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

PART I - COST REPORT STATUS

PROVIDER USE ONLY
1. [X] ELECTRONICALLY FILED COST REPORT DATE: 05-29-2012 TIME: 11:22_____
2. [ ] MANUALLY SUBMITTED COST REPORT
3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [F] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY PROVENA ST. JOSEPH MEDICAL CENTER (14-0007) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2011 AND ENDING 12/31/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-1,424,797	504,986			1
2	SUBPROVIDER - IPF		78,161				2
3	SUBPROVIDER - IRF		-39,208				3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-1,385,844	504,986			200

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

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

PROVIDER CCN: 14-0007 PROVENA ST. JOSEPH MEDICAL CEN | KPMG LLP COMPU-MAX MICRO SYSTEM | VERSION: 2011.10
PERIOD FROM 01/01/2011 TO 12/31/2011 | IN LIEU OF FORM CMS-2552-10 (08/2011) | 05/29/2012 11:22

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 333 NORTH MADISON STREET P.O.BOX: 1
2 CITY: JOLIET STATE: IL ZIP CODE: 60435 COUNTY: CHAMPAIGN 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	PROVENA ST. JOSEPH MEDICAL CE	14-0007	16974	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF	SJMC PSYCH UNIT	14-S007	16974	4	09/01/1984	N	P	O	4
5	SUBPROVIDER - IRF	SJMC PHYSICAL MED & REHAB	14-T007	16974	5	09/07/1987	N	P	O	5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2011		TO: 12/31/2011						20
21	TYPE OF CONTROL			1						21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	13,326	1,771	68	15	706		24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	125	15			6		25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:		ENDING:			36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:		ENDING:			38

	PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL	V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2 PART I (CONT)

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

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

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

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS				
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63

		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				64

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

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

		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2
PART I (CONT)

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2 PART I (CONT)

	MISCELLANEOUS COST REPORTING INFORMATION	1	2	
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	2		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: 1,081,242 AND/OR SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121
	TRANSPLANT CENTER INFORMATION			
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134
	ALL PROVIDERS			
		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	148003	140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME: PROVENA HEALTH	CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 00131	141
142	STREET: 19065 HICKORY CREEK DRIVE, S	P.O. BOX: 2952		142
143	CITY: MOKENA	STATE: IL	ZIP CODE: 60448	143

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

		PART A	PART B	
		1	2	
155	HOSPITAL	N	N	155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

MULTICAMPUS

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

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

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

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

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
	PROVIDER ORGANIZATION AND OPERATION	1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N			1

		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y			3

		Y/N	TYPE	DATE	
	FINANCIAL DATA AND REPORTS	1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5

		Y/N	Y/N	
	APPROVED EDUCATIONAL ACTIVITIES	1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	Y		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	Y		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11

		Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	N	14

BED COMPLEMENT

15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
	PS&R REPORT DATA	1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	05/21/2012	Y	05/21/2012	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

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

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

CAPITAL RELATED COST

22 HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. 22

23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 23

24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 24

25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 25

26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 26

27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 27

INTEREST EXPENSE

28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 28

29 DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. 29

30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. 30

31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. 31

PURCHASED SERVICES

32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. 32

33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 33

PROVIDER-BASED PHYSICIANS

34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. 34

35 IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 35

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

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO. 1	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V 5	TITLE XVIII 6	TITLE XIX 7	TOTAL ALL PATIENTS 8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	378	136,792			47,035	12,242	86,758	1
2	HMO						3,177	706		2
3	HMO IPF									3
4	HMO IRF						236	6		4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		378	136,792			47,035	12,242	86,758	7
8	INTENSIVE CARE UNIT	31	20	7,300			3,736	139	7,006	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34	17	6,205			2,939	183	5,608	11
12	NEO NATAL INTENSIVE CARE	35								12
13	NURSERY	43						2,337	4,841	13
14	TOTAL (SEE INSTRUCTIONS)		415	150,297			53,710	14,901	104,213	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40		1,178			185	185	551	16
17	SUBPROVIDER - IRF	41	31	11,315			6,222	140	8,024	17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		446							27
28	OBSERVATION BED DAYS							1,175	9,333	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)							279	564	32
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES --- TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					10,792	4,438	25,369	1
2	HMO						660			2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	NEO NATAL INTENSIVE CARE	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)		1.04	2,021.67			10,792	4,438	25,369	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40		2.67			24	23	87	16
17	SUBPROVIDER - IRF	41		38.31			544	13	676	17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		1.04	2,062.65						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART II & III

PART II - WAGE DATA

		WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	130,765,232	-3,836,908	126,928,324	4,290,305.00	29.58	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A		353,039		353,039	2,080.00	169.73	4
4.01	PHYSICIANS-PART A - DIRECT TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		3,902,171	44,225	3,946,396	119,355.00	33.06	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		428,777		428,777	6,724.00	63.77	11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A		1,395,921		1,395,921	6,783.00	205.80	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		17,300,080		17,300,080	301,155.00	57.45	14
15	HOME OFFICE: PHYSICIAN-PART A							15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		37,436,768		37,436,768			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		1,117,155		1,117,155			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A		94,380		94,380			22
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		1,422,615	-841,224	581,391	6,203.00	93.73	26
27	ADMINISTRATIVE & GENERAL		14,601,411	-3,075,976	11,525,435	430,485.00	26.77	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		3,674,976		3,674,976	22,588.00	162.70	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		3,105,589		3,105,589	125,093.00	24.83	30
31	LAUNDRY & LINEN SERVICE		167,470		167,470	12,171.00	13.76	31
32	HOUSEKEEPING		2,693,023		2,693,023	205,693.00	13.09	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		3,128,516	-1,919,039	1,209,477	90,602.00	13.35	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)		465,130		465,130	10,428.00	44.60	35
36	CAFETERIA			1,919,039	1,919,039	123,320.00	15.56	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		4,730,721		4,730,721	111,931.00	42.26	38
39	CENTRAL SERVICES AND SUPPLY		1,501,068		1,501,068	85,226.00	17.61	39
40	PHARMACY		3,887,065	-106,326	3,780,739	97,836.00	38.64	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		3,376,586		3,376,586	156,473.00	21.58	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	134,905,338	-3,836,908	131,068,430	4,323,321.0	30.32	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	3,902,171	44,225	3,946,396	119,355.00	33.06	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	131,003,167	-3,881,133	127,122,034	4,203,966.0	30.24	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	19,124,778		19,124,778	314,662.00	60.78	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	37,531,148		37,531,148		29.52%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	187,659,093	-3,881,133	183,777,960	4,518,628.0	40.67	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	42,754,170	-4,023,526	38,730,644	1,478,049.0	26.20	7

HOSPITAL WAGE RELATED COSTS — WORKSHEET S-3 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	6,095,324	3
4	PRIOR YEAR PENSION SERVICE COST		4
	PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5	401K/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	17,155,536	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	950,505	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	234,631	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	295,010	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	2,717,426	15
16	RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	9,047,116	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	188,872	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION	128,244	21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	624,198	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	37,436,862	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

	COMPONENT 0	CONTRACT LABOR 1	BENEFIT COST 2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	3,029,918		1
2	HOSPITAL	3,029,918		2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA WORKSHEET S-10

	UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION				
1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)			0.219364	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)				
2	NET REVENUE FROM MEDICAID			29,067,275	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?			Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?			Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				5
6	MEDICAID CHARGES			197,157,627	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)			43,249,286	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)			14,182,011	8
	STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)				
9	NET REVENUE FROM STAND-ALONE SCHIP				9
10	STAND-ALONE SCHIP CHARGES				10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)				11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)				12
	OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)				
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)				13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)				14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)				15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)				16
	UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)				
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE				17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)			14,182,011	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	40,251,365	2,624,787	42,876,152	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	8,829,700	575,784	9,405,484	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	282,828	14,197	297,025	22
23	COST OF CHARITY CARE	8,546,872	561,587	9,108,459	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGHTH OF STAY LIMIT (SEE INSTRUCTIONS)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)	33,076,860	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	1,532,312	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	31,544,548	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	6,919,738	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	16,028,197	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	30,210,208	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI-CATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		21,173,118	21,173,118	1,291,537	1
2	00200	CAP REL COSTS-MVBLE EQUIP				10,320,714	2
3	00300	OTHER CAPITAL RELATED COSTS					3
4	00400	EMPLOYEE BENEFITS	1,422,615	39,239,765	40,662,380	-2,769	4
5	00500	ADMINISTRATIVE & GENERAL	14,601,411	94,447,385	109,048,796	-332,476	5
6	00600	MAINTENANCE & REPAIRS					6
7	00700	OPERATION OF PLANT	3,105,589	9,272,700	12,378,289	-4,423	7
8	00800	LAUNDRY & LINEN SERVICE	167,470	1,192,149	1,359,619	-1	8
9	00900	HOUSEKEEPING	2,693,023	1,353,471	4,046,494	-5,347	9
10	01000	DIETARY	3,128,516	2,806,498	5,935,014	-3,665,544	10
11	01100	CAFETERIA				3,648,382	11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	4,730,721	352,243	5,082,964	-2,122	13
14	01400	CENTRAL SERVICES & SUPPLY	1,501,068	3,434,299	4,935,367	-2,570,535	14
15	01500	PHARMACY	3,887,065	16,093,552	19,980,617	-861,984	15
16	01600	MEDICAL RECORDS & LIBRARY	3,376,586	1,560,175	4,936,761	-797	16
17	01700	SOCIAL SERVICE					17
19	01900	NONPHYSICIAN ANESTHETISTS					19
20	02000	NURSING SCHOOL					20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				80,292	22
23	02300	PARAMED ED PRGM-(SPECIFY)	44,426	7,204	51,630	106,326	23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	37,835,384	3,837,934	41,673,318	-4,563,043	30
31	03100	INTENSIVE CARE UNIT	5,694,819	1,276,697	6,971,516	-328,903	31
34	03400	SURGICAL INTENSIVE CARE UNIT	3,997,028	1,099,856	5,096,884	-234,014	34
35	02060	NEO NATAL INTENSIVE CARE					35
40	04000	SUBPROVIDER - IPF	180,475	36,629	217,104	-75,455	40
41	04100	SUBPROVIDER - IRF	2,435,961	186,906	2,622,867	-65,379	41
43	04300	NURSERY	1,708,748	73,318	1,782,066	-47,435	43
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	9,154,844	27,433,006	36,587,850	-23,219,035	50
54	05400	RADIOLOGY-DIAGNOSTIC	9,418,555	4,421,553	13,840,108	-1,343,832	54
60	06000	LABORATORY	20,923	14,233,308	14,254,231	-2,422,214	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	06500	RESPIRATORY THERAPY	2,287,168	644,082	2,931,250	-242,484	65
66	06600	PHYSICAL THERAPY	6,466,014	2,108,770	8,574,784	-249,612	66
69	06900	ELECTROCARDIOLOGY	3,354,027	7,388,690	10,742,717	-7,121,577	69
70	07000	ELECTROENCEPHALOGRAPHY	363,034	60,444	423,478	-19,110	70
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS				16,249,236	71
72	07200	IMPL. DEV. CHARGED TO PATIENT				24,254,042	72
73	07300	DRUGS CHARGED TO PATIENTS					73
76	03140	OTHER	636,629	93,542	730,171	3,195,009	76
76.10	03551	OP PSYCH	124,322	6	124,328	74,705	76.10
76.97	07697	CARDIAC REHABILITATION	492,553	11,604	504,157	-5,068	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
91	09100	EMERGENCY	6,694,949	1,794,636	8,489,585	-565,929	91
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF					99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY					99.40
		SPECIAL PURPOSE COST CENTERS					
113	11300	INTEREST EXPENSE		11,174,926	11,174,926	-11,174,926	113
118		SUBTOTALS (SUM OF LINES 1-117)	129,523,923	266,808,466	396,332,389	96,229	118
		NONREIMBURSABLE COST CENTERS					
192.01	19201	OTHER NRCC	1,241,309	1,691,856	2,933,165	-96,229	192.01
194	07950	OTHER NON-REIMBURSABLE					194
194.01	07951	SHARED SERVICES					194.01
194.02	07952	CASE MANAGEMENT					194.02
194.04	07953	OUTPATIENT PHARMACY					194.04
194.05	07954	PRIMARY CARE PHYSICIAN					194.05
194.06	07955	PATIENT SITTERS					194.06
200		TOTAL (SUM OF LINES 118-199)	130,765,232	268,500,322	399,265,554		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
		GENERAL SERVICE COST CENTERS				
1	00100	CAP REL COSTS-BLDG & FIXT	22,464,655	-4,591,090	17,873,565	1
2	00200	CAP REL COSTS-MVBLE EQUIP	10,320,714	4,762,294	15,083,008	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	40,659,611	8,876,889	49,536,500	4
5	00500	ADMINISTRATIVE & GENERAL	108,716,320	-46,190,750	62,525,570	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	12,373,866	-51,807	12,322,059	7
8	00800	LAUNDRY & LINEN SERVICE	1,359,618		1,359,618	8
9	00900	HOUSEKEEPING	4,041,147		4,041,147	9
10	01000	DIETARY	2,269,470	-85,931	2,183,539	10
11	01100	CAFETERIA	3,648,382	-1,900,130	1,748,252	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	5,080,842	-131,146	4,949,696	13
14	01400	CENTRAL SERVICES & SUPPLY	2,364,832		2,364,832	14
15	01500	PHARMACY	19,118,633	-126,517	18,992,116	15
16	01600	MEDICAL RECORDS & LIBRARY	4,935,964	-7,723	4,928,241	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	80,292		80,292	22
23	02300	PARAMED ED PRGM-(SPECIFY)	157,956		157,956	23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	37,110,275	-697,302	36,412,973	30
31	03100	INTENSIVE CARE UNIT	6,642,613	-332,199	6,310,414	31
34	03400	SURGICAL INTENSIVE CARE UNIT	4,862,870	-273,925	4,588,945	34
35	02060	NEO NATAL INTENSIVE CARE				35
40	04000	SUBPROVIDER - IPF	141,649	-33,123	108,526	40
41	04100	SUBPROVIDER - IRF	2,557,488	-70,000	2,487,488	41
43	04300	NURSERY	1,734,631		1,734,631	43
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	13,368,815	-733,092	12,635,723	50
54	05400	RADIOLOGY-DIAGNOSTIC	12,496,276	-757,841	11,738,435	54
60	06000	LABORATORY	11,832,017	-143,697	11,688,320	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	2,688,766	-6,572	2,682,194	65
66	06600	PHYSICAL THERAPY	8,325,172	-187,255	8,137,917	66
69	06900	ELECTROCARDIOLOGY	3,621,140	-188,395	3,432,745	69
70	07000	ELECTROENCEPHALOGRAPHY	404,368	-33,750	370,618	70
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	16,249,236		16,249,236	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	24,254,042		24,254,042	72
73	07300	DRUGS CHARGED TO PATIENTS				73
76	03140	OTHER	3,925,180		3,925,180	76
76.10	03551	OP PSYCH	199,033		199,033	76.10
76.97	07697	CARDIAC REHABILITATION	499,089	-1,315	497,774	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
91	09100	EMERGENCY	7,923,656	-16,247	7,907,409	91
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
		SPECIAL PURPOSE COST CENTERS				
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	396,428,618	-42,920,624	353,507,994	118
		NONREIMBURSABLE COST CENTERS				
192.01	19201	OTHER NRCC	2,836,936		2,836,936	192.01
194	07950	OTHER NON-REIMBURSABLE				194
194.01	07951	SHARED SERVICES				194.01
194.02	07952	CASE MANAGEMENT				194.02
194.04	07953	OUTPATIENT PHARMACY				194.04
194.05	07954	PRIMARY CARE PHYSICIAN				194.05
194.06	07955	PATIENT SITTERS				194.06
200		TOTAL (SUM OF LINES 118-199)	399,265,554	-42,920,624	356,344,930	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	INCREASE LINE #	INCREASE SALARY	INCREASE OTHER	
		1	2	3	4	5	
1	CAFETERIA	A	CAFETERIA	11	1,919,039	1,729,343	1
500	TOTAL RECLASSIFICATIONS				1,919,039	1,729,343	500
	CODE LETTER - A						
1	CAPITAL INSURANCE	B	CAP REL COSTS-BLDG & FIXT	1		301,056	1
2	CAPITAL INSURANCE	B	CAP REL COSTS-MVBLE EQUIP	2		45,372	2
500	TOTAL RECLASSIFICATIONS					346,428	500
	CODE LETTER - B						
1	INTEREST	C	CAP REL COSTS-BLDG & FIXT	1		11,174,926	1
500	TOTAL RECLASSIFICATIONS					11,174,926	500
	CODE LETTER - C						
1	MEDICAL SUPPLIES AND IMPLANTS	D	MEDICAL SUPPLIES CHRGED TO PA	71		16,249,236	1
2	MEDICAL SUPPLIES AND IMPLANTS	D	IMPL. DEV. CHARGED TO PATIENT	72		24,254,042	2
3	MEDICAL SUPPLIES AND IMPLANTS	D	ADMINISTRATIVE & GENERAL	5		94,244	3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
500	TOTAL RECLASSIFICATIONS					40,597,522	500
	CODE LETTER - D						
1	ALLOCATED SALARY TO OTHER	E	ADMINISTRATIVE & GENERAL	5		2,995,684	1
2			EMPLOYEE BENEFITS	4		841,224	2
500	TOTAL RECLASSIFICATIONS					3,836,908	500
	CODE LETTER - E						
1	MME	F	CAP REL COSTS-MVBLE EQUIP	2		10,275,342	1
2			CAP REL COSTS-BLDG & FIXT	1		90,897	2
500	TOTAL RECLASSIFICATIONS					10,366,239	500
	CODE LETTER - F						
1	IV THERAPY	G	OTHER	76	2,910,220	295,206	1
500	TOTAL RECLASSIFICATIONS				2,910,220	295,206	500
	CODE LETTER - G						
1	OP PSYCH	H	OP PSYCH	76.10	62,101	12,604	1
500	TOTAL RECLASSIFICATIONS				62,101	12,604	500
	CODE LETTER - H						
1	PHARMACIST TEACHING TIME	I	PARAMED ED PRGM-(SPECIFY)	23	106,326		1
500	TOTAL RECLASSIFICATIONS				106,326		500
	CODE LETTER - I						
1	INTERN AND RESIDENT COST	J	I&R SRVCES-OTHER PRGM COSTS A	22	80,292		1
500	TOTAL RECLASSIFICATIONS				80,292		500
	CODE LETTER - J						
	GRAND TOTAL (INCREASES)				5,077,978	68,359,176	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
	1		6	7	8	9	10	
1	CAFETERIA	A	DIETARY	10	1,919,039	1,729,343		1
500	TOTAL RECLASSIFICATIONS				1,919,039	1,729,343		500
	CODE LETTER - A							
1	CAPITAL INSURANCE	B	ADMINISTRATIVE & GENERAL	5		301,056	9	1
2	CAPITAL INSURANCE	B	ADMINISTRATIVE & GENERAL	5		45,372	9	2
500	TOTAL RECLASSIFICATIONS					346,428		500
	CODE LETTER - B							
1	INTEREST	C	INTEREST EXPENSE	113		11,174,926	11	1
500	TOTAL RECLASSIFICATIONS					11,174,926		500
	CODE LETTER - C							
1	MEDICAL SUPPLIES AND IMPLANTS	D	EMPLOYEE BENEFITS	4		2,769		1
2	MEDICAL SUPPLIES AND IMPLANTS	D	OPERATION OF PLANT	7		4,423		2
3	MEDICAL SUPPLIES AND IMPLANTS	D	LAUNDRY & LINEN SERVICE	8		1		3
4			HOUSEKEEPING	9		5,347		4
5			DIETARY	10		17,162		5
6			NURSING ADMINISTRATION	13		2,122		6
7			CENTRAL SERVICES & SUPPLY	14		2,570,535		7
8			PHARMACY	15		755,658		8
9			MEDICAL RECORDS & LIBRARY	16		797		9
10			ADULTS & PEDIATRICS	30		1,357,617		10
11			INTENSIVE CARE UNIT	31		328,903		11
12			SURGICAL INTENSIVE CARE UNIT	34		234,014		12
13			SUBPROVIDER - IRF	41		65,379		13
14			SUBPROVIDER - IPF	40		750		14
15			NURSERY	43		47,435		15
16			OPERATING ROOM	50		23,219,035		16
17			RADIOLOGY-DIAGNOSTIC	54		1,343,832		17
18			LABORATORY	60		2,422,214		18
19			RESPIRATORY THERAPY	65		242,484		19
20			PHYSICAL THERAPY	66		249,612		20
21			ELECTROCARDIOLOGY	69		7,121,577		21
22			ELECTROENCEPHALOGRAPHY	70		19,110		22
23			OTHER	76		10,417		23
24			CARDIAC REHABILITATION	76.97		5,068		24
25			EMERGENCY	91		565,929		25
26			OTHER NRCC	192.01		5,332		26
500	TOTAL RECLASSIFICATIONS					40,597,522		500
	CODE LETTER - D							
1	ALLOCATED SALARY TO OTHER	E	ADMINISTRATIVE & GENERAL	5	2,995,684			1
2			EMPLOYEE BENEFITS	4	841,224			2
500	TOTAL RECLASSIFICATIONS				3,836,908			500
	CODE LETTER - E							
1	MME	F	CAP REL COSTS-BLDG & FIXT	1		10,275,342	9	1
2			OTHER NRCC	192.01		90,897	9	2
500	TOTAL RECLASSIFICATIONS					10,366,239		500
	CODE LETTER - F							
1	IV THERAPY	G	ADULTS & PEDIATRICS	30	2,910,220	295,206		1
500	TOTAL RECLASSIFICATIONS				2,910,220	295,206		500
	CODE LETTER - G							
1	OP PSYCH	H	SUBPROVIDER - IPF	40	62,101	12,604		1
500	TOTAL RECLASSIFICATIONS				62,101	12,604		500
	CODE LETTER - H							
1	PHARMACIST TEACHING TIME	I	PHARMACY	15	106,326			1
500	TOTAL RECLASSIFICATIONS				106,326			500
	CODE LETTER - I							
1	INTERN AND RESIDENT COST	J	ADMINISTRATIVE & GENERAL	5	80,292			1
500	TOTAL RECLASSIFICATIONS				80,292			500
	CODE LETTER - J							
	GRAND TOTAL (DECREASES)				8,914,886	64,522,268		

RECONCILIATION OF CAPITAL COST CENTERS — WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	1,884,595					1,884,595		1
2	LAND IMPROVEMENTS	3,208,539					3,208,539	3,148,289	2
3	BUILDINGS AND FIXTURES	326,265,338	10,419,247		10,419,247	14,289,299	322,395,286	32,323,821	3
4	BUILDING IMPROVEMENTS	1,439,521					1,439,521		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	138,546,600	15,836,023		15,836,023	32,809,595	121,573,028	41,362,390	6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	471,344,593	26,255,270		26,255,270	47,098,894	450,500,969	76,834,500	8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	471,344,593	26,255,270		26,255,270	47,098,894	450,500,969	76,834,500	10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	21,173,118						21,173,118	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (SUM OF LINES 1-2)	21,173,118						21,173,118	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	ALLOCATION OF OTHER CAPITAL INSURANCE 5	TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT	328,927,941		328,927,941	0.730138					1
2	CAP REL COSTS-MVBLE EQUIP	121,573,028		121,573,028	0.269862					2
3	TOTAL (SUM OF LINES 1-2)	450,500,969		450,500,969	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	11,146,600		6,726,965				17,873,565	1
2	CAP REL COSTS-MVBLE EQUIP	15,083,008						15,083,008	2
3	TOTAL	26,229,608		6,726,965				32,956,573	3

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)	B	-40,000	CAP REL COSTS-BLDG & FIXT	1	9	6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-7,342,751				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-1,447,318				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-1,877,170	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-103,491	PHARMACY	15		17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-22,960	CAFETERIA	11		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	MISC INCOME	B	-2,004	EMPLOYEE BENEFITS	4		33
34	MISC INCOME	B	-239,294	ADMINISTRATIVE & GENERAL	5		34
35	MISC INCOME	B	-1,760	NURSING ADMINISTRATION	13		35
36	MISC INCOME	B	-7,723	MEDICAL RECORDS & LIBRARY	16		36
37	MISC INCOME	B	-1,905	SUBPROVIDER - IPF	40		37
38	MISC INCOME	B	-35,754	RADIOLOGY-DIAGNOSTIC	54		38
39	MISC INCOME	B	-4,816	LABORATORY	60		39
40	MISC INCOME	B	-37,885	PHYSICAL THERAPY	66		40
41	MISC INCOME	B	-1,315	CARDIAC REHABILITATION	76.97		41
42	RENTAL INCOME	B	-6,832	CAP REL COSTS-BLDG & FIXT	1	9	42
42.01	RENTAL INCOME	B	-5,400	CAP REL COSTS-BLDG & FIXT	1	9	42.01
42.02	MISC INCOME	B	-20,955	ADULTS & PEDIATRICS	30		42.02
42.03	MISC INCOME	B	-1,629	OPERATING ROOM	50		42.03
43	MAINTENANCE REVENUE	B	-10,800	OPERATION OF PLANT	7		43
44	GIFT SHOP	B	-230,277	ADMINISTRATIVE & GENERAL	5		44
45	AUXILIARY	B	-56,192	ADMINISTRATIVE & GENERAL	5		45
45.01	PLANT OP	B	-41,007	OPERATION OF PLANT	7		45.01
45.02	FOOD OTHER	B	-85,931	DIETARY	10		45.02
45.03	SEMINAR REVENUE	B	-4,240	NURSING ADMINISTRATION	13		45.03
45.04	SEMINAR REVENUE	B	-12,595	ADULTS & PEDIATRICS	30		45.04
45.05	SEMINAR REVENUE	B	-1,845	INTENSIVE CARE UNIT	31		45.05
45.06	SILVER RECOVERY	B	-135,529	RADIOLOGY-DIAGNOSTIC	54		45.06
45.08	UBIT REVENUE	B	-25,036	LABORATORY	60		45.08
45.09	EMT REVENUE	B	-6,950	EMERGENCY	91		45.09
45.10	NONALLOWABLE EXP	A	-34,578	ADMINISTRATIVE & GENERAL	5		45.10
45.11	MARKETING OFFSET	A	-664,526	ADMINISTRATIVE & GENERAL	5		45.11
45.12	DUES LOBBYING PORTION	A	-43,077	ADMINISTRATIVE & GENERAL	5		45.12
45.13	NRCC DEPR EXP	A	-90,897	CAP REL COSTS-BLDG & FIXT	1	9	45.13
45.14	PATIENT TRANSPORTATION	A	-149,370	PHYSICAL THERAPY	66		45.14

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
45.15	NONALLOWABLE EXP	A	-146	NURSING ADMINISTRATION	13		45.15
45.16	NONALLOWABLE EXP	A	-93	EMPLOYEE BENEFITS	4		45.16
46	CASH FUNDING OF PENSION	A	10,157,052	EMPLOYEE BENEFITS	4		46
47	REMOVE BAD DEBT EXPENSE	A	-40,283,625	ADMINISTRATIVE & GENERAL	5		47
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-42,920,624				50

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

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ-USTMENTS (COL. 4-5)	WKST A-7 REF	
	1	2	3	4	5	6	7	
1	4	EMPLOYEE BENEFITS	EB	5,099,128	6,371,194	-1,272,066		1
2	5	ADMINISTRATIVE & GENERAL	AG	27,467,696	27,455,371	12,325		2
3	31	INTENSIVE CARE UNIT	EICU	542,171	816,096	-273,925		3
4	34	SURGICAL INTENSIVE CARE UNIT	EICU	542,171	816,096	-273,925		4
4.01	54	RADIOLOGY-DIAGNOSTIC	CPACS	1,259,321	1,299,540	-40,219		4.01
4.02	1	CAP REL COSTS-BLDG & FIXT	INTEREST	6,804,948	11,252,909	-4,447,961	11	4.02
4.03	2	CAP REL COSTS-MVBLE EQUIP	DEPR	4,762,294		4,762,294	9	4.03
4.04	60	LABORATORY	ALVERNO	11,304,817	11,218,658	86,159		4.04
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		57,782,546	59,229,864	-1,447,318		5

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

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

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

			RELATED ORGANIZATION(S) AND/OR HOME OFFICE				
	SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	B	PROVENA HEALTH		PROVENA HEALTH			6
7							7
8							8
9							9
10							10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERA-TION INCL FRINGES 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNAD-JUSTED RCE LIMIT 8	5 PERCENT OF UNAD-JUSTED RCE LIMIT 9	
1	4	EMPLOYEE BENEFITS	A	6,000	6,000		177,200	1	85	4	1
2	5	ADMINISTRATIVE & GENERAL	A	4,698,788	4,636,208	62,580	177,200	555	47,282	2,364	2
3	13	NURSING ADMINISTRATION	A	125,000	125,000		177,200	1	85	4	3
4	15	PHARMACY	A	23,026	23,026		177,200	1	85	4	4
5	30	ADULTS & PEDIATRICS	A	993,898	466,354	527,544	138,700	4,951	330,146	16,507	5
6	31	INTENSIVE CARE UNIT	A	56,429	56,429		208,000	1	100	5	6
7	40	SUBPROVIDER - IPF	A	31,440	31,107	333	154,100	3	222	11	7
8	41	SUBPROVIDER - IRF	A	70,000	70,000		138,700	1	67	3	8
9	50	OPERATING ROOM	A	764,163	698,863	65,300	208,000	327	32,700	1,635	9
10	54	RADIOLOGY-DIAGNOSTIC	A	546,339	546,339		225,300	1	108	5	10
11	60	LABORATORY	A	200,004	200,004		215,700	1	104	5	11
12	65	RESPIRATORY THERAPY	A	30,000	2,500	27,500	177,200	275	23,428	1,171	12
13	69	ELECTROCARDIOLOGY	A	212,917	182,117	30,800	165,600	308	24,522	1,226	13
14	70	ELECTROENCEPHALOGRAPHY	A	33,750	33,750		165,600	1	80	4	14
15	91	EMERGENCY	A	45,697	166	45,531	208,000	364	36,400	1,820	15
200		TOTAL		7,837,451	7,077,863	759,588		6,791	495,414	24,768	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18	
1	4	EMPLOYEE BENEFITS	A					85		6,000	1
2	5	ADMINISTRATIVE & GENERAL	A					47,282	15,298	4,651,506	2
3	13	NURSING ADMINISTRATION	A					85		125,000	3
4	15	PHARMACY	A					85		23,026	4
5	30	ADULTS & PEDIATRICS	A					330,146	197,398	663,752	5
6	31	INTENSIVE CARE UNIT	A					100		56,429	6
7	40	SUBPROVIDER - IPF	A					222	111	31,218	7
8	41	SUBPROVIDER - IRF	A					67		70,000	8
9	50	OPERATING ROOM	A					32,700	32,600	731,463	9
10	54	RADIOLOGY-DIAGNOSTIC	A					108		546,339	10
11	60	LABORATORY	A					104		200,004	11
12	65	RESPIRATORY THERAPY	A					23,428	4,072	6,572	12
13	69	ELECTROCARDIOLOGY	A					24,522	6,278	188,395	13
14	70	ELECTROENCEPHALOGRAPHY	A					80		33,750	14
15	91	EMERGENCY	A					36,400	9,131	9,297	15
200		TOTAL						495,414	264,888	7,342,751	200

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	17,873,565	17,873,565				1
2	CAP REL COSTS-MVBLE EQUIP	15,083,008		15,083,008			2
4	EMPLOYEE BENEFITS	49,536,500	82,884	14,453	49,633,837		4
5	ADMINISTRATIVE & GENERAL	62,525,570	4,445,341	1,245,362	4,527,629	72,743,902	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	12,322,059	2,612,006	1,595,711	1,219,993	17,749,769	7
8	LAUNDRY & LINEN SERVICE	1,359,618	116,597	1,946	65,789	1,543,950	8
9	HOUSEKEEPING	4,041,147	218,536	166,180	1,057,922	5,483,785	9
10	DIETARY	2,183,539	177,920	60,670	475,129	2,897,258	10
11	CAFETERIA	1,748,252	242,186	82,579	753,871	2,826,888	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	4,949,696	70,205	87,069	1,858,407	6,965,377	13
14	CENTRAL SERVICES & SUPPLY	2,364,832	351,245	354,994	589,677	3,660,748	14
15	PHARMACY	18,992,116	53,440	28,224	1,485,218	20,558,998	15
16	MEDICAL RECORDS & LIBRARY	4,928,241	144,135	33,161	1,326,451	6,431,988	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	80,292			31,542	111,834	22
23	PARAMED ED PRGM-(SPECIFY)	157,956	4,359		59,221	221,536	23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	36,412,973	4,814,226	1,112,147	13,719,892	56,059,238	30
31	INTENSIVE CARE UNIT	6,310,414	497,360	354,350	2,237,141	9,399,265	31
34	SURGICAL INTENSIVE CARE UNIT	4,588,945	394,640	250,227	1,570,184	6,803,996	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF	108,526	24,849	3,667	46,502	183,544	40
41	SUBPROVIDER - IRF	2,487,488	310,539	13,034	956,938	3,767,999	41
43	NURSERY	1,734,631	156,595	65,669	671,261	2,628,156	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	12,635,723	716,241	3,189,958	3,596,371	20,138,293	50
54	RADIOLOGY-DIAGNOSTIC	11,738,435	804,756	4,243,543	3,699,966	20,486,700	54
60	LABORATORY	11,688,320	412,423	1,356	8,219	12,110,318	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,682,194	39,925	90,893	898,487	3,711,499	65
66	PHYSICAL THERAPY	8,137,917	21,198	153,236	2,540,096	10,852,447	66
69	ELECTROCARDIOLOGY	3,432,745	331,464	1,552,964	1,317,589	6,634,762	69
70	ELECTROENCEPHALOGRAPHY	370,618	74,529	34,624	142,614	622,385	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	16,249,236				16,249,236	71
72	IMPL. DEV. CHARGED TO PATIENT	24,254,042				24,254,042	72
73	DRUGS CHARGED TO PATIENTS						73
76	OTHER	3,925,180		42,813	1,393,337	5,361,330	76
76.10	OP PSYCH	199,033		6,078	73,234	278,345	76.10
76.97	CARDIAC REHABILITATION	497,774	107,515	16,023	193,494	814,806	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	7,907,409	589,435	213,838	2,630,030	11,340,712	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	353,507,994	17,814,549	15,014,769	49,146,204	352,893,106	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC	2,836,936	59,016	68,239	487,633	3,451,824	192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	356,344,930	17,873,565	15,083,008	49,633,837	356,344,930	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	72,743,902					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	4,552,833	22,302,602				7
8	LAUNDRY & LINEN SERVICE	396,025	242,276	2,182,251			8
9	HOUSEKEEPING	1,406,596	454,092		7,344,473		9
10	DIETARY	743,150	369,698		359,241	4,369,347	10
11	CAFETERIA	725,100	503,234		93,496	10,975	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,786,626	145,879		51,782		13
14	CENTRAL SERVICES & SUPPLY	938,986	729,846		26,610		14
15	PHARMACY	5,273,404	111,041		10,788		15
16	MEDICAL RECORDS & LIBRARY	1,649,811	299,495		17,980		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	28,686					22
23	PARAMED ED PRGM-(SPECIFY)	56,824	9,058				23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	14,379,203	10,003,389	1,738,519	3,686,620	3,679,023	30
31	INTENSIVE CARE UNIT	2,410,921	1,033,455	142,580	539,760	89,868	31
34	SURGICAL INTENSIVE CARE UNIT	1,745,232	820,015	60,046	189,869	75,696	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF	47,079	51,633	15,394	44,950	21,193	40
41	SUBPROVIDER - IRF	966,496	645,263	113,552	307,099	305,386	41
43	NURSERY	674,125	325,387	111,285	47,108	185,525	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,165,492	1,488,264		758,037		50
54	RADIOLOGY-DIAGNOSTIC	5,254,859	1,672,188		290,197		54
60	LABORATORY	3,106,309	856,966		145,998		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	952,003	82,960		25,172		65
66	PHYSICAL THERAPY	2,783,664	44,047		182,317		66
69	ELECTROCARDIOLOGY	1,701,823	688,744		152,111		69
70	ELECTROENCEPHALOGRAPHY	159,642	154,862		12,586		70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	4,167,945					71
72	IMPL. DEV. CHARGED TO PATIENT	6,221,186					72
73	DRUGS CHARGED TO PATIENTS						73
76	OTHER	1,375,187					76
76.10	OP PSYCH	71,396					76.10
76.97	CARDIAC REHABILITATION	208,999	223,404				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	2,908,904	1,224,777	875	402,752	1,681	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	71,858,506	22,179,973	2,182,251	7,344,473	4,369,347	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC	885,396	122,629				192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	72,743,902	22,302,602	2,182,251	7,344,473	4,369,347	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11	13	14	15	16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	4,159,693					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	141,223	9,090,887				13
14	CENTRAL SERVICES & SUPPLY	107,525		5,463,715			14
15	PHARMACY	123,455			26,077,686		15
16	MEDICAL RECORDS & LIBRARY	197,439				8,596,713	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)	4,882					23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,603,296	5,416,107			871,572	30
31	INTENSIVE CARE UNIT	189,487	640,110			165,275	31
34	SURGICAL INTENSIVE CARE UNIT	148,099	500,296			119,859	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF	7,007	23,672			3,650	40
41	SUBPROVIDER - IRF	100,544	339,648			55,669	41
43	NURSERY	54,379	183,699			28,583	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	292,971	989,688			725,214	50
54	RADIOLOGY-DIAGNOSTIC	364,960				1,710,368	54
60	LABORATORY	1,417				1,199,968	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	99,494				153,878	65
66	PHYSICAL THERAPY	230,219				234,877	66
69	ELECTROCARDIOLOGY	122,799				511,416	69
70	ELECTROENCEPHALOGRAPHY	17,269				28,757	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			5,463,715		679,871	71
72	IMPL. DEV. CHARGED TO PATIENT					466,407	72
73	DRUGS CHARGED TO PATIENTS				26,077,686	832,689	73
76	OTHER	16,980	57,362			103,004	76
76.10	OP PSYCH	4,960	16,756			7,487	76.10
76.97	CARDIAC REHABILITATION	19,710				10,320	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	273,392	923,549			687,849	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	4,121,507	9,090,887	5,463,715	26,077,686	8,596,713	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC	38,186					192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	4,159,693	9,090,887	5,463,715	26,077,686	8,596,713	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	I&R PROGRAM COSTS 22	PARAMED EDUCATION 23	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	140,520					22
23	PARAMED ED PRGM-(SPECIFY)		292,300				23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	70,260		97,507,227	-70,260	97,436,967	30
31	INTENSIVE CARE UNIT			14,610,721		14,610,721	31
34	SURGICAL INTENSIVE CARE UNIT			10,463,108		10,463,108	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF			398,122		398,122	40
41	SUBPROVIDER - IRF			6,601,656		6,601,656	41
43	NURSERY			4,238,247		4,238,247	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	70,260		29,628,219	-70,260	29,557,959	50
54	RADIOLOGY-DIAGNOSTIC			29,779,272		29,779,272	54
60	LABORATORY			17,420,976		17,420,976	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY			5,025,006		5,025,006	65
66	PHYSICAL THERAPY			14,327,571		14,327,571	66
69	ELECTROCARDIOLOGY			9,811,655		9,811,655	69
70	ELECTROENCEPHALOGRAPHY			995,501		995,501	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			26,560,767		26,560,767	71
72	IMPL. DEV. CHARGED TO PATIENT			30,941,635		30,941,635	72
73	DRUGS CHARGED TO PATIENTS		292,300	27,202,675		27,202,675	73
76	OTHER			6,913,863		6,913,863	76
76.10	OP PSYCH			378,944		378,944	76.10
76.97	CARDIAC REHABILITATION			1,277,239		1,277,239	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY			17,764,491		17,764,491	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	140,520	292,300	351,846,895	-140,520	351,706,375	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC			4,498,035		4,498,035	192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	140,520	292,300	356,344,930	-140,520	356,204,410	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS		82,884	14,453	97,337	97,337	4
5	ADMINISTRATIVE & GENERAL	66,460	4,445,341	1,245,362	5,757,163	8,875	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	49,615	2,612,006	1,595,711	4,257,332	2,391	7
8	LAUNDRY & LINEN SERVICE		116,597	1,946	118,543	129	8
9	HOUSEKEEPING		218,536	166,180	384,716	2,074	9
10	DIETARY	4,315	177,920	60,670	242,905	931	10
11	CAFETERIA		242,186	82,579	324,765	1,478	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		70,205	87,069	157,274	3,643	13
14	CENTRAL SERVICES & SUPPLY	158,354	351,245	354,994	864,593	1,156	14
15	PHARMACY	917,872	53,440	28,224	999,536	2,911	15
16	MEDICAL RECORDS & LIBRARY		144,135	33,161	177,296	2,600	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					62	22
23	PARAMED ED PRGM-(SPECIFY)		4,359		4,359	116	23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,255	4,814,226	1,112,147	5,928,628	26,940	30
31	INTENSIVE CARE UNIT		497,360	354,350	851,710	4,385	31
34	SURGICAL INTENSIVE CARE UNIT		394,640	250,227	644,867	3,078	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF		24,849	3,667	28,516	91	40
41	SUBPROVIDER - IRF		310,539	13,034	323,573	1,876	41
43	NURSERY		156,595	65,669	222,264	1,316	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	418,756	716,241	3,189,958	4,324,955	7,049	50
54	RADIOLOGY-DIAGNOSTIC	661,064	804,756	4,243,543	5,709,363	7,252	54
60	LABORATORY	12,544	412,423	1,356	426,323	16	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	6,130	39,925	90,893	136,948	1,761	65
66	PHYSICAL THERAPY	748,750	21,198	153,236	923,184	4,979	66
69	ELECTROCARDIOLOGY	76,188	331,464	1,552,964	1,960,616	2,583	69
70	ELECTROENCEPHALOGRAPHY		74,529	34,624	109,153	280	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76	OTHER			42,813	42,813	2,731	76
76.10	OP PSYCH			6,078	6,078	144	76.10
76.97	CARDIAC REHABILITATION		107,515	16,023	123,538	379	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		589,435	213,838	803,273	5,155	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	3,122,303	17,814,549	15,014,769	35,951,621	96,381	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC	470,696	59,016	68,239	597,951	956	192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	3,592,999	17,873,565	15,083,008	36,549,572	97,337	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	5,766,038					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	360,888	4,620,611				7
8	LAUNDRY & LINEN SERVICE	31,392	50,194	200,258			8
9	HOUSEKEEPING	111,496	94,078		592,364		9
10	DIETARY	58,907	76,593		28,974	408,310	10
11	CAFETERIA	57,476	104,259		7,541	1,026	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	141,620	30,223		4,176		13
14	CENTRAL SERVICES & SUPPLY	74,430	151,208		2,146		14
15	PHARMACY	418,006	23,005		870		15
16	MEDICAL RECORDS & LIBRARY	130,775	62,049		1,450		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	2,274					22
23	PARAMED ED PRGM-(SPECIFY)	4,504	1,877				23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,139,659	2,072,483	159,539	297,344	343,800	30
31	INTENSIVE CARE UNIT	191,106	214,109	13,084	43,534	8,398	31
34	SURGICAL INTENSIVE CARE UNIT	138,339	169,889	5,510	15,314	7,074	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF	3,732	10,697	1,413	3,625	1,980	40
41	SUBPROVIDER - IRF	76,611	133,684	10,420	24,769	28,538	41
43	NURSERY	53,436	67,413	10,212	3,799	17,337	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	409,452	308,336		61,139		50
54	RADIOLOGY-DIAGNOSTIC	416,536	346,441		23,406		54
60	LABORATORY	246,227	177,545		11,775		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	75,462	17,188		2,030		65
66	PHYSICAL THERAPY	220,652	9,126		14,705		66
69	ELECTROCARDIOLOGY	134,898	142,693		12,268		69
70	ELECTROENCEPHALOGRAPHY	12,654	32,084		1,015		70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	330,379					71
72	IMPL. DEV. CHARGED TO PATIENT	493,133					72
73	DRUGS CHARGED TO PATIENTS						73
76	OTHER	109,007					76
76.10	OP PSYCH	5,659					76.10
76.97	CARDIAC REHABILITATION	16,567	46,284				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	230,579	253,747	80	32,484	157	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	5,695,856	4,595,205	200,258	592,364	408,310	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC	70,182	25,406				192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	5,766,038	4,620,611	200,258	592,364	408,310	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11	13	14	15	16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	496,545					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	16,858	353,794				13
14	CENTRAL SERVICES & SUPPLY	12,835		1,106,368			14
15	PHARMACY	14,737			1,459,065		15
16	MEDICAL RECORDS & LIBRARY	23,568				397,738	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)	583					23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	191,388	210,783			40,398	30
31	INTENSIVE CARE UNIT	22,619	24,911			7,661	31
34	SURGICAL INTENSIVE CARE UNIT	17,679	19,470			5,556	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF	836	921			169	40
41	SUBPROVIDER - IRF	12,002	13,218			2,580	41
43	NURSERY	6,491	7,149			1,325	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	34,972	38,516			33,615	50
54	RADIOLOGY-DIAGNOSTIC	43,565				78,547	54
60	LABORATORY	169				55,620	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	11,877				7,132	65
66	PHYSICAL THERAPY	27,481				10,887	66
69	ELECTROCARDIOLOGY	14,659				23,705	69
70	ELECTROENCEPHALOGRAPHY	2,061				1,333	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			1,106,368		31,513	71
72	IMPL. DEV. CHARGED TO PATIENT					21,619	72
73	DRUGS CHARGED TO PATIENTS				1,459,065	38,596	73
76	OTHER	2,027	2,232			4,774	76
76.10	OP PSYCH	592	652			347	76.10
76.97	CARDIAC REHABILITATION	2,353				478	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	32,635	35,942			31,883	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	491,987	353,794	1,106,368	1,459,065	397,738	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC	4,558					192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	496,545	353,794	1,106,368	1,459,065	397,738	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	I&R PROGRAM COSTS 22	PARAMED EDUCATION 23	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	2,336					22
23	PARAMED ED PRGM-(SPECIFY)		11,439				23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS			10,410,962		10,410,962	30
31	INTENSIVE CARE UNIT			1,381,517		1,381,517	31
34	SURGICAL INTENSIVE CARE UNIT			1,026,776		1,026,776	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF			51,980		51,980	40
41	SUBPROVIDER - IRF			627,271		627,271	41
43	NURSERY			390,742		390,742	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM			5,218,034		5,218,034	50
54	RADIOLOGY-DIAGNOSTIC			6,625,110		6,625,110	54
60	LABORATORY			917,675		917,675	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY			252,398		252,398	65
66	PHYSICAL THERAPY			1,211,014		1,211,014	66
69	ELECTROCARDIOLOGY			2,291,422		2,291,422	69
70	ELECTROENCEPHALOGRAPHY			158,580		158,580	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			1,468,260		1,468,260	71
72	IMPL. DEV. CHARGED TO PATIENT			514,752		514,752	72
73	DRUGS CHARGED TO PATIENTS			1,497,661		1,497,661	73
76	OTHER			163,584		163,584	76
76.10	OP PSYCH			13,472		13,472	76.10
76.97	CARDIAC REHABILITATION			189,599		189,599	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY			1,425,935		1,425,935	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)			35,836,744		35,836,744	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC			699,053		699,053	192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06
200	CROSS FOOT ADJUSTMENTS	2,336	11,439	13,775		13,775	200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	2,336	11,439	36,549,572		36,549,572	202

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	983,988					1
2	CAP REL COSTS-MVBLE EQUIP		9,229,599				2
4	EMPLOYEE BENEFITS	4,563	8,844	126,346,933			4
5	ADMINISTRATIVE & GENERAL	244,728	762,062	11,525,435	-72,743,902	283,601,028	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	143,798	976,448	3,105,589		17,749,769	7
8	LAUNDRY & LINEN SERVICE	6,419	1,191	167,470		1,543,950	8
9	HOUSEKEEPING	12,031	101,689	2,693,023		5,483,785	9
10	DIETARY	9,795	37,125	1,209,477		2,897,258	10
11	CAFETERIA	13,333	50,532	1,919,039		2,826,888	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	3,865	53,279	4,730,721		6,965,377	13
14	CENTRAL SERVICES & SUPPLY	19,337	217,228	1,501,068		3,660,748	14
15	PHARMACY	2,942	17,271	3,780,739		20,558,998	15
16	MEDICAL RECORDS & LIBRARY	7,935	20,292	3,376,586		6,431,988	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD			80,292		111,834	22
23	PARAMED ED PRGM-(SPECIFY)	240		150,752		221,536	23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	265,036	680,545	34,925,164		56,059,238	30
31	INTENSIVE CARE UNIT	27,381	216,834	5,694,819		9,399,265	31
34	SURGICAL INTENSIVE CARE UNIT	21,726	153,119	3,997,028		6,803,996	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF	1,368	2,244	118,374		183,544	40
41	SUBPROVIDER - IRF	17,096	7,976	2,435,961		3,767,999	41
43	NURSERY	8,621	40,184	1,708,748		2,628,156	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	39,431	1,952,000	9,154,844		20,138,293	50
54	RADIOLOGY-DIAGNOSTIC	44,304	2,596,711	9,418,555		20,486,700	54
60	LABORATORY	22,705	830	20,923		12,110,318	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,198	55,619	2,287,168		3,711,499	65
66	PHYSICAL THERAPY	1,167	93,768	6,466,014		10,852,447	66
69	ELECTROCARDIOLOGY	18,248	950,290	3,354,027		6,634,762	69
70	ELECTROENCEPHALOGRAPHY	4,103	21,187	363,034		622,385	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS					16,249,236	71
72	IMPL. DEV. CHARGED TO PATIENT					24,254,042	72
73	DRUGS CHARGED TO PATIENTS						73
76	OTHER		26,198	3,546,849		5,361,330	76
76.10	OP PSYCH		3,719	186,423		278,345	76.10
76.97	CARDIAC REHABILITATION	5,919	9,805	492,553		814,806	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	32,450	130,852	6,694,949		11,340,712	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	980,739	9,187,842	125,105,624	-72,743,902	280,149,204	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC	3,249	41,757	1,241,309		3,451,824	192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	17,873,565	15,083,008	49,633,837		72,743,902	202
203	UNIT COST MULT-WS B PT I	18.164414	1.634200	0.392838		0.256501	203
204	COST TO BE ALLOC PER B PT II			97,337		5,766,038	204
205	UNIT COST MULT-WS B PT II			0.000770		0.020332	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS OF LAUNDRY	PATIENT DAYS	MEALS SERVED	FTE'S	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	590,899					7
8	LAUNDRY & LINEN SERVICE	6,419	2,477,930				8
9	HOUSEKEEPING	12,031		20,424			9
10	DIETARY	9,795		999	397,709		10
11	CAFETERIA	13,333		260	999	158,496	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	3,865		144		5,381	13
14	CENTRAL SERVICES & SUPPLY	19,337		74		4,097	14
15	PHARMACY	2,942		30		4,704	15
16	MEDICAL RECORDS & LIBRARY	7,935		50		7,523	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)	240				186	23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	265,036	1,974,076	10,252	334,874	61,090	30
31	INTENSIVE CARE UNIT	27,381	161,899	1,501	8,180	7,220	31
34	SURGICAL INTENSIVE CARE UNIT	21,726	68,182	528	6,890	5,643	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF	1,368	17,480	125	1,929	267	40
41	SUBPROVIDER - IRF	17,096	128,937	854	27,797	3,831	41
43	NURSERY	8,621	126,363	131	16,887	2,072	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	39,431		2,108		11,163	50
54	RADIOLOGY-DIAGNOSTIC	44,304		807		13,906	54
60	LABORATORY	22,705		406		54	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,198		70		3,791	65
66	PHYSICAL THERAPY	1,167		507		8,772	66
69	ELECTROCARDIOLOGY	18,248		423		4,679	69
70	ELECTROENCEPHALOGRAPHY	4,103		35		658	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76	OTHER					647	76
76.10	OP PSYCH					189	76.10
76.97	CARDIAC REHABILITATION	5,919				751	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	32,450	993	1,120	153	10,417	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	587,650	2,477,930	20,424	397,709	157,041	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC	3,249				1,455	192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING PATIENT DAYS 9	DIETARY MEALS SERVED 10	CAFETERIA FTE'S 11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	22,302,602	2,182,251	7,344,473	4,369,347	4,159,693	202
203	UNIT COST MULT-WS B PT I	37.743509	0.880675	359.600127	10.986291	26.244782	203
204	COST TO BE ALLOC PER B PT II	4,620,611	200,258	592,364	408,310	496,545	204
205	UNIT COST MULT-WS B PT II	7.819629	0.080817	29.003329	1.026655	3.132855	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINIS-TRATION FTE'S	CENTRAL SERVICES & SUPPLY SUPPLIES	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	I&R PROGRAM COSTS ASSIGNED TIME	
		13	14	15	16	22	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	102,539					13
14	CENTRAL SERVICES & SUPPLY		39,358,539				14
15	PHARMACY			12,633,135			15
16	MEDICAL RECORDS & LIBRARY				1,646,526,437		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					100	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	61,090			166,935,819	50	30
31	INTENSIVE CARE UNIT	7,220			31,655,723		31
34	SURGICAL INTENSIVE CARE UNIT	5,643			22,957,134		34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF	267			699,162		40
41	SUBPROVIDER - IRF	3,831			10,662,550		41
43	NURSERY	2,072			5,474,634		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	11,163			138,903,262	50	50
54	RADIOLOGY-DIAGNOSTIC				327,555,980		54
60	LABORATORY				229,834,927		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY				29,472,820		65
66	PHYSICAL THERAPY				44,987,027		66
69	ELECTROCARDIOLOGY				97,953,592		69
70	ELECTROENCEPHALOGRAPHY				5,507,872		70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		39,358,539		130,218,506		71
72	IMPL. DEV. CHARGED TO PATIENT				89,332,823		72
73	DRUGS CHARGED TO PATIENTS			12,633,135	159,488,435		73
76	OTHER	647			19,728,865		76
76.10	OP PSYCH	189			1,434,001		76.10
76.97	CARDIAC REHABILITATION				1,976,725		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	10,417			131,746,580		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	102,539	39,358,539	12,633,135	1,646,526,437	100	118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC						192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINIS-TRATION FTE'S	CENTRAL SERVICES & SUPPLY SUPPLIES	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	I&R PROGRAM COSTS ASSIGNED TIME	
		13	14	15	16	22	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	9,090,887	5,463,715	26,077,686	8,596,713	140,520	202
203	UNIT COST MULT-WS B PT I	88.657847	0.138819	2.064229	0.005221	1,405.200000	203
204	COST TO BE ALLOC PER B PT II	353,794	1,106,368	1,459,065	397,738	2,336	204
205	UNIT COST MULT-WS B PT II	3.450336	0.028110	0.115495	0.000242	23.360000	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	PARAMED EDUCATION ASSIGNED TIME 23	
	GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)	100	23
	INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS		30
31	INTENSIVE CARE UNIT		31
34	SURGICAL INTENSIVE CARE UNIT		34
35	NEO NATAL INTENSIVE CARE		35
40	SUBPROVIDER - IPF		40
41	SUBPROVIDER - IRF		41
43	NURSERY		43
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM		50
54	RADIOLOGY-DIAGNOSTIC		54
60	LABORATORY		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY		65
66	PHYSICAL THERAPY		66
69	ELECTROCARDIOLOGY		69
70	ELECTROENCEPHALOGRAPHY		70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		71
72	IMPL. DEV. CHARGED TO PATIENT		72
73	DRUGS CHARGED TO PATIENTS	100	73
76	OTHER		76
76.10	OP PSYCH		76.10
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
91	EMERGENCY		91
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
99.10	CORF		99.10
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	100	118
	NONREIMBURSABLE COST CENTERS		
192.01	OTHER NRCC		192.01
194	OTHER NON-REIMBURSABLE		194
194.01	SHARED SERVICES		194.01
194.02	CASE MANAGEMENT		194.02
194.04	OUTPATIENT PHARMACY		194.04
194.05	PRIMARY CARE PHYSICIAN		194.05
194.06	PATIENT SITTERS		194.06

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	PARAMED EDUCATION	
		ASSIGNED TIME	
		23	
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	292,300	202
203	UNIT COST MULT-WS B PT I	2,923.000000	203
204	COST TO BE ALLOC PER B PT II	11,439	204
205	UNIT COST MULT-WS B PT II	114.390000	205

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	97,436,967		97,436,967	197,398	97,634,365	30
31	INTENSIVE CARE UNIT	14,610,721		14,610,721		14,610,721	31
34	SURGICAL INTENSIVE CARE UNI	10,463,108		10,463,108		10,463,108	34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF	398,122		398,122	111	398,233	40
41	SUBPROVIDER - IRF	6,601,656		6,601,656		6,601,656	41
43	NURSERY	4,238,247		4,238,247		4,238,247	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	29,557,959		29,557,959	32,600	29,590,559	50
54	RADIOLOGY-DIAGNOSTIC	29,779,272		29,779,272		29,779,272	54
60	LABORATORY	17,420,976		17,420,976		17,420,976	60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
65	RESPIRATORY THERAPY	5,025,006		5,025,006	4,072	5,029,078	65
66	PHYSICAL THERAPY	14,327,571		14,327,571		14,327,571	66
69	ELECTROCARDIOLOGY	9,811,655		9,811,655	6,278	9,817,933	69
70	ELECTROENCEPHALOGRAPHY	995,501		995,501		995,501	70
71	MEDICAL SUPPLIES CHRGED TO	26,560,767		26,560,767		26,560,767	71
72	IMPL. DEV. CHARGED TO PATIE	30,941,635		30,941,635		30,941,635	72
73	DRUGS CHARGED TO PATIENTS	27,202,675		27,202,675		27,202,675	73
76	OTHER	6,913,863		6,913,863		6,913,863	76
76.10	OP PSYCH	378,944		378,944		378,944	76.10
76.97	CARDIAC REHABILITATION	1,277,239		1,277,239		1,277,239	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	17,764,491		17,764,491	9,131	17,773,622	91
92	OBSERVATION BEDS	9,482,888		9,482,888		9,482,888	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THE						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	361,189,263		361,189,263	249,590	361,438,853	200
201	LESS OBSERVATION BEDS	9,482,888		9,482,888		9,482,888	201
202	TOTAL (SEE INSTRUCTIONS)	351,706,375		351,706,375		351,955,965	202

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	CHARGES TOTAL (COLS. 6 + 7) 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	148,820,059		148,820,059				30
31	INTENSIVE CARE UNIT	31,655,723		31,655,723				31
34	SURGICAL INTENSIVE CARE UNI	22,957,134		22,957,134				34
35	NEO NATAL INTENSIVE CARE							35
40	SUBPROVIDER - IPF	699,162		699,162				40
41	SUBPROVIDER - IRF	10,662,550		10,662,550				41
43	NURSERY	5,474,634		5,474,634				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	65,489,171	73,414,091	138,903,262	0.212795	0.212795	0.213030	50
54	RADIOLOGY-DIAGNOSTIC	116,122,204	211,433,776	327,555,980	0.090914	0.090914	0.090914	54
60	LABORATORY	125,660,599	104,174,328	229,834,927	0.075798	0.075798	0.075798	60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
65	RESPIRATORY THERAPY	26,943,617	2,529,203	29,472,820	0.170496	0.170496	0.170634	65
66	PHYSICAL THERAPY	22,281,594	22,705,433	44,987,027	0.318482	0.318482	0.318482	66
69	ELECTROCARDIOLOGY	52,884,332	45,069,260	97,953,592	0.100166	0.100166	0.100230	69
70	ELECTROENCEPHALOGRAPHY	2,305,086	3,202,786	5,507,872	0.180741	0.180741	0.180741	70
71	MEDICAL SUPPLIES CHRGED TO	91,396,164	38,822,342	130,218,506	0.203971	0.203971	0.203971	71
72	IMPL. DEV. CHARGED TO PATIE	66,404,612	22,928,211	89,332,823	0.346364	0.346364	0.346364	72
73	DRUGS CHARGED TO PATIENTS	119,376,524	40,111,911	159,488,435	0.170562	0.170562	0.170562	73
76	OTHER	56,696	19,672,169	19,728,865	0.350444	0.350444	0.350444	76
76.10	OP PSYCH	634,813	799,188	1,434,001	0.264256	0.264256	0.264256	76.10
76.97	CARDIAC REHABILITATION	13,932	1,962,793	1,976,725	0.646139	0.646139	0.646139	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	46,936,927	84,809,653	131,746,580	0.134838	0.134838	0.134908	91
92	OBSERVATION BEDS		18,115,760	18,115,760	0.523461	0.523461	0.523461	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THE							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	956,775,533	689,750,904	1,646,526,437				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	956,775,533	689,750,904	1,646,526,437				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	10,410,962		10,410,962	96,091	108.34	47,035	5,095,772	30
31	INTENSIVE CARE UNIT	1,381,517		1,381,517	7,006	197.19	3,736	736,702	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT	1,026,776		1,026,776	5,608	183.09	2,939	538,102	34
35	NEO NATAL INTENSIVE CARE								35
40	SUBPROVIDER - IPF	51,980		51,980	551	94.34	185	17,453	40
41	SUBPROVIDER - IRF	627,271		627,271	8,024	78.17	6,222	486,374	41
42	SUBPROVIDER I								42
43	NURSERY	390,742		390,742	4,841	80.72			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	13,889,248		13,889,248	122,121		60,117	6,874,403	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK APPLICABLE BOXES
[ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX
[XX] HOSPITAL (14-0007) [ ] IPF [ ] IRF
[ ] SUB (OTHER)
[XX] PPS [ ] TEFRA

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,218,034	138,903,262	0.037566	30,348,168	1,140,059	50
54	RADIOLOGY-DIAGNOSTIC	6,625,110	327,555,980	0.020226	65,886,705	1,332,624	54
60	LABORATORY	917,675	229,834,927	0.003993	71,568,890	285,775	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	252,398	29,472,820	0.008564	16,674,717	142,802	65
66	PHYSICAL THERAPY	1,211,014	44,987,027	0.026919	9,021,731	242,856	66
69	ELECTROCARDIOLOGY	2,291,422	97,953,592	0.023393	33,559,838	785,065	69
70	ELECTROENCEPHALOGRAPHY	158,580	5,507,872	0.028792	1,375,822	39,613	70
71	MEDICAL SUPPLIES CHRGED TO PA	1,468,260	130,218,506	0.011275	46,721,537	526,785	71
72	IMPL. DEV. CHARGED TO PATIENT	514,752	89,332,823	0.005762	31,772,183	183,071	72
73	DRUGS CHARGED TO PATIENTS	1,497,661	159,488,435	0.009390	66,426,541	623,745	73
76	OTHER	163,584	19,728,865	0.008292	54,412	451	76
76.10	OP PSYCH	13,472	1,434,001	0.009395	140,187	1,317	76.10
76.97	CARDIAC REHABILITATION	189,599	1,976,725	0.095916	7,861	754	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,425,935	131,746,580	0.010823	26,371,264	285,416	91
92	OBSERVATION BEDS	1,011,179	18,115,760	0.055818			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	22,958,675	1,426,257,175	1,426,257,175	399,929,856	5,590,333	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART III

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

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART III

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	96,091		47,035		30
31	INTENSIVE CARE UNIT	7,006		3,736		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT	5,608		2,939		34
35	NEO NATAL INTENSIVE CARE					35
40	SUBPROVIDER - IPF	551		185		40
41	SUBPROVIDER - IRF	8,024		6,222		41
42	SUBPROVIDER I					42
43	NURSERY	4,841				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	122,121		60,117		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0007)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS	
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA	
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF					

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS			292,300		292,300	292,300	73
76	OTHER							76
76.10	OP PSYCH							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS — WORKSHEET D PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX] HOSPITAL (14-0007)	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS
	[XX] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] TITLE XIX	[ ] IRF	[ ] NF		

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	138,903,262			30,348,168		18,649,308		50
54	RADIOLOGY-DIAGNOSTIC	327,555,980			65,886,705		52,871,086		54
60	LABORATORY	229,834,927			71,568,890		8,242,936		60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	29,472,820			16,674,717		622,903		65
66	PHYSICAL THERAPY	44,987,027			9,021,731		2,334,115		66
69	ELECTROCARDIOLOGY	97,953,592			33,559,838		16,056,536		69
70	ELECTROENCEPHALOGRAPHY	5,507,872			1,375,822		890,680		70
71	MEDICAL SUPPLIES CHRGED TO P	130,218,506			46,721,537		10,767,116		71
72	IMPL. DEV. CHARGED TO PATIEN	89,332,823			31,772,183		7,595,081		72
73	DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833	66,426,541	121,760	12,752,180	23,375	73
76	OTHER	19,728,865			54,412		5,142,766		76
76.10	OP PSYCH	1,434,001			140,187				76.10
76.97	CARDIAC REHABILITATION	1,976,725			7,861		966,185		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	131,746,580			26,371,264		12,353,688		91
92	OBSERVATION BEDS	18,115,760					5,953,361		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	1,426,257,175			399,929,856	121,760	155,197,941	23,375	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0007)	[ ]	SUB (OTHER)	[ ] S/B-SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ] S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ] ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.212795	18,649,308			3,968,479			50
54	RADIOLOGY-DIAGNOSTIC	0.090914	52,871,086			4,806,722			54
60	LABORATORY	0.075798	8,242,936			624,798			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.170496	622,903			106,202			65
66	PHYSICAL THERAPY	0.318482	2,334,115			743,374			66
69	ELECTROCARDIOLOGY	0.100166	16,056,536			1,608,319			69
70	ELECTROENCEPHALOGRAPHY	0.180741	890,680			160,982			70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971	10,767,116		64,265	2,196,179		13,108	71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364	7,595,081			2,630,663			72
73	DRUGS CHARGED TO PATIENTS	0.170562	12,752,180		9,607	2,175,037		1,639	73
76	OTHER	0.350444	5,142,766			1,802,251			76
76.10	OP PSYCH	0.264256							76.10
76.97	CARDIAC REHABILITATION	0.646139	966,185			624,290			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.134838	12,353,688			1,665,747			91
92	OBSERVATION BEDS	0.523461	5,953,361			3,116,352			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)		155,197,941		73,872	26,229,395		14,747	200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)		155,197,941		73,872	26,229,395		14,747	202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S007)			[ ] TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF			

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,218,034	138,903,262	0.037566			50
54	RADIOLOGY-DIAGNOSTIC	6,625,110	327,555,980	0.020226	19,844	401	54
60	LABORATORY	917,675	229,834,927	0.003993	56,615	226	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	252,398	29,472,820	0.008564	1,010	9	65
66	PHYSICAL THERAPY	1,211,014	44,987,027	0.026919	2,427	65	66
69	ELECTROCARDIOLOGY	2,291,422	97,953,592	0.023393	2,788	65	69
70	ELECTROENCEPHALOGRAPHY	158,580	5,507,872	0.028792	882	25	70
71	MEDICAL SUPPLIES CHRGED TO PA	1,468,260	130,218,506	0.011275	2,772	31	71
72	IMPL. DEV. CHARGED TO PATIENT	514,752	89,332,823	0.005762			72
73	DRUGS CHARGED TO PATIENTS	1,497,661	159,488,435	0.009390	43,830	412	73
76	OTHER	163,584	19,728,865	0.008292			76
76.10	OP PSYCH	13,472	1,434,001	0.009395	12,179	114	76.10
76.97	CARDIAC REHABILITATION	189,599	1,976,725	0.095916			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,425,935	131,746,580	0.010823	39,892	432	91
92	OBSERVATION BEDS	1,011,179	18,115,760	0.055818			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	22,958,675	1,426,257,175	1,426,257,175	182,239	1,780	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

CHECK	[ ] TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[XX]	IPF (14-S007)	[ ]	SNF			[ ]	TEFRA
BOXES	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS			292,300		292,300	292,300	73
76	OTHER							76
76.10	OP PSYCH							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS — WORKSHEET D PART IV

CHECK	[ ] TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[XX]	IPF (14-S007)	[ ]	SNF			[ ]	TEFRA
BOXES	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	138,903,262							50
54	RADIOLOGY-DIAGNOSTIC	327,555,980			19,844				54
60	LABORATORY	229,834,927			56,615				60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	29,472,820			1,010				65
66	PHYSICAL THERAPY	44,987,027			2,427				66
69	ELECTROCARDIOLOGY	97,953,592			2,788				69
70	ELECTROENCEPHALOGRAPHY	5,507,872			882				70
71	MEDICAL SUPPLIES CHRGED TO P	130,218,506			2,772				71
72	IMPL. DEV. CHARGED TO PATIEN	89,332,823							72
73	DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833	43,830	80			73
76	OTHER	19,728,865							76
76.10	OP PSYCH	1,434,001			12,179				76.10
76.97	CARDIAC REHABILITATION	1,976,725							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	131,746,580			39,892				91
92	OBSERVATION BEDS	18,115,760							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	1,426,257,175			182,239	80			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[XX]	IPF (14-S007)	[ ]	SNF	[ ]	S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.212795							50
54	RADIOLOGY-DIAGNOSTIC	0.090914							54
60	LABORATORY	0.075798							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.170496							65
66	PHYSICAL THERAPY	0.318482							66
69	ELECTROCARDIOLOGY	0.100166							69
70	ELECTROENCEPHALOGRAPHY	0.180741							70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971							71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364							72
73	DRUGS CHARGED TO PATIENTS	0.170562							73
76	OTHER	0.350444							76
76.10	OP PSYCH	0.264256							76.10
76.97	CARDIAC REHABILITATION	0.646139							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.134838							91
92	OBSERVATION BEDS	0.523461							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS — WORKSHEET D PART II

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[ ]	TITLE XIX	[XX]	IRF (14-T007)			

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,218,034	138,903,262	0.037566	37,518	1,409	50
54	RADIOLOGY-DIAGNOSTIC	6,625,110	327,555,980	0.020226	788,496	15,948	54
60	LABORATORY	917,675	229,834,927	0.003993	2,539,258	10,139	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	252,398	29,472,820	0.008564	500,117	4,283	65
66	PHYSICAL THERAPY	1,211,014	44,987,027	0.026919	7,838,022	210,992	66
69	ELECTROCARDIOLOGY	2,291,422	97,953,592	0.023393	339,411	7,940	69
70	ELECTROENCEPHALOGRAPHY	158,580	5,507,872	0.028792			70
71	MEDICAL SUPPLIES CHRGED TO PA	1,468,260	130,218,506	0.011275	1,178,669	13,289	71
72	IMPL. DEV. CHARGED TO PATIENT	514,752	89,332,823	0.005762	246,699	1,421	72
73	DRUGS CHARGED TO PATIENTS	1,497,661	159,488,435	0.009390	2,514,934	23,615	73
76	OTHER	163,584	19,728,865	0.008292			76
76.10	OP PSYCH	13,472	1,434,001	0.009395			76.10
76.97	CARDIAC REHABILITATION	189,599	1,976,725	0.095916			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,425,935	131,746,580	0.010823			91
92	OBSERVATION BEDS	1,011,179	18,115,760	0.055818			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	22,958,675	1,426,257,175	1,426,257,175	15,983,124	289,036	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

CHECK	[ ] TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ] TITLE XIX	[XX]	IRF (14-T007)	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS			292,300		292,300	292,300	73
76	OTHER							76
76.10	OP PSYCH							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS — WORKSHEET D PART IV

CHECK	[ ] TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ] TITLE XIX	[XX]	IRF (14-T007)	[ ]	NF				

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	138,903,262			37,518				50
54	RADIOLOGY-DIAGNOSTIC	327,555,980			788,496				54
60	LABORATORY	229,834,927			2,539,258				60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	29,472,820			500,117				65
66	PHYSICAL THERAPY	44,987,027			7,838,022				66
69	ELECTROCARDIOLOGY	97,953,592			339,411				69
70	ELECTROENCEPHALOGRAPHY	5,507,872							70
71	MEDICAL SUPPLIES CHRGED TO P	130,218,506			1,178,669				71
72	IMPL. DEV. CHARGED TO PATIEN	89,332,823			246,699				72
73	DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833	2,514,934	4,610			73
76	OTHER	19,728,865							76
76.10	OP PSYCH	1,434,001							76.10
76.97	CARDIAC REHABILITATION	1,976,725							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	131,746,580							91
92	OBSERVATION BEDS	18,115,760							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	1,426,257,175			15,983,124	4,610			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[XX]	IRF (14-T007)	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.212795							50
54	RADIOLOGY-DIAGNOSTIC	0.090914							54
60	LABORATORY	0.075798							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.170496							65
66	PHYSICAL THERAPY	0.318482							66
69	ELECTROCARDIOLOGY	0.100166							69
70	ELECTROENCEPHALOGRAPHY	0.180741							70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971							71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364							72
73	DRUGS CHARGED TO PATIENTS	0.170562							73
76	OTHER	0.350444							76
76.10	OP PSYCH	0.264256							76.10
76.97	CARDIAC REHABILITATION	0.646139							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.134838							91
92	OBSERVATION BEDS	0.523461							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	10,410,962		10,410,962	96,091	108.34	12,242	1,326,298	30
31	INTENSIVE CARE UNIT	1,381,517		1,381,517	7,006	197.19	139	27,409	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT	1,026,776		1,026,776	5,608	183.09	183	33,505	34
35	NEO NATAL INTENSIVE CARE								35
40	SUBPROVIDER - IPF	51,980		51,980	551	94.34	185	17,453	40
41	SUBPROVIDER - IRF	627,271		627,271	8,024	78.17	140	10,944	41
42	SUBPROVIDER I								42
43	NURSERY	390,742		390,742	4,841	80.72	2,337	188,643	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	13,889,248		13,889,248	122,121		15,226	1,604,252	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0007)	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[XX] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,218,034	138,903,262	0.037566			50
54	RADIOLOGY-DIAGNOSTIC	6,625,110	327,555,980	0.020226			54
60	LABORATORY	917,675	229,834,927	0.003993			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	252,398	29,472,820	0.008564			65
66	PHYSICAL THERAPY	1,211,014	44,987,027	0.026919			66
69	ELECTROCARDIOLOGY	2,291,422	97,953,592	0.023393			69
70	ELECTROENCEPHALOGRAPHY	158,580	5,507,872	0.028792			70
71	MEDICAL SUPPLIES CHRGED TO PA	1,468,260	130,218,506	0.011275			71
72	IMPL. DEV. CHARGED TO PATIENT	514,752	89,332,823	0.005762			72
73	DRUGS CHARGED TO PATIENTS	1,497,661	159,488,435	0.009390			73
76	OTHER	163,584	19,728,865	0.008292			76
76.10	OP PSYCH	13,472	1,434,001	0.009395			76.10
76.97	CARDIAC REHABILITATION	189,599	1,976,725	0.095916			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,425,935	131,746,580	0.010823			91
92	OBSERVATION BEDS	1,011,179	18,115,760	0.055818			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	22,958,675	1,426,257,175	1,426,257,175			200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D
PART III

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

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART III

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	96,091		12,242		30
31	INTENSIVE CARE UNIT	7,006		139		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT	5,608		183		34
35	NEO NATAL INTENSIVE CARE					35
40	SUBPROVIDER - IPF	551		185		40
41	SUBPROVIDER - IRF	8,024		140		41
42	SUBPROVIDER I					42
43	NURSERY	4,841		2,337		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	122,121		15,226		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0007)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS			292,300		292,300	292,300	73
76	OTHER							76
76.10	OP PSYCH							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS — WORKSHEET D PART IV

CHECK	[ ] TITLE V	[XX]	HOSPITAL (14-0007)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX] TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	138,903,262							50
54	RADIOLOGY-DIAGNOSTIC	327,555,980							54
60	LABORATORY	229,834,927							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	29,472,820							65
66	PHYSICAL THERAPY	44,987,027							66
69	ELECTROCARDIOLOGY	97,953,592							69
70	ELECTROENCEPHALOGRAPHY	5,507,872							70
71	MEDICAL SUPPLIES CHRGED TO P	130,218,506							71
72	IMPL. DEV. CHARGED TO PATIEN	89,332,823							72
73	DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833					73
76	OTHER	19,728,865							76
76.10	OP PSYCH	1,434,001							76.10
76.97	CARDIAC REHABILITATION	1,976,725							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	131,746,580							91
92	OBSERVATION BEDS	18,115,760							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	1,426,257,175							200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0007)	[ ]	SUB (OTHER)	[ ]	S/B-SNF	
APPLICABLE	[ ]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF	
BOXES	[XX]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.212795							50
54	RADIOLOGY-DIAGNOSTIC	0.090914							54
60	LABORATORY	0.075798							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.170496							65
66	PHYSICAL THERAPY	0.318482							66
69	ELECTROCARDIOLOGY	0.100166							69
70	ELECTROENCEPHALOGRAPHY	0.180741							70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971							71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364							72
73	DRUGS CHARGED TO PATIENTS	0.170562							73
76	OTHER	0.350444							76
76.10	OP PSYCH	0.264256							76.10
76.97	CARDIAC REHABILITATION	0.646139							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.134838							91
92	OBSERVATION BEDS	0.523461							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS — WORKSHEET D PART II

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S007)			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[XX] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,218,034	138,903,262	0.037566			50
54	RADIOLOGY-DIAGNOSTIC	6,625,110	327,555,980	0.020226			54
60	LABORATORY	917,675	229,834,927	0.003993			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	252,398	29,472,820	0.008564			65
66	PHYSICAL THERAPY	1,211,014	44,987,027	0.026919			66
69	ELECTROCARDIOLOGY	2,291,422	97,953,592	0.023393			69
70	ELECTROENCEPHALOGRAPHY	158,580	5,507,872	0.028792			70
71	MEDICAL SUPPLIES CHRGED TO PA	1,468,260	130,218,506	0.011275			71
72	IMPL. DEV. CHARGED TO PATIENT	514,752	89,332,823	0.005762			72
73	DRUGS CHARGED TO PATIENTS	1,497,661	159,488,435	0.009390			73
76	OTHER	163,584	19,728,865	0.008292			76
76.10	OP PSYCH	13,472	1,434,001	0.009395			76.10
76.97	CARDIAC REHABILITATION	189,599	1,976,725	0.095916			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,425,935	131,746,580	0.010823			91
92	OBSERVATION BEDS	1,011,179	18,115,760	0.055818			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	22,958,675	1,426,257,175	1,426,257,175			200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S007)	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS			292,300		292,300	292,300	73
76	OTHER							76
76.10	OP PSYCH							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS — WORKSHEET D PART IV

CHECK	[ ] TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ] TITLE XVIII-PT A	[XX]	IPF (14-S007)	[ ]	SNF			[ ]	TEFRA
BOXES	[XX] TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	138,903,262							50
54	RADIOLOGY-DIAGNOSTIC	327,555,980							54
60	LABORATORY	229,834,927							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	29,472,820							65
66	PHYSICAL THERAPY	44,987,027							66
69	ELECTROCARDIOLOGY	97,953,592							69
70	ELECTROENCEPHALOGRAPHY	5,507,872							70
71	MEDICAL SUPPLIES CHRGED TO P	130,218,506							71
72	IMPL. DEV. CHARGED TO PATIEN	89,332,823							72
73	DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833					73
76	OTHER	19,728,865							76
76.10	OP PSYCH	1,434,001							76.10
76.97	CARDIAC REHABILITATION	1,976,725							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	131,746,580							91
92	OBSERVATION BEDS	18,115,760							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	1,426,257,175							200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[ ]	TITLE XVIII-PT B	[XX]	IPF (14-S007)	[ ]	SNF	[ ]	S/B-NF
BOXES	[XX]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.212795							50
54	RADIOLOGY-DIAGNOSTIC	0.090914							54
60	LABORATORY	0.075798							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.170496							65
66	PHYSICAL THERAPY	0.318482							66
69	ELECTROCARDIOLOGY	0.100166							69
70	ELECTROENCEPHALOGRAPHY	0.180741							70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971							71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364							72
73	DRUGS CHARGED TO PATIENTS	0.170562							73
76	OTHER	0.350444							76
76.10	OP PSYCH	0.264256							76.10
76.97	CARDIAC REHABILITATION	0.646139							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.134838							91
92	OBSERVATION BEDS	0.523461							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[XX]	IRF (14-T007)			[XX] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,218,034	138,903,262	0.037566			50
54	RADIOLOGY-DIAGNOSTIC	6,625,110	327,555,980	0.020226			54
60	LABORATORY	917,675	229,834,927	0.003993			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	252,398	29,472,820	0.008564			65
66	PHYSICAL THERAPY	1,211,014	44,987,027	0.026919			66
69	ELECTROCARDIOLOGY	2,291,422	97,953,592	0.023393			69
70	ELECTROENCEPHALOGRAPHY	158,580	5,507,872	0.028792			70
71	MEDICAL SUPPLIES CHRGED TO PA	1,468,260	130,218,506	0.011275			71
72	IMPL. DEV. CHARGED TO PATIENT	514,752	89,332,823	0.005762			72
73	DRUGS CHARGED TO PATIENTS	1,497,661	159,488,435	0.009390			73
76	OTHER	163,584	19,728,865	0.008292			76
76.10	OP PSYCH	13,472	1,434,001	0.009395			76.10
76.97	CARDIAC REHABILITATION	189,599	1,976,725	0.095916			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,425,935	131,746,580	0.010823			91
92	OBSERVATION BEDS	1,011,179	18,115,760	0.055818			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	22,958,675	1,426,257,175	1,426,257,175			200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

CHECK	[ ] TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX] TITLE XIX	[XX]	IRF (14-T007)	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS			292,300		292,300	292,300	73
76	OTHER							76
76.10	OP PSYCH							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)			292,300		292,300	292,300	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS — WORKSHEET D PART IV

CHECK	[ ] TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX] TITLE XIX	[XX]	IRF (14-T007)	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	138,903,262							50
54	RADIOLOGY-DIAGNOSTIC	327,555,980							54
60	LABORATORY	229,834,927							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	29,472,820							65
66	PHYSICAL THERAPY	44,987,027							66
69	ELECTROCARDIOLOGY	97,953,592							69
70	ELECTROENCEPHALOGRAPHY	5,507,872							70
71	MEDICAL SUPPLIES CHRGED TO P	130,218,506							71
72	IMPL. DEV. CHARGED TO PATIEN	89,332,823							72
73	DRUGS CHARGED TO PATIENTS	159,488,435	0.001833	0.001833					73
76	OTHER	19,728,865							76
76.10	OP PSYCH	1,434,001							76.10
76.97	CARDIAC REHABILITATION	1,976,725							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	131,746,580							91
92	OBSERVATION BEDS	18,115,760							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	1,426,257,175							200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[ ]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[XX]	TITLE XIX - O/P	[XX]	IRF (14-T007)	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.212795							50
54	RADIOLOGY-DIAGNOSTIC	0.090914							54
60	LABORATORY	0.075798							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.170496							65
66	PHYSICAL THERAPY	0.318482							66
69	ELECTROCARDIOLOGY	0.100166							69
70	ELECTROENCEPHALOGRAPHY	0.180741							70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971							71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364							72
73	DRUGS CHARGED TO PATIENTS	0.170562							73
76	OTHER	0.350444							76
76.10	OP PSYCH	0.264256							76.10
76.97	CARDIAC REHABILITATION	0.646139							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.134838							91
92	OBSERVATION BEDS	0.523461							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0007)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	96,091	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	96,091	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	96,091	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	47,035	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	97,634,365	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	97,634,365	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	141,129,277	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	141,129,277	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.691808	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,468.70	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	97,634,365	37

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1 PART II

CHECK APPLICABLE BOXES: [ ] TITLE V-INPT [XX] TITLE XVIII-PT A [ ] TITLE XIX-INPT | [XX] HOSPITAL (14-0007) [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,016.06	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	47,790,382	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	47,790,382	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	14,610,721	7,006	2,085.46	3,736	7,791,279	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT	10,463,108	5,608	1,865.75	2,939	5,483,439	46
47	NEO NATAL INTENSIVE CARE						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					62,694,085	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					123,759,185	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					6,370,576	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					5,712,093	51
52	TOTAL PROGRAM EXCLUDABLE COST					12,082,669	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					111,676,516	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)	9,333	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	1,016.06	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	9,482,888	89

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
90	CAPITAL-RELATED COST	10,410,962	97,634,365	0.106632	9,482,888	1,011,179	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S007)	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	551	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	551	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	551	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	185	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	398,233	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	398,233	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	8,389,944	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,389,944	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.047466	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	15,226.76	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	398,233	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S007)			[ ] TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF			[ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	722.75	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	133,709	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	133,709	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	24,119	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	157,828	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	17,453	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	1,860	51
52	TOTAL PROGRAM EXCLUDABLE COST	19,313	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	138,515	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (LINE 54 x LINE 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT		57
58	BONUS PAYMENT (SEE INSTRUCTIONS)		58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET		59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E		61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[XX]	IRF (14-T007)	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	8,024	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,024	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,024	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	6,222	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,601,656	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,601,656	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	10,662,550	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	10,662,550	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.619144	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,328.83	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	6,601,656	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[XX]	IRF (14-T007)			[ ]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	822.74	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	5,119,088	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	5,119,088	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	3,642,587	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	8,761,675	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	486,374	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	293,646	51
52	TOTAL PROGRAM EXCLUDABLE COST	780,020	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	7,981,655	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (LINE 54 x LINE 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT		57
58	BONUS PAYMENT (SEE INSTRUCTIONS)		58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET		59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E		61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0007)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[XX]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	96,091	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	96,091	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	96,091	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	12,242	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	4,841	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	2,337	16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	97,436,967	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	97,436,967	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	141,129,277	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	141,129,277	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.690409	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,468.70	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	97,436,967	37

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1 PART II

CHECK APPLICABLE BOXES: [ ] TITLE V-INPT [XX] HOSPITAL (14-0007) [ ] SUB (OTHER) | [ ] PPS [ ] TEFRA [XX] OTHER
[ ] TITLE XVIII-PT A [ ] IPF
[XX] TITLE XIX-INPT [ ] IRF

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS						
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)					1,014.01	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)					12,413,510	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)					12,413,510	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)	4,238,247	4,841	875.49	2,337	2,046,020	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	14,610,721	7,006	2,085.46	139	289,879	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT	10,463,108	5,608	1,865.75	183	341,432	46
47	NEO NATAL INTENSIVE CARE						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					15,090,841	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					1,575,855	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST					1,575,855	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)					9,333	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)						88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)						89

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

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S007)	[ ]	SNF			[ ] TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[XX] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	551	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	551	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	551	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	185	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	398,122	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	398,122	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	8,389,944	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,389,944	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.047452	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	15,226.76	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	398,122	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S007)			[ ] TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF			[XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	722.54	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	133,670	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	133,670	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	133,670	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	17,453	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST	17,453	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (LINE 54 x LINE 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT		57
58	BONUS PAYMENT (SEE INSTRUCTIONS)		58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET		59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E		61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ] TEFRA
BOXES	[XX]	TITLE XIX-INPT	[XX]	IRF (14-T007)	[ ]	NF			[XX] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	8,024	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,024	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,024	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	140	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,601,656	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,601,656	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	10,662,550	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	10,662,550	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.619144	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,328.83	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	6,601,656	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX-INPT	[XX]	IRF (14-T007)			[XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	822.74	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	115,184	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	115,184	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	115,184	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	10,944	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST	10,944	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (LINE 54 x LINE 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT		57
58	BONUS PAYMENT (SEE INSTRUCTIONS)		58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET		59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E		61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0007)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		65,617,638		30
31	INTENSIVE CARE UNIT		16,916,992		31
34	SURGICAL INTENSIVE CARE UNIT		12,597,424		34
35	NEO NATAL INTENSIVE CARE				35
40	SUBPROVIDER - IPF				40
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.213030	30,348,168	6,465,070	50
54	RADIOLOGY-DIAGNOSTIC	0.090914	65,886,705	5,990,024	54
60	LABORATORY	0.075798	71,568,890	5,424,779	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.170634	16,674,717	2,845,274	65
66	PHYSICAL THERAPY	0.318482	9,021,731	2,873,259	66
69	ELECTROCARDIOLOGY	0.100230	33,559,838	3,363,703	69
70	ELECTROENCEPHALOGRAPHY	0.180741	1,375,822	248,667	70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971	46,721,537	9,529,839	71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364	31,772,183	11,004,740	72
73	DRUGS CHARGED TO PATIENTS	0.170562	66,426,541	11,329,844	73
76	OTHER	0.350444	54,412	19,068	76
76.10	OP PSYCH	0.264256	140,187	37,045	76.10
76.97	CARDIAC REHABILITATION	0.646139	7,861	5,079	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.134908	26,371,264	3,557,694	91
92	OBSERVATION BEDS	0.523461			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		399,929,856	62,694,085	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		399,929,856		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S007)	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
35	NEO NATAL INTENSIVE CARE				35
40	SUBPROVIDER - IPF		223,776		40
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.213030			50
54	RADIOLOGY-DIAGNOSTIC	0.090914	19,844	1,804	54
60	LABORATORY	0.075798	56,615	4,291	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.170634	1,010	172	65
66	PHYSICAL THERAPY	0.318482	2,427	773	66
69	ELECTROCARDIOLOGY	0.100230	2,788	279	69
70	ELECTROENCEPHALOGRAPHY	0.180741	882	159	70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971	2,772	565	71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364			72
73	DRUGS CHARGED TO PATIENTS	0.170562	43,830	7,476	73
76	OTHER	0.350444			76
76.10	OP PSYCH	0.264256	12,179	3,218	76.10
76.97	CARDIAC REHABILITATION	0.646139			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.134908	39,892	5,382	91
92	OBSERVATION BEDS	0.523461			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		182,239	24,119	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		182,239		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[XX]	IRF (14-T007)	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
35	NEO NATAL INTENSIVE CARE				35
40	SUBPROVIDER - IPF				40
41	SUBPROVIDER - IRF		7,744,283		41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.213030	37,518	7,992	50
54	RADIOLOGY-DIAGNOSTIC	0.090914	788,496	71,685	54
60	LABORATORY	0.075798	2,539,258	192,471	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.170634	500,117	85,337	65
66	PHYSICAL THERAPY	0.318482	7,838,022	2,496,269	66
69	ELECTROCARDIOLOGY	0.100230	339,411	34,019	69
70	ELECTROENCEPHALOGRAPHY	0.180741			70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971	1,178,669	240,414	71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364	246,699	85,448	72
73	DRUGS CHARGED TO PATIENTS	0.170562	2,514,934	428,952	73
76	OTHER	0.350444			76
76.10	OP PSYCH	0.264256			76.10
76.97	CARDIAC REHABILITATION	0.646139			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.134908			91
92	OBSERVATION BEDS	0.523461			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		15,983,124	3,642,587	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		15,983,124		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0007)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
35	NEO NATAL INTENSIVE CARE				35
40	SUBPROVIDER - IPF				40
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.212795			50
54	RADIOLOGY-DIAGNOSTIC	0.090914			54
60	LABORATORY	0.075798			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.170496			65
66	PHYSICAL THERAPY	0.318482			66
69	ELECTROCARDIOLOGY	0.100166			69
70	ELECTROENCEPHALOGRAPHY	0.180741			70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971			71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364			72
73	DRUGS CHARGED TO PATIENTS	0.170562			73
76	OTHER	0.350444			76
76.10	OP PSYCH	0.264256			76.10
76.97	CARDIAC REHABILITATION	0.646139			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.134838			91
92	OBSERVATION BEDS	0.523461			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S007)	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
35	NEO NATAL INTENSIVE CARE				35
40	SUBPROVIDER - IPF				40
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.212795			50
54	RADIOLOGY-DIAGNOSTIC	0.090914			54
60	LABORATORY	0.075798			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.170496			65
66	PHYSICAL THERAPY	0.318482			66
69	ELECTROCARDIOLOGY	0.100166			69
70	ELECTROENCEPHALOGRAPHY	0.180741			70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971			71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364			72
73	DRUGS CHARGED TO PATIENTS	0.170562			73
76	OTHER	0.350444			76
76.10	OP PSYCH	0.264256			76.10
76.97	CARDIAC REHABILITATION	0.646139			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.134838			91
92	OBSERVATION BEDS	0.523461			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[XX]	IRF (14-T007)	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
35	NEO NATAL INTENSIVE CARE				35
40	SUBPROVIDER - IPF				40
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.212795			50
54	RADIOLOGY-DIAGNOSTIC	0.090914			54
60	LABORATORY	0.075798			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.170496			65
66	PHYSICAL THERAPY	0.318482			66
69	ELECTROCARDIOLOGY	0.100166			69
70	ELECTROENCEPHALOGRAPHY	0.180741			70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.203971			71
72	IMPL. DEV. CHARGED TO PATIENT	0.346364			72
73	DRUGS CHARGED TO PATIENTS	0.170562			73
76	OTHER	0.350444			76
76.10	OP PSYCH	0.264256			76.10
76.97	CARDIAC REHABILITATION	0.646139			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.134838			91
92	OBSERVATION BEDS	0.523461			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0007)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	83,439,094	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	2,765,506	2
3	MANAGED CARE SIMULATED PAYMENTS	5,256,052	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	386.20	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)	9.00	6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.	5.85	7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)	3.15	9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	1.04	10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)	1.04	12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	1.08	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	0.68	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	0.93	15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	0.93	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.002408	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.023290	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.002408	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	116,723	22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)	-2.11	24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)	116,723	29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0275	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1516	31
32	SUM OF LINES 30 AND 31	0.1791	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0439	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	3,662,976	34
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	89,984,299	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	89,984,299	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	7,562,244	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0007)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)	47,500	52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)	121,760	58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	97,715,803	59
60	PRIMARY PAYER PAYMENTS	55,053	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	97,660,750	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	7,709,596	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	675,500	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	1,310,529	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	917,370	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	955,078	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	90,193,024	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	90,193,024	71
72	INTERIM PAYMENTS	91,617,821	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-1,424,797	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	870,555	75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2	90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2	91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)	94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)	95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)	96

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-0007) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	14,747	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	26,206,020	2
3	PPS PAYMENTS	23,104,020	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	102,419	4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200	23,375	9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	14,747	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	73,872	12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)	73,872	14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	73,872	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)	59,125	19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	14,747	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)	23,229,814	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	5,119,493	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	18,125,068	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)	9,397	28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	18,134,465	30
31	PRIMARY PAYER PAYMENTS	7,664	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	18,126,801	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	754,978	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	528,485	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	570,495	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	18,655,286	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	-195	38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	18,655,481	40
41	INTERIM PAYMENTS	18,150,495	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	504,986	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [ ] HOSPITAL [XX] IPF (14-S007) [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART B

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [XX] IRF (14-T007)
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED WORKSHEET E-1 PART I

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-0007) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	INPATIENT PART B MM/DD/YYYY 3	INPATIENT PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				91,088,622		18,096,589	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01	07/22/2011	529,199	07/22/2011	53,906	3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.50		NONE		NONE	3.50
			.51					3.51
		PROVIDER TO PROGRAM	.52					3.52
			.53					3.53
			.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		529,199		53,906	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				91,617,821		18,150,495	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01		NONE		NONE	5.01
			.02					5.02
			.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER TO PROGRAM	.50		NONE		NONE	5.50
			.51					5.51
			.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01				504,986	6.01
		PROVIDER TO PROGRAM	.02		-1,424,797			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				90,193,024		18,655,481	7

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED — WORKSHEET E-1 PART I

CHECK APPLICABLE BOX: [ ] HOSPITAL [XX] IPF (14-S007) [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	INPATIENT PART B MM/DD/YYYY 3	INPATIENT PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				131,265			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01		NONE		NONE	3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.50		NONE		NONE	3.50
			.51					3.51
		PROVIDER TO PROGRAM	.52					3.52
			.53					3.53
			.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				131,265			4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01		NONE		NONE	5.01
			.02					5.02
			.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER TO PROGRAM	.50		NONE		NONE	5.50
			.51					5.51
			.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01		78,161			6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				209,426			7

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED — WORKSHEET E-1 PART I

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [XX] IRF (14-T007) [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	INPATIENT PART B MM/DD/YYYY 3	INPATIENT PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				7,970,033			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE		NONE	3.01
			.02					3.02
		PROGRAM TO PROVIDER	.03					3.03
			.04					3.04
			.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.50	07/22/2011	5,319		NONE	3.50
			.51					3.51
		PROVIDER TO PROGRAM	.52					3.52
			.53					3.53
			.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		-5,319			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				7,964,714			4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE		NONE	5.01
			.02					5.02
		PROGRAM TO PROVIDER	.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.50		NONE		NONE	5.50
		PROVIDER TO PROGRAM	.51					5.51
			.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01					6.01
		PROVIDER TO PROGRAM	.02		-39,208			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				7,925,506			7

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT WORKSHEET E-1 PART II

CHECK APPLICABLE BOX [XX] HOSPITAL (14-0007) [ ] CAH

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	25,369	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	53,710	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3,177	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	99,372	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,646,526,437	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	42,876,152	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART II

CHECK [ ] HOSPITAL
APPLICABLE BOX: [XX] IPF (14-S007)

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS	148,856	1
2	NET IPF PPS OUTLIER PAYMENT	221	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	1.509589	9
10	MEDICAL EDUCATION ADJUSTMENT FACTOR {((1 + (LINE 8/LINE 9)) RAISED TO THE POWER OF .5150 -1}		10
11	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	149,077	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	149,077	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (LINE 16 LESS LINE 17)	149,077	18
19	DEDUCTIBLES	11,288	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	137,789	20
21	COINSURANCE	6,525	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	131,264	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	111,545	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	78,082	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	100,000	25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	209,346	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	80	28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	209,426	31
32	INTERIM PAYMENTS	131,265	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS THE SUM OF LINES 32 AND 33)	78,161	34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (SEE INSTRUCTIONS)	50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)	52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	53

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART III

CHECK [ ] HOSPITAL
APPLICABLE BOX: [XX] IRF (14-T007)

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	7,702,569	1
2	MEDICARE SSI RATIO (SEE INSTRUCTIONS)	0.010900	2
3	INPATIENT REHABILITATION LIP PAYMENTS (SEE INSTRUCTIONS)	102,583	3
4	OUTLIER PAYMENTS	171,790	4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		5
6	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM (SEE INSTRUCTIONS)		7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM (SEE INSTRUCTIONS)		8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		9
10	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	21.983562	10
11	MEDICAL EDUCATION ADJUSTMENT FACTOR {((1 + (LINE 9/LINE 10)) RAISED TO THE POWER OF .6876 -1}		11
12	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 11)		12
13	TOTAL PPS PAYMENT (SUM OF LINES 1, 3, 4 AND 12)	7,976,942	13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		14
15	ORGAN ACQUISITION		15
16	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		16
17	SUBTOTAL (SEE INSTRUCTIONS)	7,976,942	17
18	PRIMARY PAYER PAYMENTS	2,540	18
19	SUBTOTAL LINE 17b LESS LINE 18)	7,974,402	19
20	DEDUCTIBLES	25,940	20
21	SUBTOTAL (LINE 19 MINUS LINE 20)	7,948,462	21
22	COINSURANCE	35,941	22
23	SUBTOTAL (LINE 21 MINUS LINE 22)	7,912,521	23
24	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	11,964	24
25	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	8,375	25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		26
27	SUBTOTAL (SUM OF LINES 23 AND 25)	7,920,896	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		28
29	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	4,610	29
30	OUTLIER PAYMENTS RECONCILIATION		30
31	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	7,925,506	32
33	INTERIM PAYMENTS	7,964,714	33
34	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		34
35	BALANCE DUE PROVIDER/PROGRAM (LINE 32 MINUS THE SUM OF LINES 33 AND 34)	-39,208	35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (SEE INSTRUCTIONS)	50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)	52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	53

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0007)	[ ]	SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
BOXES:			[ ]	IRF	[ ]	ICF/MR	[XX]	OTHER
			[ ]	SUB (OTHER)				

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

	COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	15,090,841	1
2	MEDICAL AND OTHER SERVICES		2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	15,090,841	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	15,090,841	7
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES		8
9	ANCILLARY SERVICE CHARGES		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
	CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS)	15,090,841	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
	PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS		22
23	OUTLIER PAYMENTS		23
24	PROGRAM CAPITAL PAYMENTS		24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29	SUM OF LINES 27 AND 21		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)		30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32	DEDUCTIBLES		32
33	COINSURANCE		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	UTILIZATION REVIEW		35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

CHECK APPLICABLE BOXES:	[ ]	TITLE V	[ ]	HOSPITAL		[ ]	SNF	[ ]	PPS	
	[XX]	TITLE XIX	[XX]	IPF	(14-S007)	[ ]	NF	[ ]	TEFRA	
			[ ]	IRF		[ ]	ICF/MR	[XX]	OTHER	
			[ ]	SUB (OTHER)						

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

	COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	133,670	1
2	MEDICAL AND OTHER SERVICES		2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	133,670	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	133,670	7
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES		8
9	ANCILLARY SERVICE CHARGES		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
	CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS)	133,670	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
	PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS		22
23	OUTLIER PAYMENTS		23
24	PROGRAM CAPITAL PAYMENTS		24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29	SUM OF LINES 27 AND 21		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)		30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32	DEDUCTIBLES		32
33	COINSURANCE		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	UTILIZATION REVIEW		35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
BOXES:			[XX]	IRF (14-T007)	[ ]	ICF/MR	[XX]	OTHER
			[ ]	SUB (OTHER)				

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

	COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	115,184	1
2	MEDICAL AND OTHER SERVICES		2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	115,184	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	115,184	7
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES		8
9	ANCILLARY SERVICE CHARGES		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
	CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS)	115,184	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
	PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS		22
23	OUTLIER PAYMENTS		23
24	PROGRAM CAPITAL PAYMENTS		24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29	SUM OF LINES 27 AND 21		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)		30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32	DEDUCTIBLES		32
33	COINSURANCE		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	UTILIZATION REVIEW		35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS WORKSHEET E-4

CHECK APPLICABLE BOX: [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)			9.00	2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			5.85	3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011				4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)			3.15	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			1.04	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			1.04	7
		PRIMARY CARE 1	OTHER 2	TOTAL 3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.96		0.96	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.96		0.96	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR				10
11	TOTAL WEIGHTED FTE COUNT	0.96			11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)	0.92			12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)	0.79			13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)	0.89			14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS				15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.89			17
18	PER RESIDENT AMOUNT	109,455.95	95,706.96		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	97,416		97,416	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			97,416	25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	60,117	3,413		26
27	TOTAL INPATIENT DAYS	107,947	107,947		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.556912	0.031617		28
29	PROGRAM DIRECT GME AMOUNT	54,252	3,080		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		435		30
31	NET PROGRAM DIRECT GME AMOUNT			56,897	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)			132,678,688	37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)				38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)				39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			57,593	40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			132,621,095	41
	PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			26,244,142	42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			7,664	43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			26,236,478	44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			158,857,573	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			0.834843	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			0.165157	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			56,897	48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			47,500	49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			9,397	50

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS WORKSHEET E-4

CHECK APPLICABLE BOX: [ ] TITLE V [ ] TITLE XVIII [XX] TITLE XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)				3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011				4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)				5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)				6
7	ENTER THE LESSER OF LINE 5 OR LINE 6				7
		PRIMARY CARE 1	OTHER 2	TOTAL 3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR				8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6				9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR				10
11	TOTAL WEIGHTED FTE COUNT				11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)				12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)				13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)				14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS				15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				16
17	ADJUSTED ROLLING AVERAGE FTE COUNT				17
18	PER RESIDENT AMOUNT				18
19	APPROVED AMOUNT FOR RESIDENT COSTS				19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	12,889	712		26
27	TOTAL INPATIENT DAYS	107,947	107,947		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.119401	0.006596		28
29	PROGRAM DIRECT GME AMOUNT				29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30
31	NET PROGRAM DIRECT GME AMOUNT				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)				37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)				38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)				39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)				40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)				41
	PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)				42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)				43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)				44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)				45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)				46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)				48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)				49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)				50

BALANCE SHEET — WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	16,503,359				1
2	TEMPORARY INVESTMENTS	1,209,454				2
3	NOTES RECEIVABLE	161,048				3
4	ACCOUNTS RECEIVABLE	61,031,027				4
5	OTHER RECEIVABLES	1,805,162				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY	6,756,279				7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	7,175,255				9
10	DUE FROM OTHER FUNDS	360,998				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	95,002,582				11
	FIXED ASSETS					
12	LAND	1,884,595				12
13	LAND IMPROVEMENTS	3,208,539				13
14	ACCUMULATED DEPRECIATION	-3,194,775				14
15	BUILDINGS	322,395,286				15
16	ACCUMULATED DEPRECIATION	-118,763,967				16
17	LEASEHOLD IMPROVEMENTS	1,439,521				17
18	ACCUMULATED AMORTIZATION	-884,441				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	121,573,028				23
24	ACCUMULATED DEPRECIATION	-76,822,481				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	250,835,305				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	5,050,795				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	5,050,795				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	350,888,682				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	26,770,829				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)	891,087				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	46,680,661				43
44	OTHER CURRENT LIABILITIES	7,121,338				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	81,463,915				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	2,692,549				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	2,883,031				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	5,575,580				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	87,039,495				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	263,849,187				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED					54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	263,849,187				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	350,888,682				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1 2	3 4	5 6	7 8	
1	FUND BALANCES AT BEGINNING OF PERIOD	270,703,000				1
2	NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)	13,194,548				2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	283,897,548				3
4	ADDITIONS (CREDIT ADJUST-MENTS)					4
5	TRANSFERS FROM CORPORATE					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)					10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	283,897,548				11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)					12
13	ASSETS RELEASED FROM OPERATI 20,048,361					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)	20,048,361				18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	263,849,187				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	189,134,515		189,134,515	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	189,134,515		189,134,515	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	NEO NATAL INTENSIVE CARE				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	189,134,515		189,134,515	17
18	ANCILLARY SERVICES	767,664,304		767,664,304	18
19	OUTPATIENT SERVICES		697,421,579	697,421,579	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	956,798,819	697,421,579	1,654,220,398	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		399,265,554	29
30	ADD (SPECIFY)			30
31				31
32	ROUNDING	3		32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)		3	36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		399,265,557	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	1,654,220,398	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	1,245,596,380	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	408,624,018	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	399,265,557	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	9,358,461	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	406,400	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (ASSETS RELEASED FROM RESTRICTIONS)	295,489	24
24.01	OTHER (UNRESTRICTED CONTRIBUTIONS)	247,066	24.01
24.02	OTHER (OTHER OPERATING REVENUE)	3,574,679	24.02
24.03	OTHER (MISC)	-108,311	24.03
24.04	OTHER (MISC)	237,952	24.04
24.05	OTHER (IMPAIRMENTS)	-817,188	24.05
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	3,836,087	25
26	TOTAL (LINE 5 PLUS LINE 25)	13,194,548	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	13,194,548	29

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

CHECK APPLICABLE BOXES	[ ]	TITLE V	[XX]	HOSPITAL ((14-000)	[XX]	PPS	
	[XX]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD	
	[ ]	TITLE XIX					

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	6,774,751	1
2	CAPITAL DRG OUTLIER PAYMENTS	530,730	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	272.25	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	0.93	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0010	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	6,775	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.0275	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.1516	8
9	SUM OF LINES 7 AND 8	0.1791	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0369	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	249,988	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	7,562,244	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES AP						21
22	I&R SRVCES-OTHER PRGM COSTS AP						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
34	SURGICAL INTENSIVE CARE UNIT						34
35	NEO NATAL INTENSIVE CARE						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHRGED TO PAT						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76	OTHER						76
76.10	OP PSYCH						76.10
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAP						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
192.01	OTHER NRCC						192.01
194	OTHER NON-REIMBURSABLE						194
194.01	SHARED SERVICES						194.01
194.02	CASE MANAGEMENT						194.02
194.04	OUTPATIENT PHARMACY						194.04
194.05	PRIMARY CARE PHYSICIAN						194.05
194.06	PATIENT SITTERS						194.06
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINE 118 AND LINES 190-201)						202
203	TOTAL STATISTICAL BASIS						203
204	UNIT COST MULTIPLIER						204
204	UNIT COST MULTIPLIER						204