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: 01-31-2012 TIME: 08:13_____
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 ST. FRANCIS HOSPITAL (14-1350) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2010 AND ENDING 06/30/2011, 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		336,544	308,262		617,075	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-2,980				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		333,564	308,262		617,075	200

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1215 FRANCISCAN DRIVE P.O.BOX: 1
2 CITY: LITCHFIELD STATE: IL ZIP CODE: 62056 COUNTY: MONTGOMERY 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	ST. FRANCIS HOSPITAL	14-1350	00014	1	12/01/2005	N	O	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	ST. FRANCIS HOSPITAL	14-Z350	00014		05/31/2007	N	O	O	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: 07/01/2010	TO: 06/30/2011							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.	N	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.	1	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.							24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:			ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:			ENDING:		38

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

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

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
		Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N			61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
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.		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				64

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

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

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

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

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

	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	
	1	2	3	4	5	
67						67
67.01						67.01
67.02						67.02
67.03						67.03
67.04						67.04
67.05						67.05
67.06						67.06
67.07						67.07
67.08						67.08
67.09						67.09
67.10						67.10
67.11						67.11
67.12						67.12
67.13						67.13
67.14						67.14
67.15						67.15
67.16						67.16
67.17						67.17
67.18						67.18
67.19						67.19
67.20						67.20
67.21						67.21
67.22						67.22
67.23						67.23
67.24						67.24
67.25						67.25
67.26						67.26
67.27						67.27
67.28						67.28
67.29						67.29
67.30						67.30
67.31						67.31
67.32						67.32
67.33						67.33
67.34						67.34
67.35						67.35
67.36						67.36
67.37						67.37
67.38						67.38
67.39						67.39
67.40						67.40
67.41						67.41
67.42						67.42
67.43						67.43
67.44						67.44
67.45						67.45
67.46						67.46
67.47						67.47
67.48						67.48
67.49						67.49

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. — N — 70

71 IF LINE 70 YES: — 71
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.

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. — N — 75

76 IF LINE 75 YES: — 76
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.

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)?	Y	105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.	N	106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.	N	N	107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108

		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.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	2		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.	1,000,000	3,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

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

	ALL PROVIDERS	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	14H005	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: HOSPITAL SISTERS HEALTH SYSTEM	CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICES	CONTRACTOR'S NUMBER: 00131	141
142	STREET: 4736 LAVERNA ROAD	P.O. BOX:		142
143	CITY: SPRINGFIELD	STATE: IL	ZIP CODE: 62707	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		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 1	PART B 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 1	DATE 2		
PROVIDER ORGANIZATION AND OPERATION					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N			1

		Y/N 1	DATE 2	V/I 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)	N			3

		Y/N 1	TYPE 2	DATE 3	
FINANCIAL DATA AND REPORTS					
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.	Y			5

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

		Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	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.	N	15

		PART A		PART B		
		Y/N 1	DATE 2	Y/N 3	DATE 4	
PS&R REPORT DATA						
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	01/16/2012	Y	01/16/2012	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.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
	INTEREST EXPENSE		
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	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.	Y	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	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.	N	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.	Y	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.	N	35

		Y/N	DATE	
	HOME OFFICE COSTS	1	2	
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	Y		36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	Y		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.	N		38
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.	Y		39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N		40

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

	COMPONENT	WKST A LINE NO.	NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	25	9,125	122,660.00		3,833	626	5,111	1
2	HMO									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						121		121	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								8	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		25	9,125	122,660.00		3,954	626	5,240	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	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						400	500	13
14	TOTAL (SEE INSTRUCTIONS)		25	9,125	122,660.00		3,954	1,026	5,740	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								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)		25							27
28	OBSERVATION BED DAYS								1,091	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								85	30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									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					883	314	1,465	1
2	HMO									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	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)			230.77			883	314	1,465	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								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)			230.77						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	10,787,302					1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A							4
4.01	PHYSICIANS-PART A - DIRECT TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		146,027					10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)							11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN-PART A							15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)							17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A							22
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		119,027					26
27	ADMINISTRATIVE & GENERAL		1,902,519					27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS		329,158					29
30	OPERATION OF PLANT		64,707					30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		338,273					32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		396,897	-273,200				34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA			273,200				36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		156,898					38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY		302,167					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		413,705					41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	10,787,302	10,787,302	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	146,027	146,027	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	10,641,275	10,641,275	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)			4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)			5
6	TOTAL (SUM OF LINES 3 THRU 5)	10,641,275	10,641,275	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	4,023,351	4,023,351	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	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)	8
9	PRESCRIPTION DRUG PLAN	9
10	DENTAL, HEARING AND VISION PLAN	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15	WORKERS' COMPENSATION INSURANCE	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	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19	UNEMPLOYMENT INSURANCE	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	20
	OTHER	
21	EXECUTIVE DEFERRED COMPENSATION	21
22	DAY CARE COSTS AND ALLOWANCES	22
23	TUITION REIMBURSEMENT	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	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			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

WORKSHEET S-7

		Y/N (1)	DATE (2)	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N		2

	GROUP (1)	SNF DAYS (2)	SWING BED SNF DAYS (3)	TOTAL (COLS. 2 + 3) (4)	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68

PROSPECTIVE PAYMENT FOR SNF | WORKSHEET S-7
STATISTICAL DATA

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

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

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA — WORKSHEET S-10

	UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION		
1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)	0.335173	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	4,518,184	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	17,722,587	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	5,940,133	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)	1,421,949	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	1,346	17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS	26,104	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)	1,421,949	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	1,747,319	175,221	1,922,540	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	585,654	58,729	644,383	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	38,529	11,958	50,487	22
23	COST OF CHARITY CARE	547,125	46,771	593,896	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)	2,722,683	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	987,104	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	1,735,579	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	581,719	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	1,175,615	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	2,597,564	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFICATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		483,349	483,349	45,332	1
2	00200	CAP REL COSTS-MVBLE EQUIP		1,066,318	1,066,318	913	2
3	00300	OTHER CAPITAL RELATED COSTS					3
4	00400	EMPLOYEE BENEFITS	119,027	4,862,863	4,981,890	13,967	4
5.01	00570	ADMITTING	365,387	36,089	401,476		5.01
5.02	00580	PATIENT ACCOUNTING	324,940	2,907,408	3,232,348	-31	5.02
5.03	00590	ADMIN & GENERAL	1,212,192	5,444,085	6,656,277	-244,418	5.03
6	00600	MAINTENANCE & REPAIRS	329,158	27,858	357,016		6
7	00700	OPERATION OF PLANT	64,707	990,768	1,055,475	-43,796	7
8	00800	LAUNDRY & LINEN SERVICE		5,670	5,670	112,474	8
9	00900	HOUSEKEEPING	338,273	104,216	442,489	422	9
10	01000	DIETARY	396,897	284,030	680,927	-471,157	10
11	01100	CAFETERIA				468,709	11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	156,898	5,616	162,514	327	13
14	01400	CENTRAL SERVICES & SUPPLY					14
15	01500	PHARMACY	302,167	853,124	1,155,291	-494,675	15
16	01600	MEDICAL RECORDS & LIBRARY	413,705	123,553	537,258	3,766	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					22
23	02300	PARAMED ED PRGM-(SPECIFY)					23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	2,557,613	200,220	2,757,833	-1,075,948	30
43	04300	NURSERY				70,918	43
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	825,879	1,027,853	1,853,732	-687,682	50
52	05200	DELIVERY ROOM & LABOR ROOM				444,204	52
53	05300	ANESTHESIOLOGY		654,731	654,731	-15,541	53
54	05400	RADIOLOGY-DIAGNOSTIC	872,400	476,947	1,349,347	-16,883	54
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	44,012	138,645	182,657	-1,310	57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	74,870	166,414	241,284	4,068	58
60	06000	LABORATORY	776,055	964,597	1,740,652	52,666	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	06500	RESPIRATORY THERAPY	256,364	116,043	372,407	25,382	65
66	06600	PHYSICAL THERAPY	279,871	69,725	349,596	-2,625	66
70	07000	ELECTROENCEPHALOGRAPHY		8,048	8,048		70
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS		65,843	65,843	243,902	71
72	07200	IMPL. DEV. CHARGED TO PATIENT				482,722	72
73	07300	DRUGS CHARGED TO PATIENTS				1,119,113	73
76.97	07697	CARDIAC REHABILITATION	118,810	5,197	124,007		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
91	09100	EMERGENCY	812,050	1,839,677	2,651,727	-29,820	91
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
		SPECIAL PURPOSE COST CENTERS					
118		SUBTOTALS (SUM OF LINES 1-117)	10,641,275	22,928,887	33,570,162	4,999	118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		22,818	22,818		190
192	19200	PHYSICIANS' PRIVATE OFFICES	122,262	1,443,908	1,566,170	-24,498	192
192.01	19201	MEDICAL OFFICE BUILDING				19,499	192.01
194	07950	OTHER NONALLOWABLE	23,765	59,211	82,976		194
200		TOTAL (SUM OF LINES 118-199)	10,787,302	24,454,824	35,242,126		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	528,681		528,681	1
2	00200	CAP REL COSTS-MVBLE EQUIP	1,067,231		1,067,231	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	4,995,857	-1,164,632	3,831,225	4
5.01	00570	ADMITTING	401,476		401,476	5.01
5.02	00580	PATIENT ACCOUNTING	3,232,317	-2,722,333	509,984	5.02
5.03	00590	ADMIN & GENERAL	6,411,859	-1,908,283	4,503,576	5.03
6	00600	MAINTENANCE & REPAIRS	357,016		357,016	6
7	00700	OPERATION OF PLANT	1,011,679		1,011,679	7
8	00800	LAUNDRY & LINEN SERVICE	118,144		118,144	8
9	00900	HOUSEKEEPING	442,911	-12,167	430,744	9
10	01000	DIETARY	209,770		209,770	10
11	01100	CAFETERIA	468,709	-62,299	406,410	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	162,841		162,841	13
14	01400	CENTRAL SERVICES & SUPPLY				14
15	01500	PHARMACY	660,616	-230	660,386	15
16	01600	MEDICAL RECORDS & LIBRARY	541,024	-868	540,156	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				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	1,681,885		1,681,885	30
43	04300	NURSERY	70,918		70,918	43
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	1,166,050		1,166,050	50
52	05200	DELIVERY ROOM & LABOR ROOM	444,204		444,204	52
53	05300	ANESTHESIOLOGY	639,190	-525,496	113,694	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,332,464	-1,059	1,331,405	54
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	181,347		181,347	57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	245,352		245,352	58
60	06000	LABORATORY	1,793,318		1,793,318	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	397,789	-57,860	339,929	65
66	06600	PHYSICAL THERAPY	346,971		346,971	66
70	07000	ELECTROENCEPHALOGRAPHY	8,048	-8,048		70
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	309,745		309,745	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	482,722		482,722	72
73	07300	DRUGS CHARGED TO PATIENTS	1,119,113		1,119,113	73
76.97	07697	CARDIAC REHABILITATION	124,007		124,007	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
91	09100	EMERGENCY	2,621,907	-1,618,275	1,003,632	91
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
		SPECIAL PURPOSE COST CENTERS				
118		SUBTOTALS (SUM OF LINES 1-117)	33,575,161	-8,081,550	25,493,611	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,818		22,818	190
192	19200	PHYSICIANS' PRIVATE OFFICES	1,541,672	-1,336,857	204,815	192
192.01	19201	MEDICAL OFFICE BUILDING	19,499		19,499	192.01
194	07950	OTHER NONALLOWABLE	82,976		82,976	194
200		TOTAL (SUM OF LINES 118-199)	35,242,126	-9,418,407	25,823,719	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1			NURSERY	43	64,257	7,807	1
2	RECLASSIFY L&D AND NURSERY COSTS	A	DELIVERY ROOM & LABOR ROOM	52	398,194	48,382	2
500	TOTAL RECLASSIFICATIONS				462,451	56,189	500
	CODE LETTER -						
1	RECLASSIFY DRUG COSTS	B	DRUGS CHARGED TO PATIENTS	73		654,192	1
500	TOTAL RECLASSIFICATIONS					654,192	500
	CODE LETTER - B						
1	RECLASSIFY CAFETERIA COSTS	C	CAFETERIA	11	273,200	195,509	1
500	TOTAL RECLASSIFICATIONS				273,200	195,509	500
	CODE LETTER - C						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11	RECLASSIFY LAUNDRY COSTS	D	LAUNDRY & LINEN SERVICE	8		112,474	11
500	TOTAL RECLASSIFICATIONS					112,474	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9			MEDICAL SUPPLIES CHRGED TO PA	71		243,902	9
10	RECLASSIFY MEDICAL SUPPLY COSTS	E	IMPL. DEV. CHARGED TO PATIENT	72		482,722	10
500	TOTAL RECLASSIFICATIONS					726,624	500
	CODE LETTER -						
1			LABORATORY	60	38,719	2,662	1
2	RECLASSIFY DRUG ADMINISTRATION COST	F	DRUGS CHARGED TO PATIENTS	73	435,251	29,967	2
500	TOTAL RECLASSIFICATIONS				473,970	32,629	500
	CODE LETTER -						
1			CAP REL COSTS-MVBLE EQUIP	2		913	1
2	RECLASSIFY DEPREC COSTS FOR MOB	G	MEDICAL OFFICE BUILDING	192.01		19,499	2
500	TOTAL RECLASSIFICATIONS					20,412	500
	CODE LETTER -						
1			EMPLOYEE BENEFITS	4		13,967	1
2			PATIENT ACCOUNTING	5.02		221	2
3			HOUSEKEEPING	9		422	3
4			NURSING ADMINISTRATION	13		327	4
5			PHARMACY	15		159,517	5
6			MEDICAL RECORDS & LIBRARY	16		3,766	6
7			RADIOLOGY-DIAGNOSTIC	54		887	7
8			LABORATORY	60		11,683	8
9			RESPIRATORY THERAPY	65		47,866	9
10	RECLASSIFY SHARED SERVICE COSTS	H	EMERGENCY	91		5,762	10
500	TOTAL RECLASSIFICATIONS					244,418	500
	CODE LETTER -						
1							1
2							2
3	RECLASSIFY BUILDING INSURANCE COSTS	I	CAP REL COSTS-BLDG & FIXT	1		45,332	3
500	TOTAL RECLASSIFICATIONS					45,332	500
	CODE LETTER -						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1			COMPUTED TOMOGRAPHY (CT) SCAN	57	2,822	1
2	RECLASSIFY RADIOLOGY MGR COSTS	J	MAGNETIC RESONANCE IMAGING (M	58	4,288	2
500	TOTAL RECLASSIFICATIONS				7,110	500
	CODE LETTER -					
	GRAND TOTAL (INCREASES)				1,216,731	2,087,779

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							1
2	RECLASSIFY L&D AND NURSERY COSTS	A	ADULTS & PEDIATRICS	30	462,451	56,189	2
500	TOTAL RECLASSIFICATIONS				462,451	56,189	500
	CODE LETTER -						
1	RECLASSIFY DRUG COSTS	B	PHARMACY	15		654,192	1
500	TOTAL RECLASSIFICATIONS					654,192	500
	CODE LETTER - B						
1	RECLASSIFY CAFETERIA COSTS	C	DIETARY	10	273,200	195,509	1
500	TOTAL RECLASSIFICATIONS				273,200	195,509	500
	CODE LETTER - C						
1			DIETARY	10		2,448	1
2			ADULTS & PEDIATRICS	30		51,694	2
3			OPERATING ROOM	50		17,585	3
4			RADIOLOGY-DIAGNOSTIC	54		10,393	4
5			COMPUTED TOMOGRAPHY (CT) SCAN	57		4,132	5
6			MAGNETIC RESONANCE IMAGING (M	58		220	6
7			LABORATORY	60		343	7
8			RESPIRATORY THERAPY	65		435	8
9			PHYSICAL THERAPY	66		2,621	9
10			EMERGENCY	91		19,801	10
11	RECLASSIFY LAUNDRY COSTS	D	PHYSICIANS' PRIVATE OFFICES	192		2,802	11
500	TOTAL RECLASSIFICATIONS					112,474	500
	CODE LETTER -						
1			NURSERY	43		161	1
2			OPERATING ROOM	50		670,097	2
3			DELIVERY ROOM & LABOR ROOM	52		2,372	3
4			ANESTHESIOLOGY	53		15,541	4
5			RADIOLOGY-DIAGNOSTIC	54		267	5
6			LABORATORY	60		55	6
7			RESPIRATORY THERAPY	65		22,049	7
8			PHYSICAL THERAPY	66		4	8
9			DRUGS CHARGED TO PATIENTS	73		297	9
10	RECLASSIFY MEDICAL SUPPLY COSTS	E	EMERGENCY	91		15,781	10
500	TOTAL RECLASSIFICATIONS					726,624	500
	CODE LETTER -						
1			ADULTS & PEDIATRICS	30	473,092	32,522	1
2	RECLASSIFY DRUG ADMINISTRATION COST	F	NURSERY	43	878	107	2
500	TOTAL RECLASSIFICATIONS				473,970	32,629	500
	CODE LETTER -						
1						9	1
2	RECLASSIFY DEPREC COSTS FOR MOB	G	PHYSICIANS' PRIVATE OFFICES	192		20,412	2
500	TOTAL RECLASSIFICATIONS					20,412	500
	CODE LETTER -						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10	RECLASSIFY SHARED SERVICE COSTS	H	ADMIN & GENERAL	5.03		244,418	10
500	TOTAL RECLASSIFICATIONS					244,418	500
	CODE LETTER -						
1			PATIENT ACCOUNTING	5.02		252	1
2			OPERATION OF PLANT	7		43,796	2
3	RECLASSIFY BUILDING INSURANCE COSTS	I	PHYSICIANS' PRIVATE OFFICES	192		1,284	12 3
500	TOTAL RECLASSIFICATIONS					45,332	500
	CODE LETTER -						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1							1
2	RECLASSIFY RADIOLOGY MGR COSTS	J	RADIOLOGY-DIAGNOSTIC	54	7,110		2
500	TOTAL RECLASSIFICATIONS				7,110		500
	CODE LETTER - GRAND TOTAL (DECREASES)				1,216,731	2,087,779	

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	76,883					76,883		1
2	LAND IMPROVEMENTS	1,007,759					1,007,759	739,384	2
3	BUILDINGS AND FIXTURES	14,963,634	1,033,036		1,033,036		15,996,670	6,271,149	3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	15,920,868	784,777		784,777	353,971	16,351,674	11,011,766	6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	31,969,144	1,817,813		1,817,813	353,971	33,432,986	18,022,299	8
9	RECONCILING ITEMS	335,506	765,214		765,214		1,100,720		9
10	TOTAL (LINE 7 MINUS LINE 9)	31,633,638	1,052,599		1,052,599	353,971	32,332,266	18,022,299	10

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

SUMMARY OF CAPITAL

	DESCRIPTION	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	483,349						483,349	1
2	CAP REL COSTS-MVBLE EQUIP	1,066,318						1,066,318	2
3	TOTAL (SUM OF LINES 1-2)	1,549,667						1,549,667	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS — ALLOCATION OF OTHER CAPITAL

	DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT									1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (SUM OF LINES 1-2)									3

SUMMARY OF CAPITAL

	DESCRIPTION	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	483,349			45,332			528,681	1
2	CAP REL COSTS-MVBLE EQUIP	1,067,231						1,067,231	2
3	TOTAL	1,550,580			45,332			1,595,912	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)					6	
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	B	-1,109	RADIOLOGY-DIAGNOSTIC	54	7	
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)					8	
9	PARKING LOT (CHAPTER 21)					9	
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,209,679			10	
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11	
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-446,090			12	
13	LAUNDRY AND LINEN SERVICE					13	
14	CAFETERIA - EMPLOYEES AND GUESTS					14	
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15	
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-60,381	CAFETERIA	11	16	
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-230	PHARMACY	15	17	
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-868	MEDICAL RECORDS & LIBRARY	16	18	
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19	
20	VENDING MACHINES					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	MISCELLANEOUS INCOME	B	-235,163	ADMIN & GENERAL	5.03	33	
33.01	MISCELLANEOUS INCOME	B	50	RADIOLOGY-DIAGNOSTIC	54	33.01	
34	REBATES AND REFUNDS	B	-1,918	CAFETERIA	11	34	
35	HOUSEKEEPING INCOME	B	-12,167	HOUSEKEEPING	9	35	
36	MEDICAID ASSESSMENT	A	-651,648	ADMIN & GENERAL	5.03	36	
37	PHYSICIAN RECRUITMENT	A	-461,192	ADMIN & GENERAL	5.03	37	
38	NONALLOWABLE LEGAL FEES	A	-185,225	ADMIN & GENERAL	5.03	38	
39	SELF INS PMT/EMPLE CLAIMS	A	-1,001,045	EMPLOYEE BENEFITS	4	39	
40	INTEREST EXPENSE	A	-20,722	ADMIN & GENERAL	5.03	40	
41	BAD DEBT EXPENSE	A	-2,722,683	PATIENT ACCOUNTING	5.02	41	
42	CHARITY EXPENSE	A	350	PATIENT ACCOUNTING	5.02	42	
43	LOBBYING/ADVERTISEMENT COSTS	A	-71,830	ADMIN & GENERAL	5.03	43	
44	PURCHASED SVCS-HSHS MEDICAL GRP	A	-1,336,857	PHYSICIANS' PRIVATE OFFICES	192	44	
45						45	
46						46	
47						47	
48						48	
49						49	
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-9,418,407			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	SELF INS PREMIUMS	3,074,057	3,237,644	-163,587		1
2	4	EMPLOYEE BENEFITS	EAP SERVICES-SMD	8,435	8,435			2
3	5.03	ADMIN & GENERAL	CONTRACT SERVICES-HSHS	1,505,497	1,788,000	-282,503		3
4	5.03	ADMIN & GENERAL	SHARED SERVICES-HSHS	330,270	330,270			4
4.01	5.03	ADMIN & GENERAL	SHARED SERVICES-SJS	319,816	319,816			4.01
4.02	8	LAUNDRY & LINEN SERVICE	SHARED SERVICES-SJS	112,934	112,934			4.02
4.03	50	OPERATING ROOM	SHARED SERVICES-SJS	68	68			4.03
4.04	60	LABORATORY	SHARED SERVICES-SJS	86,119	86,119			4.04
4.05	60	LABORATORY	SHARED SERVICES-SJB	3,309	3,309			4.05
4.06	66	PHYSICAL THERAPY	SHARED SERVICES-SJS	45,678	45,678			4.06
4.07	71	MEDICAL SUPPLIES CHRGED TO PATI	SHARED SERVICES-SJS	24	24			4.07
4.08	71	MEDICAL SUPPLIES CHRGED TO PATI	SHARED SERVICES-SJH	68	68			4.08
4.09	73	DRUGS CHARGED TO PATIENTS	SHARED SERVICES-SJS	49	49			4.09
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		5,486,324	5,932,414	-446,090		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			HOSPITAL SISTERS HEALTH SYSTEM	100.00	CORPORATE OFFICE	6
7	G			ST. MARY'S HOSPITAL		HOSPITAL	7
8	G			ST. JOHN'S HOSPITAL		HOSPITAL	8
9	G			ST. JOSEPH'S HOSPITAL-BREESE		HOSPITAL	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: FINANCIAL

PROVIDER-BASED PHYSICIAN ADJUSTMENTS — WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERATION INCL FRINGES	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT	
	1	2		3	4	5	6	7	8	9	
1	53	ANESTHESIOLOGY	VARIOUS	525,496	525,496						1
2	60	LABORATORY	VARIOUS	30,000		30,000					2
3	65	RESPIRATORY THERAPY	VARIOUS	57,860	57,860						3
4	70	ELECTROENCEPHALOGRAPHY	VARIOUS	8,048	8,048						4
5	91	EMERGENCY	VARIOUS	1,774,361	1,618,275	156,086					5
200		TOTAL		2,395,765	2,209,679	186,086					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	53	ANESTHESIOLOGY	VARIOUS							525,496	1
2	60	LABORATORY	VARIOUS								2
3	65	RESPIRATORY THERAPY	VARIOUS							57,860	3
4	70	ELECTROENCEPHALOGRAPHY	VARIOUS							8,048	4
5	91	EMERGENCY	VARIOUS							1,618,275	5
200		TOTAL								2,209,679	200

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	ADMITTING 5.01	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	528,681	528,681				1
2	CAP REL COSTS-MVBLE EQUIP	1,067,231		1,067,231			2
4	EMPLOYEE BENEFITS	3,831,225	10,911	5,555	3,847,691		4
5.01	ADMITTING	401,476	4,307	6,000	131,783	543,566	5.01
5.02	PATIENT ACCOUNTING	509,984	24,332	2,085	117,195		5.02
5.03	ADMIN & GENERAL	4,503,576	98,197	234,315	437,198		5.03
6	MAINTENANCE & REPAIRS	357,016			118,716		6
7	OPERATION OF PLANT	1,011,679	105,129	16,147	23,338		7
8	LAUNDRY & LINEN SERVICE	118,144	4,287				8
9	HOUSEKEEPING	430,744	5,356	693	122,004		9
10	DIETARY	209,770	29,232	10,190	44,613		10
11	CAFETERIA	406,410	8,304		98,534		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	162,841	2,560	24,017	56,588		13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	660,386	4,309	2,783	108,982		15
16	MEDICAL RECORDS & LIBRARY	540,156	10,371	35,077	149,210		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,681,885	67,086	45,115	585,482	31,251	30
43	NURSERY	70,918	2,475		22,865	1,417	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,166,050	24,208	166,027	297,867	38,029	50
52	DELIVERY ROOM & LABOR ROOM	444,204	7,291		143,615	8,551	52
53	ANESTHESIOLOGY	113,694	841	40,766		21,868	53
54	RADIOLOGY-DIAGNOSTIC	1,331,405	20,262	224,423	312,082	68,544	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	181,347	1,511	132,013	16,891	66,850	57
58	MAGNETIC RESONANCE IMAGING (MRI)	245,352			28,550	30,626	58
60	LABORATORY	1,793,318	14,686	67,792	293,825	70,787	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	339,929	7,724	21,340	92,462	63,065	65
66	PHYSICAL THERAPY	346,971	17,989	9,959	100,940	10,251	66
70	ELECTROENCEPHALOGRAPHY			2,903		163	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	309,745	6,630			20,286	71
72	IMPL. DEV. CHARGED TO PATIENT	482,722	1,592			6,070	72
73	DRUGS CHARGED TO PATIENTS	1,119,113			156,553	34,711	73
76.97	CARDIAC REHABILITATION	124,007	5,232	6,912	42,851	1,917	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,003,632	16,416	7,175	292,880	69,180	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	25,493,611	501,238	1,061,287	3,795,024	543,566	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,818	1,097	368			190
192	PHYSICIANS' PRIVATE OFFICES	204,815	26,346	5,038	44,096		192
192.01	MEDICAL OFFICE BUILDING	19,499					192.01
194	OTHER NONALLOWABLE	82,976		538	8,571		194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	25,823,719	528,681	1,067,231	3,847,691	543,566	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	PATIENT ACCOUNTING 5.02	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5.03	MAIN-TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMITTING						5.01
5.02	PATIENT ACCOUNTING	653,596					5.02
5.03	ADMIN & GENERAL		5,273,286	5,273,286			5.03
6	MAINTENANCE & REPAIRS		475,732	122,074	597,806		6
7	OPERATION OF PLANT		1,156,293	296,707	160,754	1,613,754	7
8	LAUNDRY & LINEN SERVICE		122,431	31,416	6,555	24,205	8
9	HOUSEKEEPING		558,797	143,388	8,190	30,241	9
10	DIETARY		293,805	75,391	44,701	165,054	10
11	CAFETERIA		513,248	131,700	12,698	46,886	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		246,006	63,126	3,914	14,453	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY		776,460	199,241	6,590	24,332	15
16	MEDICAL RECORDS & LIBRARY		734,814	188,555	15,860	58,560	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	37,574	2,448,393	628,270	102,587	378,789	30
43	NURSERY	1,703	99,378	25,501	3,785	13,977	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	45,724	1,737,905	445,950	37,019	136,687	50
52	DELIVERY ROOM & LABOR ROOM	10,281	613,942	157,539	11,150	41,168	52
53	ANESTHESIOLOGY	26,292	203,461	52,208	1,286	4,749	53
54	RADIOLOGY-DIAGNOSTIC	82,412	2,039,128	523,244	30,984	114,404	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	80,376	478,988	122,909	2,310	8,529	57
58	MAGNETIC RESONANCE IMAGING (MRI)	36,823	341,351	87,591			58
60	LABORATORY	85,160	2,325,568	596,745	22,458	82,924	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	75,825	600,345	154,050	11,812	43,614	65
66	PHYSICAL THERAPY	12,325	498,435	127,899	27,508	101,570	66
70	ELECTROENCEPHALOGRAPHY	197	3,263	837			70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	24,390	361,051	92,646	10,139	37,436	71
72	IMPL. DEV. CHARGED TO PATIENT	7,298	497,682	127,706	2,435	8,990	72
73	DRUGS CHARGED TO PATIENTS	41,734	1,352,111	346,954			73
76.97	CARDIAC REHABILITATION	2,305	183,224	47,016	8,001	29,542	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	83,177	1,472,460	377,836	25,104	92,692	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	653,596	25,407,557	5,166,499	555,840	1,458,802	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		24,283	6,231	1,678	6,194	190
192	PHYSICIANS' PRIVATE OFFICES		280,295	71,924	40,288	148,758	192
192.01	MEDICAL OFFICE BUILDING		19,499	5,003			192.01
194	OTHER NONALLOWABLE		92,085	23,629			194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	653,596	25,823,719	5,273,286	597,806	1,613,754	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		8	9	10	11	13	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	184,607					8
9	HOUSEKEEPING		740,616				9
10	DIETARY	4,002		582,953			10
11	CAFETERIA				704,532		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		10,748		4,622	342,869	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY		4,410		56,459		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	70,845	286,757	582,953	160,839	165,700	30
43	NURSERY	4,720	9,049		4,858	5,005	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	28,686	98,066		74,571	76,825	50
52	DELIVERY ROOM & LABOR ROOM	8,938			30,470	31,391	52
53	ANESTHESIOLOGY		3,307				53
54	RADIOLOGY-DIAGNOSTIC	16,989	24,574		77,024		54
57	COMPUTED TOMOGRAPHY (CT) SCAN	6,754	4,410		3,868		57
58	MAGNETIC RESONANCE IMAGING (MRI)	360			5,896		58
60	LABORATORY	560	16,490		70,467		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	710	22,415		28,206		65
66	PHYSICAL THERAPY	4,742	20,945		21,602		66
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		8,957				71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS		11,942		62,826		73
76.97	CARDIAC REHABILITATION		14,055		9,245		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	32,367	65,316		62,072	63,948	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	179,673	601,441	582,953	673,025	342,869	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,205				190
192	PHYSICIANS' PRIVATE OFFICES	4,934	136,511		29,432		192
192.01	MEDICAL OFFICE BUILDING						192.01
194	OTHER NONALLOWABLE		459		2,075		194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	184,607	740,616	582,953	704,532	342,869	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
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	1,006,623					15
16	MEDICAL RECORDS & LIBRARY		1,058,658				16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		60,865	4,885,998		4,885,998	30
43	NURSERY		2,759	169,032		169,032	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		74,067	2,709,776		2,709,776	50
52	DELIVERY ROOM & LABOR ROOM		16,653	911,251		911,251	52
53	ANESTHESIOLOGY		42,590	307,601		307,601	53
54	RADIOLOGY-DIAGNOSTIC		133,496	2,959,843		2,959,843	54
57	COMPUTED TOMOGRAPHY (CT) SCAN		130,198	757,966		757,966	57
58	MAGNETIC RESONANCE IMAGING (MRI)		59,647	494,845		494,845	58
60	LABORATORY		137,873	3,253,085		3,253,085	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		122,826	983,978		983,978	65
66	PHYSICAL THERAPY		19,965	822,666		822,666	66
70	ELECTROENCEPHALOGRAPHY		318	4,418		4,418	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		39,508	549,737		549,737	71
72	IMPL. DEV. CHARGED TO PATIENT		11,822	648,635		648,635	72
73	DRUGS CHARGED TO PATIENTS	1,006,623	67,603	2,848,059		2,848,059	73
76.97	CARDIAC REHABILITATION		3,733	294,816		294,816	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		134,735	2,326,530		2,326,530	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	1,006,623	1,058,658	24,928,236		24,928,236	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			40,591		40,591	190
192	PHYSICIANS' PRIVATE OFFICES			712,142		712,142	192
192.01	MEDICAL OFFICE BUILDING			24,502		24,502	192.01
194	OTHER NONALLOWABLE			118,248		118,248	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,006,623	1,058,658	25,823,719		25,823,719	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		10,911	5,555	16,466	16,466	4
5.01	ADMITTING		4,307	6,000	10,307	564	5.01
5.02	PATIENT ACCOUNTING		24,332	2,085	26,417	501	5.02
5.03	ADMIN & GENERAL	307,364	98,197	234,315	639,876	1,870	5.03
6	MAINTENANCE & REPAIRS					508	6
7	OPERATION OF PLANT	1,119	105,129	16,147	122,395	100	7
8	LAUNDRY & LINEN SERVICE		4,287		4,287		8
9	HOUSEKEEPING		5,356	693	6,049	522	9
10	DIETARY		29,232	10,190	39,422	191	10
11	CAFETERIA		8,304		8,304	422	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		2,560	24,017	26,577	242	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY		4,309	2,783	7,092	466	15
16	MEDICAL RECORDS & LIBRARY		10,371	35,077	45,448	638	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		67,086	45,115	112,201	2,510	30
43	NURSERY		2,475		2,475	98	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6	24,208	166,027	190,241	1,274	50
52	DELIVERY ROOM & LABOR ROOM		7,291		7,291	614	52
53	ANESTHESIOLOGY	682	841	40,766	42,289		53
54	RADIOLOGY-DIAGNOSTIC		20,262	224,423	244,685	1,335	54
57	COMPUTED TOMOGRAPHY (CT) SCAN		1,511	132,013	133,524	72	57
58	MAGNETIC RESONANCE IMAGING (MRI)					122	58
60	LABORATORY	1,994	14,686	67,792	84,472	1,257	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	14,104	7,724	21,340	43,168	396	65
66	PHYSICAL THERAPY		17,989	9,959	27,948	432	66
70	ELECTROENCEPHALOGRAPHY			2,903	2,903		70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	7,694	6,630		14,324		71
72	IMPL. DEV. CHARGED TO PATIENT		1,592		1,592		72
73	DRUGS CHARGED TO PATIENTS	150,270			150,270	670	73
76.97	CARDIAC REHABILITATION		5,232	6,912	12,144	183	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		16,416	7,175	23,591	1,253	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	483,233	501,238	1,061,287	2,045,758	16,240	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	92	1,097	368	1,557		190
192	PHYSICIANS' PRIVATE OFFICES		26,346	5,038	31,384	189	192
192.01	MEDICAL OFFICE BUILDING						192.01
194	OTHER NONALLOWABLE	5,500		538	6,038	37	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	488,825	528,681	1,067,231	2,084,737	16,466	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	ADMITTING 5.01	PATIENT ACCOUNTING 5.02	ADMIN & GENERAL 5.03	MAIN-TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMITTING	10,871					5.01
5.02	PATIENT ACCOUNTING		26,918				5.02
5.03	ADMIN & GENERAL			641,746			5.03
6	MAINTENANCE & REPAIRS			14,856	15,364		6
7	OPERATION OF PLANT			36,109	4,132	162,736	7
8	LAUNDRY & LINEN SERVICE			3,823	168	2,441	8
9	HOUSEKEEPING			17,450	210	3,050	9
10	DIETARY			9,175	1,149	16,645	10
11	CAFETERIA			16,028	326	4,728	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION			7,682	101	1,458	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY			24,247	169	2,454	15
16	MEDICAL RECORDS & LIBRARY			22,947	408	5,905	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	626	1,550	76,454	2,637	38,197	30
43	NURSERY	28	70	3,103	97	1,409	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	762	1,886	54,271	951	13,784	50
52	DELIVERY ROOM & LABOR ROOM	171	424	19,172	287	4,152	52
53	ANESTHESIOLOGY	438	1,085	6,354	33	479	53
54	RADIOLOGY-DIAGNOSTIC	1,373	3,400	63,678	796	11,537	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	1,339	3,316	14,958	59	860	57
58	MAGNETIC RESONANCE IMAGING (MRI)	614	1,519	10,660			58
60	LABORATORY	1,401	3,469	72,623	577	8,362	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,264	3,128	18,748	304	4,398	65
66	PHYSICAL THERAPY	205	508	15,565	707	10,243	66
70	ELECTROENCEPHALOGRAPHY	3	8	102			70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	406	1,006	11,275	261	3,775	71
72	IMPL. DEV. CHARGED TO PATIENT	122	301	15,542	63	907	72
73	DRUGS CHARGED TO PATIENTS	695	1,722	42,224			73
76.97	CARDIAC REHABILITATION	38	95	5,722	206	2,979	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,386	3,431	45,982	645	9,347	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	10,871	26,918	628,750	14,286	147,110	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			758	43	625	190
192	PHYSICIANS' PRIVATE OFFICES			8,753	1,035	15,001	192
192.01	MEDICAL OFFICE BUILDING			609			192.01
194	OTHER NONALLOWABLE			2,876			194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	10,871	26,918	641,746	15,364	162,736	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		8	9	10	11	13	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	10,719					8
9	HOUSEKEEPING		27,281				9
10	DIETARY	232		66,814			10
11	CAFETERIA				29,808		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		396		196	36,652	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY		162		2,389		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	4,115	10,564	66,814	6,805	17,713	30
43	NURSERY	274	333		206	535	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,666	3,612		3,155	8,212	50
52	DELIVERY ROOM & LABOR ROOM	519			1,289	3,356	52
53	ANESTHESIOLOGY		122				53
54	RADIOLOGY-DIAGNOSTIC	986	905		3,259		54
57	COMPUTED TOMOGRAPHY (CT) SCAN	392	162		164		57
58	MAGNETIC RESONANCE IMAGING (MRI)	21			249		58
60	LABORATORY	33	607		2,981		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	41	826		1,193		65
66	PHYSICAL THERAPY	275	772		914		66
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		330				71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS		440		2,658		73
76.97	CARDIAC REHABILITATION		518		391		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,879	2,406		2,626	6,836	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	10,433	22,155	66,814	28,475	36,652	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		81				190
192	PHYSICIANS' PRIVATE OFFICES	286	5,028		1,245		192
192.01	MEDICAL OFFICE BUILDING						192.01
194	OTHER NONALLOWABLE		17		88		194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	10,719	27,281	66,814	29,808	36,652	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
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	34,428					15
16	MEDICAL RECORDS & LIBRARY		77,897				16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		4,481	344,667		344,667	30
43	NURSERY		203	8,831		8,831	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		5,452	285,266		285,266	50
52	DELIVERY ROOM & LABOR ROOM		1,226	38,501		38,501	52
53	ANESTHESIOLOGY		3,135	53,935		53,935	53
54	RADIOLOGY-DIAGNOSTIC		9,827	341,781		341,781	54
57	COMPUTED TOMOGRAPHY (CT) SCAN		9,585	164,431		164,431	57
58	MAGNETIC RESONANCE IMAGING (MRI)		4,391	17,576		17,576	58
60	LABORATORY		10,113	185,895		185,895	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		9,042	82,508		82,508	65
66	PHYSICAL THERAPY		1,470	59,039		59,039	66
70	ELECTROENCEPHALOGRAPHY		23	3,039		3,039	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		2,908	34,285		34,285	71
72	IMPL. DEV. CHARGED TO PATIENT		870	19,397		19,397	72
73	DRUGS CHARGED TO PATIENTS	34,428	4,977	238,084		238,084	73
76.97	CARDIAC REHABILITATION		275	22,551		22,551	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		9,919	109,301		109,301	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	34,428	77,897	2,009,087		2,009,087	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			3,064		3,064	190
192	PHYSICIANS' PRIVATE OFFICES			62,921		62,921	192
192.01	MEDICAL OFFICE BUILDING			609		609	192.01
194	OTHER NONALLOWABLE			9,056		9,056	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	34,428	77,897	2,084,737		2,084,737	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	ADMITTING PATIENT REVENUE 5.01	PATIENT ACCOUNTING PATIENT REVENUE 5.02	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	187,945					1
2	CAP REL COSTS-MVBLE EQUIP		1,066,318				2
4	EMPLOYEE BENEFITS	3,879	5,550	10,668,275			4
5.01	ADMITTING	1,531	5,995	365,387	89,271,031		5.01
5.02	PATIENT ACCOUNTING	8,650	2,083	324,940		89,271,031	5.02
5.03	ADMIN & GENERAL	34,909	234,115	1,212,192			5.03
6	MAINTENANCE & REPAIRS			329,158			6
7	OPERATION OF PLANT	37,372	16,133	64,707			7
8	LAUNDRY & LINEN SERVICE	1,524					8
9	HOUSEKEEPING	1,904	692	338,273			9
10	DIETARY	10,392	10,181	123,697			10
11	CAFETERIA	2,952		273,200			11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	910	23,996	156,898			13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	1,532	2,781	302,167			15
16	MEDICAL RECORDS & LIBRARY	3,687	35,047	413,705			16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	23,849	45,076	1,623,343	5,132,390	5,132,390	30
43	NURSERY	880		63,396	232,682	232,682	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	8,606	165,885	825,879	6,245,602	6,245,602	50
52	DELIVERY ROOM & LABOR ROOM	2,592		398,194	1,404,279	1,404,279	52
53	ANESTHESIOLOGY	299	40,731		3,591,354	3,591,354	53
54	RADIOLOGY-DIAGNOSTIC	7,203	224,231	865,290	11,256,972	11,256,972	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	537	131,900	46,834	10,978,868	10,978,868	57
58	MAGNETIC RESONANCE IMAGING (MRI)			79,158	5,029,712	5,029,712	58
60	LABORATORY	5,221	67,734	814,670	11,626,435	11,626,435	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,746	21,322	256,364	10,357,194	10,357,194	65
66	PHYSICAL THERAPY	6,395	9,950	279,871	1,683,530	1,683,530	66
70	ELECTROENCEPHALOGRAPHY		2,901		26,844	26,844	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	2,357			3,331,515	3,331,515	71
72	IMPL. DEV. CHARGED TO PATIENT	566			996,899	996,899	72
73	DRUGS CHARGED TO PATIENTS			434,065	5,700,528	5,700,528	73
76.97	CARDIAC REHABILITATION	1,860	6,906	118,810	314,791	314,791	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	5,836	7,169	812,050	11,361,436	11,361,436	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	178,189	1,060,378	10,522,248	89,271,031	89,271,031	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	390	368				190
192	PHYSICIANS' PRIVATE OFFICES	9,366	5,034	122,262			192
192.01	MEDICAL OFFICE BUILDING						192.01
194	OTHER NONALLOWABLE		538	23,765			194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	528,681	1,067,231	3,847,691	543,566	653,596	202
203	UNIT COST MULT-WS B PT I	2.812956	1.000856	0.360667	0.006089	0.007321	203
204	COST TO BE ALLOC PER B PT II			16,466	10,871	26,918	204
205	UNIT COST MULT-WS B PT II			0.001543	0.000122	0.000302	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	RECON-CILIATION	ADMIN & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		5A.03	5.03	6	7	8	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL	-5,273,286	20,550,433				5.03
6	MAINTENANCE & REPAIRS		475,732	138,976			6
7	OPERATION OF PLANT		1,156,293	37,372	101,604		7
8	LAUNDRY & LINEN SERVICE		122,431	1,524	1,524	221,440	8
9	HOUSEKEEPING		558,797	1,904	1,904		9
10	DIETARY		293,805	10,392	10,392	4,800	10
11	CAFETERIA		513,248	2,952	2,952		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		246,006	910	910		13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY		776,460	1,532	1,532		15
16	MEDICAL RECORDS & LIBRARY		734,814	3,687	3,687		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		2,448,393	23,849	23,849	84,980	30
43	NURSERY		99,378	880	880	5,662	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		1,737,905	8,606	8,606	34,409	50
52	DELIVERY ROOM & LABOR ROOM		613,942	2,592	2,592	10,721	52
53	ANESTHESIOLOGY		203,461	299	299		53
54	RADIOLOGY-DIAGNOSTIC		2,039,128	7,203	7,203	20,379	54
57	COMPUTED TOMOGRAPHY (CT) SCAN		478,988	537	537	8,102	57
58	MAGNETIC RESONANCE IMAGING (MRI)		341,351			432	58
60	LABORATORY		2,325,568	5,221	5,221	672	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		600,345	2,746	2,746	852	65
66	PHYSICAL THERAPY		498,435	6,395	6,395	5,688	66
70	ELECTROENCEPHALOGRAPHY		3,263				70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		361,051	2,357	2,357		71
72	IMPL. DEV. CHARGED TO PATIENT		497,682	566	566		72
73	DRUGS CHARGED TO PATIENTS		1,352,111				73
76.97	CARDIAC REHABILITATION		183,224	1,860	1,860		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		1,472,460	5,836	5,836	38,825	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	-5,273,286	20,134,271	129,220	91,848	215,522	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		24,283	390	390		190
192	PHYSICIANS' PRIVATE OFFICES		280,295	9,366	9,366	5,918	192
192.01	MEDICAL OFFICE BUILDING		19,499				192.01
194	OTHER NONALLOWABLE		92,085				194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I		5,273,286	597,806	1,613,754	184,607	202
203	UNIT COST MULT-WS B PT I		0.256602	4.301505	15.882780	0.833666	203
204	COST TO BE ALLOC PER B PT II		641,746	15,364	162,736	10,719	204
205	UNIT COST MULT-WS B PT II		0.031228	0.110551	1.601669	0.048406	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
		HOURS OF SERVICE	MEALS SERVED	FTES	FTES	COSTED REQUIS.	
		9	10	11	13	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING	16,124					9
10	DIETARY		35,140				10
11	CAFETERIA			14,937			11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	234		98	7,056		13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY					100	15
16	MEDICAL RECORDS & LIBRARY	96		1,197			16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	6,243	35,140	3,410	3,410		30
43	NURSERY	197		103	103		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,135		1,581	1,581		50
52	DELIVERY ROOM & LABOR ROOM			646	646		52
53	ANESTHESIOLOGY	72					53
54	RADIOLOGY-DIAGNOSTIC	535		1,633			54
57	COMPUTED TOMOGRAPHY (CT) SCAN	96		82			57
58	MAGNETIC RESONANCE IMAGING (MRI)			125			58
60	LABORATORY	359		1,494			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	488		598			65
66	PHYSICAL THERAPY	456		458			66
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	195					71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS	260		1,332		100	73
76.97	CARDIAC REHABILITATION	306		196			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,422		1,316	1,316		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	13,094	35,140	14,269	7,056	100	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48					190
192	PHYSICIANS' PRIVATE OFFICES	2,972		624			192
192.01	MEDICAL OFFICE BUILDING						192.01
194	OTHER NONALLOWABLE	10		44			194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	740,616	582,953	704,532	342,869	1,006,623	202
203	UNIT COST MULT-WS B PT I	45.932523	16.589442	47.166901	48.592545	10,066.230000	203
204	COST TO BE ALLOC PER B PT II	27,281	66,814	29,808	36,652	34,428	204
205	UNIT COST MULT-WS B PT II	1.691950	1.901366	1.995581	5.194444	344.280000	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY PATIENT REVENUE 16	
	GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5.01	ADMITTING		5.01
5.02	PATIENT ACCOUNTING		5.02
5.03	ADMIN & GENERAL		5.03
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	89,271,031	16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
	INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS	5,132,390	30
43	NURSERY	232,682	43
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	6,245,602	50
52	DELIVERY ROOM & LABOR ROOM	1,404,279	52
53	ANESTHESIOLOGY	3,591,354	53
54	RADIOLOGY-DIAGNOSTIC	11,256,972	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	10,978,868	57
58	MAGNETIC RESONANCE IMAGING (MRI)	5,029,712	58
60	LABORATORY	11,626,435	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	10,357,194	65
66	PHYSICAL THERAPY	1,683,530	66
70	ELECTROENCEPHALOGRAPHY	26,844	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	3,331,515	71
72	IMPL. DEV. CHARGED TO PATIENT	996,899	72
73	DRUGS CHARGED TO PATIENTS	5,700,528	73
76.97	CARDIAC REHABILITATION	314,791	76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
91	EMERGENCY	11,361,436	91
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	89,271,031	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192	PHYSICIANS' PRIVATE OFFICES		192
192.01	MEDICAL OFFICE BUILDING		192.01
194	OTHER NONALLOWABLE		194
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	1,058,658	202
203	UNIT COST MULT-WS B PT I	0.011859	203
204	COST TO BE ALLOC PER B PT II	77,897	204
205	UNIT COST MULT-WS B PT II	0.000873	205

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	4,885,998		4,885,998			30
43	NURSERY	169,032		169,032			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,709,776		2,709,776			50
52	DELIVERY ROOM & LABOR ROOM	911,251		911,251			52
53	ANESTHESIOLOGY	307,601		307,601			53
54	RADIOLOGY-DIAGNOSTIC	2,959,843		2,959,843			54
57	COMPUTED TOMOGRAPHY (CT) SC	757,966		757,966			57
58	MAGNETIC RESONANCE IMAGING	494,845		494,845			58
60	LABORATORY	3,253,085		3,253,085			60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
65	RESPIRATORY THERAPY	983,978		983,978			65
66	PHYSICAL THERAPY	822,666		822,666			66
70	ELECTROENCEPHALOGRAPHY	4,418		4,418			70
71	MEDICAL SUPPLIES CHRGED TO	549,737		549,737			71
72	IMPL. DEV. CHARGED TO PATIE	648,635		648,635			72
73	DRUGS CHARGED TO PATIENTS	2,848,059		2,848,059			73
76.97	CARDIAC REHABILITATION	294,816		294,816			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	2,326,530		2,326,530			91
92	OBSERVATION BEDS	843,048		843,048			92
	OTHER REIMBURSABLE COST CENTERS						
200	SUBTOTAL (SEE INSTRUCTIONS)	25,771,284		25,771,284			200
201	LESS OBSERVATION BEDS	843,048		843,048			201
202	TOTAL (SEE INSTRUCTIONS)	24,928,236		24,928,236			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	3,708,698		3,708,698				30
43	NURSERY	229,837		229,837				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	994,240	5,096,969	6,091,209	0.444867			50
52	DELIVERY ROOM & LABOR ROOM	769,812	627,625	1,397,437	0.652087			52
53	ANESTHESIOLOGY	683,747	2,841,863	3,525,610	0.087248			53
54	RADIOLOGY-DIAGNOSTIC	776,804	10,254,966	11,031,770	0.268302			54
57	COMPUTED TOMOGRAPHY (CT) SC	783,433	10,025,263	10,808,696	0.070126			57
58	MAGNETIC RESONANCE IMAGING	158,942	4,743,243	4,902,185	0.100944			58
60	LABORATORY	2,535,701	8,859,531	11,395,232	0.285478			60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
65	RESPIRATORY THERAPY	468,506	2,358,325	2,826,831	0.348085			65
66	PHYSICAL THERAPY	202,136	1,374,380	1,576,516	0.521825			66
70	ELECTROENCEPHALOGRAPHY	1,851	24,993	26,844	0.164581			70
71	MEDICAL SUPPLIES CHRGED TO	1,596,264	1,698,963	3,295,227	0.166828			71
72	IMPL. DEV. CHARGED TO PATIE	874,897	113,330	988,227	0.656362			72
73	DRUGS CHARGED TO PATIENTS	2,176,319	3,469,445	5,645,764	0.504459			73
76.97	CARDIAC REHABILITATION		314,791	314,791	0.936545			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	175,695	7,579,931	7,755,626	0.299980			91
92	OBSERVATION BEDS	74,013	1,295,094	1,369,107	0.615765			92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)	16,210,895	60,678,712	76,889,607				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		60,678,712	76,889,607				202

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1350)	[ ]	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	0.444867		1,997,814			888,762		50
52	DELIVERY ROOM & LABOR ROOM	0.652087		4,413			2,878		52
53	ANESTHESIOLOGY	0.087248		1,055,892			92,124		53
54	RADIOLOGY-DIAGNOSTIC	0.268302		4,206,913			1,128,723		54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.070126		4,371,697			306,570		57
58	MAGNETIC RESONANCE IMAGING (MRI	0.100944		1,645,241			166,077		58
60	LABORATORY	0.285478		4,683,772			1,337,114		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.348085		1,103,646			384,163		65
66	PHYSICAL THERAPY	0.521825		337,772			176,258		66
70	ELECTROENCEPHALOGRAPHY	0.164581		9,257			1,524		70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.166828		734,737			122,575		71
72	IMPL. DEV. CHARGED TO PATIENT	0.656362		48,344			31,731		72
73	DRUGS CHARGED TO PATIENTS	0.504459		1,837,644			927,016		73
76.97	CARDIAC REHABILITATION	0.936545		186,317			174,494		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.299980		2,808,021			842,350		91
92	OBSERVATION BEDS	0.615765		875,420			539,053		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)			25,906,900			7,121,412		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			25,906,900			7,121,412		202

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

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B-SNF (14-Z350)
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	0.444867							50
52	DELIVERY ROOM & LABOR ROOM	0.652087							52
53	ANESTHESIOLOGY	0.087248							53
54	RADIOLOGY-DIAGNOSTIC	0.268302							54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.070126							57
58	MAGNETIC RESONANCE IMAGING (MRI	0.100944							58
60	LABORATORY	0.285478							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.348085							65
66	PHYSICAL THERAPY	0.521825							66
70	ELECTROENCEPHALOGRAPHY	0.164581							70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.166828							71
72	IMPL. DEV. CHARGED TO PATIENT	0.656362							72
73	DRUGS CHARGED TO PATIENTS	0.504459							73
76.97	CARDIAC REHABILITATION	0.936545							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.299980							91
92	OBSERVATION BEDS	0.615765							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 (14-1350)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[XX]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	6,331	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,202	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	86	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,116	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	69	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)	52	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	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,833	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)	69	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)	52	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)	4,885,998	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)	93,500	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,792,498	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,757,169	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	66,486	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,690,683	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.275561	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	773.09	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	603.45	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	169.64	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	216.39	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	18,610	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	4,773,888	37

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

CHECK APPLICABLE BOXES	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1350)	[ ]	SUB (OTHER)	[ ] PPS
	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
	[ ]	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)	769.73	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	2,950,375	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)	2,950,375	41

		TOTAL INPATIENT COST (1)	TOTAL INPATIENT DAYS (2)	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) (3)	PROGRAM DAYS (4)	PROGRAM COST (COL. 3 x COL. 4) (5)	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					2,614,202	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					5,564,577	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)					53,111	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)					40,026	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					93,137	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)	1,091	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	772.73	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	843,048	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	344,667	4,792,498	0.071918	843,048	60,630	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1350)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		2,717,294		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.444867	760,137	338,160	50
52	DELIVERY ROOM & LABOR ROOM	0.652087	2,162	1,410	52
53	ANESTHESIOLOGY	0.087248	382,971	33,413	53
54	RADIOLOGY-DIAGNOSTIC	0.268302	616,911	165,518	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.070126	492,182	34,515	57
58	MAGNETIC RESONANCE IMAGING (MRI	0.100944	123,443	12,461	58
60	LABORATORY	0.285478	1,793,158	511,907	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.348085	428,161	149,036	65
66	PHYSICAL THERAPY	0.521825	163,868	85,510	66
70	ELECTROENCEPHALOGRAPHY	0.164581	1,851	305	70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.166828	1,111,754	185,472	71
72	IMPL. DEV. CHARGED TO PATIENT	0.656362	462,746	303,729	72
73	DRUGS CHARGED TO PATIENTS	0.504459	1,570,690	792,349	73
76.97	CARDIAC REHABILITATION	0.936545			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.299980	1,390	417	91
92	OBSERVATION BEDS	0.615765			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		7,911,424	2,614,202	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		7,911,424		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B SNF(14-Z350)	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST 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
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.444867			50
52	DELIVERY ROOM & LABOR ROOM	0.652087			52
53	ANESTHESIOLOGY	0.087248			53
54	RADIOLOGY-DIAGNOSTIC	0.268302	532	143	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.070126			57
58	MAGNETIC RESONANCE IMAGING (MRI	0.100944			58
60	LABORATORY	0.285478	6,074	1,734	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.348085	7,103	2,472	65
66	PHYSICAL THERAPY	0.521825	20,287	10,586	66
70	ELECTROENCEPHALOGRAPHY	0.164581			70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.166828	25,990	4,336	71
72	IMPL. DEV. CHARGED TO PATIENT	0.656362			72
73	DRUGS CHARGED TO PATIENTS	0.504459	20,244	10,212	73
76.97	CARDIAC REHABILITATION	0.936545			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.299980			91
92	OBSERVATION BEDS	0.615765			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		80,230	29,483	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		80,230		202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-1350) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	7,121,412	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)	7,121,412	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)		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)	7,192,626	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)	62,967	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	4,262,837	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	2,866,822	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)	2,866,822	30
31	PRIMARY PAYER PAYMENTS	204	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,866,618	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)	864,678	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	864,678	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	795,036	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	3,731,296	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)	3,731,296	40
41	INTERIM PAYMENTS	3,423,034	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	308,262	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 (14-1350) [ ] SUB (OTHER) | [ ] IPF [ ] SNF | [ ] IRF [ ] SWING BED SNF

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				4,666,719		3,420,335	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	10/04/2010	44,623	10/04/2010	2,699	3.01
		.02					3.02
	PROGRAM	.03					3.03
	TO	.04					3.04
	PROVIDER	.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER	.52					3.52
	TO	.53					3.53
	PROGRAM	.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		44,623		2,699	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)				4,711,342		3,423,034	4
TO BE COMPLETED BY CONTRACTOR							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01					5.01
	TO	.02					5.02
	PROVIDER	.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER	.50					5.50
	TO	.51					5.51
	PROGRAM	.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
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					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)							7

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

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

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF [XX] SUB (OTHER) SNF SWING BED SNF (14-Z350)

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				118,178			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	10/04/2010	660		NONE	3.01
		.02	01/10/2011	7,705			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		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		8,365			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)				126,543			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					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					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					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)							7

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

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

CHECK APPLICABLE BOX [XX] HOSPITAL (14-1350) [ ] CAH

	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,465	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	3,833	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	5,111	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	76,889,607	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	1,922,540	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 - SWING BEDS WORKSHEET E-2

CHECK	[ ]	TITLE V	[XX]	SWING BED - SNF (14-Z350)
APPLICABLE	[XX]	TITLE XVIII	[ ]	SWING BED - NF
BOXES	[ ]	TITLE XIX		

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	94,068		1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)			2
3	ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	29,778		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			4
5	PROGRAM DAYS	121		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	123,846		8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	123,846		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)			11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	123,846		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	283		13
14	80% OF PART B COSTS (LINE 12 x 80%)			14
15	SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	123,563		15
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			16
17	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			17
18	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			18
19	TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	123,563		19
20	INTERIM PAYMENTS	126,543		20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	-2,980		22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART V

CHECK [XX] HOSPITAL (14-1350)
APPLICABLE BOX: [ ] SUB (OTHER)

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

1	INPATIENT SERVICES	5,564,577	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	5,564,577	4
5	PRIMARY PAYER PAYMENTS	13,900	5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	5,606,323	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6, 17 AND 18)	5,606,323	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	680,014	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	4,926,309	22
23	COINSURANCE	849	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	4,925,460	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	122,426	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	122,426	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	100,074	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	5,047,886	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	5,047,886	30
31	INTERIM PAYMENTS	4,711,342	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	336,544	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

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	3,274,778				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	10,269,332				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-8,271,798				6
7	INVENTORY	449,241				7
8	PREPAID EXPENSES	432,201				8
9	OTHER CURRENT ASSETS	694,885				9
10	DUE FROM OTHER FUNDS	970,000				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	7,818,639				11
	FIXED ASSETS					
12	LAND	99,383				12
13	LAND IMPROVEMENTS	1,059,741				13
14	ACCUMULATED DEPRECIATION	-990,007				14
15	BUILDINGS	6,186,910				15
16	ACCUMULATED DEPRECIATION	-4,769,369				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	11,175,960				19
20	ACCUMULATED DEPRECIATION	-8,094,988				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	16,398,601				23
24	ACCUMULATED DEPRECIATION	-13,678,177				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)	7,388,054				30
	OTHER ASSETS					
31	INVESTMENTS	32,985,000				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	110,307				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	33,095,307				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	48,302,000				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,236,175				37
38	SALARIES, WAGES & FEES PAYABLE	1,627,000				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	1,832,825				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	4,696,000				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE	11,517,020				46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	8,750,842				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	20,267,862				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	24,963,862				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	23,338,138				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)	23,338,138				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	48,302,000				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD		17,124,707							1
2	NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		4,086,795							2
3	TOTAL (SUM OF LINE 1 AND LINE 2)		21,211,502							3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5	CHANGE IN TEMP RESTRICTED AS	209,228								5
6	TRANSFER FFROM/TO AFFILIATE	1,917,408								6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)		2,126,636							10
11	SUBTOTAL (LINE 3 PLUS LINE 10)		23,338,138							11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13										13
14										14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		23,338,138							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	3,971,796		3,971,796	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)	3,971,796		3,971,796	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	OTHER SPECIAL CARE (SPECIFY)				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)	3,971,796		3,971,796	17
18	ANCILLARY SERVICES	12,447,016	53,071,656	65,518,672	18
19	OUTPATIENT SERVICES		11,111,453	11,111,453	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
27.01	OBSERVATION PATIENTS	74,013	1,295,094	1,369,107	27.01
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	16,492,825	65,478,203	81,971,028	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		35,242,126	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37	DEDUCT (SPECIFY)			37
38	ROUNDING	-1		38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)	-1		42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		35,242,125	43

STATEMENT OF REVENUES AND EXPENSES — WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	81,971,028	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	46,119,572	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	35,851,456	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	35,242,125	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	609,331	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	27,660	6
7	INCOME FROM INVESTMENTS	2,754,293	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	2,717	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	60,381	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	230	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	868	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	34,091	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	198,473	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISCELLANEOUS OPERATING REVENUE)	303,939	24
24.01	OTHER (SURGERY CLINIC REVENUE)	101,594	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	3,484,246	25
26	TOTAL (LINE 5 PLUS LINE 25)	4,093,577	26
27	OTHER EXPENSES (GAIN/LOSS ON SALE OF EQUIPMENT)	6,782	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	6,782	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	4,086,795	29

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

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES AP						21
22	I&R SRVCES-OTHER PRGM COSTS AP						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
57	COMPUTED TOMOGRAPHY (CT) SCAN						57
58	MAGNETIC RESONANCE IMAGING (MR						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHRGED TO PAT						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CA						190
192	PHYSICIANS' PRIVATE OFFICES						192
192.01	MEDICAL OFFICE BUILDING						192.01
194	OTHER NONALLOWABLE						194
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