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

PART I - COST REPORT STATUS

PROVIDER USE ONLY
1. [X] ELECTRONICALLY FILED COST REPORT DATE: 05-16-2012 TIME: 14:10_____
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 VAN MATRE HEALTHSOUTH REHABILITATION (14-3028) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2011 AND ENDING 12/31/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		115,888				1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		115,888				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: 950 S. MULFORD P.O.BOX: 1
2 CITY: ROCKFORD STATE: IL ZIP CODE: 61108- COUNTY: WINNEBAGO 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	VAN MATRE HEALTHSOUTH REHABIL	14-3028	40420	5	02/19/2002	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2011	TO: 12/31/2011							20
21	TYPE OF CONTROL		5							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.	3	N	23

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							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.	845	165				27	25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:			ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:			ENDING:		38

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

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

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
		Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N			61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				64

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

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

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

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

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

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

INPATIENT PSYCHIATRIC FACILITY PPS

70 IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO. — 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. — Y — 75

76 IF LINE 75 YES: — N — 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.	Y	N	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.	Y	N	91
92 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93 DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94 DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95 IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96 DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97 IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97

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

	PHY-SICAL	OCCUP-ATIONAL	SPEECH	RESPI-RATORY	
109 IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N				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.		1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		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.		N		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	019005	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: HEALTHSOUTH CORPORATION	CONTRACTOR'S NAME: CAHABA GBA	CONTRACTOR'S NUMBER: 10101	141
142	STREET: 3660 GRANDVIEW PARKWAY, SUIT P.O. BOX:			142
143	CITY: BIRMINGHAM	STATE: AL	ZIP CODE: 35243	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	PART B	
		1	2	
155	HOSPITAL	N	N	155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	165

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

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

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

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

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

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

COMPLETED BY ALL HOSPITALS

		Y/N 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)	Y			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.	N			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)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	03/04/2012	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: UB REV CODES 320 AND 324 SPLIT BETWE	Y		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

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

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

	CAPITAL RELATED COST	
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	27
	INTEREST EXPENSE	
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	31
	PURCHASED SERVICES	
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	33
	PROVIDER-BASED PHYSICIANS	
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	35

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

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

	COMPONENT	WKST A LINE NO. 1	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V 5	TITLE XVIII 6	TITLE XIX 7	TOTAL ALL PATIENTS 8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	50	18,250			10,259	865	16,050	1
2	HMO							172		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.)		50	18,250			10,259	865	16,050	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)		50	18,250			10,259	865	16,050	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)		50							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 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					801	68	1,202	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)			179.27			801	68	1,202	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)			179.27						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	9,131,314	694,894		372,885.10		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)			806,862		23,667.00		10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		268,306			5,446.68		11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A		151,161			1,111.00		13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		837,823			10,966.00		14
15	HOME OFFICE: PHYSICIAN-PART A							15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		1,663,894					17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		148,850					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							26
27	ADMINISTRATIVE & GENERAL		1,535,924	-110,676		39,768.17		27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		1,965			7.80		28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		149,019			6,275.49		30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		161,846			14,541.02		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)		16,993			1,238.57		33
34	DIETARY		287,722			19,290.18		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		554,943			14,233.76		38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		161,186			8,278.58		41
42	SOCIAL SERVICE		338,071			10,985.21		42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	9,150,272	694,894	9,845,166	374,131.47	26.31	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		806,862	806,862	23,667.00	34.09	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	9,150,272	-111,968	9,038,304	350,464.47	25.79	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	1,257,290		1,257,290	17,523.68	71.75	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	1,663,894		1,663,894		18.41%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	12,071,456	-111,968	11,959,488	367,988.15	32.50	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,207,669	-110,676	3,096,993	114,618.78	27.02	7

HOSPITAL WAGE RELATED COSTS WORKSHEET S-3
PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	144,279	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)	984,834	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	16,729	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	138,570	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	651,806	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	38,142	20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION		21
22	DAY CARE COSTS AND ALLOWANCES	-161,615	22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	1,812,745	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	898,185	166,917	1
2	HOSPITAL	898,185	166,917	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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI-CATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		676,089	676,089	238,551	1
2	00200	CAP REL COSTS-MVBLE EQUIP		350,263	350,263	49,130	2
3	00300	OTHER CAPITAL RELATED COSTS		272,851	272,851	-272,851	3
4	00400	EMPLOYEE BENEFITS		1,790,279	1,790,279		4
5	00500	ADMINISTRATIVE & GENERAL	1,535,924	2,711,972	4,247,896	-195,242	5
7	00700	OPERATION OF PLANT	149,019	527,725	676,744	71,375	7
8	00800	LAUNDRY & LINEN SERVICE		100,864	100,864	-5,659	8
9	00900	HOUSEKEEPING	161,846	98,574	260,420	-1,159	9
10	01000	DIETARY	287,722	274,187	561,909		10
11	01100	CAFETERIA					11
13	01300	NURSING ADMINISTRATION	554,943	3,882	558,825		13
16	01600	MEDICAL RECORDS & LIBRARY	161,186	49,689	210,875		16
17	01700	SOCIAL SERVICE	338,071	3,935	342,006		17
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	3,001,951	138,619	3,140,570	-59,080	30
		ANCILLARY SERVICE COST CENTERS					
54	05400	RADIOLOGY-DIAGNOSTIC	40,315	220,260	260,575	-204,001	54
54.01	05401	RADIOLOGY SUA				193,261	54.01
60	06000	LABORATORY		218,947	218,947	67,473	60
65	06500	RESPIRATORY THERAPY	239,143	9,593	248,736		65
66	06600	PHYSICAL THERAPY	1,088,152	115,168	1,203,320	-470,222	66
67	06700	OCCUPATIONAL THERAPY	876,535	154,436	1,030,971	-138,797	67
68	06800	SPEECH PATHOLOGY	298,666	16,060	314,726	-84,335	68
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	76,879	261,356	338,235	3,670	71
73	07300	DRUGS CHARGED TO PATIENTS	320,962	492,186	813,148		73
76	03550	PSYCHOLOGY		18,400	18,400	-18,067	76
76.01	03950	SPECIAL PROCEDURES		3,837	3,837	-3,837	76.01
76.97	07697	CARDIAC REHABILITATION					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
		SPECIAL PURPOSE COST CENTERS					
113	11300	INTEREST EXPENSE		22,196	22,196		113
118		SUBTOTALS (SUM OF LINES 1-117)	9,131,314	8,531,368	17,662,682	-829,790	118
		NONREIMBURSABLE COST CENTERS					
192	19200	PHYSICIANS' PRIVATE OFFICES		405	405	-405	192
194	07950	MARKETING				114,809	194
194.01	07951	GUEST MEALS					194.01
194.02	07952	CLINICAL PSYCH				19,200	194.02
194.05	07953	STAFFING RMH				696,186	194.05
200		TOTAL (SUM OF LINES 118-199)	9,131,314	8,531,773	17,663,087		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	914,640	161,967	1,076,607	1
2	00200	CAP REL COSTS-MVBLE EQUIP	399,393	-28,687	370,706	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	1,790,279	13,892	1,804,171	4
5	00500	ADMINISTRATIVE & GENERAL	4,052,654	623,422	4,676,076	5
7	00700	OPERATION OF PLANT	748,119	-79,925	668,194	7
8	00800	LAUNDRY & LINEN SERVICE	95,205		95,205	8
9	00900	HOUSEKEEPING	259,261		259,261	9
10	01000	DIETARY	561,909	-29,441	532,468	10
11	01100	CAFETERIA				11
13	01300	NURSING ADMINISTRATION	558,825	-34	558,791	13
16	01600	MEDICAL RECORDS & LIBRARY	210,875	-103	210,772	16
17	01700	SOCIAL SERVICE	342,006	-21	341,985	17
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	3,081,490	-211	3,081,279	30
		ANCILLARY SERVICE COST CENTERS				
54	05400	RADIOLOGY-DIAGNOSTIC	56,574	-1,959	54,615	54
54.01	05401	RADIOLOGY SUA	193,261	-25,666	167,595	54.01
60	06000	LABORATORY	286,420	-5,492	280,928	60
65	06500	RESPIRATORY THERAPY	248,736		248,736	65
66	06600	PHYSICAL THERAPY	733,098	469,893	1,202,991	66
67	06700	OCCUPATIONAL THERAPY	892,174	140,296	1,032,470	67
68	06800	SPEECH PATHOLOGY	230,391	84,335	314,726	68
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	341,905	-1,279	340,626	71
73	07300	DRUGS CHARGED TO PATIENTS	813,148	-3,771	809,377	73
76	03550	PSYCHOLOGY	333	-333		76
76.01	03950	SPECIAL PROCEDURES				76.01
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
		SPECIAL PURPOSE COST CENTERS				
113	11300	INTEREST EXPENSE	22,196	-22,196		113
118		SUBTOTALS (SUM OF LINES 1-117)	16,832,892	1,294,687	18,127,579	118
		NONREIMBURSABLE COST CENTERS				
192	19200	PHYSICIANS' PRIVATE OFFICES				192
194	07950	MARKETING	114,809		114,809	194
194.01	07951	GUEST MEALS				194.01
194.02	07952	CLINICAL PSYCH	19,200		19,200	194.02
194.05	07953	STAFFING RMH	696,186		696,186	194.05
200		TOTAL (SUM OF LINES 118-199)	17,663,087	1,294,687	18,957,774	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	CAP REL COSTS-BLDG & FIXT	1		12,297	1
2	INSURANCE	A	CAP REL COSTS-MVBLE EQUIP	2		2,533	2
3	INSURANCE	A					3
500	TOTAL RECLASSIFICATIONS					14,830	500
	CODE LETTER - A						
1	MARKETING	B	MARKETING	194	110,676	4,133	1
2	MARKETING	B					2
500	TOTAL RECLASSIFICATIONS				110,676	4,133	500
	CODE LETTER - B						
1	PHYSICIANS	C	ADULTS & PEDIATRICS	30		3,667	1
2	PHYSICIANS	C					2
500	TOTAL RECLASSIFICATIONS					3,667	500
	CODE LETTER - C						
1	UTILITIES	D	OPERATION OF PLANT	7		15,334	1
2	UTILITIES	D					2
3	UTILITIES	D					3
4	UTILITIES	D					4
500	TOTAL RECLASSIFICATIONS					15,334	500
	CODE LETTER - D						
1	CLINICAL PSYCHOLOGY	E	CLINICAL PSYCH	194.02		19,200	1
2	CLINICAL PSYCHOLOGY	E					2
3	CLINICAL PSYCHOLOGY	E					3
500	TOTAL RECLASSIFICATIONS					19,200	500
	CODE LETTER - E						
1	SERVICE UNDER ARRANGEMENT	F	RADIOLOGY SUA	54.01		194,244	1
2	SERVICE UNDER ARRANGEMENT	F					2
3	SERVICE UNDER ARRANGEMENT	F					3
500	TOTAL RECLASSIFICATIONS					194,244	500
	CODE LETTER - F						
1	SECURITY RECLASS	G	OPERATION OF PLANT	7		59,711	1
2	SECURITY RECLASS	G					2
500	TOTAL RECLASSIFICATIONS					59,711	500
	CODE LETTER - G						
1	COURIER EXPENSE	H	LABORATORY	60		22,904	1
2	COURIER EXPENSE	H					2
3	COURIER EXPENSE	H					3
500	TOTAL RECLASSIFICATIONS					22,904	500
	CODE LETTER - H						
1	OXYGEN RECLASS	I	MEDICAL SUPPLIES CHRGED TO PA	71		3,670	1
2	OXYGEN RECLASS	I					2
500	TOTAL RECLASSIFICATIONS					3,670	500
	CODE LETTER - I						
1	RMH EMPLOYEE LEASE	J	STAFFING RMH	194.05	696,186		1
2	RMH EMPLOYEE LEASE	J					2
3	RMH EMPLOYEE LEASE	J					3
4	RMH EMPLOYEE LEASE	J					4
5	RMH EMPLOYEE LEASE	J					5
500	TOTAL RECLASSIFICATIONS				696,186		500
	CODE LETTER - J						
1	OTHER PHYSICIAN EXPENSE	K	ADMINISTRATIVE & GENERAL	5		405	1
2	OTHER PHYSICIAN EXPENSE	K					2
500	TOTAL RECLASSIFICATIONS					405	500
	CODE LETTER - K						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	INCREASE LINE #	INCREASE SALARY	INCREASE OTHER	
		1	2	3	4	5	
1	SPECIAL PROCEDURES RECLASS	L	RADIOLOGY-DIAGNOSTIC	54		3,837	1
2	SPECIAL PROCEDURES RECLASS	L					2
500	TOTAL RECLASSIFICATIONS					3,837	500
	CODE LETTER - L						
1	CONTRACT LABOR	M	OCCUPATIONAL THERAPY	67		1,540	1
2	CONTRACT LABOR	M					2
500	TOTAL RECLASSIFICATIONS					1,540	500
	CODE LETTER - M						
1	RMH LAB EXPENSE	N	ADMINISTRATIVE & GENERAL	5		7,019	1
2	RMH LAB EXPENSE	N	LABORATORY	60		50,605	2
3	RMH LAB EXPENSE	N					3
4	RMH LAB EXPENSE	N					4
5	RMH LAB EXPENSE	N					5
6	RMH LAB EXPENSE	N					6
500	TOTAL RECLASSIFICATIONS					57,624	500
	CODE LETTER - N						
	GRAND TOTAL (INCREASES)				806,862	401,099	

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	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	ADMINISTRATIVE & GENERAL	5		14,830		3
500	TOTAL RECLASSIFICATIONS					14,830		500
	CODE LETTER - A							
1	MARKETING	B						1
2	MARKETING	B	ADMINISTRATIVE & GENERAL	5	110,676	4,133		2
500	TOTAL RECLASSIFICATIONS				110,676	4,133		500
	CODE LETTER - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	PSYCHOLOGY	76		3,667		2
500	TOTAL RECLASSIFICATIONS					3,667		500
	CODE LETTER - C							
1	UTILITIES	D						1
2	UTILITIES	D	ADMINISTRATIVE & GENERAL	5		8,516		2
3	UTILITIES	D	LAUNDRY & LINEN SERVICE	8		5,659		3
4	UTILITIES	D	HOUSEKEEPING	9		1,159		4
500	TOTAL RECLASSIFICATIONS					15,334		500
	CODE LETTER - D							
1	CLINICAL PSYCHOLOGY	E						1
2	CLINICAL PSYCHOLOGY	E	ADMINISTRATIVE & GENERAL	5		4,800		2
3	CLINICAL PSYCHOLOGY	E	PSYCHOLOGY	76		14,400		3
500	TOTAL RECLASSIFICATIONS					19,200		500
	CODE LETTER - E							
1	SERVICE UNDER ARRANGEMENT	F						1
2	SERVICE UNDER ARRANGEMENT	F	ADULTS & PEDIATRICS	30		6,175		2
3	SERVICE UNDER ARRANGEMENT	F	RADIOLOGY-DIAGNOSTIC	54		188,069		3
500	TOTAL RECLASSIFICATIONS					194,244		500
	CODE LETTER - F							
1	SECURITY RECLASS	G						1
2	SECURITY RECLASS	G	ADMINISTRATIVE & GENERAL	5		59,711		2
500	TOTAL RECLASSIFICATIONS					59,711		500
	CODE LETTER - G							
1	COURIER EXPENSE	H						1
2	COURIER EXPENSE	H	ADULTS & PEDIATRICS	30		22,796		2
3	COURIER EXPENSE	H	RADIOLOGY-DIAGNOSTIC	54		108		3
500	TOTAL RECLASSIFICATIONS					22,904		500
	CODE LETTER - H							
1	OXYGEN RECLASS	I						1
2	OXYGEN RECLASS	I	OPERATION OF PLANT	7		3,670		2
500	TOTAL RECLASSIFICATIONS					3,670		500
	CODE LETTER - I							
1	RMH EMPLOYEE LEASE	J						1
2	RMH EMPLOYEE LEASE	J	ADULTS & PEDIATRICS	30	1,292			2
3	RMH EMPLOYEE LEASE	J	PHYSICAL THERAPY	66		470,222		3
4	RMH EMPLOYEE LEASE	J	OCCUPATIONAL THERAPY	67		140,337		4
5	RMH EMPLOYEE LEASE	J	SPEECH PATHOLOGY	68		84,335		5
500	TOTAL RECLASSIFICATIONS				1,292	694,894		500
	CODE LETTER - J							
1	OTHER PHYSICIAN EXPENSE	K						1
2	OTHER PHYSICIAN EXPENSE	K	PHYSICIANS' PRIVATE OFFICES	192		405		2
500	TOTAL RECLASSIFICATIONS					405		500
	CODE LETTER - K							

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	SPECIAL PROCEDURES RECLASS	L					1
2	SPECIAL PROCEDURES RECLASS	L	SPECIAL PROCEDURES	76.01		3,837	2
500	TOTAL RECLASSIFICATIONS					3,837	500
	CODE LETTER - L						
1	CONTRACT LABOR	M					1
2	CONTRACT LABOR	M	RADIOLOGY-DIAGNOSTIC	54		1,540	2
500	TOTAL RECLASSIFICATIONS					1,540	500
	CODE LETTER - M						
1	RMH LAB EXPENSE	N					1
2	RMH LAB EXPENSE	N					2
3	RMH LAB EXPENSE	N	ADULTS & PEDIATRICS	30		32,484	3
4	RMH LAB EXPENSE	N	RADIOLOGY-DIAGNOSTIC	54		18,121	4
5	RMH LAB EXPENSE	N	RADIOLOGY SUA	54.01		983	5
6	RMH LAB EXPENSE	N	LABORATORY	60		6,036	6
500	TOTAL RECLASSIFICATIONS					57,624	500
	CODE LETTER - N						
	GRAND TOTAL (DECREASES)				111,968	1,095,993	

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

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND								1
2	LAND IMPROVEMENTS	9,720					9,720		2
3	BUILDINGS AND FIXTURES	4,161,549				3,790	4,157,759		3
4	BUILDING IMPROVEMENTS	8,743,167	425,954		425,954	5,544	9,163,577		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	2,783,759	23,806		23,806	62,049	2,745,516		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	15,698,195	449,760		449,760	71,383	16,076,572		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	15,698,195	449,760		449,760	71,383	16,076,572		10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 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	525,260	150,829					676,089	1
2	CAP REL COSTS-MVBLE EQUIP	294,086	56,177					350,263	2
3	TOTAL (SUM OF LINES 1-2)	819,346	207,006					1,026,352	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	ALLOCATION OF OTHER CAPITAL INSURANCE 5	TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT	13,331,056		13,331,056	0.829223		226,254		226,254	1
2	CAP REL COSTS-MVBLE EQUIP	2,745,516		2,745,516	0.170777		46,597		46,597	2
3	TOTAL (SUM OF LINES 1-2)	16,076,572		16,076,572	1.000000		272,851		272,851	3

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 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	667,253		204,004	12,297	193,053		1,076,607	1
2	CAP REL COSTS-MVBLE EQUIP	272,237	56,177		2,533	39,759		370,706	2
3	TOTAL	939,490	56,177	204,004	14,830	232,812		1,447,313	3

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
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)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2					10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	2,676,417				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						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						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							33
34							34
35							35
36							36
37	INTEREST	A	-22,196	INTEREST EXPENSE	113		37
37.01	INSURANCE	A	-161,681	EMPLOYEE BENEFITS	4		37.01
37.02	INSURANCE	A	-132,902	ADMINISTRATIVE & GENERAL	5		37.02
37.03	PROPERTY TAX	A	-33,201	CAP REL COSTS-BLDG & FIXT	1	13	37.03
37.04	PROPERTY TAX	A	-6,838	CAP REL COSTS-MVBLE EQUIP	2	13	37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-51,206	ADMINISTRATIVE & GENERAL	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-21	SOCIAL SERVICE	17		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-49	PHYSICAL THERAPY	66		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-41	OCCUPATIONAL THERAPY	67		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-198	MEDICAL SUPPLIES CHRGED TO PATI	71		37.09
37.10	PATIENT TELEPHONE	A	-9,052	CAP REL COSTS-MVBLE EQUIP	2	9	37.10
37.11	PATIENT TELEPHONE	A	-3,514	EMPLOYEE BENEFITS	4		37.11
37.12	PATIENT TELEPHONE	A	-26,771	ADMINISTRATIVE & GENERAL	5		37.12
37.13	PATIENT TELEVISION	A	-10,682	CAP REL COSTS-MVBLE EQUIP	2	9	37.13
37.14	PATIENT TELEVISION	A	-5,595	OPERATION OF PLANT	7		37.14
37.15	PRINTING	A	-15,466	ADMINISTRATIVE & GENERAL	5		37.15
37.16	PRINTING	A	-8	OPERATION OF PLANT	7		37.16
37.17	PRINTING	A	-763	MEDICAL SUPPLIES CHRGED TO PATI	71		37.17
37.18	LOBBYING EXPENSE	A	-245	EMPLOYEE BENEFITS	4		37.18
37.19	LOBBYING EXPENSE	A	-5,770	ADMINISTRATIVE & GENERAL	5		37.19
37.20	MISCELLANEOUS INCOME	B	-7,613	CAP REL COSTS-BLDG & FIXT	1	11	37.20
37.21	MISCELLANEOUS INCOME	B	-6,589	ADMINISTRATIVE & GENERAL	5		37.21
37.22	MISCELLANEOUS INCOME	B	-1,128	OPERATION OF PLANT	7		37.22
37.23	MISCELLANEOUS INCOME	B	-29,441	DIETARY	10		37.23
37.24	MISCELLANEOUS INCOME	B	-103	MEDICAL RECORDS & LIBRARY	16		37.24

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
37.25	MISCELLANEOUS INCOME	B	-177	ADULTS & PEDIATRICS	30		37.25
37.26	MISCELLANEOUS INCOME	B	-39	RADIOLOGY-DIAGNOSTIC	54		37.26
37.27	MISCELLANEOUS INCOME	B	-280	PHYSICAL THERAPY	66		37.27
37.28	MISCELLANEOUS INCOME	B	-318	MEDICAL SUPPLIES CHRGED TO PATI	71		37.28
37.29	MISCELLANEOUS INCOME	B	-594	DRUGS CHARGED TO PATIENTS	73		37.29
37.30	PATIENT TRANSPORTATION	A	-4,815	EMPLOYEE BENEFITS	4		37.30
37.31	PATIENT TRANSPORTATION	A	-73,194	OPERATION OF PLANT	7		37.31
37.32	MISC. TAX	A	-756,013	ADMINISTRATIVE & GENERAL	5		37.32
37.33	PROFESSIONAL FEES	A	-8,240	ADMINISTRATIVE & GENERAL	5		37.33
37.34	PROFESSIONAL FEES	A	-34	NURSING ADMINISTRATION	13		37.34
37.35	PROFESSIONAL FEES	A	-34	ADULTS & PEDIATRICS	30		37.35
37.36	PROFESSIONAL FEES	A	-1,920	RADIOLOGY-DIAGNOSTIC	54		37.36
37.37	WAYPORT WIRELESS	A	-3,850	ADMINISTRATIVE & GENERAL	5		37.37
37.38	PRINTSHOP DELIVERY	A	-816	ADMINISTRATIVE & GENERAL	5		37.38
37.39	PHYSICIAN ACCRUALS	A	-333	PSYCHOLOGY	76		37.39
38							38
39							39
40							40
41							41
42							42
43							43
44							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)		1,294,687				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	5	ADMINISTRATIVE & GENERAL	TO OFFSET MANAGEMENT FEES		561,059	-561,059		1
2	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFI	141,993		141,993	9	2
3	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFI	211,617		211,617	11	3
4	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFI	1,686,793		1,686,793		4
4.01	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFI	508,551		508,551		4.01
4.02	2	CAP REL COSTS-MVBLE EQUIP	INTERCOMPANY WAGE AND EXPENSE	1,302	1,302		9	4.02
4.03	4	EMPLOYEE BENEFITS	INTERCOMPANY WAGE AND EXPENSE	1,838,029	1,838,029			4.03
4.04	5	ADMINISTRATIVE & GENERAL	INTERCOMPANY WAGE AND EXPENSE	-5,578,497	-5,578,497			4.04
4.05	7	OPERATION OF PLANT	INTERCOMPANY WAGE AND EXPENSE	20,059	20,059			4.05
4.06	9	HOUSEKEEPING	INTERCOMPANY WAGE AND EXPENSE	444	444			4.06
4.07	10	DIETARY	INTERCOMPANY WAGE AND EXPENSE	-5,420	-5,420			4.07
4.08	16	MEDICAL RECORDS & LIBRARY	INTERCOMPANY WAGE AND EXPENSE	910	910			4.08
4.09	17	SOCIAL SERVICE	INTERCOMPANY WAGE AND EXPENSE	2,184	2,184			4.09
4.10	30	ADULTS & PEDIATRICS	INTERCOMPANY WAGE AND EXPENSE	2,962	2,962			4.10
4.11	54	RADIOLOGY-DIAGNOSTIC	INTERCOMPANY WAGE AND EXPENSE	-5,376	-5,376			4.11
4.12	65	RESPIRATORY THERAPY	INTERCOMPANY WAGE AND EXPENSE	100	100			4.12
4.13	66	PHYSICAL THERAPY	INTERCOMPANY WAGE AND EXPENSE	-268	-268			4.13
4.14	68	SPEECH PATHOLOGY	INTERCOMPANY WAGE AND EXPENSE	313	313			4.14
4.15	71	MEDICAL SUPPLIES CHRGED TO PATI	INTERCOMPANY WAGE AND EXPENSE	-517	-517			4.15
4.16	73	DRUGS CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENSE	470,468	470,468			4.16
4.17	113	INTEREST EXPENSE	INTERCOMPANY WAGE AND EXPENSE	22,131	22,131			4.17
4.18	2	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY - MCD ADJUSTMENT	42,305	44,420	-2,115	9	4.18
4.19	66	PHYSICAL THERAPY	RELATED PARTY - MOTORIKA	13	13			4.19
4.20	1	CAP REL COSTS-BLDG & FIXT	RELATED PARTY - RMH GROUND LSE		150,829	-150,829	10	4.20
4.21	5	ADMINISTRATIVE & GENERAL	RELATED PARTY - RHS		3,240	-3,240		4.21
4.22	54.01	RADIOLOGY SUA	RELATED PARTY - RHS	15,461	41,127	-25,666		4.22
4.23	60	LABORATORY	RELATED PARTY - RHS	256,621	262,113	-5,492		4.23
4.24	73	DRUGS CHARGED TO PATIENTS	RELATED PARTY - RHS	1,136	4,313	-3,177		4.24
4.25	4	EMPLOYEE BENEFITS	RELATED PARTY-EMP LSE FROM RMH	166,918	166,918			4.25
4.26	5	ADMINISTRATIVE & GENERAL	RELATED PARTY-EMP LSE FROM RMH	28,996	28,996			4.26
4.27	13	NURSING ADMINISTRATION	RELATED PARTY-EMP LSE FROM RMH	257,784	257,784			4.27
4.28	17	SOCIAL SERVICE	RELATED PARTY-EMP LSE FROM RMH	92,841	92,841			4.28
4.29	30	ADULTS & PEDIATRICS	RELATED PARTY-EMP LSE FROM RMH	125,211	125,211			4.29
4.30	67	OCCUPATIONAL THERAPY	RELATED PARTY-EMP LSE FROM RMH	125,046	125,046			4.30
4.31	4	EMPLOYEE BENEFITS	RELATED PARTY-EMP LSE TO RMH	184,147		184,147		4.31
4.32	66	PHYSICAL THERAPY	RELATED PARTY-EMP LSE TO RMH	470,222		470,222		4.32
4.33	67	OCCUPATIONAL THERAPY	RELATED PARTY-EMP LSE TO RMH	140,337		140,337		4.33
4.34	68	SPEECH PATHOLOGY	RELATED PARTY-EMP LSE TO RMH	84,335		84,335		4.34
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		1,309,151	-1,367,266	2,676,417		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		50.00	HEALTHSOUTH CORPORATION		HEALTHCARE	6
7	B		50.00	ROCKFORD HEALTH SYSTEM		JV PARTNER	7
8	G	ROCKFORD MEMORIAL HOSPITAL				HEALTHCARE	8
9	G	MED CENTER DIRECT				SUPPLIES	9
10	G	OTHER HS FACILITIES				HEALTHCARE	10
10.01	G	MOTORIKA				EQUIPMENT	10.01

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	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	30	ADULTS & PEDIATRICS	DR. A	3,667		3,667	171,400	132	10,877	544	1
200		TOTAL		3,667		3,667		132	10,877	544	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	30	ADULTS & PEDIATRICS	DR. A					10,877			1
200		TOTAL						10,877			200

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	1,076,607	1,076,607				1
2	CAP REL COSTS-MVBLE EQUIP	370,706		370,706			2
4	EMPLOYEE BENEFITS	1,804,171			1,804,171		4
5	ADMINISTRATIVE & GENERAL	4,676,076	27,779	9,565	261,687	4,975,107	5
7	OPERATION OF PLANT	668,194	322,579	111,073	27,361	1,129,207	7
8	LAUNDRY & LINEN SERVICE	95,205	6,139	2,114		103,458	8
9	HOUSEKEEPING	259,261	7,974	2,746	29,716	299,697	9
10	DIETARY	532,468	63,274	21,787	52,828	670,357	10
11	CAFETERIA						11
13	NURSING ADMINISTRATION	558,791	31,311	10,781	101,892	702,775	13
16	MEDICAL RECORDS & LIBRARY	210,772	11,317	3,897	29,595	255,581	16
17	SOCIAL SERVICE	341,985	7,888	2,716	62,073	414,662	17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	3,081,279	347,960	119,811	550,946	4,099,996	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	54,615	1,372	472	7,402	63,861	54
54.01	RADIOLOGY SUA	167,595				167,595	54.01
60	LABORATORY	280,928				280,928	60
65	RESPIRATORY THERAPY	248,736	7,425	2,557	43,909	302,627	65
66	PHYSICAL THERAPY	1,202,991	134,539	46,326	199,793	1,583,649	66
67	OCCUPATIONAL THERAPY	1,032,470	78,947	27,184	160,939	1,299,540	67
68	SPEECH PATHOLOGY	314,726	4,801	1,653	54,837	376,017	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	340,626	9,345	3,218	14,116	367,305	71
73	DRUGS CHARGED TO PATIENTS	809,377	10,734	3,696	58,931	882,738	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	18,127,579	1,073,384	369,596	1,656,025	17,975,100	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES		2,246	773		3,019	192
194	MARKETING	114,809	977	337	20,321	136,444	194
194.01	GUEST MEALS						194.01
194.02	CLINICAL PSYCH	19,200				19,200	194.02
194.05	STAFFING RMH	696,186			127,825	824,011	194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	18,957,774	1,076,607	370,706	1,804,171	18,957,774	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	4,975,107					5
7	OPERATION OF PLANT	406,652	1,535,859				7
8	LAUNDRY & LINEN SERVICE	37,258	12,982	153,698			8
9	HOUSEKEEPING	107,927	16,862		424,486		9
10	DIETARY	241,410	133,812		37,716	1,083,295	10
11	CAFETERIA					205,366	11
13	NURSING ADMINISTRATION	253,085	66,217		18,664		13
16	MEDICAL RECORDS & LIBRARY	92,040	23,934		6,746		16
17	SOCIAL SERVICE	149,329	16,681		4,702		17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,476,496	735,855	153,698	207,408	811,119	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	22,998	2,901		818		54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY	101,168					60
65	RESPIRATORY THERAPY	108,983	15,702		4,426		65
66	PHYSICAL THERAPY	570,307	284,522		80,195		66
67	OCCUPATIONAL THERAPY	467,993	166,956		47,058		67
68	SPEECH PATHOLOGY	135,412	10,154		2,862		68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	132,275	19,763		5,571		71
73	DRUGS CHARGED TO PATIENTS	317,893	22,701		6,398		73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	4,621,226	1,529,042	153,698	422,564	1,016,485	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	1,087	4,750		1,339		192
194	MARKETING	49,136	2,067		583		194
194.01	GUEST MEALS					66,810	194.01
194.02	CLINICAL PSYCH	6,914					194.02
194.05	STAFFING RMH	296,744					194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	4,975,107	1,535,859	153,698	424,486	1,083,295	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		11	13	16	17	24	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	205,366					11
13	NURSING ADMINISTRATION	14,607	1,055,348				13
16	MEDICAL RECORDS & LIBRARY	4,243		382,544			16
17	SOCIAL SERVICE	8,898			594,272		17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	78,981	1,055,348	146,065	594,272	9,359,238	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	1,061		436		92,075	54
54.01	RADIOLOGY SUA					167,595	54.01
60	LABORATORY			17,963		400,059	60
65	RESPIRATORY THERAPY	6,294		6,775		444,807	65
66	PHYSICAL THERAPY	28,641		82,286		2,629,600	66
67	OCCUPATIONAL THERAPY	23,071		63,233		2,067,851	67
68	SPEECH PATHOLOGY	7,861		15,679		547,985	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	2,024		17,654		544,592	71
73	DRUGS CHARGED TO PATIENTS	8,448		32,453		1,270,631	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	184,129	1,055,348	382,544	594,272	17,524,433	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES					10,195	192
194	MARKETING	2,913				191,143	194
194.01	GUEST MEALS					66,810	194.01
194.02	CLINICAL PSYCH					26,114	194.02
194.05	STAFFING RMH	18,324				1,139,079	194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	205,366	1,055,348	382,544	594,272	18,957,774	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT			1
2	CAP REL COSTS-MVBLE EQUIP			2
4	EMPLOYEE BENEFITS			4
5	ADMINISTRATIVE & GENERAL			5
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
13	NURSING ADMINISTRATION			13
16	MEDICAL RECORDS & LIBRARY			16
17	SOCIAL SERVICE			17
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS		9,359,238	30
	ANCILLARY SERVICE COST CENTERS			
54	RADIOLOGY-DIAGNOSTIC		92,075	54
54.01	RADIOLOGY SUA		167,595	54.01
60	LABORATORY		400,059	60
65	RESPIRATORY THERAPY		444,807	65
66	PHYSICAL THERAPY		2,629,600	66
67	OCCUPATIONAL THERAPY		2,067,851	67
68	SPEECH PATHOLOGY		547,985	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		544,592	71
73	DRUGS CHARGED TO PATIENTS		1,270,631	73
76	PSYCHOLOGY			76
76.01	SPECIAL PROCEDURES			76.01
76.97	CARDIAC REHABILITATION			76.97
76.98	HYPERBARIC OXYGEN THERAPY			76.98
76.99	LITHOTRIPSY			76.99
	OUTPATIENT SERVICE COST CENTERS			
92	OBSERVATION BEDS			92
	OTHER REIMBURSABLE COST CENTERS			
	SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE			113
118	SUBTOTALS (SUM OF LINES 1-117)		17,524,433	118
	NONREIMBURSABLE COST CENTERS			
192	PHYSICIANS' PRIVATE OFFICES		10,195	192
194	MARKETING		191,143	194
194.01	GUEST MEALS		66,810	194.01
194.02	CLINICAL PSYCH		26,114	194.02
194.05	STAFFING RMH		1,139,079	194.05
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	TOTAL (SUM OF LINES 118-201)		18,957,774	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	ADMINIS-TRATIVE & GENERAL 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL		27,779	9,565	37,344	37,344	5
7	OPERATION OF PLANT		322,579	111,073	433,652	3,052	7
8	LAUNDRY & LINEN SERVICE		6,139	2,114	8,253	280	8
9	HOUSEKEEPING		7,974	2,746	10,720	810	9
10	DIETARY		63,274	21,787	85,061	1,812	10
11	CAFETERIA						11
13	NURSING ADMINISTRATION		31,311	10,781	42,092	1,900	13
16	MEDICAL RECORDS & LIBRARY		11,317	3,897	15,214	691	16
17	SOCIAL SERVICE		7,888	2,716	10,604	1,121	17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		347,960	119,811	467,771	11,083	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC		1,372	472	1,844	173	54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY					759	60
65	RESPIRATORY THERAPY		7,425	2,557	9,982	818	65
66	PHYSICAL THERAPY		134,539	46,326	180,865	4,281	66
67	OCCUPATIONAL THERAPY		78,947	27,184	106,131	3,513	67
68	SPEECH PATHOLOGY		4,801	1,653	6,454	1,016	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		9,345	3,218	12,563	993	71
73	DRUGS CHARGED TO PATIENTS		10,734	3,696	14,430	2,386	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)		1,073,384	369,596	1,442,980	34,688	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES		2,246	773	3,019	8	192
194	MARKETING		977	337	1,314	369	194
194.01	GUEST MEALS						194.01
194.02	CLINICAL PSYCH					52	194.02
194.05	STAFFING RMH					2,227	194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		1,076,607	370,706	1,447,313	37,344	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT	436,704					7
8	LAUNDRY & LINEN SERVICE	3,691	12,224				8
9	HOUSEKEEPING	4,795		16,325			9
10	DIETARY	38,048		1,450	126,371		10
11	CAFETERIA				23,957	23,957	11
13	NURSING ADMINISTRATION	18,828		718		1,704	13
16	MEDICAL RECORDS & LIBRARY	6,805		259		495	16
17	SOCIAL SERVICE	4,743		181		1,038	17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	209,230	12,224	7,979	94,620	9,215	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	825		31		124	54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY						60
65	RESPIRATORY THERAPY	4,465		170		734	65
66	PHYSICAL THERAPY	80,901		3,084		3,341	66
67	OCCUPATIONAL THERAPY	47,472		1,810		2,691	67
68	SPEECH PATHOLOGY	2,887		110		917	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	5,620		214		236	71
73	DRUGS CHARGED TO PATIENTS	6,455		246		985	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	434,765	12,224	16,252	118,577	21,480	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	1,351		51			192
194	MARKETING	588		22		340	194
194.01	GUEST MEALS				7,794		194.01
194.02	CLINICAL PSYCH						194.02
194.05	STAFFING RMH					2,137	194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	436,704	12,224	16,325	126,371	23,957	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	NURSING ADMINIS-TRATION 13	MEDICAL RECORDS + LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
13	NURSING ADMINISTRATION	65,242					13
16	MEDICAL RECORDS & LIBRARY		23,464				16
17	SOCIAL SERVICE			17,687			17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	65,242	8,962	17,687	904,013		30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC		27		3,024		54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY		1,102		1,861		60
65	RESPIRATORY THERAPY		415		16,584		65
66	PHYSICAL THERAPY		5,046		277,518		66
67	OCCUPATIONAL THERAPY		3,878		165,495		67
68	SPEECH PATHOLOGY		961		12,345		68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		1,083		20,709		71
73	DRUGS CHARGED TO PATIENTS		1,990		26,492		73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	65,242	23,464	17,687	1,428,041		118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES				4,429		192
194	MARKETING				2,633		194
194.01	GUEST MEALS				7,794		194.01
194.02	CLINICAL PSYCH				52		194.02
194.05	STAFFING RMH				4,364		194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	65,242	23,464	17,687	1,447,313		202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B, PART II

	COST CENTER DESCRIPTION	TOTAL (26)	
	GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5	ADMINISTRATIVE & GENERAL		5
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
13	NURSING ADMINISTRATION		13
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
	INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS	904,013	30
	ANCILLARY SERVICE COST CENTERS		
54	RADIOLOGY-DIAGNOSTIC	3,024	54
54.01	RADIOLOGY SUA		54.01
60	LABORATORY	1,861	60
65	RESPIRATORY THERAPY	16,584	65
66	PHYSICAL THERAPY	277,518	66
67	OCCUPATIONAL THERAPY	165,495	67
68	SPEECH PATHOLOGY	12,345	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	20,709	71
73	DRUGS CHARGED TO PATIENTS	26,492	73
76	PSYCHOLOGY		76
76.01	SPECIAL PROCEDURES		76.01
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
	SPECIAL PURPOSE COST CENTERS		
113	INTEREST EXPENSE		113
118	SUBTOTALS (SUM OF LINES 1-117)	1,428,041	118
	NONREIMBURSABLE COST CENTERS		
192	PHYSICIANS' PRIVATE OFFICES	4,429	192
194	MARKETING	2,633	194
194.01	GUEST MEALS	7,794	194.01
194.02	CLINICAL PSYCH	52	194.02
194.05	STAFFING RMH	4,364	194.05
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	1,447,313	202

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	62,785					1
2	CAP REL COSTS-MVBLE EQUIP		62,785				2
4	EMPLOYEE BENEFITS			9,826,208			4
5	ADMINISTRATIVE & GENERAL	1,620	1,620	1,425,248	-4,975,107	13,815,072	5
7	OPERATION OF PLANT	18,812	18,812	149,019		1,129,207	7
8	LAUNDRY & LINEN SERVICE	358	358			103,458	8
9	HOUSEKEEPING	465	465	161,846		299,697	9
10	DIETARY	3,690	3,690	287,722		670,357	10
11	CAFETERIA						11
13	NURSING ADMINISTRATION	1,826	1,826	554,943		702,775	13
16	MEDICAL RECORDS & LIBRARY	660	660	161,186		255,581	16
17	SOCIAL SERVICE	460	460	338,071		414,662	17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	20,292	20,292	3,000,659		4,099,996	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	80	80	40,315		63,861	54
54.01	RADIOLOGY SUA				-167,595		54.01
60	LABORATORY					280,928	60
65	RESPIRATORY THERAPY	433	433	239,143		302,627	65
66	PHYSICAL THERAPY	7,846	7,846	1,088,152		1,583,649	66
67	OCCUPATIONAL THERAPY	4,604	4,604	876,535		1,299,540	67
68	SPEECH PATHOLOGY	280	280	298,666		376,017	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	545	545	76,879		367,305	71
73	DRUGS CHARGED TO PATIENTS	626	626	320,962		882,738	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	62,597	62,597	9,019,346	-5,142,702	12,832,398	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	131	131			3,019	192
194	MARKETING	57	57	110,676		136,444	194
194.01	GUEST MEALS						194.01
194.02	CLINICAL PSYCH					19,200	194.02
194.05	STAFFING RMH			696,186		824,011	194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,076,607	370,706	1,804,171		4,975,107	202
203	UNIT COST MULT-WS B PT I	17.147519	5.904372	0.183608		0.360122	203
204	COST TO BE ALLOC PER B PT II					37,344	204
205	UNIT COST MULT-WS B PT II					0.002703	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	PATIENT DAYS	SQUARE FEET	MEALS SERVED	GROSS SALARIES	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT	42,353					7
8	LAUNDRY & LINEN SERVICE	358	16,050				8
9	HOUSEKEEPING	465		41,530			9
10	DIETARY	3,690		3,690	64,307		10
11	CAFETERIA				12,191	7,802,373	11
13	NURSING ADMINISTRATION	1,826		1,826		554,943	13
16	MEDICAL RECORDS & LIBRARY	660		660		161,186	16
17	SOCIAL SERVICE	460		460		338,071	17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	20,292	16,050	20,292	48,150	3,000,659	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	80		80		40,315	54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY						60
65	RESPIRATORY THERAPY	433		433		239,143	65
66	PHYSICAL THERAPY	7,846		7,846		1,088,152	66
67	OCCUPATIONAL THERAPY	4,604		4,604		876,535	67
68	SPEECH PATHOLOGY	280		280		298,666	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	545		545		76,879	71
73	DRUGS CHARGED TO PATIENTS	626		626		320,962	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	42,165	16,050	41,342	60,341	6,995,511	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	131		131			192
194	MARKETING	57		57		110,676	194
194.01	GUEST MEALS				3,966		194.01
194.02	CLINICAL PSYCH						194.02
194.05	STAFFING RMH					696,186	194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,535,859	153,698	424,486	1,083,295	205,366	202
203	UNIT COST MULT-WS B PT I	36.263287	9.576199	10.221190	16.845678	0.026321	203
204	COST TO BE ALLOC PER B PT II	436,704	12,224	16,325	126,371	23,957	204
205	UNIT COST MULT-WS B PT II	10.311052	0.761620	0.393089	1.965120	0.003070	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINIS-TRATION PATIENT DAYS 13	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	SOCIAL SERVICE PATIENT DAYS 17	
	GENERAL SERVICE COST CENTERS				
1	CAP REL COSTS-BLDG & FIXT				1
2	CAP REL COSTS-MVBLE EQUIP				2
4	EMPLOYEE BENEFITS				4
5	ADMINISTRATIVE & GENERAL				5
7	OPERATION OF PLANT				7
8	LAUNDRY & LINEN SERVICE				8
9	HOUSEKEEPING				9
10	DIETARY				10
11	CAFETERIA				11
13	NURSING ADMINISTRATION	16,050			13
16	MEDICAL RECORDS & LIBRARY		33,513,656		16
17	SOCIAL SERVICE			16,050	17
	INPATIENT ROUTINE SERV COST CENTERS				
30	ADULTS & PEDIATRICS	16,050	12,797,222	16,050	30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC		38,213		54
54.01	RADIOLOGY SUA				54.01
60	LABORATORY		1,573,602		60
65	RESPIRATORY THERAPY		593,502		65
66	PHYSICAL THERAPY		7,208,560		66
67	OCCUPATIONAL THERAPY		5,539,438		67
68	SPEECH PATHOLOGY		1,373,555		68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		1,546,584		71
73	DRUGS CHARGED TO PATIENTS		2,842,980		73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
	SPECIAL PURPOSE COST CENTERS				
118	SUBTOTALS (SUM OF LINES 1-117)	16,050	33,513,656	16,050	118
	NONREIMBURSABLE COST CENTERS				
192	PHYSICIANS' PRIVATE OFFICES				192
194	MARKETING				194
194.01	GUEST MEALS				194.01
194.02	CLINICAL PSYCH				194.02
194.05	STAFFING RMH				194.05
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	COST TO BE ALLOC PER B PT I	1,055,348	382,544	594,272	202
203	UNIT COST MULT-WS B PT I	65.753769	0.011415	37.026293	203
204	COST TO BE ALLOC PER B PT II	65,242	23,464	17,687	204
205	UNIT COST MULT-WS B PT II	4.064922	0.000700	1.101994	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	9,359,238		9,359,238		9,359,238	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	92,075		92,075		92,075	54
54.01	RADIOLOGY SUA	167,595		167,595		167,595	54.01
60	LABORATORY	400,059		400,059		400,059	60
65	RESPIRATORY THERAPY	444,807		444,807		444,807	65
66	PHYSICAL THERAPY	2,629,600		2,629,600		2,629,600	66
67	OCCUPATIONAL THERAPY	2,067,851		2,067,851		2,067,851	67
68	SPEECH PATHOLOGY	547,985		547,985		547,985	68
71	MEDICAL SUPPLIES CHRGED TO	544,592		544,592		544,592	71
73	DRUGS CHARGED TO PATIENTS	1,270,631		1,270,631		1,270,631	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	17,524,433		17,524,433		17,524,433	200
201	LESS OBSERVATION BEDS						201
202	TOTAL (SEE INSTRUCTIONS)	17,524,433		17,524,433		17,524,433	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	12,797,222		12,797,222				30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	38,213		38,213	2.409520	2.409520	2.409520	54
54.01	RADIOLOGY SUA	335,848		335,848	0.499020	0.499020	0.499020	54.01
60	LABORATORY	1,573,571	31	1,573,602	0.254231	0.254231	0.254231	60
65	RESPIRATORY THERAPY	593,465	37	593,502	0.749462	0.749462	0.749462	65
66	PHYSICAL THERAPY	4,633,057	2,575,503	7,208,560	0.364789	0.364789	0.364789	66
67	OCCUPATIONAL THERAPY	4,493,045	1,046,393	5,539,438	0.373296	0.373296	0.373296	67
68	SPEECH PATHOLOGY	795,672	577,883	1,373,555	0.398954	0.398954	0.398954	68
71	MEDICAL SUPPLIES CHRGED TO	1,545,653	932	1,546,585	0.352125	0.352125	0.352125	71
73	DRUGS CHARGED TO PATIENTS	2,842,980		2,842,980	0.446936	0.446936	0.446936	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	29,648,726	4,200,779	33,849,505				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	29,648,726	4,200,779	33,849,505				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	904,013		904,013	16,050	56.32	10,259	577,787	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	904,013		904,013	16,050		10,259	577,787	200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-3028)	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF			

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	3,024	38,213	0.079135	8,162	646	54
54.01	RADIOLOGY SUA		335,848	335,848	227,270		54.01
60	LABORATORY	1,861	1,573,602	0.001183	1,047,267	1,239	60
65	RESPIRATORY THERAPY	16,584	593,502	0.027943	400,307	11,186	65
66	PHYSICAL THERAPY	277,518	7,208,560	0.038498	2,991,473	115,166	66
67	OCCUPATIONAL THERAPY	165,495	5,539,438	0.029876	2,893,589	86,449	67
68	SPEECH PATHOLOGY	12,345	1,373,555	0.008988	460,815	4,142	68
71	MEDICAL SUPPLIES CHRGED TO PA	20,709	1,546,585	0.013390	994,025	13,310	71
73	DRUGS CHARGED TO PATIENTS	26,492	2,842,980	0.009318	1,801,679	16,788	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	524,028	21,052,283	21,052,283	10,824,587	248,926	200

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

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

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

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

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	16,050		10,259		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	16,050		10,259		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-3028)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY SUA							54.01
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHRGED TO PA							71
73	DRUGS CHARGED TO PATIENTS							73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX]	HOSPITAL (14-3028)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
	[XX] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	38,213			8,162				54
54.01	RADIOLOGY SUA	335,848			227,270				54.01
60	LABORATORY	1,573,602			1,047,267				60
65	RESPIRATORY THERAPY	593,502			400,307				65
66	PHYSICAL THERAPY	7,208,560			2,991,473				66
67	OCCUPATIONAL THERAPY	5,539,438			2,893,589				67
68	SPEECH PATHOLOGY	1,373,555			460,815				68
71	MEDICAL SUPPLIES CHRGED TO P	1,546,585			994,025				71
73	DRUGS CHARGED TO PATIENTS	2,842,980			1,801,679				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	21,052,283			10,824,587				200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-3028)	[ ]	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								
54	RADIOLOGY-DIAGNOSTIC	2.409520							54
54.01	RADIOLOGY SUA	0.499020							54.01
60	LABORATORY	0.254231							60
65	RESPIRATORY THERAPY	0.749462							65
66	PHYSICAL THERAPY	0.364789							66
67	OCCUPATIONAL THERAPY	0.373296							67
68	SPEECH PATHOLOGY	0.398954							68
71	MEDICAL SUPPLIES CHRGED TO PATI	0.352125							71
73	DRUGS CHARGED TO PATIENTS	0.446936							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	904,013		904,013	16,050	56.32	865	48,717	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	904,013		904,013	16,050		865	48,717	200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-3028)	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[ ] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	3,024	38,213	0.079135			54
54.01	RADIOLOGY SUA		335,848	335,848			54.01
60	LABORATORY	1,861	1,573,602	0.001183			60
65	RESPIRATORY THERAPY	16,584	593,502	0.027943			65
66	PHYSICAL THERAPY	277,518	7,208,560	0.038498			66
67	OCCUPATIONAL THERAPY	165,495	5,539,438	0.029876			67
68	SPEECH PATHOLOGY	12,345	1,373,555	0.008988			68
71	MEDICAL SUPPLIES CHRGED TO PA	20,709	1,546,585	0.013390			71
73	DRUGS CHARGED TO PATIENTS	26,492	2,842,980	0.009318			73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	524,028	21,052,283	21,052,283			200

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

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

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

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

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	16,050		865		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	16,050		865		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-3028)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY SUA							54.01
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHRGED TO PA							71
73	DRUGS CHARGED TO PATIENTS							73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX]	HOSPITAL (14-3028)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
	[ ] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
	[XX] TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	38,213							54
54.01	RADIOLOGY SUA	335,848							54.01
60	LABORATORY	1,573,602							60
65	RESPIRATORY THERAPY	593,502							65
66	PHYSICAL THERAPY	7,208,560							66
67	OCCUPATIONAL THERAPY	5,539,438							67
68	SPEECH PATHOLOGY	1,373,555							68
71	MEDICAL SUPPLIES CHRGED TO P	1,546,585							71
73	DRUGS CHARGED TO PATIENTS	2,842,980							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	21,052,283							200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-3028)	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[ ]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[XX]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	2.409520							54
54.01	RADIOLOGY SUA	0.499020							54.01
60	LABORATORY	0.254231							60
65	RESPIRATORY THERAPY	0.749462							65
66	PHYSICAL THERAPY	0.364789							66
67	OCCUPATIONAL THERAPY	0.373296							67
68	SPEECH PATHOLOGY	0.398954							68
71	MEDICAL SUPPLIES CHRGED TO PATI	0.352125							71
73	DRUGS CHARGED TO PATIENTS	0.446936							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								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 (14-3028)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	16,050	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	16,050	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	16,050	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	10,259	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	9,359,238	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	9,359,238	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	12,797,222	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	12,797,222	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.731349	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	797.33	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	9,359,238	37

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

CHECK APPLICABLE BOXES: [ ] TITLE V-INPT [XX] TITLE XVIII-PT A [ ] TITLE XIX-INPT; [XX] HOSPITAL (14-3028) [ ] SUB (OTHER); [ ] IPF [ ] IRF; [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	583.13	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	5,982,331	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	5,982,331	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)					4,209,863	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					10,192,194	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					577,787	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					248,926	51
52	TOTAL PROGRAM EXCLUDABLE COST					826,713	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					9,365,481	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)		87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	583.13	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)		89

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

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-3028)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	16,050	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	16,050	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	16,050	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	865	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	9,359,238	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	9,359,238	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	12,797,222	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	12,797,222	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.731349	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	797.33	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	9,359,238	37

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

CHECK APPLICABLE BOXES: [ ] TITLE V-INPT [XX] HOSPITAL (14-3028) [ ] SUB (OTHER) | [XX] PPS
[ ] TITLE XVIII-PT A [ ] IPF | [ ] TEFRA
[XX] TITLE XIX-INPT [ ] IRF | [ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	583.13	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	504,407	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)	504,407	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)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					504,407	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					48,717	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					48,717	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					455,690	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

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

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

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-3028)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		8,176,878		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	2.409520	8,162	19,667	54
54.01	RADIOLOGY SUA	0.499020	227,270	113,412	54.01
60	LABORATORY	0.254231	1,047,267	266,248	60
65	RESPIRATORY THERAPY	0.749462	400,307	300,015	65
66	PHYSICAL THERAPY	0.364789	2,991,473	1,091,256	66
67	OCCUPATIONAL THERAPY	0.373296	2,893,589	1,080,165	67
68	SPEECH PATHOLOGY	0.398954	460,815	183,844	68
71	MEDICAL SUPPLIES CHRGED TO PATI	0.352125	994,025	350,021	71
73	DRUGS CHARGED TO PATIENTS	0.446936	1,801,679	805,235	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		10,824,587	4,209,863	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		10,824,587		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-3028)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	2.409520			54
54.01	RADIOLOGY SUA	0.499020			54.01
60	LABORATORY	0.254231			60
65	RESPIRATORY THERAPY	0.749462			65
66	PHYSICAL THERAPY	0.364789			66
67	OCCUPATIONAL THERAPY	0.373296			67
68	SPEECH PATHOLOGY	0.398954			68
71	MEDICAL SUPPLIES CHRGED TO PATI	0.352125			71
73	DRUGS CHARGED TO PATIENTS	0.446936			73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-3028) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

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

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

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-3028) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	INPATIENT PART B MM/DD/YYYY 3	INPATIENT PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				13,303,409			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE		NONE	3.01
			.02					3.02
		PROGRAM	.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					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)				13,303,409			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: _____

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART III

CHECK [XX] HOSPITAL (14-3028)
APPLICABLE BOX: [ ] IRF

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	13,034,608	1
2	MEDICARE SSI RATIO (SEE INSTRUCTIONS)	0.030800	2
3	INPATIENT REHABILITATION LIP PAYMENTS (SEE INSTRUCTIONS)	559,628	3
4	OUTLIER PAYMENTS	6,063	4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		5
6	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM (SEE INSTRUCTIONS)		7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM (SEE INSTRUCTIONS)		8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		9
10	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	43.972603	10
11	MEDICAL EDUCATION ADJUSTMENT FACTOR {((1 + (LINE 9/LINE 10)) RAISED TO THE POWER OF .6876 -1}		11
12	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 11)		12
13	TOTAL PPS PAYMENT (SUM OF LINES 1, 3, 4 AND 12)	13,600,299	13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		14
15	ORGAN ACQUISITION		15
16	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		16
17	SUBTOTAL (SEE INSTRUCTIONS)	13,600,299	17
18	PRIMARY PAYER PAYMENTS	3,868	18
19	SUBTOTAL LINE 17b LESS LINE 18)	13,596,431	19
20	DEDUCTIBLES	125,620	20
21	SUBTOTAL (LINE 19 MINUS LINE 20)	13,470,811	21
22	COINSURANCE	76,976	22
23	SUBTOTAL (LINE 21 MINUS LINE 22)	13,393,835	23
24	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	36,374	24
25	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	25,462	25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	29,128	26
27	SUBTOTAL (SUM OF LINES 23 AND 25)	13,419,297	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		28
29	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		29
30	OUTLIER PAYMENTS RECONCILIATION		30
31	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	13,419,297	32
33	INTERIM PAYMENTS	13,303,409	33
34	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		34
35	BALANCE DUE PROVIDER/PROGRAM (LINE 32 MINUS THE SUM OF LINES 33 AND 34)	115,888	35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		36

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-3028)	[ ]	SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
BOXES:			[ ]	IRF	[ ]	ICF/MR	[ ]	OTHER
			[ ]	SUB (OTHER)				

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

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

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	2,608,219				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3,631,380				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-770,420				6
7	INVENTORY	80,030				7
8	PREPAID EXPENSES	140,992				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	5,690,201				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	12,994,737				15
16	ACCUMULATED DEPRECIATION	-3,755,224				16
17	LEASEHOLD IMPROVEMENTS	336,319				17
18	ACCUMULATED AMORTIZATION	-2,803				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	2,745,516				23
24	ACCUMULATED DEPRECIATION	-2,193,179				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)	10,125,366				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	2,350,000				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	2,350,000				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	18,165,567				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	244,860				37
38	SALARIES, WAGES & FEES PAYABLE	668,162				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	1,695,197				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,608,219				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	7,948,357				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	7,948,357				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	10,556,576				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	7,608,991				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)	7,608,991				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	18,165,567				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

			GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
			1	2	3	4	5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD			7,378,033							1
2	NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)			5,049,351							2
3	TOTAL (SUM OF LINE 1 AND LINE 2)			12,427,384							3
4	ADDITIONS (CREDIT ADJUST-MENTS)										4
5											5
6											6
7											7
8											8
9											9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)										10
11	SUBTOTAL (LINE 3 PLUS LINE 10)			12,427,384							11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)										12
13	MINORITY INTEREST DIST	2,524,675									13
14	HS GEN PARTNER DIST	2,293,718									14
15											15
16											16
17											17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)			4,818,393							18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)			7,608,991							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	12,797,222		12,797,222	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)	12,797,222		12,797,222	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)	12,797,222		12,797,222	17
18	ANCILLARY SERVICES	16,851,504	4,200,778	21,052,282	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	29,648,726	4,200,778	33,849,504	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		17,663,087	29
30	ADD (SPECIFY)			30
31	ROUNDING	2		31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)		2	36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		17,663,089	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	33,849,504	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	12,357,944	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	21,491,560	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	17,663,089	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	3,828,471	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	14,217	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	8	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	35,580	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	5,457	22
23	GOVERNMENTAL APPROPRIATIONS		23
24		1,165,618	24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,220,880	25
26	TOTAL (LINE 5 PLUS LINE 25)	5,049,351	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	5,049,351	29