from HI Program patients (Line 19 minus Line 22, if Line 22 is greater than Line 19 enter zero and do not complete Lines 24, 25,26)		
24	Gross bad debts (Line 21 or 23 whichever is lower)		
25	Bad debts applicable to professional component and unallowed under Title XVIII		

NOT APPLICABLE

10	Less: Deductibles billed to HI outpatients	$	2,335
11	Net Cost (Line 9 minus Line 10)	$	1,676
12	80% of Net Cost - reimbursable expenses - HI Program	$	1,341
13	Add: Reimbursable return on equity capital	$	201
14	Subtotal	$	1,542
	REIMBURSABLE BAD DEBTS		
15	Total applicable outpatient expenses (Line 9 above)		
16	Add: Return on equity capital (apportioned on basis of Line 15)		
17	Subtotal (Line 15 + Line 16)		
18	Amount received and to be received from intermediary		
19	Balance to be recovered from HI program outpatients		
20	Deductibles and coinsurance billed		
21	Less: Bad debts for deductibles and coinsurance, net of bad debt recoveries		
22	Net deductibles and coinsurance billed to HI program outpatients		
23	Unrecovered from HI Program patients (Line 19 minus Line 22, if Line 22 is greater than Line 19 enter zero and do not complete Lines 24, 25,26)		
24	Gross bad debts (Line 21 or 23 whichever is lower)		
25	Bad debts applicable to professional component and unallowed under Title XVIII		
26	Reimbursable bad debts (Line 24 minus Line 25)		
27	Inpatient services rendered by hospital-based radiologists and pathologists	$	3,494
28	Total (Line 14 + Line 26 + Line 27)	$	5,036

NOT APPLICABLE

HOSPITAL NO. II

CALCULATION OF REIMBURSEMENT SETTLEMENT, GENERAL SERVICE COST CENTER,
SUPPORT-RELATED EXPENSES
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

1	Administration and General	$ 305,034
2	Employee Health and Welfare	
3	Operation of Plant	
4	Maintenance of Plant	40,151
5	Laundry and Linen	846
6	Housekeeping	11,075
7	Dietary - Raw Food	53,792
8	Dietary - Other	73,919
9	Cafeteria	
10	Maintenance of Personnel	
11	Medical Supplies and Expense	136,920
12	Pharmacy	126,572
13	Medical Records	66,113
14	Intern-Resident Service	38,884
15		
16		
17	Total	$ 853,306
18	Less: Unallowed Expenses	-0-
19	Net Allowable Expenses	$ 853,306
20	Total Charges, All Patients	$ 2,107,761
21	Total Charges, All Inpatents	$ 2,010,805
22	Percent (line 21 to line 20)	95.4%
23	Total Inpatient Days	21,172
24	Total Inpatient Days, Medicare	6,776
25	Percent (line 24 to line 23)	32.0045%
26	Line 25 times line 22	.3053229%
27	Total Occasions of Service	6,228
28	Total Occasions of Service, Medicare	189
29	Percent (line 28 to line 27	3.0346%
30	Total Charges, All Outpatients	$ 96,956

13	Medical Records	66,113
14	Intern-Resident Service	38,884
15		
16		
17	Total	$ 853,306
18	Less: Unallowed Expenses	-0-
19	Net Allowable Expenses	$ 853,306
20	Total Charges, All Patients	$ 2,107,761
21	Total Charges, All Inpatents	$ 2,010,805
22	Percent (line 21 to line 20)	95.4%
23	Total Inpatient Days	21,172
24	Total Inpatient Days, Medicare	6,776
25	Percent (line 24 to line 23)	32.0045%
26	Line 25 times line 22	.3053229%
27	Total Occasions of Service	6,228
28	Total Occasions of Service, Medicare	189
29	Percent (line 28 to line 27	3.0346%
30	Total Charges, All Outpatients	$ 96,956
31	Percent (line 30 to line 20)	4.6%
32	Line 31 times line 29	.0013959%
33	Line 26 times line 19	$ 260,534
34	Line 32 times line 19	$ 1,191

HOSPITAL NO. II

CALCULATION OF INPATIENT ROUTINE SERVICE COST
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

	INPATIENT DAYS	
1	Total inpatient days - all patients	21,172
2	Total inpatient days - aged, pediatric, maternity	7,380
3	Total inpatient days - other	13,792
4	Inpatient days Applicable to Title XVIII (Medicare)	6,776
5	Inpatient Days - aged, pediatric, maternity plus 8½%	8,007
6	Total adjusted inpatient days	21,799
	INPATIENT ROUTINE COSTS	
7	Total inpatient routine nursing salary cost (excluding nursery)	$ 475,486
8	Total inpatient routine service costs excluding inpatient routine nursing salary cost on Line 7	$ 230,508
9	Total inpatient routine service costs (Line 7 + Line 8)	$ 705,994
10	Inpatient routine nursing salary cost plus 8½%	$ 515,902
	COMPUTATION OF INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)	
11	Adjusted average per diem inpatient routine nursing salary cost (Line 10 ÷ Line 6)	$ 23.67
12	Average per diem inpatient routine nursing salary cost - unadjusted (Line 7 ÷ Line 1)	$ 22.46
13	Average per diem inpatient routine nursing salary cost differential adjustment factor (Line 11 minus Line 12)	$ 1.21
14	Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare (Line 4 x Line 13)	$ 8,199
	APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE) AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE	
	DEPARTMENTAL RCCAC	
15	Total billed inpatient charges (gross) for routine services all patients, excluding nursery	$ 837,728
16	Total billed inpatient charges (gross) for routine services Medicare	$ 280,600
17	Percent Medicare charges to total charges (Line 16 ÷ Line 15)	33.50%
18	Inpatient routine service cost applicable to Medicare [illegible]	

	ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)	
11	Adjusted average per diem inpatient routine nursing salary cost (Line 10 ÷ Line 6)	$ 23.67
12	Average per diem inpatient routine nursing salary cost - unadjusted (Line 7 ÷ Line 1)	$ 22.46
13	Average per diem inpatient routine nursing salary cost differential adjustment factor (Line 11 minus Line 12)	$ 1.21
14	Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare (Line 4 x Line 13)	$ 8,199
	APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE) AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE	
	DEPARTMENTAL RCCAC	
15	Total billed inpatient charges (gross) for routine services all patients, excluding nursery	$ 837,728
16	Total billed inpatient charges (gross) for routine services Medicare	$ 280,600
17	Percent Medicare charges to total charges (Line 16 ÷ Line 15)	33.50%
18	Inpatient routine service cost applicable to Medicare excluding inpatient routine nursing salary cost differential adjustment factor (Line 9 x Line 17)	$ 236,508
19	Total inpatient routine service cost applicable to Medicare (Line 14 + Line 18)	$ 244,707
	COMBINATION METHOD	
20	Inpatient routine average per diem cost (Line 9 ÷ Line 1)	
21	Inpatient routine service cost applicable to Medicare excluding inpatient routine nursing salary cost differential adjustment factor (Line 4 x Line 20)	
22	Total inpatient routine service cost applicable to Medicare (Line 14 + Line 21)	

HOSPITAL NO. III

HOSPITAL NO. III

SUMMARY OF REIMBURSEMENT
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

Total	Hospital Insurance Program	Supplementary Medical Insurance Program
$	$ 751,448	$ 32,461
	591,162	1,801
$1,376,872	$1,342,610	$ 34,262

HOSPITAL NO. III

CALCULATION OF REIMBURSEMENT - INPATI
EXCLUDING TITLE XVIII, PART
WEIGHTED AVERAGE IMPACT PROP
1972

Cost Center	Total Billed Inpatient Charges All Patients	Total Billed Inpatient Charges Health Care Program	Col. 2	Perc
Operating Room				
Delivery Room				
Anesthesia				
X-Ray				
Laboratory				
Blood Bank				
Oxygen Therapy				
Physical Therapy				
Cost of Medical Supplies				
Cost of Drugs Sold				
Subtotals	$2,939,011	$ 755,365		25.7
Inpatient Routine Service	$2,919,953	$ 825,493		
Total Inpatient Days				
Average Per Diem Cost				
Inpatient Routine Service Cost				
Subtotals				
Less: Ampount Paid by Workman's Compensation				
Subtotals				
Less: Net Deductibles + Coinsurance				
Differential in Room Charge				
Net Cost of Covered Services				
Reimbursable Return on Equity				
Total Cost Reimbursable				

HOSPITAL NO. III

CULATION OF REIMBURSEMENT - INPATIENT SERVICES
EXCLUDING TITLE XVIII, PART B
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

Total Billed patient Charges All atients	Total Billed Inpatient Charges Health Care Program	Percent Col. 2 / Col. 1	Total Inpatient Expenses	Inpatient Expenses Applicable To Health Care Program Departmental Method	Combination Method
939,011	$ 755,365	25.701	$1,587,428		$ 407,985
919,953	$ 825,493		$1,502,360		
			57,343		
			$ 26.1995		
				$ 431,008	
				$ 838,993	
				-0-	
				$ 838,993	
				$ 87,545	
				-0-	
				$ 751,448	
				-0-	
				751,448	

HOSPITAL NO. III

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII, PART B
AND PART A OUTPATIENT
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

1	Total amount of outpatient charges (gross) all outpatients	$	235,126
2	Total amount of outpatient charges (gross) Health Insurance Program outpatients	$	10,056
3	Percent (Line 2 ÷ Line 1)		4.2768%
4	Total amount of hospital expenses for outpatient services	$	195,067
5	Outpatient expenses applicable to Health Insurance Program	$	8,343
6	Add: Cost of inpatient ancillary services covered by Supplementary Medical Insurance	$	350
	Outpatient services rendered by hospital-based physicians	$	135
	Cost of ambulance services		-0-
7	Subtotal	$	8,828
8	Less: Amounts paid and payable by Workman's Compensation		-0-
9	Subtotal	$	8,828
10	Less: Deductibles billed to HI outpatients	$	4,270
11	Net Cost (Line 9 minus Line 10)	$	4,558
12	80% of Net Cost - reimbursable expenses - HI Program	$	3,646
13	Add: Reimbursable return on equity capital		-0-
14	Subtotal	$	3,646
	REIMBURSABLE BAD DEBTS		
15	Total applicable outpatient expenses (Line 9 above)	$	8.828
16	Add: Return on equity capital (apportioned on basis of Line 15)		-0-
17	Subtotal (Line 15 + Line 16)	$	8,828
18	Amount received and to be received from intermediary	$	5,966
19	Balance to be recovered from HI Program outpatients	$	2,862
20	Deductibles and coninsurance billed	$	5,532
21	Less: Bad debts for deductibles and coinsurance, net of bad debt recoveries		-0-
22	Net deductibles and coinsurance billed to HI Program outpatients	$	5,532
23	Unrecovered from HI Program patients (Line 19 minus Line 22, if Line 22 is greater than Line 19 enter zero and do not complete Lines 24, 25, 26)		-0-
24	Gross bad debts (Line 21 or 23 whichever is lower)		
25	Bad debts applicable to [illegible]		

10	Less: Deductibles billed to HI outpatients	$	4,270
11	Net Cost (Line 9 minus Line 10)	$	4,558
12	80% of Net Cost - reimbursable expenses - HI Program	$	3,646
13	Add: Reimbursable return on equity capital		-0-
14	Subtotal	$	3,646
	REIMBURSABLE BAD DEBTS		
15	Total applicable outpatient expenses (Line 9 above)	$	8.828
16	Add: Return on equity capital (apportioned on basis of Line 15)		-0-
17	Subtotal (Line 15 + Line 16)	$	8,828
18	Amount received and to be received from intermediary	$	5,966
19	Balance to be recovered from HI Program outpatients	$	2,862
20	Deductibles and coninsurance billed	$	5,532
21	Less: Bad debts for deductibles and coinsurance, net of bad debt recoveries		-0-
22	Net deductibles and coinsurance billed to HI Program outpatients	$	5,532
23	Unrecovered from HI Program patients (Line 19 minus Line 22, if Line 22 is greater than Line 19 enter zero and do not complete Lines 24, 25, 26)		-0-
24	Gross bad debts (Line 21 or 23 whichever is lower)		
25	Bad debts applicable to professional component and unallowed under Title XVIII		
26	Reimbursable bad debts (Line 24 minus Line 25)		
27	Inpatient services rendered by hospital-based radiologists and pathologists	$	28,815
28	Total (Line 14 + Line 26 + Line 27)	$	32,461

HOSPITAL NO. III

CALCULATION OF REIMBURSEMENT SETTLEMENT, GENERAL SERVICE COST CENTER,
SUPPORT-RELATED EXPENSES
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

1	Administration and General	$ 731,443
2	Employee Health and Welfare	363,645
3	Operation of Plant	197,305
4	Maintenance of Plant	
5	Laundry and Linen	23,553
6	Housekeeping	161,440
7	Dietary - Raw Food	309,563
8	Dietary - Other	
9	Cafeteria	
10	Maintenance of Personnel	
11	Medical Supplies and Expense	134,206
12	Pharmacy	242,677
13	Medical Records	80,301
14		
15		
16		
17	Total	$ 2,244,133
18	Less: Unallowed Expenses	$ 30,840
19	Net Allowable Expenses	$ 2,213,293
20	Total Charges, All Patients	$ 6,309,400
21	Total Charges, All Inpatients	$ 6,074,274
22	Percent (line 21 to line 20)	96.2734%
23	Total Inpatient Days	57,343
24	Total Inpatient Days, Medicare	15,909
25	Percent (line 24 to line 23)	27.7435%
26	Line 25 times line 22	.2670961%
27	Total Occasions of Service	13,646
28	Total Occasions of Service, Medicare	298
29	Percent (line 28 to line 27)	2.1837%
30	Total Charges, All Outpatients	$ 235,126
31	Percent (line 30 to line 20)	

14		88,301
15		
16		
17	Total	$ 2,244,133
18	Less: Unallowed Expenses	$ 30,840
19	Net Allowable Expenses	$ 2,213,293
20	Total Charges, All Patients	$ 6,309,400
21	Total Charges, All Inpatients	$ 6,074,274
22	Percent (line 21 to line 20)	96.2734%
23	Total Inpatient Days	57,343
24	Total Inpatient Days, Medicare	15,909
25	Percent (line 24 to line 23)	27.7435%
26	Line 25 times line 22	.2670961%
27	Total Occasions of Service	13,646
28	Total Occasions of Service, Medicare	298
29	Percent (line 28 to line 27)	2.1837%
30	Total Charges, All Outpatients	$ 235,126
31	Percent (line 30 to line 20)	3.7266%
32	Line 31 times line 29	.0008138%
33	Line 26 times line 19	$ 591,162
34	Line 32 times line 19	$ 1,801

HOSPITAL NO. III

CALCULATION OF INPATIENT ROUTINE SERVICE COST
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

	INPATIENT DAYS	
1	Total inpatient days - all patients	57,343
2	Total inpatient days - aged, pediatric, maternity	25,201
3	Total inpatient days - other	32,142
4	Inpatient days applicable to Title XVIII (Medicare)	15,909
5	Inpatient days - aged, pediatric, maternity plus 8½%	27,343
6	Total adjusted inpatient days	59,485
	INPATIENT ROUTINE COSTS	
7	Total inpatient routine nursing salary cost (excluding nursery)	$1,114,496
8	Total inpatient routine service costs excluding inpatient routine nursing salary cost on Line 7	$ 387,864
9	Total inpatient routine service costs (Line 7 + Line 8)	$1,502,360
10	Inpatient routine nursing salary cost plus 8½%	$1,209,228
	COMPUTATION OF INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)	
11	Adjusted average per diem inpatient routine nursing salary cost (Line 10 ÷ Line 6)	$ 20.3282
12	Average per diem inpatient routine nursing salary cost - unadjusted (Line 7 ÷ Line 1)	$ 19.4356
13	Average per diem inpatient routine nursing salary cost differential adjustment factor (Line 11 minus Line 12)	$ .8926
14	Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare (Line 4 x Line 13)	$ 14,200
	APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE) AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE	
	DEPARTMENTAL RCCAC	
15	Total billed inpatient charges (gross) for routine services all patients, excluding nursery	
16	Total billed inpatient charges (gross) for routine services Medicare	
17	Percent Medicare charges to total charges (Line 16 ÷ Line 15)	
18	Inpatient routine service cost applicable to Medicare	

ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)

11	Adjusted average per diem inpatient routine nursing salary cost (Line 10 ÷ Line 6)	$ 20.3282
12	Average per diem inpatient routine nursing salary cost - unadjusted (Line 7 ÷ Line 1)	$ 19.4356
13	Average per diem inpatient routine nursing salary cost differential adjustment factor (Line 11 minus Line 12)	$ .8926
14	Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare (Line 4 x Line 13)	$ 14,200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE) AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE

DEPARTMENTAL RCCAC

15	Total billed inpatient charges (gross) for routine services all patients, excluding nursery	
16	Total billed inpatient charges (gross) for routine services Medicare	
17	Percent Medicare charges to total charges (Line 16 ÷ Line 15)	
18	Inpatient routine service cost applicable to Medicare excluding inpatient routine nursing salary cost differential adjustment factor (Line 9 x Line 17)	
19	Total inpatient routine service cost applicable to Medicare (Line 14 + Line 18)	

COMBINATION METHOD

20	Inpatient routine average per diem cost (Line 9 ÷ Line 1)	$ 26.1995
21	Inpatient routine service cost applicable to Medicare excluding inpatient routine nursing salary cost differential adjustment factor (Line 4 x Line 20)	$ 416,808
22	Total inpatient routine service cost applicable to Medicare (Line 14 + Line 21)	$ 431,008

HOSPITAL NO. III

UNALLOWED EXPENSES
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

	Vending Machines	Gift Shop	Home
Unallowed Cost Center Expense After Depreciation Distribution	$ 10,469	$ 1,388	$ 13,147
Add:			
Administration & General	1,582	209	1,987
Operation of Plant	440	1,019	
Employee Health & Welfare			519
Cafetaria			80
Total Unallowed Expense	$ 12,491	$ 2,616	$ 15,733

HOSPITAL NO. IV

HOSPITAL NO. IV

SUMMARY OF REIMBURSEMENT
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

Total	Hospital Insurance Program	Supplementary Medical Insurance Program
$	$ 991,253	$ 3,677
		11,597
	801,019	5,373
$1,812,919	$1,792,272	$ 20,647

HOSPITAL NO. IV

CALCULATION OF REIMBURSEMENT - INPATII
EXCLUDING TITLE XVIII, PART
WEIGHTED AVERAGE IMPACT PROPC
1972

Cost Center	Total Billed Inpatient Charges All Patients	Total Billed Inpatient Charges Health Care Program	Perc Col. 2
Operating Room			
Delivery Room			
Anesthesia			
X-Ray			
Laboratory			
Blood Bank			
Oxygen Therapy			
Physical Therapy			
Cost of Medical Supplies			
Cost of Drugs Sold			
Subtotals	$2,919,051	$ 870,351	29.81
Inpatient Routine Service	$2,869,881	$ 977,528	
Total Inpatient Days			
Average Per Diem Cost			
Inpatient Routine Service Cost Subtotals	$5,788,932	$1,847,879	
Less: Amount Paid by Workman's Compensation			
Subtotals			
Less: Net Deductibles + Coinsurance			
Differential in Room Charge			
Net Cost of Covered Services			
Reimbursable Return on Equity			
Total Cost Reimbursable			

HOSPITAL NO. IV

LCULATION OF REIMBURSEMENT - INPATIENT SERVICES
EXCLUDING TITLE XVIII, PART B
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

Total Billed npatient Charges All Patients	Total Billed Inpatient Charges Health Care Program	Percent Col. 2 / Col. 1	Total Inpatient Expenses	Inpatient Expenses Applicable To Health Care Program Departmental Method	Combination Method
,919,051	$ 870,351	29.8162	$1,765,398		$ 526,375
,869,881	$ 977,528		$1,629,592		
			52,554		
			$ 31.0080		
					$ 572,994
,788,932	$1,847,879				$1,099,369
					-0-
					$1,099,369
					108,116
					-0-
					$ 991,253
					-0-
					$ 991,253

HOSPITAL NO. IV

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII, PART B
AND PART A OUTPATIENT
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

1	Total amount of outpatient charges (gross) all outpatients	$ 272,765
2	Total amount of outpatient charges (gross) Health Insurance Program outpatients	$ 17,303
3	Percent (Line 2 ÷ Line 1)	6.34356%
4	Total amount of hospital expenses for outpatient services	$ 163,620
5	Outpatient expenses applicable to Health Insurance Program	$ 10,379
6	Add: Cost of inpatient ancillary services covered by Supplementary Medical Insurance	$ 1,413
	Outpatient services rendered by hospital-based physicians	-0-
	Cost of ambulance services	-0-
7	Subtotal	$ 11,792
8	Less: Amounts paid and payable by Workman's Compensation	-0-
9	Subtotal	$ 11,792
10	Less: Deductibles billed to HI outpatients	$ 7,196
11	Net Cost (Line 9 minus Line 10)	$ 4,596
12	80% of Net Cost - reimbursable expenses - HI Program	3,677
13	Add: reimbursable return on equity capital	-0-
14	Subtotal	$ 3,677

REIMBURSABLE BAD DEBTS

15	Total applicable outpatient expenses (Line 9 above)	
16	Add: Return on equity capital (apportioned on basis of Line 15)	
17	Subtotal (Line 15 + Line 16)	
18	Amount received and to be received from intermediary	
19	Balance to be recovered from HI Program outpatients	
20	Deductibles and coinsurance billed	
21	Less: bad debts for deductibles and coinsurance, net of bad debt recoveries	
22	Net deductibles and coinsurance billed to HI Program outpatients	
23	Unrecovered from HI Program patients (Line 19 minus Line 22, if line 22 is greater than Line 19 enter zero and do not complete Lines 24, 25, 26)	
24	Gross bad debts (Line 21 or 23 whichever is lower)	
25	Bad debts applicable to professional component [illegible]	

NOT APPLICABLE

		$	11,792
10	Less: Deductibles billed to HI outpatients	$	7,196
11	Net Cost (Line 9 minus Line 10)	$	4,596
12	80% of Net Cost - reimbursable expenses - HI Program		3,677
13	Add: reimbursable return on equity capital		-0-
14	Subtotal	$	3,677
	REIMBURSABLE BAD DEBTS		
15	Total applicable outpatient expenses (Line 9 above)		
16	Add: Return on equity capital (apportioned on basis of Line 15)		
17	Subtotal (Line 15 + Line 16)		
18	Amount received and to be received from intermediary		NOT APPLICABLE
19	Balance to be recovered from HI Program outpatients		
20	Deductibles and coinsurance billed		
21	Less: bad debts for deductibles and coinsurance, net of bad debt recoveries		
22	Net deductibles and coinsurance billed to HI Program outpatients		
23	Unrecovered from HI Program patients (Line 19 minus Line 22, if line 22 is greater than Line 19 enter zero and do not complete Lines 24, 25, 26)		
24	Gross bad debts (Line 21 or 23 whichever is lower)		
25	Bad debts applicable to professional component and unallowed under Title XVIII		
26	Reimbursable bad debts (Line 24 minus Line 25)		
27	Inpatient services rendered by hospital-based radiologists and pathologists		-0-
28	Total (Line 14 + Line 26 + Line 27)	$	3,677

HOSPITAL NO. IV

CALCULATION OF REIMBURSEMENT SETTLEMENT, GENERAL SERVICE COST CENTER,
SUPPORT-RELATED EXPENSES
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

1	Administration and General	$ 503,182
2	Employee Health and Welfare	261,790
3	Operation of Plant	45,753
4	Maintenance of Plant	209,874
5	Laundry and Linen	117,356
6	Housekeeping	167,370
7	Dietary - Raw Food	389,378
8	Dietary - Other	
9	Cafeteria	
10	Maintenance of Personnel	
11	Medical Supplies and Expense	197,451
12	Pharmacy	294,206
13	Medical Records	93,927
14	Nursing School	48,274
15	Intern-Resident Service	133,668
16		
17	Total	$ 2,462,229
18	Less: Unallowed Expenses	-0-
19	Net Allowable Expenses	$ 2,462,229
20	Total Charges, All Patients	$ 6,110,045
21	Total Charges, All Inpatients	$ 5,837,280
22	Percent (line 21 to line 20)	95.5357%
23	Total Inpatient Days	52,554
24	Total Inpatient Days, Medicare	17,896
25	Percent (line 24 to line 23)	34.0525%
26	Line 25 times line 22	.3253229
27	Total Occasions of Service	22,545
28	Total Occasions of Service, Medicare	1.102
29	Percent (line 28 to line 27	4.8880%
30	Total Charges, All Outpatients	

13	Medical Records	93,927
14	Nursing School	48,274
15	Intern-Resident Service	133,668
16		
17	Total	$ 2,462,229
18	Less: Unallowed Expenses	-0-
19	Net Allowable Expenses	$ 2,462,229
20	Total Charges, All Patients	$ 6,110,045
21	Total Charges, All Inpatients	$ 5,837,280
22	Percent (line 21 to line 20)	95.5357%
23	Total Inpatient Days	52,554
24	Total Inpatient Days, Medicare	17,896
25	Percent (line 24 to line 23)	34.0525%
26	Line 25 times line 22	.3253229
27	Total Occasions of Service	22,545
28	Total Occasions of Service, Medicare	1.102
29	Percent (line 28 to line 27	4.8880%
30	Total Charges, All Outpatients	$ 272,765
31	Percent (line 30 to line 20)	4.4643%
32	Line 31 times line 29	.0021821%
33	Line 26 times line 19	$ 801,019
34	Line 32 times line 19	$ 5,373

HOSPITAL NO. IV

CALCULATION OF INPATIENT ROUTINE SERVICE COST
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

	INPATIENT DAYS	
1	Total inpatient days - all patients	52,554
2	Total inpatient days - aged, pediatric, maternity	24,111
3	Total inpatient days - other	28,443
4	Inpatient days applicable to Title XVIII (Medicare)	17,896
5	Inpatient days - aged, pediatric, maternity plus 8½%	26,160
6	Total adjusted inpatient days	54,603
	INPATIENT ROUTINE COSTS	
7	Total inpatient routine nursing salary cost (excluding nursery)	$1,202,857
8	Total inpatient routine service costs excluding inpatient routine nursing salary cost on Line 7	$ 426,735
9	Total inpatient routine service costs (Line 7 ÷ Line 8)	$1,629,592
10	Inpatient routine nursing salary cost plus 8½%	$1,305,100
	COMPUTATION OF INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)	
11	Adjusted average per diem inpatient routine nursing salary cost (Line 10 ÷ Line 6)	$ 23.90
12	Average per diem inpatient routine nursing salary cost (Line 7 ÷ Line 1)	$ 22.89
13	Average per diem inpatient routine nursing salary cost differential adjustment factor (Line 11 minus Line 12)	$ 1.01
14	Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare (Line 4 x Line 13)	$ 18,075
	APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE) AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE	
	DEPARTMENTAL RCCAC	
15	Total billed inpatient charges (gross) for routine services all patients, excluding nursery	
16	Total billed inpatient charges (gross) for routine services Medicare	
17	Percent Medicare charges to total charges (Line 16 ÷ Line 15)	
18	Inpatient routine service cost applicable to Medicare excluding inpatient	

ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)

11	Adjusted average per diem inpatient routine nursing salary cost (Line 10 ÷ Line 6)	$ 23.90
12	Average per diem inpatient routine nursing salary cost (Line 7 ÷ Line 1)	$ 22.89
13	Average per diem inpatient routine nursing salary cost differential adjustment factor (Line 11 minus Line 12)	$ 1.01
14	Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare (Line 4 x Line 13)	$ 18,075

APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE) AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE

DEPARTMENTAL RCCAC

15	Total billed inpatient charges (gross) for routine services all patients, excluding nursery	
16	Total billed inpatient charges (gross) for routine services Medicare	
17	Percent Medicare charges to total charges (Line 16 ÷ Line 15)	
18	Inpatient routine service cost applicable to Medicare excluding inpatient routine nursing salary cost differential adjustment factor (Line 9 x Line 17)	
19	Total inpatient routine service cost applicable to Medicare (Line 14 + Line 18)	

COMBINATION METHOD

20	Inpatient routine average per diem cost (Line 9 ÷ Line 1)	$ 31.0080
21	Inpatient routine service cost applicable to Medicare excluding inpatient routine nursing salary cost differential adjustment factor (Line 4 x Line 20)	$ 554,919
22	Total inpatient routine service cost applicable to Medicare (Line 14 + Line 21)	$ 572,994

HOSPITAL NO. IV

COMPUTATION OF INPATIENT HOSPITAL ANCILLARY SERVICES COVERED BY
SUPPLEMENTARY MEDICAL INSURANCE
(TITLE XVIII, PART B ONLY)
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

Cost Center	Total Billed Inpatient Charges All Patients	Total Billed Inpatient Charges Part B Title XVIII	Percent Column 2 / Column 1	Total Inpatient Expenses	Inpatient Expenses Applicable to Part B Title XVIII
	1	2	3	4	5
X-Ray	$ 234,426	$	$	$ 169,317	$
Laboratory	709,819			393,086	
Total	$ 944,245	$ 2,372 *	$ .2512%	$ 562,403	$ 1,413

* Estimated by hospital, per Exhibit F, SSA 1972, as submitted to fiscal intermediary.

HOSPITAL NO. IV

SUPPLEMENTARY COST FORM
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

CALCULATION OF REIMBURSEMENT SETTLEMENT (RESIDENTS AND INTERNS NOT UNDER APPROVED TEACHING PROGRAM) - INPATIENT AND OUTPATIENT SERVICES - MEDICAL PLAN (PART B)

AMOUNT OF EXPENSES - SUBJECT SERVICES

1	Salaries	$ 46,305

ALLOCATION OF TOTAL AMOUNT OF EXPENSES BASIS OF TIME

2	Inpatient services 91.3% x Line 1	$ 42,276
3	Outpatient services 8.7% x Line 1	$ 4,029
4	Total services 100% x Line 1	$ 46,305

APPORTIONMENT OF EXPENSES - INPATIENT SERVICES

5	Total inpatient days - all patients (including 1/3 of newborn days)	53,128
6	Average expense for inpatient day (Line 2 ÷ Line 5)	$ .7957
7	Inpatient days - Health Care Program	17,896
8	Expenses - inpatient services - Health Care Program (Line 6 x Line 7)	$ 14,240

APPORTIONMENT OF EXPENSES - OUTPATIENT SERVICES

9	Percent - HI Program outpatient services received - sum of HI Program Part A and Part B outpatient charges / total outpatient charges - all patients	6.34356%
10	Expenses - outpatient services HI Program (Line 9 x Line 3)	$ 256

SUMMARY

11	Total expenses - services - HI Program (Line 8 + Line 10)	$ 14,496
12	Less: Deductibles billed to Health Insurance Program patients	-0-
13	Net Cost	$ 14,496
14	80% of net expenses - services - HI Program	$ 11,597
15	Add: bad debts for subject services, net of bad debt recoveries (HI Program - Part B beneficiaries)	-0-
16	Total	$ 11,597

	[redacted]	$	.7957
	Inpatient days - Health Care Program		17,896
8	Expenses - inpatient services - Health Care Program (Line 6 x Line 7)	$	14,240
	APPORTIONMENT OF EXPENSES - OUTPATIENT SERVICES		
9	Percent - HI Program outpatient services received - sum of HI Program Part A and Part B outpatient charges total outpatient charges - all patients		6.34356%
10	Expenses - outpatient services HI Program (Line 9 x Line 3)	$	256
	SUMMARY		
11	Total expenses - services - HI Program (Line 8 + Line 10)	$	14,496
12	Less: Deductibles billed to Health Insurance Program patients		-0-
13	Net Cost	$	14,496
14	80% of net expenses - services - HI Program	$	11,597
15	Add: bad debts for subject services, net of bad debt recoveries (HI Program - Part B beneficiaries)		-0-
16	Total	$	11,597

HOSPITAL NO. V

HOSPITAL NO. V

SUMMARY OF REIMBURSEMENT
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

Total	Hospital Insurance Program	Supplementary Medical Insurance Program
$	$ 735,343	$ 32,262
		12,156
	547,543	9,866
$1,337,170	$1,282,886	$ 54,284

HOSPITAL NO. V

CALCULATION OF REIMBURSEMENT - INPAT
EXCLUDING TITLE XVIII, PAR
WEIGHTED AVERAGE IMPACT PRO
1972

Cost Center	Total Billed Inpatient Charges All Patients	Total Billed Inpatient Charges Health Care Program	Col. 2	Per
Operating Room				
Delivery Room				
Anesthesia				
X-Ray				
Laboratory				
Blood Bank				
Oxygen Therapy				
Physical Therapy				
Cost of Medical Supplies				
Cost of Drugs Sold				
Subtotals	$3,467,396	$ 865,923		.249
Inpatient Routine Service	$3,076,391	$ 847,655		
Total Inpatient Days				
Average Per Diem Cost				
Inpatient Routine Service Cost				
Subtotals	$6,543,787	$1,713,578		
Less: Amount Paid by Workman's Compensation				
Subtotals				
Less: Net Deductibles + Coinsurance				
Differential in Room Charge				
Net Cost of Covered Services				
Reimbursable Return on Equity				
Total Cost Reimbursable				

HOSPITAL NO. V

ALCULATION OF REIMBURSEMENT - INPATIENT SERVICES
EXCLUDING TITLE XVIII, PART B
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

Total Billed Inpatient Charges All Patients	Total Billed Inpatient Charges Health Care Program	Percent Col. 2 / Col. 1	Total Inpatient Expenses	Inpatient Expenses Applicable To Health Care Program Departmental Method	Combination Method
467,396	$ 865,923	.24973	$1,592,404		$ 397,671
076,391	$ 847,655		$1,552,721		
			64,339		
			$ 24.1334		
					$ 443,104
543,787	$1,713,578				$ 840,775
					-0-
					$ 840,775
					$ 105,432
					-0-
					$ 735,343
					-0-
					$ 735,343

HOSPITAL NO. V

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII, PART B
AND PART A OUTPATIENT
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

1	Total amount of outpatient charges (gross) all outpatients	$ 695,444
2	Total amount of outpatient charges (gross) Health Insurance Program outpatients	$ 30,639
3	Percent (Line 2 ÷ Line 1)	4.4056%
4	Total amount of hospital expenses for outpatient services	$ 226,252
5	Outpatient expenses applicable to Health Insurance Program	$ 9,968
6	Add: Cost of inpatient ancillary services covered by Supplementary Medical Insurance	$ 272
	Outpatient services rendered by hospital-based physicians	$ 375
	Cost of ambulance services	-0-
7	Subtotal	$ 10,615
8	Less: Amounts paid and payable by Workman's Compensation	-0-
9	Subtotal	$ 10,615
10	Less: Deductibles billed to HI outpatients	$ 15,712
11	Net Cost (Line 9 minus Line 10)	$ (5,097)
12	80% of Net Cost - reimbursable expenses - HI Program	$ (4,078)
13	Add: reimbursable return on equity capital	-0-
14	Subtotal	$ (4,078)
	REIMBURSABLE BAD DEBTS	
15	Total applicable outpatient expenses (Line 9 above)	$ 10,615
16	Add: Return on equity capital (apportioned on basis of Line 15)	-0-
17	Subtotal (Line 15 + Line 16)	$ 10,615
18	Amount received and to be received from intermediary	$ (5,317)
19	Balance to be recovered from HI Program outpatients	$ (15,932)
20	Deductibles and coinsurance billed	$ 18,851
21	Less: bad debts for deductibles and coinsurance, net of bad debt recoveries	-0-
22	Net deductibles and coinsurance billed to HI Program outpatients	$ 18,851
23	Unrecovered from HI Program patients (Line 19 minus Line 22, if Line 22 is greater than Line 19 enter zero and do not complete Lines 24, 25, 26)	-0-
24	Gross bad debts (Line 21 or 23 whichever is lwer)	-0-
25	Bad debts applicable to professional	

		$ 10,615
10	Less: Deductibles billed to HI outpatients	$ 15,712
11	Net Cost (Line 9 minus Line 10)	$ (5,097)
12	80% of Net Cost - reimbursable expenses - HI Program	$ (4,078)
13	Add: reimbursable return on equity capital	-0-
14	Subtotal	$ (4,078)
	REIMBURSABLE BAD DEBTS	
15	Total applicable outpatient expenses (Line 9 above)	$ 10,615
16	Add: Return on equity capital (apportioned on basis of Line 15)	-0-
17	Subtotal (Line 15 + Line 16)	$ 10,615
18	Amount received and to be received from intermediary	$ (5,317)
19	Balance to be recovered from HI Program outpatients	$ (15,932)
20	Deductibles and coinsurance billed	$ 18,851
21	Less: bad debts for deductibles and coinsurance, net of bad debt recoveries	-0-
22	Net deductibles and coinsurance billed to HI Program outpatients	$ 18,851
23	Unrecovered from HI Program patients (Line 19 minus Line 22, if Line 22 is greater than Line 19 enter zero and do not complete Lines 24, 25, 26)	-0-
24	Gross bad debts (Line 21 or 23 whichever is lwer)	-0-
25	Bad debts applicable to professional component and unallowed under Title XVIII	-0-
26	Reimbursable bad debts (Line 24 minus Line 25)	-0-
27	Inpatient services rendered by hospital-based radiologists and pathologists	$ 36,340
28	Total (Line 14 + Line 26 + Line 27)	$ 32,262

HOSPITAL NO. V

CALCULATION OF REIMBURSEMENT SETTLEMENT, GENERAL SERVICE COST CENTER,
SUPPORT-RELATED EXPENSES
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

1	Administration and General	$ 741,247
2	Employee Health and Welfare	54,961
3	Operation of Plant	216,227
4	Maintenance of Plant	
5	Laundry and Linen	93,882
6	Housekeeping	177,391
7	Dietary - Raw Food	395,742
8	Dietary - Other	
9	Cafeteria	
10	Maintenance of Personnel	
11	Medical Supplies and Expense	123,327
12	Pharmacy	308,289
13	Medical Records	84,770
14		
15		
16		
17	Total	$ 2,195,836
18	Less: Unallowed Expenses	$ 646
19	Net Allowable Expenses	$ 2,195,190
20	Total Charges, All Patients	$ 7,426,083
21	Total Charges, All Inpatients	$ 6,730,639
22	Percent (line 21 to line 20)	90.6351%
23	Total Inpatient Days	64,339
24	Total Inpatient Days, Medicare	17,701
25	Percent (line 24 to line 23	24.5120%
26	Line 25 times line 23	24.9355
27	Total Occasions of Service	29,323
28	Total Occasions of Service, Medicare	1,407
29	Percent (line 28 to line 27)	4.7982
30	Total Charges, All Outpatients	$ 695,444

		84,770
15		
16		
17	Total	$ 2,195,836
18	Less: Unallowed Expenses	$ 646
19	Net Allowable Expenses	$ 2,195,190
20	Total Charges, All Patients	$ 7,426,083
21	Total Charges, All Inpatients	$ 6,730,639
22	Percent (line 21 to line 20)	90.6351%
23	Total Inpatient Days	64,339
24	Total Inpatient Days, Medicare	17,701
25	Percent (line 24 to line 23	24.5120%
26	Line 25 times line 23	24.9355
27	Total Occasions of Service	29,323
28	Total Occasions of Service, Medicare	1,407
29	Percent (line 28 to line 27)	4.7982
30	Total Charges, All Outpatients	$ 695,444
31	Percent (line 30 to line 20)	9.3649%
32	Line 31 times line 29	.4493
33	Line 26 times line 19	$ 547,543
34	Line 32 times line 19	$ 9,866

HOSPITAL NO. V

CALCULATION OF INPATIENT ROUTINE SERVICE COST
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

	INPATIENT DAYS	
1	Total inpatient days - all patients	64,339
2	Total inpatient days - aged, pediatric, maternity	25,417
3	Total inpatient days - other	38,922
4	Inpatient days applicable to Title XVIII (Medicare)	17,701
5	Inpatient days - aged, pediatric, maternity plus 8½%	27,577
6	Total Adjusted inpatient days	66,499
	INPATIENT ROUTINE COSTS	
7	Total inpatient routine nursing salary cost (excluding nursery)	$1,762,826
8	Total inpatient routine service costs excluding inpatient routine nursing salary cost on Line 7	$ 389,895
9	Total inpatient routine service costs (Line 7 + Line 8)	$1,552,721
10	Inpatient routine nursing salary cost plus 8½%	$1,261,666
	COMPUTATION OF INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)	
11	Adjusted average per diem inpatient routine nursing salary cost (Line 10 ÷ Line 6)	$ 18.9727
12	Average per diem inpatient routine nursing salary cost - unadjusted (Line 7 ÷ Line 1)	$ 18.0734
13	Average per diem inpatient routine nursing salary cost differential adjustment factor (Line 11 minus Line 12)	$ .8993
14	Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare (Line 4 x Line 13)	$ 15,919
	APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE) AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE	
	DEPARTMENTAL RCCAC	
15	Total billed inpatient charges (gross) for routine services all patients, excluding nursery	
16	Total billed inpatient charges (gross) for routine services Medicare	
17	Percent Medicare charges to total charges (Line 16 ÷ Line 15)	

[redacted] ROUTINE NURSING SALARY COST DIFFERENTIAL
ADJUSTMENT FACTOR APPLICABLE TO TITLE XVIII (MEDICARE)

11	Adjusted average per diem inpatient routine nursing salary cost (Line 10 ÷ Line 6)	$ 18.9727
12	Average per diem inpatient routine nursing salary cost - unadjusted (Line 7 ÷ Line 1)	$ 18.0734
13	Average per diem inpatient routine nursing salary cost differential adjustment factor (Line 11 minus Line 12)	$ .8993
14	Inpatient routine nursing salary cost differential adjustment factor applicable to Medicare (Line 4 x Line 13)	$ 15,919

APPORTIONMENT OF INPATIENT ROUTINE SERVICE COST TO TITLE XVIII (MEDICARE)
AND COMPUTATION OF TOTAL ROUTINE COST APPLICABLE TO MEDICARE

DEPARTMENTAL RCCAC

15	Total billed inpatient charges (gross) for routine services all patients, excluding nursery	
16	Total billed inpatient charges (gross) for routine services Medicare	
17	Percent Medicare charges to total charges (Line 16 ÷ Line 15)	
18	Inpatient routine service cost applicable to Medicare excluding inpatient routine nursing salary cost differential adjustment factor (Line 9 x Line 17)	
19	Total inpatient routine service cost applicable to Medicare (Line 14 + Line 18)	

COMBINATION METHOD

20	Inpatient routine average per diem cost (Line 9 ÷ Line 1)	$ 24.1334
21	Inpatient routine service cots applicable to Medicare excluding inpatient routine nursing salary cost differential adjustment factor (Line 4 x Line 20)	$ 427,185
22	Total inpatient routine service cost applicable to Medicare (Line 14 + Line 21)	$ 443,104

HOSPITAL NO. V

SUPPLEMENTARY COST FORM
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

CALCULATION OF REIMBURSEMENT SETTLEMENT (RESIDENTS AND INTERNS NOT UNDER APPROVED TEACHING PROGRAM - INPATIENT AND OUTPATIENT SERVICES - MEDICAL PLAN (PART B)

AMOUNT OF EXPENSES - SUBJECT SERVICES

1	Salaries	$	229,352

ALLOCATION OF TOTAL AMOUNT OF EXPENSES BASIS OF TIME

2	Inpatient services 9.95% x Line 1	$	22,821
3	Outpatient services 90.05% x Line 1	$	206,531
4	Total services 100% x Line 1	$	229,352

APPORTIONMENT OF EXPENSES - INPATIENT SERVICES

5	Total inpatient days - all patients (including 1/3 of newborn days)		66,269
6	Average expense for inpatient day (Line 2 ÷ Line 5)	$	.34437
7	Inpatient days - Health Care Program		17,701
8	Expenses - inpatient services - Health Care Program (Line 6 x Line 7)	$	6,096

APPORTIONMENT OF EXPENSES - OUTPATIENT SERVICES

9	Percent - HI Program outpatient services received - sum of HI Program Part A and Part B outpatient charges total outpatient charges - all patients		4.4056%
10	Expenses - outpatient services - HI Program (Line 9 x Line 3)	$	9,099

SUMMARY

11	Total expenses - services - HI Program (Line 8 + Line 10)	$	15,195
12	Less: Deductibles billed to Health Insurance Program patients		-0-
13	Net Cost	$	15,195
14	80% of Net Expenses - services - HI Program	$	12,156
15	Add: bad debts for subject services, net of bad debt recoveries (HI Program - Part B beneficiaries)		-0-
16	Total	$	12,156

	Average expense for inpatient day (Line 2 ÷ Line 5)	$	66,289 .34437
7	Inpatient days - Health Care Program		17,701
8	Expenses - inpatient services - Health Care Program (Line 6 x Line 7)	$	6,096
	APPORTIONMENT OF EXPENSES - OUTPATIENT SERVICES		
9	Percent - HI Program outpatient services received - sum of HI Program Part A and Part B outpatient charges total outpatient charges - all patients		4.4056%
10	Expenses - outpatient services - HI Program (Line 9 x Line 3)	$	9,099
	SUMMARY		
11	Total expenses - services - HI Program (Line 8 + Line 10)	$	15,195
12	Less: Deductibles billed to Health Insurance Program patients		-0-
13	Net Cost	$	15,195
14	80% of Net Expenses - services - HI Program	$	12,156
15	Add: bad debts for subject services, net of bad debt recoveries (HI Program - Part B beneficiaries)		-0-
16	Total	$	12,156

HOSPITAL NO. V

UNALLOWED EXPENSES
WEIGHTED AVERAGE IMPACT PROPOSAL
1972

	Gift Shop		
Unallowed Cost Center Expense After Depreciation Distribution	$ 394	$	$
Add:			
Administration & General	32	(.00826%	X 391,073)
Purchasing	5	(.0148%	X 30,697)
Operation of Plant	215	(.2476%	X 86,677)
Total Unallowed Expense	$ 646	$	$

APPENDIX III

RESULTS OF

MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS

GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT

VERSUS PATIENT DAYS AND OCCASIONS OF SERVICE

HOSPITAL NO. I

HOSPITAL NO. I

RESULTS OF MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS
GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT, VERSUS
PATIENT DAYS AND OCCASIONS OF SERVICE
1972

Cost Center	α	β	s_β	β t-test	γ	s_γ	γ t-test
Administration & General	1,623,880	(20.3470)	6.1901	(3.2870)	15.2466	9.6578	1.5787
Employee Health & Welfare	1,045,370	(13.6642)	.6570	(20.7978)	1.1557	1.0250	1.1274
Operation of Plant	365,060	(1.7221)	.7623	(2.2589)	(3.3185)	1.1894	(2.7901)
Laundry	63,895	(.1694)	.5745	(.2949)	1.1915	.8964	1.3293
Housekeeping	311,847	(2.7458)	.8540	(3.2153)	.9575	1.3324	.7186
Dietary	184,579	.9187	1.1555	.7951	2.4004	1.8028	1.3315
Medical Supplies & Expense	51,941	.8059	1.2849	.6272	(.1440)	2.0046	(.0272)
Pharmacy	526,751	7.9176	1.9124	(3.7838)	9.2367	2.9837	3.0957
Medical Records	197,699	(2.4543)	.6510	(3.7700)	1.3865	1.0157	1.3651
Nursing School	(360,052)	7.9176	3.2177	2.4607	(3.9236)	5.0202	(.7816)
Intern-Resident Service	(256,995)	1.4216	2.6714	.5322	12.8562	4.1679	3.0846

HOSPITAL NO. I

RESULTS OF MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS
GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT, VERSUS
PATIENT DAYS AND OCCASIONS OF SERVICE
1972

Cost Center	s_e	F Ratio	R	r
Administration & General	65,103.7	5.6070	.7889	.8882
Employee Health & Welfare	6,909.9	336.0260	.9956	.9978
Operation of Plant	8,017.7	17.3289	.9203	.9593
Laundry	6,042.4	1.1298	.4296	.6555
Housekeeping	8,981.7	6.5983	.8148	.9026
Dietary	12,152.5	3.1105	.6747	.8214
Medical Supplies & Expense	13,513.2	.2841	.1592	.3990
Pharmacy	20,113.4	7.5740	.8347	.9136
Medical Records	6,846.8	7.9629	.8415	.8375
Intern-Resident Service	28,095.8	9.8681	.8681	.9317

HOSPITAL NO. II

HOSPITAL NO. II

RESULTS OF MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS
GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT, VERSUS
PATIENT DAYS AND OCCASIONS OF SERVICE
1972

Cost Center	α	β	s_β	β t-test	γ	s_γ	γ t-test
Administration & General	2,971,350	(123.2470)	16.1602	(7.6266)	(8.5771)	2.8444	(3.0154)
Maintenance of Plant	480,901	(20.1232)	7.4136	2.7144	(1.7393)	1.3049	(1.3329)
Housekeeping	(168,685)	7.9536	4.9212	1.6162	1.6502	.8662	1.9051
Dietary - Raw Food	263,342	(9.7388)	3.7749	(2.5799)	(.2745)	.6644	(.4132)
Dietary - Other	876,955	(36.7332)	9.2744	(3.9607)	(3.2202)	1.6324	(1.9727)
Medical Supplies & Expense	1,899,370	(80.2549)	20.5953	(3.8968)	(8.4733)	3.6250	(2.3374)
Pharmacy	1,368,900	(69.5371)	25.7897	(2.6963)	(4.4443)	4.5393	(.9791)
Medical Records	1,149,100	(49.4882)	14.7674	(3.3512)	(4.4161)	2.5993	(1.6990)
Intern-Resident Service	480,239	(20.4642)	3.1271	(6.5442)	(1.0427)	.5504	(1.8944)

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HOSPITAL NO. II

RESULTS OF MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS
GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT, VERSUS
PATIENT DAYS AND OCCASIONS OF SERVICE
1972

Cost Center	s_e	F Ratio	R	r
Administration & General	13,155.6	34.1790	.9580	.9788
Maintenance of Plant	6,035.3	4.6584	.7564	.8697
Housekeeping	4,006.3	3.1937	.6804	.8249
Dietary - Raw Food	3,073.0	3.4398	.6963	.8345
Dietary - Other	7,550.1	9.9754	.8693	.9324
Medical Supplies & Expense	16,766.1	10.5405	.8754	.9356
Pharmacy	20,994.8	4.1776	.7358	.8578
Medical Records	12,021.8	7.1970	.8275	.9097
Intern-Resident Service	2,545.7	23.5072	.9400	.9695

HOSPITAL NO. III

HOSPITAL NO. III

RESULTS OF MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS
GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT, VERSUS
PATIENT DAYS AND OCCASIONS OF SERVICE
1972

Cost Center	α	β	s_β	β t-test	γ	s_γ	γ t-test
Administration & General	(394,860)	18.1919	11.8085	1.5406	5.9696	26.0634	.2290
Employee Health & Welfare	(111,121)	3.6549	17.8225	.2051	18.2361	39.3372	.4636
Operation & Maintenance of Plant	127,413	(2.9862)	2.4841	(1.2021)	17.4148	5.4829	3.1762
Laundry	239,098	(7.3714)	4.9223	(1.4976)	15.4097	10.8643	1.4184
Housekeeping	93,651	(1.7641)	5.3233	(.3314)	12.7179	11.7495	1.0824
Dietary	(175,432)	10.2470	2.5626	3.9987	(7.5246)	5.6560	(1.3304)
Medical Supplies & Expense	56,829	(.6480)	11.4434	(.0566)	9.1899	25.2574	.3639
Pharmacy	(82,624)	4.1284	6.0728	.6798	5.9174	13.4037	.4415
Medical Records	(59,895)	2.4466	3.5214	.6948	.0638	7.7724	.0082

HOSPITAL NO. III

RESULTS OF MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS
GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT, VERSUS
PATIENT DAYS AND OCCASIONS OF SERVICE
1972

Cost Center	s_e	F Ratio	R	r
Administration & General	19,877.6	219.5590	.9932	.9966
Employee Health & Welfare	30,001.0	31.3248	.9543	.9769
Operation and Maintenance of Plant	4,181.6	275.3600	.9946	.9973
Laundry	8,285.8	1.5038	.5006	.7076
Dietary	4,313.6	502.2750	.9970	.9985
Medical Supplies & Expense	19,262.9	6.6335	.8156	.9031
Pharmacy	10,222.5	88.0722	.9833	.9916
Medical Records	5,927.7	33.0780	.9566	.9781

HOSPITAL NO. IV

HOSPITAL NO. IV

RESULTS OF MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS
GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT, VERSUS
PATIENT DAYS AND OCCASIONS OF SERVICE
1972

Cost Center	α	β	s_β	β t-test	γ	s_γ	γ t-test
Administration & General	1,377,230	(14.1439)	7.0785	(1.9982)	(6.9639)	5.7852	(1.2038)
Employee Health & Welfare	1,432,420	(21.2888)	11.2197	(1.8975)	(3.7200)	9.1697	(.4057)
Operation of Plant	144,970	(1.6656)	.4677	(3.5612)	(.6051)	.3822	(1.5829)
Maintenance of Plant	865,835	(12.6043)	1.7300	(7.2860)	.5473	1.4139	.3871
Laundry	(361,810)	5.5280	1.4047	3.9354	8.4827	1.1480	7.3890
Housekeeping	567,754	(8.2671)	1.8377	(4.4986)	1.7325	1.5019	1.1535
Dietary	866,795	(14.2825)	7.7376	(1.8459)	13.1548	6.3239	2.0802
Medical Supplies & Expense	1,158,640	(18.2897)	3.3426	(5.4717)	(.6730)	2.7319	(.2463)
Pharmacy	950,865	(14.4253)	3.8066	(3.7896)	4.5369	3.1110	1.4583
Medical Records	294,811	(3.9355)	1.4718	(2.6739)	.0401	1.2029	.0334
Nursing School	105,342	(1.1496)	.3788	(3.0344)	.1504	.3096	.4858
Intern-Resident Service	503,549	(6.8806)	2.8283	(2.4328)	(.8949)	2.3115	(.3871)

HOSPITAL NO. IV

RESULTS OF MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS
GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT, VERSUS
PATIENT DAYS AND OCCASIONS OF SERVICE
1972

Cost Center	s_e	F Ratio	R	r
Administration & General	33,992.3	2.0315	.5752	.7585
Employee Health & Welfare	53,879.0	1.9755	.5684	.7539
Operation of Plant	2,246.0	6.3558	.8091	.8995
Maintenance of Plant	8,307.5	36.6668	.9607	.9802
Laundry	6,745.5	27.3748	.9481	.9737
Housekeeping	8,825.0	17.4344	.9208	.9596
Dietary	37,157.6	7.5131	.8336	.9130
Medical Supplies & Expense	16,051.7	18.7917	.9261	.9623
Pharmacy	18,279.8	14.3216	.9052	.9514
Medical Records	7,067.8	4.7409	.7596	.8716
Nursing School	1,819.3	7.1251	.8261	.9089
Intern-Resident Service	13,582.0	3.3746	.6923	.8320

HOSPITAL NO. V

HOSPITAL NO. V

RESULTS OF MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS
GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT, VERSUS
PATIENT DAYS AND OCCASIONS OF SERVICE
1972

Cost Center	α	β	s_β	β t-test	γ	s_γ	γ t-test
Administration & General	81,243	14.8080	3.2656	4.5346	(12.1299)	7.2314	(1.6774)
Employee Health & Welfare	(11,207)	1.5419	.1744	8.8392	(1.2723)	.3863	(3.2938)
Operation of Plant	(12,860)	4.9121	.0704	69.7798	(2.9115)	.1559	(18.6777)
Laundry	(10,481)	2.0378	.0971	20.9892	(.9009)	.2150	(4.1904)
Housekeeping	(10,050)	3.5386	.2101	16.8455	(1.5353)	.4652	(3.3005)
Dietary	(59,272)	7.7757	1.0880	7.1469	(2.3119)	2.4092	(.9596)
Medical Supplies & Expense	(12,098)	1.3640	.9889	1.3792	.8174	2.1899	.3733
Pharmacy	(44,829)	7.1019	.6877	10.3271	(4.0972)	1.5229	(2.6905)
Medical Records	(9,260)	1.8670	.6028	3.0970	(1.4101)	1.3349	(1.0563)

HOSPITAL NO. V

RESULTS OF MULTIPLE LINEAR REGRESSION AND CORRELATION ANALYSIS
GENERAL SERVICE COST CENTER EXPENSES, BY DEPARTMENT, VERSUS
PATIENT DAYS AND OCCASIONS OF SERVICE
1972

Cost Center	s_e	F Ratio	R	r
Administration & General	71,157.5	15.8112	.9134	.9557
Employee Health & Welfare	3,801.0	59.8162	.9755	.9877
Operation of Plant	1,533.9	4,431.9900	.9997	.9998
Laundry	2,115.5	449.6330	.9967	.9983
Housekeeping	4,577.3	291.4430	.9949	.9974
Dietary	23,707.2	58.1864	.9749	.9876
Medical Supplies & Expense	21,548.7	4.0779	.7311	.8550
Pharmacy	14,985.0	98.2439	.9850	.9925
Medical Records	13,135.5	7.7290	.8375	.9151

BIBLIOGRAPHY

Books

American Hospital Association. Chart of Accounts for Hospitals. Chicago: The Association, 1968.

American Hospital Association. Cost Finding and Rate Setting for Hospitals. Chicago: The Association, 1968.

American Hospital Association. Hospitals, Journal of the American Hospital Association, August 1 Guide Issue; Part Two. Chicago: The Association (Annual).

American Hospital Association. Hospital Statistics 1974 Edition. Chicago: The Association, 1974.

Commerce Clearing House. Medicare and Medicaid Guide. Chicago: Commerce Clearing House, 1969.

Hay, Leon E. Budgeting and Cost Analysis for Hospital Management. 2nd ed. Bloomington, Indiana: Pressler Publications, 1963.

Klarman, Herbert E., ed. Empirical Studies in Health Economics. Baltimore, Maryland: The Johns Hopkins Press, 1970.

_____. The Economics of Health. New York, New York: Columbia University Press, 1965.

Myers, Robert J. Medicare. Homewood, Illinois: Richard D. Irwin, Inc., 1970.

Seawell, L. Vann, etal. Hospital Accounting and Financial Management. Berwyn, Illinois: Physicians' Record Company, 1964.

Somers, Herman M., and Somers, Anne R. Doctors, Patients, and Health Insurance, The Organization and Financing of Medical Care. Washington, D.C.: The Brookings Institution, 1961.

_____. Medicare and the Hospitals: Issues and Prospects. Washington, D.C.: The Brookings Institution, 1967.

Taylor, Philip J., and Nelson, Benjamin O. Management Accounting for Hospitals. Philadelphia, Pennsylvania: Saunders, 1964.

U.S. Department of Health, Education, and Welfare. Medicare 1968. Washington, D.C.: U.S. Government Printing Office, 1972.

U.S. Department of Health, Education, and Welfare. Provider Reimbursement Manual Under Health Insurance for the Aged. Washington, D.C.: U.S. Government Printing Office, 1969.

U.S. Department of Health, Education, and Welfare. Report of the Secretary's Advisory Committee on Hospital Effectiveness. Washington, D.C.: U.S. Government Printing Office, 1968.

U.S. Department of Health, Education, and Welfare. Vital and Health Statistics. Series 10, No. 32, June, 1966.

U.S. Government. Report of the National Advisory Commission on Health Manpower. Volumes 1 and 2. Washington, D.C.: U.S. Government Printing Office, 1967.

U.S. Government. Report of the National Conference on Medical Costs. Washington, D.C.: U.S. Government Printing Office, 1968.

U.S. Government. Reimbursement Incentives for Hospitals and Medical Care: Objectives and Alternatives. Washington, D.C.: U.S. Government Printing Office, 1968.

Articles

Administrative Reviews. Hospitals. Chicago: American Hospital Association (Annually).

Allen, Richard G. "Professional Management in Today's Nursing Home." Hospital Accounting, May, 1966.

Anderson, Charles H., ed. "Post All Charges for Medicare and for You." Hospital Accounting, June, 1966.

Armstrong, Edward J. "The Relationship of the Hospital to the CPA Firm." Hospital Financial Management, September, 1968.

Assunta, Sr. Mary. "Reimbursement Under Medicare for Services of Hospital Based Physicians." Hospital Accounting, June, 1966.

Bertrand, Sr. M. "A Fellow Comments." Hospital Accounting, September, 1966.

Blanco, J., Jr. "Streamlined Billing for Medicare Outpatients." Hospitals, August 1, 1969.

Burns, Christopher E. "Revision of Asset Useful Lives." Hospital Accounting, December, 1967.

Caruana, Russell. "How to Maximize Reimbursement Through Reclassification Entries." Hospital Financial Management, November, 1971.

"Charts for Basic Options of Providers of Service Under Principles of Reimbursement." Hospital Accounting, June, 1967.

Clancy, Joseph D. "Hospital Statistics and Utilization Review." Hospital Accounting, June, 1966.

_____. "PIP-A Point of View." Hospital Accounting, March, 1968.

Coats, Robert. "Hospital Expense Auditing Techniques." Hospital Financial Management, December, 1968.

Coldewey, George T. "Depreciation Under Medicare." Hospital Accounting, June, 1966.

Cotner, Raymond W. "Accumulating Medicare Revenue." Hospital Accounting, February, 1967.

Cowan, G. T. "Reimbursement for Sisters' Maintenance; Compensation for Services of Sister-Visitors." Hospital Progress, March, 1968.

DeWaal, Stanley. "Lack of Incentives Under Medicare." Hospital Accounting, February, 1968.

Drake, D. F. "Cost Incentive Formulas." Texas Hospitals, August, 1968.

Drebin, M. E. "Financing Capital Equipment Under Medicare." Hospital Progress, June, 1969.

Elnicki, Richard A. "Accelerated Depreciation: Best for 'Growth' Hospitals." Hospital Financial Management, March, 1969.

Fahey, C. A. "Putting Medicare Cost Finding to Work for Hospital Management." Hospital Financial Management, May, 1969.

Fanning, David J. "Cost Refining Needed." Hospital Accounting, April, 1967.

Felsenthal, David S. "Beyond Medicare-Hospital Property Records as Management Control Tools." Hospital Financial Management, March, 1969.

_____. "Maximum Depreciation Benefits from Good Property Records." Hospital Accounting, June, 1966.

_____. "Ready for Medicare Auditors? Five Checkpoints for Property Records." Hospital Financial Management, December, 1969.

Forsberg, Robert. "Leasing--Economic and Medicare Aspects." Hospital Financial Management, June, 1969.

Freitag, William. "Grants, Donations, Fund Accounting, and Medicare." Hospital Accounting, June, 1966.

_____. "Medicare and Hospital Management." Southern Hospitals, January, 1968.

_____. "Medicare and the Hospital Revolution." Journal of Accountancy, January, 1969.

Freysinger, J. J. "Complexities of Contractual Reimbursement." Michigan Hospitals, January, 1968.

Hinderer, Harold. "Medicare and the Crystal Ball." Hospital Accounting, June, 1966.

Holmes, A. R. "Cost Containment Program for Maryland Hospi-Hospitals." Hospital Financial Management, May, 1969.

Jordan, James R. "Outpatient Services Under Medicare." Hospital Accounting, June, 1966.

Kovener, R. R. "Accelerated vs. Straight Line Depreciation." Hospital Accounting, November, 1966.

Krizman, Frederick E. "Medicare Side Effects." Hospital Accounting, January, 1966.

Laetz, Ernest C. "The Birth and Purpose of a Utilization Committee." (Part I). Hospital Accounting, January, 1967.

_____. "The Birth and Purpose of a Utilization Committee." (Part II). Hospital Accounting, February, 1967.

La' Frombois, Edward L. "Keys to Effective Financial Management for the Small Hospital." Hospital Financial Management, November, 1968.

Lamson, Ernest L. "Use of Estimated Percentages for Medicare Reimbursement." Hospital Financial Management, February, 1969.

LeBlanc, Lawrence. "Maximizing Medicare Reimbursement." Hospital Financial Management, November, 1968.

Leveson, I. "Medical Care Cost Incentives: Some Questions and Approaches for Research." Inquiry, December, 1968.

Levi, Joseph. "Medicare Reimbursement Formula . . . . A Dissent." Hospital Accounting, September, 1966.

Link, Hans M., and Plaster, Jerry G. "How to Maximize Medicare Reimbursement." Hospital Accounting, September, 1967.

Martin, Lawrence E. "Financing Hospital Care in the Third Party Era." Hospital Accounting, November, 1967.

May, D. P. "Incentive Program to Contain Costs in Connecticut Hospitals." Hospital Financial Management, May, 1969.

"Medicare Questions and Answers." Hospital Accounting, September, 1966.

Michela, William A. "An Ounce of Prevention." Hospital Accounting, June, 1966.

Miller, Ralph F. "Checklist for Hospital Administration." Hospital Accounting, June, 1966.

Moore, H. C. "Accounting Records and Statistical Information for Cost Finding Under Medicare." Hospital Accounting, November, 1966.

Moritz, Robert. "Hospital Accounting/Medicare Audits = Adjustments." Hospital Accounting, March, 1968.

Murphy, Thomas. "Audit Requirements of Medicare." Hospital Accounting, October, 1967.

Nelson, Benjamin O. "Accounting for Whole Blood." Hospital Financial Management, September, 1969.

Nikel, Casimir M. "What's Wrong with Medicare?" Hospital Accounting, April, 1967.

Norris, Jacquelyn S. "Inpatient Admitting and Billing for Medicare." June, 1966.

Perry, James E. "The Cost of Hospitalization - Oklahoma Hospitals." The Journal of the Oklahoma State Medical Association, November, 1975.

Pointer, Dennis D. "Multiple Regression Analysis, A Tool for Examining Health Care Costs." Medical Group Management, January/February, 1974.

Powers, Franklin W. "Accumulating Medicare Revenue and Calculating Payment." Hospital Accounting, February, 1967.

_____. "Why Beat Medicare to Death?" Hospital Accounting, November, 1967.

"Project Parade." Hospital Financial Management, November, 1968.

"Recommended Specifications for the Preparation of Property Records Under Medicare's Reimbursement Principles." Hospital Accounting, May, 1967.

Ruther, Martin. "Health Insurance for the Aged: Persons Insured, Mid-1966 to Mid-1970." Social Security Bulletin, Vol. 35, No. 9, September, 1972.

Schlag, Darwin W. "A Simplified Approach to Medicare Analysis." Hospital Financial Management, February, 1969.

Schultze, Robert L. "Medicare Billing of the Hospital Bills for Hospital Based Physicians." Hospital Accounting, June, 1966.

Seago, W. E. "Effect of Cost Finding on Medicare Reimbursement - 1968." Hospital Financial Management, December, 1968.

Senn, Elizabeth. "Cost Finding - A Must for all Hospitals." Hospital Financial Management, November, 1968.

Sibley, Hiram. "A Case for Depreciation on Replacement Costs." Hospital Accounting, November, 1966.

Sigmond, R. M. "Notion of Hospital Incentives." Hospital Progress, January, 1969.

Snyder, Robert A. "How Changes in the Medicare Law Will Affect Your Hospital." Hospital Accounting, March, 1968.

"Statistics - Medicare and Otherwise." Hospital Accounting, November, 1967.

Steinert, Jeff. "Cost Reimbursement Formulae - A Review." Hospital Accounting, June, 1966.

_____. "Depreciation and Medicare." Hospital Accounting, May, 1967.

_____. "Medicare - Almost Ideal." Hospital Accounting, April, 1968.

West, Howard. "Five Years of Medicare - A Statistical Review." Social Security Bulletin, Vol. 34, December, 1971

Wolkstein, I. "Incentive Reimbursement Plans Offer a Variety of Approaches to Cost Control." Hospitals, June, 1969.

Woolworth, Richard L. "Effects of Medicare on the Hospital's Statement of Income." Hospital Accounting, September, 1967.

Proceedings

James E. Perry and Lanny W. Gallup. "The Economics of Hospitals." Southwestern Society of Economists, Proceedings. San Antonio, Texas, March, 1976.