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: _____ TIME: _____
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 COMMUNITY HOSPITAL (15-0125) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2010 AND ENDING 06/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-53,514	74,992			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		-12,209				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		-65,723	74,992			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: 901 MACARTHUR BOULEVARD P.O.BOX: 1
2 CITY: MUNSTER STATE: IN ZIP CODE: 46321 COUNTY: LAKE 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	COMMUNITY HOSPITAL	15-0125	23844	1	10/03/1973	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF	THE REHAB CENTER AT COMMUNITY	15-T125	23844	5	06/30/1996	N	P	P	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	COMMUNITY HOME HEALTH SERVICE	15-7487	23844		01/07/1997	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2010	TO: 06/30/2011							20
21	TYPE OF CONTROL		2							21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	3,610	742	1,367	581	9,660		24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

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

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

		1	2	3	
TEACHING HOSPITALS					
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60

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

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

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

		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

TITLE V AND XIX INPATIENT SERVICES	V 1	XIX 2	
90 DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91 IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93 DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94 DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95 IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96 DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97 IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97

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

	PHY-SICAL	OCCUP-ATIONAL	SPEECH	RESPI-RATORY	
109 IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	N	N	109

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

MISCELLANEOUS COST REPORTING INFORMATION

		1	2	
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	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	1	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	158054	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: COMMUNITY FOUNDATION OF NW IN,	CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 00450	141
142	STREET: 10100 DON POWERS DRIVE	P.O. BOX:		142
143	CITY: MUNSTER	STATE: IN	ZIP CODE: 46321	143

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

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

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

MULTICAMPUS

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

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

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

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

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

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

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

COMPLETED BY ALL HOSPITALS

		Y/N 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.			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			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.			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	DATE	Y/N	DATE	
	PS&R REPORT DATA	1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	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	11/01/2011	Y	11/01/2011	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

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

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

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

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

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

	COMPONENT	WKST A LINE NO. 1	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V 5	TITLE XVIII 6	TITLE XIX 7	TOTAL ALL PATIENTS 8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	347	126,655			50,380	2,993	83,786	1
2	HMO						2,211	11,608		2
3	HMO IPF									3
4	HMO IRF						279	62		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.)		347	126,655			50,380	2,993	83,786	7
8	INTENSIVE CARE UNIT	31	34	12,410			5,422	216	9,764	8
9	CORONARY CARE UNIT	32								9
9.01	NEONATAL INTENSIVE CARE	32.01	25	9,125				693	6,177	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						450	4,895	13
14	TOTAL (SEE INSTRUCTIONS)		406	148,190			55,802	4,352	104,622	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41	46	16,790			13,316	75	14,812	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					37,206	1,271	43,931	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)		452							27
28	OBSERVATION BED DAYS							1,388	6,954	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					10,347	649	22,062	1
2	HMO						392			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
9.01	NEONATAL INTENSIVE CARE	32.01								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)			2,647.00			10,347	649	22,062	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41		73.00			1,243	7	1,395	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		34.00						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)			2,754.00						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	160,696,132		160,696,132	5,590,800.00	28.74	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B		2,771,550		2,771,550	32,947.00	84.12	3
4	PHYSICIAN-PART A							4
4.01	PHYSICIANS-PART A - DIRECT TEACHING							4.01
5	PHYSICIAN-PART B		6,628,856		6,628,856	36,209.00	183.07	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)		21,060,807	55,473	21,116,280	639,168.00	33.04	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		1,995,770		1,995,770	21,952.00	90.92	11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A		948,758		948,758	6,021.00	157.57	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		12,881,042		12,881,042	350,155.00	36.79	14
15	HOME OFFICE: PHYSICIAN-PART A							15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		40,679,232		40,679,232			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		5,264,525		5,264,525			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B		602,815		602,815			21
22	PHYSICIAN PART A							22
23	PHYSICIAN PART B		1,097,315		1,097,315			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		829,917		829,917	28,965.00	28.65	26
27	ADMINISTRATIVE & GENERAL		12,890,446	-72,079	12,818,367	463,928.00	27.63	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		2,411,230		2,411,230	17,004.00	141.80	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		4,431,181		4,431,181	178,230.00	24.86	30
31	LAUNDRY & LINEN SERVICE		136,651		136,651	8,594.00	15.90	31
32	HOUSEKEEPING		3,421,285		3,421,285	232,248.00	14.73	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		3,650,466	-1,379,229	2,271,237	130,634.00	17.39	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA			1,379,229	1,379,229	99,675.00	13.84	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,527,515		1,527,515	34,707.00	44.01	38
39	CENTRAL SERVICES AND SUPPLY			72,079	72,079	4,992.00	14.44	39
40	PHARMACY		3,560,752		3,560,752	100,032.00	35.60	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		3,461,402		3,461,402	174,910.00	19.79	41
42	SOCIAL SERVICE		670,207		670,207	24,716.00	27.12	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	153,706,956		153,706,956	5,538,648.0	27.75	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	21,060,807	55,473	21,116,280	639,168.00	33.04	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	132,646,149	-55,473	132,590,676	4,899,480.0	27.06	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	15,825,570		15,825,570	378,128.00	41.85	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	40,679,232		40,679,232		30.68%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	189,150,951	-55,473	189,095,478	5,277,608.0	35.83	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	36,991,052		36,991,052	1,498,635.0	24.68	7

HOSPITAL WAGE RELATED COSTS — WORKSHEET S-3 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	18,815,000	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	374,952	6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	15,834,133	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	877,506	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	116,536	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	77,296	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	394,546	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	8,427,997	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	2,263,450	18
19	UNEMPLOYMENT INSURANCE	289,495	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	172,976	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	47,643,887	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

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

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)	0.343568	1

MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)

2	NET REVENUE FROM MEDICAID	16,519,096	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	96,669,852	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	33,212,668	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)	16,693,572	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)	11,802	13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)		16

UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS	27,451	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)	16,693,572	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	15,500,389		15,500,389	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	5,325,438		5,325,438	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	149,264		149,264	22
23	COST OF CHARITY CARE	5,176,174		5,176,174	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM				24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGHTH OF STAY LIMIT (SEE INSTRUCTIONS)				25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			16,540,425	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			1,560,047	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			14,980,378	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			5,146,779	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			10,322,953	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			27,016,525	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFICATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		10,699,388	10,699,388	336,646	1
2	00200	CAP REL COSTS-MVBLE EQUIP		9,464,880	9,464,880	547,893	2
3	00300	OTHER CAPITAL RELATED COSTS					3
4	00400	EMPLOYEE BENEFITS	829,917	47,512,619	48,342,536	-6,324	4
5	00500	ADMINISTRATIVE & GENERAL	12,890,446	42,884,753	55,775,199	-1,693,287	5
6	00600	MAINTENANCE & REPAIRS					6
7	00700	OPERATION OF PLANT	4,431,181	7,930,624	12,361,805	537,856	7
8	00800	LAUNDRY & LINEN SERVICE	136,651	1,378,539	1,515,190		8
9	00900	HOUSEKEEPING	3,421,285	824,267	4,245,552	-8,066	9
10	01000	DIETARY	3,650,466	2,965,834	6,616,300	-2,868,325	10
11	01100	CAFETERIA				2,814,950	11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	1,527,515	203,980	1,731,495	-41,992	13
14	01400	CENTRAL SERVICES & SUPPLY		1,361,095	1,361,095	72,079	14
15	01500	PHARMACY	3,560,752	13,164,519	16,725,271		15
16	01600	MEDICAL RECORDS & LIBRARY	3,461,402	346,364	3,807,766	-877	16
17	01700	SOCIAL SERVICE	670,207	23,666	693,873		17
19	01900	NONPHYSICIAN ANESTHETISTS					19
20	02000	NURSING SCHOOL					20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	02300	PARAMED ED PRGM-(SPECIFY)					23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	31,353,487	4,150,346	35,503,833	-312,892	30
31	03100	INTENSIVE CARE UNIT	7,372,490	771,197	8,143,687	87,602	31
32.01	02060	NEONATAL INTENSIVE CARE	3,192,605	304,040	3,496,645	33,059	32.01
41	04100	SUBPROVIDER - IRF	3,792,785	1,765,087	5,557,872	55,473	41
43	04300	NURSERY	1,675,080	286,068	1,961,148	21,053	43
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	22,972,898	35,213,122	58,186,020	-22,024,930	50
52	05200	DELIVERY ROOM & LABOR ROOM	2,058,442	249,139	2,307,581	24,896	52
54	05400	RADIOLOGY-DIAGNOSTIC	7,331,338	6,140,405	13,471,743	-4,468	54
60	06000	LABORATORY	5,371,268	5,511,846	10,883,114		60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	383,451	3,202,372	3,585,823		62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	06500	RESPIRATORY THERAPY	3,354,369	484,797	3,839,166	-120	65
66	06600	PHYSICAL THERAPY	4,241,996	3,723,647	7,965,643	-17,244	66
70	07000	ELECTROENCEPHALOGRAPHY	689,547	372,644	1,062,191	-1,748	70
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS				13,296,662	71
72	07200	IMPL. DEV. CHARGED TO PATIENT				26,246,258	72
73	07300	DRUGS CHARGED TO PATIENTS					73
76	03140	CARDIOLOGY	6,966,936	22,831,635	29,798,571	-17,527,032	76
76.97	07697	CARDIAC REHABILITATION	543,035	29,588	572,623		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
90	09000	CLINIC	1,563,088	505,577	2,068,665	-12,059	90
91	09100	EMERGENCY	5,985,473	1,396,667	7,382,140	89,634	91
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF					99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY					99.40
101	10100	HOME HEALTH AGENCY	1,954,477	1,307,952	3,262,429	-60,095	101
		SPECIAL PURPOSE COST CENTERS					
118		SUBTOTALS (SUM OF LINES 1-117)	145,382,587	227,006,657	372,389,244	-415,398	118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
191	19100	RESEARCH	265,084	166,651	431,735	-2,625	191
192	19200	PHYSICIANS' PRIVATE OFFICES	12,779,489	4,024,047	16,803,536	-81,035	192
194	07950	ADVERTISING				761,696	194
194.01	07951	FITNESS POINTE	1,620,865	1,139,923	2,760,788	-262,638	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	265,462	79,870	345,332		194.02
194.03	07953	RETAIL PHARMACY	382,645	3,129,791	3,512,436		194.03
194.04	07954	HOSPICE					194.04
194.05	07955	RUSH RESIDENTS					194.05
200		TOTAL (SUM OF LINES 118-199)	160,696,132	235,546,939	396,243,071		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	11,036,034	-30,091	11,005,943	1
2	00200	CAP REL COSTS-MVBLE EQUIP	10,012,773	2,504,651	12,517,424	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	48,336,212	-6,339,561	41,996,651	4
5	00500	ADMINISTRATIVE & GENERAL	54,081,912	-6,621,437	47,460,475	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	12,899,661	11,685	12,911,346	7
8	00800	LAUNDRY & LINEN SERVICE	1,515,190		1,515,190	8
9	00900	HOUSEKEEPING	4,237,486	1,969	4,239,455	9
10	01000	DIETARY	3,747,975	-2,212	3,745,763	10
11	01100	CAFETERIA	2,814,950	-1,598,104	1,216,846	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	1,689,503		1,689,503	13
14	01400	CENTRAL SERVICES & SUPPLY	1,433,174		1,433,174	14
15	01500	PHARMACY	16,725,271	-1,547	16,723,724	15
16	01600	MEDICAL RECORDS & LIBRARY	3,806,889	-25,259	3,781,630	16
17	01700	SOCIAL SERVICE	693,873		693,873	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	35,190,941	-50,153	35,140,788	30
31	03100	INTENSIVE CARE UNIT	8,231,289		8,231,289	31
32.01	02060	NEONATAL INTENSIVE CARE	3,529,704	-37,925	3,491,779	32.01
41	04100	SUBPROVIDER - IRF	5,613,345		5,613,345	41
43	04300	NURSERY	1,982,201	-4,384	1,977,817	43
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	36,161,090	-11,343,395	24,817,695	50
52	05200	DELIVERY ROOM & LABOR ROOM	2,332,477		2,332,477	52
54	05400	RADIOLOGY-DIAGNOSTIC	13,467,275	-91,403	13,375,872	54
60	06000	LABORATORY	10,883,114	-8,880	10,874,234	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,585,823		3,585,823	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	3,839,046		3,839,046	65
66	06600	PHYSICAL THERAPY	7,948,399	-239,995	7,708,404	66
70	07000	ELECTROENCEPHALOGRAPHY	1,060,443	-28,275	1,032,168	70
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	13,296,662		13,296,662	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	26,246,258		26,246,258	72
73	07300	DRUGS CHARGED TO PATIENTS				73
76	03140	CARDIOLOGY	12,271,539	-758,874	11,512,665	76
76.97	07697	CARDIAC REHABILITATION	572,623		572,623	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
90	09000	CLINIC	2,056,606	-49,868	2,006,738	90
91	09100	EMERGENCY	7,471,774	-58,708	7,413,066	91
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
101	10100	HOME HEALTH AGENCY	3,202,334	-14	3,202,320	101
		SPECIAL PURPOSE COST CENTERS				
118		SUBTOTALS (SUM OF LINES 1-117)	371,973,846	-24,771,780	347,202,066	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
191	19100	RESEARCH	429,110		429,110	191
192	19200	PHYSICIANS' PRIVATE OFFICES	16,722,501	-96,888	16,625,613	192
194	07950	ADVERTISING	761,696		761,696	194
194.01	07951	FITNESS POINTE	2,498,150		2,498,150	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	345,332		345,332	194.02
194.03	07953	RETAIL PHARMACY	3,512,436	34,908	3,547,344	194.03
194.04	07954	HOSPICE				194.04
194.05	07955	RUSH RESIDENTS				194.05
200		TOTAL (SUM OF LINES 118-199)	396,243,071	-24,833,760	371,409,311	200

RECLASSIFICATIONS — WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	OPERATING RM SUPPLIES	A	MEDICAL SUPPLIES CHRGED TO PA	71		13,296,662	1
2			IMPL. DEV. CHARGED TO PATIENT	72		26,246,258	2
500	TOTAL RECLASSIFICATIONS					39,542,920	500
	CODE LETTER - A						
1	NURSING FLOAT SALARIES	B	INTENSIVE CARE UNIT	31	87,602		1
2			NURSERY	43	21,053		2
3			NEONATAL INTENSIVE CARE	32.01	33,059		3
4			DELIVERY ROOM & LABOR ROOM	52	24,896		4
5			EMERGENCY	91	90,809		5
6			SUBPROVIDER - IRF	41	55,473		6
500	TOTAL RECLASSIFICATIONS				312,892		500
	CODE LETTER - B						
1	STOREROOM SALARY RECLASS	C	CENTRAL SERVICES & SUPPLY	14	72,079		1
500	TOTAL RECLASSIFICATIONS				72,079		500
	CODE LETTER - C						
1	CAFETERIA EXPENSE	D	CAFETERIA	11	1,379,229	1,435,721	1
500	TOTAL RECLASSIFICATIONS				1,379,229	1,435,721	500
	CODE LETTER - D						
1	INTEREST EXPENSE	E	CARDIOLOGY	76		5,866	1
2			CAP REL COSTS-MVBLE EQUIP	2		539,737	2
500	TOTAL RECLASSIFICATIONS					545,603	500
	CODE LETTER - E						
1	BUILDING INSURANCE	F	CAP REL COSTS-BLDG & FIXT	1		336,646	1
2			CAP REL COSTS-MVBLE EQUIP	2		8,156	2
500	TOTAL RECLASSIFICATIONS					344,802	500
	CODE LETTER - F						
1	UTILITY RECLASS	G	OPERATION OF PLANT	7		537,856	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	TOTAL RECLASSIFICATIONS					537,856	500
	CODE LETTER - G						
1	ADVERTISING NON-REIMBURSEABLE	H	ADVERTISING	194		761,696	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
500	TOTAL RECLASSIFICATIONS					761,696	500
	CODE LETTER - H						
	GRAND TOTAL (INCREASES)				1,764,200	43,168,598	

RECLASSIFICATIONS — WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	OPERATING RM SUPPLIES	A	OPERATING ROOM	50		22,019,899		1
2			CARDIOLOGY	76		17,523,021		2
500	TOTAL RECLASSIFICATIONS					39,542,920		500
	CODE LETTER - A							
1	NURSING FLOAT SALARIES	B	ADULTS & PEDIATRICS	30	312,892			1
2								2
3								3
4								4
5								5
6								6
500	TOTAL RECLASSIFICATIONS				312,892			500
	CODE LETTER - B							
1	STOREROOM SALARY RECLASS	C	ADMINISTRATIVE & GENERAL	5	72,079			1
500	TOTAL RECLASSIFICATIONS				72,079			500
	CODE LETTER - C							
1	CAFETERIA EXPENSE	D	DIETARY	10	1,379,229	1,435,721		1
500	TOTAL RECLASSIFICATIONS				1,379,229	1,435,721		500
	CODE LETTER - D							
1	INTEREST EXPENSE	E	ADMINISTRATIVE & GENERAL	5		513,095	11	1
2			NURSING ADMINISTRATION	13		32,508	11	2
500	TOTAL RECLASSIFICATIONS					545,603		500
	CODE LETTER - E							
1	BUILDING INSURANCE	F	ADMINISTRATIVE & GENERAL	5		344,802	12	1
2							12	2
500	TOTAL RECLASSIFICATIONS					344,802		500
	CODE LETTER - F							
1	UTILITY RECLASS	G	HOME HEALTH AGENCY	101		53,530		1
2			ADMINISTRATIVE & GENERAL	5		106,334		2
3			FITNESS POINTE	194.01		262,638		3
4			PHYSICIANS' PRIVATE OFFICES	192		81,035		4
5			HOUSEKEEPING	9		8,066		5
6			PHYSICAL THERAPY	66		12,354		6
7			CLINIC	90		11,274		7
8			RESEARCH	191		2,625		8
500	TOTAL RECLASSIFICATIONS					537,856		500
	CODE LETTER - G							
1	ADVERTISING NON-REIMBURSEABLE	H	CLINIC	90		785		1
2			HOME HEALTH AGENCY	101		6,565		2
3			NURSING ADMINISTRATION	13		9,484		3
4			ADMINISTRATIVE & GENERAL	5		656,977		4
5			MEDICAL RECORDS & LIBRARY	16		877		5
6			PHYSICAL THERAPY	66		4,890		6
7			ELECTROENCEPHALOGRAPHY	70		1,748		7
8			RESPIRATORY THERAPY	65		120		8
9			RADIOLOGY-DIAGNOSTIC	54		4,468		9
10			DIETARY	10		53,375		10
11			OPERATING ROOM	50		5,031		11
12			EMPLOYEE BENEFITS	4		6,324		12
13			CARDIOLOGY	76		9,877		13
14			EMERGENCY	91		1,175		14
500	TOTAL RECLASSIFICATIONS					761,696		500
	CODE LETTER - H							
	GRAND TOTAL (DECREASES)				1,764,200	43,168,598		

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	1,940,035	453,176		453,176		2,393,211		1
2	LAND IMPROVEMENTS	6,444,488					6,444,488		2
3	BUILDINGS AND FIXTURES	234,400,168				662,652	233,737,516		3
4	BUILDING IMPROVEMENTS	49,851,194	2,656,024		2,656,024	97,235	52,409,983		4
5	FIXED EQUIPMENT	2,691,624				312,502	2,379,122		5
6	MOVABLE EQUIPMENT	115,518,326	8,214,589		8,214,589	3,626,059	120,106,856		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	410,845,835	11,323,789		11,323,789	4,698,448	417,471,176		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	410,845,835	11,323,789		11,323,789	4,698,448	417,471,176		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	10,699,388						10,699,388	1
2	CAP REL COSTS-MVBLE EQUIP	9,464,880						9,464,880	2
3	TOTAL (SUM OF LINES 1-2)	20,164,268						20,164,268	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	297,364,321		297,364,321	0.712299					1
2	CAP REL COSTS-MVBLE EQUIP	120,106,856		120,106,856	0.287701					2
3	TOTAL (SUM OF LINES 1-2)	417,471,177		417,471,177	1.000000					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	10,669,297			336,646			11,005,943	1
2	CAP REL COSTS-MVBLE EQUIP	12,509,268			8,156			12,517,424	2
3	TOTAL	23,178,565			344,802			23,523,367	3

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-539,737	CAP REL COSTS-MVBLE EQUIP	2	11	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-617	ADMINISTRATIVE & GENERAL	5		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	-11,811,022				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-2,910,540				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	B	-1,547	PHARMACY	15		17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-25,259	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	OFFSET IHA LOBBYING DUES	A	-5,034	ADMINISTRATIVE & GENERAL	5		33
34	BABY PHOTO INCOME	B	-225	NURSERY	43		34
35	A&G OTHER INCOME	B	-139,370	ADMINISTRATIVE & GENERAL	5		35
36	FITNESS POINTE RENTAL-CARDIAC R	B	-134,784	CARDIOLOGY	76		36
37	FITNESS POINTE RENTAL-PHYSICAL	B	-269,016	PHYSICAL THERAPY	66		37
38	PHYSICIAN RENTAL/X RAY SALES-RA	B	-11,130	RADIOLOGY-DIAGNOSTIC	54		38
39	VARIOUS OTHER REV OFFSET	B	-50,500	CARDIOLOGY	76		39
40	PHYSICIAN RENTAL-LAB	B	-585	LABORATORY	60		40
41	HOSPICE/OTHER RENTAL	B	-77,711	ADMINISTRATIVE & GENERAL	5		41
42	VARIOUS EH&W OFFSETS	B	-17,925	EMPLOYEE BENEFITS	4		42
43							43
43.02	OFFSET RESEARCH COSTS HEART CTR	A	-187,412	CARDIOLOGY	76		43.02
44	OFFSET BIORTERRORISM GRANT	B	-4,662	ADMINISTRATIVE & GENERAL	5		44
45	MEDICAL RESTRICTED	A	-101,017	ADMINISTRATIVE & GENERAL	5		45
45.01	EMPLOYEE CAFETERIA REVENUE	B	-1,598,104	CAFETERIA	11		45.01
45.03	GUEST TRAYS/CANDLELIGHT DINNERS	B	-365	DIETARY	10		45.03
45.04	TELEPHONE SERVICE	A	-135,316	ADMINISTRATIVE & GENERAL	5		45.04
45.05	TELEPHONE SERVICE	A	-4,163	CAP REL COSTS-BLDG & FIXT	1	9	45.05
45.06	TELEPHONE SERVICE	A	-11,587	CAP REL COSTS-MVBLE EQUIP	2	9	45.06
45.07	TELEPHONE SERVICE	A	-21,636	EMPLOYEE BENEFITS	4		45.07
45.08	TELEVISION SERVICE	A	-9,611	OPERATION OF PLANT	7		45.08
45.09	TELEVISION SERVICE	A	-35,692	CAP REL COSTS-MVBLE EQUIP	2	9	45.09
45.10	PENSION CONTRIBTN EXCESS OF EXP	A	-6,300,000	EMPLOYEE BENEFITS	4		45.10
45.11	SERVICE CHGS ON CHECKING	A	-107,879	ADMINISTRATIVE & GENERAL	5		45.11
45.12	OTHER NONOP REVENUE	B	-14	DIETARY	10		45.12
45.13	OFFSET COPYING FEES	B	-14	HOME HEALTH AGENCY	101		45.13
45.14	OFFSET COPY FEES	B	-28	OPERATING ROOM	50		45.14
45.18	MOB-DEPRECIATION	A	-248,404	CAP REL COSTS-BLDG & FIXT	1	9	45.18
45.19	CAPITALIZED INTEREST	A	1,589	CAP REL COSTS-BLDG & FIXT	1	9	45.19

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED — COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
45.20	1992 MME DEPRECIATION	A	1,183	CAP REL COSTS-MVBLE EQUIP	2	9	45.20
45.21	PARETN ASSET DEP AJE	A	-2,672	CAP REL COSTS-BLDG & FIXT	1	9	45.21
45.23	1996 TRADE-IN DEPRECIATION	A	-48	CAP REL COSTS-MVBLE EQUIP	2	9	45.23
45.24	1997 TRADE-IN DEPRECIATION	A	377	CAP REL COSTS-MVBLE EQUIP	2	9	45.24
45.28	1996 ASSET LIFE ADJUSTMENT	A	6,312	CAP REL COSTS-BLDG & FIXT	1	9	45.28
45.29	OFFSET RELEASED TEMP REST OP INC	B	-4,159	NURSERY	43		45.29
45.30	OFFSET RELEASED TEMP REST OP INC	B	-2,475	CARDIOLOGY	76		45.30
45.31	OFFSET RELEASED TEMP REST OP INC	B	-1,000	ADMINISTRATIVE & GENERAL	5		45.31
45.32	OFFSET RELEASED TEMP REST OP ONC	B	-4,662	ADMINISTRATIVE & GENERAL	5		45.32
45.33	NON-PT CARE RELATED EXPENSES	A	-43,120	ADMINISTRATIVE & GENERAL	5		45.33
45.36	OFFSET MISC ER PHYS COSTS 2805	A	-11,883	EMERGENCY	91		45.36
45.37	OTHER DIETARY INCOME	B	-1,833	DIETARY	10		45.37
45.40	OFFSET PHYSICIAN RENTAL	B	-4,343	NEONATAL INTENSIVE CARE	32.01		45.40
45.41	MAMMOGRAPHY READING FEES	A	-6,120	RADIOLOGY-DIAGNOSTIC	54		45.41
46							46
47							47
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-24,833,760				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	50	OPERATING ROOM	MOB LEASE EXP		825,393	-825,393		1
2	76	CARDIOLOGY	MOB LEASE EXP		311,055	-311,055		2
3	70	ELECTROENCEPHALOGRAPHY	MOB LEASE EXP		63,168	-63,168		3
4	5	ADMINISTRATIVE & GENERAL	MOB LEASE EXP		347,940	-347,940		4
4.01	192	PHYSICIANS' PRIVATE OFFICES	MOB LEASE EXP		176,152	-176,152		4.01
4.03	5	ADMINISTRATIVE & GENERAL	MOB DEPRECIATION	90,098		90,098		4.03
4.04	7	OPERATION OF PLANT	MOB DEPRECIATION	21,928		21,928		4.04
4.05	50	OPERATING ROOM	MOB DEPRECIATION	471,598		471,598		4.05
4.06	66	PHYSICAL THERAPY	MOB DEPRECIATION	20,580		20,580		4.06
4.07	70	ELECTROENCEPHALOGRAPHY	MOB DEPRECIATION	38,140		38,140		4.07
4.08	76	CARDIOLOGY	MOB DEPRECIATION	195,248		195,248		4.08
4.09	194.03	RETAIL PHARMACY	MOB DEPRECIATION	24,755		24,755		4.09
4.10	9	HOUSEKEEPING	MOB DEPRECIATION	1,396		1,396		4.10
4.11	60	LABORATORY	MOB DEPRECIATION	2,918		2,918		4.11
4.12	192	PHYSICIANS' PRIVATE OFFICES	MOB DEPRECIATION	56,210		56,210		4.12
4.15	7	OPERATION OF PLANT	MOB A&G EXP	8,994		8,994		4.15
4.16	9	HOUSEKEEPING	MOB A&G EXP	573		573		4.16
4.17	50	OPERATING ROOM	MOB A&G EXP	193,424		193,424		4.17
4.18	66	PHYSICAL THERAPY	MOB A&G EXP	8,441		8,441		4.18
4.19	60	LABORATORY	MOB A&G EXP	1,197		1,197		4.19
4.20	70	ELECTROENCEPHALOGRAPHY	MOB A&G EXP	15,643		15,643		4.20
4.21	76	CARDIOLOGY	MOB A&G EXP	80,080		80,080		4.21
4.22	5	ADMINISTRATIVE & GENERAL	MOB A&G EXP	36,953		36,953		4.22
4.23	192	PHYSICIANS' PRIVATE OFFICES	MOB A&G EXP	23,054		23,054		4.23
4.24	194.03	RETAIL PHARMACY	MOB A&G EXP	10,153		10,153		4.24
4.27	5	ADMINISTRATIVE & GENERAL	CDC DEPRECIATION	49,749		49,749		4.27
4.28	7	OPERATION OF PLANT	CDC DEPRECIATION	15,565		15,565		4.28
4.29	54	RADIOLOGY-DIAGNOSTIC	CDC DEPRECIATION	75,668		75,668		4.29
4.30	76	CARDIOLOGY	CDC DEPRECIATION	2,302		2,302		4.30
4.31	90	CLINIC	CDC DEPRECIATION	12,030		12,030		4.31
4.32	60	LABORATORY	CDC DEPRECIATION	7,223		7,223		4.32
4.37	5	ADMINISTRATIVE & GENERAL	CDC LEASE EXPENSE		74,573	-74,573		4.37
4.38	7	OPERATION OF PLANT	CDC LEASE EXPENSE		25,191	-25,191		4.38
4.39	54	RADIOLOGY-DIAGNOSTIC	CDC LEASE EXPENSE		125,788	-125,788		4.39
4.40	60	LABORATORY	CDC LEASE EXPENSE		11,729	-11,729		4.40
4.41	90	CLINIC	CDC LEASE EXPENSE		12,773	-12,773		4.41
4.42	76	CARDIOLOGY	CDC LEASE EXPENSE		10,086	-10,086		4.42
4.44	1	CAP REL COSTS-BLDG & FIXT	HOME OFFICE EQ DEPR	217,247		217,247	9	4.44
4.45	5	ADMINISTRATIVE & GENERAL	HOME OFFICE A&G	27,564,010	33,262,024	-5,698,014		4.45
4.46	2	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE BLDG DEPR	3,090,155		3,090,155	9	4.46
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		32,335,332	35,245,872	-2,910,540		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		100.00	CFNI		PARENT	6
7							7
8							8
9							9
10							10

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

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

	WKST A LINE NO.	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	5	ADMINISTRATIVE & GENERAL	AGGREGATE	156,700	16,792	139,908	171,400	1,389	114,459	5,723	1
2	32.01	NEONATAL INTENSIVE CARE	AGGREGATE	41,163	30,000	11,163	171,400	92	7,581	379	2
3	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE	25,832		25,832	231,100	109	12,111	606	3
4	50	OPERATING ROOM	AGGREGATE	11,182,996	11,182,996						4
5	60	LABORATORY	AGGREGATE	25,000		25,000	219,500	162	17,096	855	5
6	65	RESPIRATORY THERAPY	AGGREGATE	21,875		21,875	171,400	292	24,062	1,203	6
7	76	CARDIOLOGY	AGGREGATE	464,622	136,646	327,976	171,400	1,510	124,430	6,222	7
8	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE	23,200		23,200	231,100	116	12,888	644	8
9	30	ADULTS & PEDIATRICS	AGGREGATE	28,800		28,800	171,400	96	7,911	396	9
10	30	ADULTS & PEDIATRICS	AGGREGATE	49,700		49,700	171,400	248	20,436	1,022	10
11	90	CLINIC	AGGREGATE	124,113		124,113	171,400	910	74,988	3,749	11
12	70	ELECTROENCEPHALOGRAPHY	AGGREGATE	35,700		35,700	171,400	204	16,810	841	12
13	91	EMERGENCY	AGGREGATE	108,545		108,545	171,400	749	61,720	3,086	13
14	5	ADMINISTRATIVE & GENERAL	AGGREGATE	26,947		26,947	171,400	144	11,866	593	14
200		TOTAL		12,315,193	11,366,434	948,759		6,021	506,358	25,319	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	5	ADMINISTRATIVE & GENERAL	AGGREGATE					114,459	25,449	42,241	1
2	32.01	NEONATAL INTENSIVE CARE	AGGREGATE					7,581	3,582	33,582	2
3	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE					12,111	13,721	13,721	3
4	50	OPERATING ROOM	AGGREGATE							11,182,996	4
5	60	LABORATORY	AGGREGATE					17,096	7,904	7,904	5
6	65	RESPIRATORY THERAPY	AGGREGATE					24,062			6
7	76	CARDIOLOGY	AGGREGATE					124,430	203,546	340,192	7
8	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE					12,888	10,312	10,312	8
9	30	ADULTS & PEDIATRICS	AGGREGATE					7,911	20,889	20,889	9
10	30	ADULTS & PEDIATRICS	AGGREGATE					20,436	29,264	29,264	10
11	90	CLINIC	AGGREGATE					74,988	49,125	49,125	11
12	70	ELECTROENCEPHALOGRAPHY	AGGREGATE					16,810	18,890	18,890	12
13	91	EMERGENCY	AGGREGATE					61,720	46,825	46,825	13
14	5	ADMINISTRATIVE & GENERAL	AGGREGATE					11,866	15,081	15,081	14
200		TOTAL						506,358	444,588	11,811,022	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	11,005,943	11,005,943				1
2	CAP REL COSTS-MVBLE EQUIP	12,517,424		12,517,424			2
4	EMPLOYEE BENEFITS	41,996,651	48,639	10,163	42,055,453		4
5	ADMINISTRATIVE & GENERAL	47,460,475	2,988,759	858,896	3,372,089	54,680,219	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	12,911,346	1,260,442	421,641	1,165,697	15,759,126	7
8	LAUNDRY & LINEN SERVICE	1,515,190	18,980		35,948	1,570,118	8
9	HOUSEKEEPING	4,239,455	38,504	31,769	900,027	5,209,755	9
10	DIETARY	3,745,763	134,245	28,668	597,488	4,506,164	10
11	CAFETERIA	1,216,846	141,199	32,922	362,830	1,753,797	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,689,503	19,690	80,365	401,839	2,191,397	13
14	CENTRAL SERVICES & SUPPLY	1,433,174			18,962	1,452,136	14
15	PHARMACY	16,723,724	54,469	298,941	936,716	18,013,850	15
16	MEDICAL RECORDS & LIBRARY	3,781,630	98,922	8,079	910,581	4,799,212	16
17	SOCIAL SERVICE	693,873	22,977	971	176,309	894,130	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	35,140,788	1,828,135	677,149	8,165,685	45,811,757	30
31	INTENSIVE CARE UNIT	8,231,289	259,125	486,248	1,962,504	10,939,166	31
32.01	NEONATAL INTENSIVE CARE	3,491,779	70,517	113,467	848,566	4,524,329	32.01
41	SUBPROVIDER - IRF	5,613,345	303,779	64,656	1,012,350	6,994,130	41
43	NURSERY	1,977,817	27,045	3,222	446,197	2,454,281	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	24,817,695	440,720	1,851,912	6,043,411	33,153,738	50
52	DELIVERY ROOM & LABOR ROOM	2,332,477	149,252	173,654	548,057	3,203,440	52
54	RADIOLOGY-DIAGNOSTIC	13,375,872	501,303	4,148,515	1,928,633	19,954,323	54
60	LABORATORY	10,874,234	236,680	367,455	1,413,003	12,891,372	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,585,823	17,880	29,049	100,873	3,733,625	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	3,839,046	41,118	202,776	882,424	4,965,364	65
66	PHYSICAL THERAPY	7,708,404	413,143	75,796	1,115,929	9,313,272	66
70	ELECTROENCEPHALOGRAPHY	1,032,168	19,252	166,725	181,397	1,399,542	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	13,296,662				13,296,662	71
72	IMPL. DEV. CHARGED TO PATIENT	26,246,258				26,246,258	72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIOLOGY	11,512,665	298,386	1,525,411	1,832,771	15,169,233	76
76.97	CARDIAC REHABILITATION	572,623	28,204	5,954	142,855	749,636	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	2,006,738	88,622	65,605	411,197	2,572,162	90
91	EMERGENCY	7,413,066	366,277	532,563	1,598,469	9,910,375	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	3,202,320	42,277	49,310	514,158	3,808,065	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	347,202,066	9,958,541	12,311,882	38,026,965	341,920,634	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		26,170			26,170	190
191	RESEARCH	429,110		1,708	69,735	500,553	191
192	PHYSICIANS' PRIVATE OFFICES	16,625,613	299,403	54,935	3,361,862	20,341,813	192
194	ADVERTISING	761,696				761,696	194
194.01	FITNESS POINTE	2,498,150	552,319	113,767	426,396	3,590,632	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	345,332	85,985	4,304	69,834	505,455	194.02
194.03	RETAIL PHARMACY	3,547,344		30,828	100,661	3,678,833	194.03
194.04	HOSPICE		83,525			83,525	194.04
194.05	RUSH RESIDENTS						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	371,409,311	11,005,943	12,517,424	42,055,453	371,409,311	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	54,680,219					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	2,720,656	18,479,782				7
8	LAUNDRY & LINEN SERVICE	271,065	52,288	1,893,471			8
9	HOUSEKEEPING	899,412	106,074		6,215,241		9
10	DIETARY	777,944	369,825	1,497	3,151	5,658,581	10
11	CAFETERIA	302,776	388,981		37,807		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	378,323	54,242		5,131		13
14	CENTRAL SERVICES & SUPPLY	250,697			3,781		14
15	PHARMACY	3,109,911	150,054		20,254		15
16	MEDICAL RECORDS & LIBRARY	828,536	272,515		44,513		16
17	SOCIAL SERVICE	154,363	63,299		6,031		17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	7,909,050	5,036,227	774,698	2,084,140	4,417,655	30
31	INTENSIVE CARE UNIT	1,888,538	713,848	107,068	335,384	397,925	31
32.01	NEONATAL INTENSIVE CARE	781,080	194,262	16,727	117,544		32.01
41	SUBPROVIDER - IRF	1,207,467	836,863	118,754	298,955	756,611	41
43	NURSERY	423,707	74,506	16,510	12,494		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,723,661	1,214,115	195,866	1,111,320		50
52	DELIVERY ROOM & LABOR ROOM	553,042	411,166	45,314	279,835	86,390	52
54	RADIOLOGY-DIAGNOSTIC	3,444,914	1,381,012	107,319	214,969		54
60	LABORATORY	2,225,566	652,015		99,018		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	644,573	49,258				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	857,220	113,274	1,884	19,921		65
66	PHYSICAL THERAPY	1,607,843	1,138,144	32,556	72,319		66
70	ELECTROENCEPHALOGRAPHY	241,617	53,037	8,228	13,088		70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	2,295,536					71
72	IMPL. DEV. CHARGED TO PATIENT	4,531,154					72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIOLOGY	2,618,816	822,007	101,563	255,891		76
76.97	CARDIAC REHABILITATION	129,417	77,698	852			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	444,058	244,139	9,140	28,472		90
91	EMERGENCY	1,710,927	1,009,037	267,008	743,763		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	657,424	116,466		10,802		101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	49,589,293	15,594,352	1,804,984	5,818,583	5,658,581	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,518	72,095				190
191	RESEARCH	86,415					191
192	PHYSICIANS' PRIVATE OFFICES	3,511,811	824,809	237	352,100		192
194	ADVERTISING	131,499					194
194.01	FITNESS POINTE	619,887	1,521,554	88,250	44,558		194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	87,262	236,874				194.02
194.03	RETAIL PHARMACY	635,114					194.03
194.04	HOSPICE	14,420	230,098				194.04
194.05	RUSH RESIDENTS						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	54,680,219	18,479,782	1,893,471	6,215,241	5,658,581	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS-TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	2,483,361					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	22,220	2,651,313				13
14	CENTRAL SERVICES & SUPPLY	3,126		1,709,740			14
15	PHARMACY	64,341			21,358,410		15
16	MEDICAL RECORDS & LIBRARY	109,444				6,054,220	16
17	SOCIAL SERVICE	15,746					17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	759,400	1,203,744			2,270,331	30
31	INTENSIVE CARE UNIT	155,759	246,894			296,657	31
32.01	NEONATAL INTENSIVE CARE	58,779	93,174			108,976	32.01
41	SUBPROVIDER - IRF	98,621	156,326			193,735	41
43	NURSERY	37,432	59,336			60,542	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	333,581	528,773			1,507,501	50
52	DELIVERY ROOM & LABOR ROOM	44,257	70,143				52
54	RADIOLOGY-DIAGNOSTIC	123,367				127,139	54
60	LABORATORY	129,345				490,392	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,098				24,217	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	65,343				108,976	65
66	PHYSICAL THERAPY	53,999				48,434	66
70	ELECTROENCEPHALOGRAPHY	5,561				24,217	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			1,709,740			71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS				21,358,410		73
76	CARDIOLOGY	135,297				151,356	76
76.97	CARDIAC REHABILITATION	10,055					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	30,894	36,991				90
91	EMERGENCY	161,463	255,932			641,747	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	44,687					101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	2,469,815	2,651,313	1,709,740	21,358,410	6,054,220	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
191	RESEARCH	5,757					191
192	PHYSICIANS' PRIVATE OFFICES						192
194	ADVERTISING						194
194.01	FITNESS POINTE						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03	RETAIL PHARMACY	7,789					194.03
194.04	HOSPICE						194.04
194.05	RUSH RESIDENTS						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	2,483,361	2,651,313	1,709,740	21,358,410	6,054,220	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		17	24	25	26	
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE	1,133,569				17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	990,388	71,257,390		71,257,390	30
31	INTENSIVE CARE UNIT	97,988	15,179,227		15,179,227	31
32.01	NEONATAL INTENSIVE CARE	211	5,895,082		5,895,082	32.01
41	SUBPROVIDER - IRF	2,534	10,663,996		10,663,996	41
43	NURSERY		3,138,808		3,138,808	43
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	6,758	43,775,313		43,775,313	50
52	DELIVERY ROOM & LABOR ROOM	1,267	4,694,854		4,694,854	52
54	RADIOLOGY-DIAGNOSTIC		25,353,043		25,353,043	54
60	LABORATORY		16,487,708		16,487,708	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		4,458,771		4,458,771	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY		6,131,982		6,131,982	65
66	PHYSICAL THERAPY		12,266,567		12,266,567	66
70	ELECTROENCEPHALOGRAPHY		1,745,290		1,745,290	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		17,301,938		17,301,938	71
72	IMPL. DEV. CHARGED TO PATIENT		30,777,412		30,777,412	72
73	DRUGS CHARGED TO PATIENTS		21,358,410		21,358,410	73
76	CARDIOLOGY	4,435	19,258,598		19,258,598	76
76.97	CARDIAC REHABILITATION		967,658		967,658	76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	CLINIC		3,365,856		3,365,856	90
91	EMERGENCY	29,988	14,730,240		14,730,240	91
92	OBSERVATION BEDS					92
	OTHER REIMBURSABLE COST CENTERS					
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
101	HOME HEALTH AGENCY		4,637,444		4,637,444	101
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	1,133,569	333,445,587		333,445,587	118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		102,783		102,783	190
191	RESEARCH		592,725		592,725	191
192	PHYSICIANS' PRIVATE OFFICES		25,030,770		25,030,770	192
194	ADVERTISING		893,195		893,195	194
194.01	FITNESS POINTE		5,864,881		5,864,881	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		829,591		829,591	194.02
194.03	RETAIL PHARMACY		4,321,736		4,321,736	194.03
194.04	HOSPICE		328,043		328,043	194.04
194.05	RUSH RESIDENTS					194.05
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	1,133,569	371,409,311		371,409,311	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS	26,818	48,639	10,163	85,620	85,620	4
5	ADMINISTRATIVE & GENERAL	227,634	2,988,759	858,896	4,075,289	6,871	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	4,689	1,260,442	421,641	1,686,772	2,375	7
8	LAUNDRY & LINEN SERVICE		18,980		18,980	73	8
9	HOUSEKEEPING	9,820	38,504	31,769	80,093	1,834	9
10	DIETARY	14,203	134,245	28,668	177,116	1,217	10
11	CAFETERIA		141,199	32,922	174,121	739	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	13,988	19,690	80,365	114,043	819	13
14	CENTRAL SERVICES & SUPPLY	245,708			245,708	39	14
15	PHARMACY	16,337	54,469	298,941	369,747	1,909	15
16	MEDICAL RECORDS & LIBRARY	169,148	98,922	8,079	276,149	1,855	16
17	SOCIAL SERVICE	2,944	22,977	971	26,892	359	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	15,016	1,828,135	677,149	2,520,300	16,567	30
31	INTENSIVE CARE UNIT	17,816	259,125	486,248	763,189	3,999	31
32.01	NEONATAL INTENSIVE CARE	397	70,517	113,467	184,381	1,729	32.01
41	SUBPROVIDER - IRF	7,511	303,779	64,656	375,946	2,063	41
43	NURSERY	155	27,045	3,222	30,422	909	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	915,171	440,720	1,851,912	3,207,803	12,313	50
52	DELIVERY ROOM & LABOR ROOM	1,169	149,252	173,654	324,075	1,117	52
54	RADIOLOGY-DIAGNOSTIC	1,052,181	501,303	4,148,515	5,701,999	3,930	54
60	LABORATORY	306,701	236,680	367,455	910,836	2,879	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		17,880	29,049	46,929	206	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	31,076	41,118	202,776	274,970	1,798	65
66	PHYSICAL THERAPY	16,193	413,143	75,796	505,132	2,274	66
70	ELECTROENCEPHALOGRAPHY	185,337	19,252	166,725	371,314	370	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIOLOGY	1,696,609	298,386	1,525,411	3,520,406	3,734	76
76.97	CARDIAC REHABILITATION		28,204	5,954	34,158	291	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	52,332	88,622	65,605	206,559	838	90
91	EMERGENCY	11,130	366,277	532,563	909,970	3,257	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	4,974	42,277	49,310	96,561	1,048	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	5,045,057	9,958,541	12,311,882	27,315,480	77,412	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		26,170		26,170		190
191	RESEARCH	38,456		1,708	40,164	142	191
192	PHYSICIANS' PRIVATE OFFICES		299,403	54,935	354,338	6,850	192
194	ADVERTISING						194
194.01	FITNESS POINTE	6,025	552,319	113,767	672,111	869	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		85,985	4,304	90,289	142	194.02
194.03	RETAIL PHARMACY			30,828	30,828	205	194.03
194.04	HOSPICE		83,525		83,525		194.04
194.05	RUSH RESIDENTS						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	5,089,538	11,005,943	12,517,424	28,612,905	85,620	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	4,082,160					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	203,104	1,892,251				7
8	LAUNDRY & LINEN SERVICE	20,236	5,354	44,643			8
9	HOUSEKEEPING	67,143	10,862		159,932		9
10	DIETARY	58,075	37,869	35	81	274,393	10
11	CAFETERIA	22,603	39,830		973		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	28,243	5,554		132		13
14	CENTRAL SERVICES & SUPPLY	18,715			97		14
15	PHARMACY	232,162	15,365		521		15
16	MEDICAL RECORDS & LIBRARY	61,852	27,904		1,145		16
17	SOCIAL SERVICE	11,524	6,482		155		17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	590,580	515,685	18,266	53,627	214,219	30
31	INTENSIVE CARE UNIT	140,984	73,095	2,524	8,630	19,296	31
32.01	NEONATAL INTENSIVE CARE	58,310	19,892	394	3,025		32.01
41	SUBPROVIDER - IRF	90,140	85,691	2,800	7,693	36,689	41
43	NURSERY	31,631	7,629	389	322		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	427,285	124,320	4,618	28,597		50
52	DELIVERY ROOM & LABOR ROOM	41,286	42,102	1,068	7,201	4,189	52
54	RADIOLOGY-DIAGNOSTIC	257,171	141,410	2,530	5,532		54
60	LABORATORY	166,144	66,764		2,548		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	48,119	5,044				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	63,994	11,599	44	513		65
66	PHYSICAL THERAPY	120,029	116,541	768	1,861		66
70	ELECTROENCEPHALOGRAPHY	18,037	5,431	194	337		70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	171,367					71
72	IMPL. DEV. CHARGED TO PATIENT	338,262					72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIOLOGY	195,501	84,170	2,395	6,585		76
76.97	CARDIAC REHABILITATION	9,661	7,956	20			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	33,150	24,999	216	733		90
91	EMERGENCY	127,725	103,321	6,295	19,139		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	49,078	11,926		278		101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	3,702,111	1,596,795	42,556	149,725	274,393	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	337	7,382				190
191	RESEARCH	6,451					191
192	PHYSICIANS' PRIVATE OFFICES	262,165	84,457	6	9,060		192
194	ADVERTISING	9,817					194
194.01	FITNESS POINTE	46,276	155,801	2,081	1,147		194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	6,514	24,255				194.02
194.03	RETAIL PHARMACY	47,413					194.03
194.04	HOSPICE	1,076	23,561				194.04
194.05	RUSH RESIDENTS						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	4,082,160	1,892,251	44,643	159,932	274,393	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS-TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	238,266					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	2,132	150,923				13
14	CENTRAL SERVICES & SUPPLY	300		264,859			14
15	PHARMACY	6,173			625,877		15
16	MEDICAL RECORDS & LIBRARY	10,501				379,406	16
17	SOCIAL SERVICE	1,511					17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	72,862	68,520			142,277	30
31	INTENSIVE CARE UNIT	14,944	14,054			18,591	31
32.01	NEONATAL INTENSIVE CARE	5,640	5,304			6,829	32.01
41	SUBPROVIDER - IRF	9,462	8,899			12,141	41
43	NURSERY	3,591	3,378			3,794	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	32,005	30,100			94,472	50
52	DELIVERY ROOM & LABOR ROOM	4,246	3,993				52
54	RADIOLOGY-DIAGNOSTIC	11,836				7,968	54
60	LABORATORY	12,410				30,732	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	681				1,518	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	6,269				6,829	65
66	PHYSICAL THERAPY	5,181				3,035	66
70	ELECTROENCEPHALOGRAPHY	534				1,518	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			264,859			71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS				625,877		73
76	CARDIOLOGY	12,981				9,485	76
76.97	CARDIAC REHABILITATION	965					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	2,964	2,106				90
91	EMERGENCY	15,492	14,569			40,217	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	4,287					101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	236,967	150,923	264,859	625,877	379,406	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
191	RESEARCH	552					191
192	PHYSICIANS' PRIVATE OFFICES						192
194	ADVERTISING						194
194.01	FITNESS POINTE						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03	RETAIL PHARMACY	747					194.03
194.04	HOSPICE						194.04
194.05	RUSH RESIDENTS						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	238,266	150,923	264,859	625,877	379,406	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE	46,923				17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	40,996	4,253,899		4,253,899	30
31	INTENSIVE CARE UNIT	4,056	1,063,362		1,063,362	31
32.01	NEONATAL INTENSIVE CARE	9	285,513		285,513	32.01
41	SUBPROVIDER - IRF	105	631,629		631,629	41
43	NURSERY		82,065		82,065	43
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	280	3,961,793		3,961,793	50
52	DELIVERY ROOM & LABOR ROOM	52	429,329		429,329	52
54	RADIOLOGY-DIAGNOSTIC		6,132,376		6,132,376	54
60	LABORATORY		1,192,313		1,192,313	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		102,497		102,497	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY		366,016		366,016	65
66	PHYSICAL THERAPY		754,821		754,821	66
70	ELECTROENCEPHALOGRAPHY		397,735		397,735	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		436,226		436,226	71
72	IMPL. DEV. CHARGED TO PATIENT		338,262		338,262	72
73	DRUGS CHARGED TO PATIENTS		625,877		625,877	73
76	CARDIOLOGY	184	3,835,441		3,835,441	76
76.97	CARDIAC REHABILITATION		53,051		53,051	76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	CLINIC		271,565		271,565	90
91	EMERGENCY	1,241	1,241,226		1,241,226	91
92	OBSERVATION BEDS					92
	OTHER REIMBURSABLE COST CENTERS					
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
101	HOME HEALTH AGENCY		163,178		163,178	101
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	46,923	26,618,174		26,618,174	118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		33,889		33,889	190
191	RESEARCH		47,309		47,309	191
192	PHYSICIANS' PRIVATE OFFICES		716,876		716,876	192
194	ADVERTISING		9,817		9,817	194
194.01	FITNESS POINTE		878,285		878,285	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY		121,200		121,200	194.02
194.03	RETAIL PHARMACY		79,193		79,193	194.03
194.04	HOSPICE		108,162		108,162	194.04
194.05	RUSH RESIDENTS					194.05
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	46,923	28,612,905		28,612,905	202

COST ALLOCATION - STATISTICAL BASIS — WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES NEW- SQ FT 1	CAP MOVABLE EQUIPMENT NEW- $ VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	930,680					1
2	CAP REL COSTS-MVBLE EQUIP		9,576,212				2
4	EMPLOYEE BENEFITS	4,113	7,775	159,866,215			4
5	ADMINISTRATIVE & GENERAL	252,734	657,082	12,818,367	-54,680,219	316,729,092	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	106,585	322,568	4,431,181		15,759,126	7
8	LAUNDRY & LINEN SERVICE	1,605		136,651		1,570,118	8
9	HOUSEKEEPING	3,256	24,304	3,421,285		5,209,755	9
10	DIETARY	11,352	21,932	2,271,237		4,506,164	10
11	CAFETERIA	11,940	25,186	1,379,229		1,753,797	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,665	61,482	1,527,515		2,191,397	13
14	CENTRAL SERVICES & SUPPLY			72,079		1,452,136	14
15	PHARMACY	4,606	228,699	3,560,752		18,013,850	15
16	MEDICAL RECORDS & LIBRARY	8,365	6,181	3,461,402		4,799,212	16
17	SOCIAL SERVICE	1,943	743	670,207		894,130	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	154,590	518,040	31,040,595		45,811,757	30
31	INTENSIVE CARE UNIT	21,912	371,995	7,460,092		10,939,166	31
32.01	NEONATAL INTENSIVE CARE	5,963	86,806	3,225,664		4,524,329	32.01
41	SUBPROVIDER - IRF	25,688	49,464	3,848,258		6,994,130	41
43	NURSERY	2,287	2,465	1,696,133		2,454,281	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	37,268	1,416,770	22,972,898		33,153,738	50
52	DELIVERY ROOM & LABOR ROOM	12,621	132,851	2,083,338		3,203,440	52
54	RADIOLOGY-DIAGNOSTIC	42,391	3,173,738	7,331,338		19,954,323	54
60	LABORATORY	20,014	281,114	5,371,268		12,891,372	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,512	22,223	383,451		3,733,625	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	3,477	155,130	3,354,369		4,965,364	65
66	PHYSICAL THERAPY	34,936	57,986	4,241,996		9,313,272	66
70	ELECTROENCEPHALOGRAPHY	1,628	127,550	689,547		1,399,542	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS					13,296,662	71
72	IMPL. DEV. CHARGED TO PATIENT					26,246,258	72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIOLOGY	25,232	1,166,986	6,966,936		15,169,233	76
76.97	CARDIAC REHABILITATION	2,385	4,555	543,035		749,636	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	7,494	50,190	1,563,088		2,572,162	90
91	EMERGENCY	30,973	407,427	6,076,282		9,910,375	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	3,575	37,724	1,954,477		3,808,065	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	842,110	9,418,966	144,552,670	-54,680,219	287,240,415	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,213				26,170	190
191	RESEARCH		1,307	265,084		500,553	191
192	PHYSICIANS' PRIVATE OFFICES	25,318	42,027	12,779,489		20,341,813	192
194	ADVERTISING					761,696	194
194.01	FITNESS POINTE	46,705	87,035	1,620,865		3,590,632	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	7,271	3,293	265,462		505,455	194.02
194.03	RETAIL PHARMACY		23,584	382,645		3,678,833	194.03
194.04	HOSPICE	7,063				83,525	194.04
194.05	RUSH RESIDENTS						194.05

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES NEW- SQ FT 1	CAP MOVABLE EQUIPMENT NEW- $ VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	11,005,943	12,517,424	42,055,453		54,680,219	202
203	UNIT COST MULT-WS B PT I	11.825701	1.307137	0.263067		0.172640	203
204	COST TO BE ALLOC PER B PT II			85,620		4,082,160	204
205	UNIT COST MULT-WS B PT II			0.000536		0.012888	205

COST ALLOCATION - STATISTICAL BASIS — WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS	TIME SPENT	PATIENT MEALS	FTES	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	567,248					7
8	LAUNDRY & LINEN SERVICE	1,605	566,777				8
9	HOUSEKEEPING	3,256		690,454			9
10	DIETARY	11,352	448	350	329,795		10
11	CAFETERIA	11,940		4,200		190,670	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,665		570		1,706	13
14	CENTRAL SERVICES & SUPPLY			420		240	14
15	PHARMACY	4,606		2,250		4,940	15
16	MEDICAL RECORDS & LIBRARY	8,365		4,945		8,403	16
17	SOCIAL SERVICE	1,943		670		1,209	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	154,590	231,892	231,528	257,471	58,306	30
31	INTENSIVE CARE UNIT	21,912	32,049	37,258	23,192	11,959	31
32.01	NEONATAL INTENSIVE CARE	5,963	5,007	13,058		4,513	32.01
41	SUBPROVIDER - IRF	25,688	35,547	33,211	44,097	7,572	41
43	NURSERY	2,287	4,942	1,388		2,874	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	37,268	58,629	123,457		25,612	50
52	DELIVERY ROOM & LABOR ROOM	12,621	13,564	31,087	5,035	3,398	52
54	RADIOLOGY-DIAGNOSTIC	42,391	32,124	23,881		9,472	54
60	LABORATORY	20,014		11,000		9,931	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,512				545	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	3,477	564	2,213		5,017	65
66	PHYSICAL THERAPY	34,936	9,745	8,034		4,146	66
70	ELECTROENCEPHALOGRAPHY	1,628	2,463	1,454		427	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIOLOGY	25,232	30,401	28,427		10,388	76
76.97	CARDIAC REHABILITATION	2,385	255			772	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	7,494	2,736	3,163		2,372	90
91	EMERGENCY	30,973	79,924	82,625		12,397	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	3,575		1,200		3,431	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	478,678	540,290	646,389	329,795	189,630	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,213					190
191	RESEARCH					442	191
192	PHYSICIANS' PRIVATE OFFICES	25,318	71	39,115			192
194	ADVERTISING						194
194.01	FITNESS POINTE	46,705	26,416	4,950			194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	7,271					194.02
194.03	RETAIL PHARMACY					598	194.03
194.04	HOSPICE	7,063					194.04
194.05	RUSH RESIDENTS						194.05

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS	TIME SPENT	PATIENT MEALS	FTES	
		7	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	18,479,782	1,893,471	6,215,241	5,658,581	2,483,361	202
203	UNIT COST MULT-WS B PT I	32.577959	3.340769	9.001673	17.157874	13.024393	203
204	COST TO BE ALLOC PER B PT II	1,892,251	44,643	159,932	274,393	238,266	204
205	UNIT COST MULT-WS B PT II	3.335844	0.078766	0.231633	0.832011	1.249625	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINISTRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY COSTED REQ. 14	PHARMACY COSTED REQ. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 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
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	2,671,182					13
14	CENTRAL SERVICES & SUPPLY		100				14
15	PHARMACY			10,000			15
16	MEDICAL RECORDS & LIBRARY				1,000		16
17	SOCIAL SERVICE					268,389	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,212,766			375	234,489	30
31	INTENSIVE CARE UNIT	248,744			49	23,200	31
32.01	NEONATAL INTENSIVE CARE	93,872			18	50	32.01
41	SUBPROVIDER - IRF	157,497			32	600	41
43	NURSERY	59,781			10		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	532,735			249	1,600	50
52	DELIVERY ROOM & LABOR ROOM	70,669				300	52
54	RADIOLOGY-DIAGNOSTIC				21		54
60	LABORATORY				81		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS				4		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY				18		65
66	PHYSICAL THERAPY				8		66
70	ELECTROENCEPHALOGRAPHY				4		70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		100				71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS			10,000			73
76	CARDIOLOGY				25	1,050	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	37,268					90
91	EMERGENCY	257,850			106	7,100	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY						101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	2,671,182	100	10,000	1,000	268,389	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
191	RESEARCH						191
192	PHYSICIANS' PRIVATE OFFICES						192
194	ADVERTISING						194
194.01	FITNESS POINTE						194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY						194.02
194.03	RETAIL PHARMACY						194.03
194.04	HOSPICE						194.04
194.05	RUSH RESIDENTS						194.05

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINISTRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY COSTED REQ. 14	PHARMACY COSTED REQ. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	2,651,313	1,709,740	21,358,410	6,054,220	1,133,569	202
203	UNIT COST MULT-WS B PT I	0.992562	17,097.400000	2,135.841000	6,054.220000	4.223605	203
204	COST TO BE ALLOC PER B PT II	150,923	264,859	625,877	379,406	46,923	204
205	UNIT COST MULT-WS B PT II	0.056500	2,648.590000	62.587700	379.406000	0.174832	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	
	GENERAL SERVICE COST CENTERS	
1	CAP REL COSTS-BLDG & FIXT	1
2	CAP REL COSTS-MVBLE EQUIP	2
4	EMPLOYEE BENEFITS	4
5	ADMINISTRATIVE & GENERAL	5
6	MAINTENANCE & REPAIRS	6
7	OPERATION OF PLANT	7
8	LAUNDRY & LINEN SERVICE	8
9	HOUSEKEEPING	9
10	DIETARY	10
11	CAFETERIA	11
12	MAINTENANCE OF PERSONNEL	12
13	NURSING ADMINISTRATION	13
14	CENTRAL SERVICES & SUPPLY	14
15	PHARMACY	15
16	MEDICAL RECORDS & LIBRARY	16
17	SOCIAL SERVICE	17
19	NONPHYSICIAN ANESTHETISTS	19
20	NURSING SCHOOL	20
21	I&R SRVCES-SALARY & FRINGES APPRVD	21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
	INPATIENT ROUTINE SERV COST CENTERS	
30	ADULTS & PEDIATRICS	30
31	INTENSIVE CARE UNIT	31
32.01	NEONATAL INTENSIVE CARE	32.01
41	SUBPROVIDER - IRF	41
43	NURSERY	43
	ANCILLARY SERVICE COST CENTERS	
50	OPERATING ROOM	50
52	DELIVERY ROOM & LABOR ROOM	52
54	RADIOLOGY-DIAGNOSTIC	54
60	LABORATORY	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65	RESPIRATORY THERAPY	65
66	PHYSICAL THERAPY	66
70	ELECTROENCEPHALOGRAPHY	70
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	71
72	IMPL. DEV. CHARGED TO PATIENT	72
73	DRUGS CHARGED TO PATIENTS	73
76	CARDIOLOGY	76
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
	OUTPATIENT SERVICE COST CENTERS	
90	CLINIC	90
91	EMERGENCY	91
92	OBSERVATION BEDS	92
	OTHER REIMBURSABLE COST CENTERS	
99.10	CORF	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	99.40
101	HOME HEALTH AGENCY	101
	SPECIAL PURPOSE COST CENTERS	
118	SUBTOTALS (SUM OF LINES 1-117)	118
	NONREIMBURSABLE COST CENTERS	
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190
191	RESEARCH	191
192	PHYSICIANS' PRIVATE OFFICES	192
194	ADVERTISING	194
194.01	FITNESS POINTE	194.01
194.02	FITNESS POINTE SPA/PRO SHOP/DIETARY	194.02
194.03	RETAIL PHARMACY	194.03
194.04	HOSPICE	194.04
194.05	RUSH RESIDENTS	194.05

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	
200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	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	71,257,390		71,257,390	50,153	71,307,543	30
31	INTENSIVE CARE UNIT	15,179,227		15,179,227		15,179,227	31
32.01	NEONATAL INTENSIVE CARE	5,895,082		5,895,082	3,582	5,898,664	32.01
41	SUBPROVIDER - IRF	10,663,996		10,663,996		10,663,996	41
43	NURSERY	3,138,808		3,138,808		3,138,808	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	43,775,313		43,775,313		43,775,313	50
52	DELIVERY ROOM & LABOR ROOM	4,694,854		4,694,854		4,694,854	52
54	RADIOLOGY-DIAGNOSTIC	25,353,043		25,353,043	24,033	25,377,076	54
60	LABORATORY	16,487,708		16,487,708	7,904	16,495,612	60
62	WHOLE BLOOD & PACKED RED BL	4,458,771		4,458,771		4,458,771	62
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
65	RESPIRATORY THERAPY	6,131,982		6,131,982		6,131,982	65
66	PHYSICAL THERAPY	12,266,567		12,266,567		12,266,567	66
70	ELECTROENCEPHALOGRAPHY	1,745,290		1,745,290	18,890	1,764,180	70
71	MEDICAL SUPPLIES CHRGED TO	17,301,938		17,301,938		17,301,938	71
72	IMPL. DEV. CHARGED TO PATIE	30,777,412		30,777,412		30,777,412	72
73	DRUGS CHARGED TO PATIENTS	21,358,410		21,358,410		21,358,410	73
76	CARDIOLOGY	19,258,598		19,258,598	203,546	19,462,144	76
76.97	CARDIAC REHABILITATION	967,658		967,658		967,658	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	3,365,856		3,365,856	49,125	3,414,981	90
91	EMERGENCY	14,730,240		14,730,240	46,825	14,777,065	91
92	OBSERVATION BEDS	5,464,731		5,464,731		5,464,731	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THE						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	4,637,444		4,637,444		4,637,444	101
200	SUBTOTAL (SEE INSTRUCTIONS)	338,910,318		338,910,318	404,058	339,314,376	200
201	LESS OBSERVATION BEDS	5,464,731		5,464,731		5,464,731	201
202	TOTAL (SEE INSTRUCTIONS)	333,445,587		333,445,587	404,058	333,849,645	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	70,626,129		70,626,129				30
31	INTENSIVE CARE UNIT	13,425,816		13,425,816				31
32.01	NEONATAL INTENSIVE CARE	9,954,068		9,954,068				32.01
41	SUBPROVIDER - IRF	8,438,120		8,438,120				41
43	NURSERY	2,811,445		2,811,445				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	59,311,884	71,399,796	130,711,680	0.334900	0.334900	0.334900	50
52	DELIVERY ROOM & LABOR ROOM	4,403,268	1,529,538	5,932,806	0.791338	0.791338	0.791338	52
54	RADIOLOGY-DIAGNOSTIC	51,618,052	120,864,651	172,482,703	0.146989	0.146989	0.147128	54
60	LABORATORY	60,775,696	64,042,533	124,818,229	0.132094	0.132094	0.132157	60
62	WHOLE BLOOD & PACKED RED BL	7,507,243	2,557,895	10,065,138	0.442992	0.442992	0.442992	62
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
65	RESPIRATORY THERAPY	27,382,736	1,326,762	28,709,498	0.213587	0.213587	0.213587	65
66	PHYSICAL THERAPY	20,942,779	12,451,680	33,394,459	0.367323	0.367323	0.367323	66
70	ELECTROENCEPHALOGRAPHY	1,591,292	5,922,345	7,513,637	0.232283	0.232283	0.234797	70
71	MEDICAL SUPPLIES CHRGED TO	25,203,352	21,226,550	46,429,902	0.372646	0.372646	0.372646	71
72	IMPL. DEV. CHARGED TO PATIE	37,890,434	17,302,974	55,193,408	0.557628	0.557628	0.557628	72
73	DRUGS CHARGED TO PATIENTS	75,510,364	18,031,176	93,541,540	0.228331	0.228331	0.228331	73
76	CARDIOLOGY	44,453,331	45,920,608	90,373,939	0.213099	0.213099	0.215351	76
76.97	CARDIAC REHABILITATION	307,103	1,045,673	1,352,776	0.715313	0.715313	0.715313	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	185,376	3,667,826	3,853,202	0.873522	0.873522	0.886271	90
91	EMERGENCY	22,538,225	35,865,005	58,403,230	0.252216	0.252216	0.253018	91
92	OBSERVATION BEDS		11,709,215	11,709,215	0.466703	0.466703	0.466703	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THE							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		6,701,269	6,701,269				101
200	SUBTOTAL (SEE INSTRUCTIONS)	544,876,713	441,565,496	986,442,209				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	544,876,713	441,565,496	986,442,209				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	4,253,899		4,253,899	90,740	46.88	50,380	2,361,814	30
31	INTENSIVE CARE UNIT	1,063,362		1,063,362	9,764	108.91	5,422	590,510	31
32	CORONARY CARE UNIT								32
32.01	NEONATAL INTENSIVE CARE	285,513		285,513	6,177	46.22			32.01
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	631,629		631,629	14,812	42.64	13,316	567,794	41
42	SUBPROVIDER I								42
43	NURSERY	82,065		82,065	4,895	16.77			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	6,316,468		6,316,468	126,388		69,118	3,520,118	200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-0125)	[ ]	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						
50	OPERATING ROOM	3,961,793	130,711,680	0.030309	27,974,539	847,880	50
52	DELIVERY ROOM & LABOR ROOM	429,329	5,932,806	0.072365	7,752	561	52
54	RADIOLOGY-DIAGNOSTIC	6,132,376	172,482,703	0.035554	28,757,222	1,022,434	54
60	LABORATORY	1,192,313	124,818,229	0.009552	33,783,577	322,701	60
62	WHOLE BLOOD & PACKED RED BLOO	102,497	10,065,138	0.010183	4,139,912	42,157	62
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	366,016	28,709,498	0.012749	16,923,636	215,759	65
66	PHYSICAL THERAPY	754,821	33,394,459	0.022603	5,963,362	134,790	66
70	ELECTROENCEPHALOGRAPHY	397,735	7,513,637	0.052935	990,959	52,456	70
71	MEDICAL SUPPLIES CHRGED TO PA	436,226	46,429,902	0.009395	14,690,503	138,017	71
72	IMPL. DEV. CHARGED TO PATIENT	338,262	55,193,408	0.006129	24,038,034	147,329	72
73	DRUGS CHARGED TO PATIENTS	625,877	93,541,540	0.006691	40,822,456	273,143	73
76	CARDIOLOGY	3,835,441	90,373,939	0.042440	31,517,669	1,337,610	76
76.97	CARDIAC REHABILITATION	53,051	1,352,776	0.039216	208,146	8,163	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	271,565	3,853,202	0.070478	94,134	6,634	90
91	EMERGENCY	1,241,226	58,403,230	0.021253	11,559,614	245,676	91
92	OBSERVATION BEDS	326,004	11,709,215	0.027842			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	20,464,532	874,485,362	874,485,362	241,471,515	4,795,310	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
32.01	NEONATAL INTENSIVE CARE						32.01
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	90,740		50,380		30
31	INTENSIVE CARE UNIT	9,764		5,422		31
32	CORONARY CARE UNIT					32
32.01	NEONATAL INTENSIVE CARE	6,177				32.01
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	14,812		13,316		41
42	SUBPROVIDER I					42
43	NURSERY	4,895				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	126,388		69,118		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-0125)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOO							62
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
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 (15-0125)	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] PPS
	[XX] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] TITLE XIX	[ ] IRF	[ ] NF		

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	130,711,680			27,974,539		20,331,855		50
52	DELIVERY ROOM & LABOR ROOM	5,932,806			7,752				52
54	RADIOLOGY-DIAGNOSTIC	172,482,703			28,757,222		41,876,768		54
60	LABORATORY	124,818,229			33,783,577		3,295,818		60
62	WHOLE BLOOD & PACKED RED BLO	10,065,138			4,139,912		687,413		62
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	28,709,498			16,923,636		410,590		65
66	PHYSICAL THERAPY	33,394,459			5,963,362		133,425		66
70	ELECTROENCEPHALOGRAPHY	7,513,637			990,959		1,531,962		70
71	MEDICAL SUPPLIES CHRGED TO P	46,429,902			14,690,503		8,369,506		71
72	IMPL. DEV. CHARGED TO PATIEN	55,193,408			24,038,034		8,793,229		72
73	DRUGS CHARGED TO PATIENTS	93,541,540			40,822,456		7,344,536		73
76	CARDIOLOGY	90,373,939			31,517,669		23,406,525		76
76.97	CARDIAC REHABILITATION	1,352,776			208,146		575,147		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3,853,202			94,134		2,020,797		90
91	EMERGENCY	58,403,230			11,559,614		6,668,763		91
92	OBSERVATION BEDS	11,709,215					3,130,319		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	874,485,362			241,471,515		128,576,653		200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (15-0125)	[ ]	SUB (OTHER)	[ ]	S/B-SNF	
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF	
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.334900	20,331,855			6,809,138			50
52	DELIVERY ROOM & LABOR ROOM	0.791338							52
54	RADIOLOGY-DIAGNOSTIC	0.146989	41,876,768			6,155,424			54
60	LABORATORY	0.132094	3,295,818			435,358			60
62	WHOLE BLOOD & PACKED RED BLOOD	0.442992	687,413			304,518			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.213587	410,590			87,697			65
66	PHYSICAL THERAPY	0.367323	133,425			49,010			66
70	ELECTROENCEPHALOGRAPHY	0.232283	1,531,962			355,849			70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.372646	8,369,506			3,118,863			71
72	IMPL. DEV. CHARGED TO PATIENT	0.557628	8,793,229			4,903,351			72
73	DRUGS CHARGED TO PATIENTS	0.228331	7,344,536		71,160	1,676,985		16,248	73
76	CARDIOLOGY	0.213099	23,406,525			4,987,907			76
76.97	CARDIAC REHABILITATION	0.715313	575,147			411,410			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.873522	2,020,797			1,765,211			90
91	EMERGENCY	0.252216	6,668,763			1,681,969			91
92	OBSERVATION BEDS	0.466703	3,130,319			1,460,929			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)		128,576,653		71,160	34,203,619		16,248	200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)		128,576,653		71,160	34,203,619		16,248	202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[ ]	TITLE XIX	[XX]	IRF (15-T125)			

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,961,793	130,711,680	0.030309	139,901	4,240	50
52	DELIVERY ROOM & LABOR ROOM	429,329	5,932,806	0.072365			52
54	RADIOLOGY-DIAGNOSTIC	6,132,376	172,482,703	0.035554	780,469	27,749	54
60	LABORATORY	1,192,313	124,818,229	0.009552	1,999,679	19,101	60
62	WHOLE BLOOD & PACKED RED BLOO	102,497	10,065,138	0.010183	192,640	1,962	62
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	366,016	28,709,498	0.012749	665,489	8,484	65
66	PHYSICAL THERAPY	754,821	33,394,459	0.022603	10,827,518	244,734	66
70	ELECTROENCEPHALOGRAPHY	397,735	7,513,637	0.052935	92,187	4,880	70
71	MEDICAL SUPPLIES CHRGED TO PA	436,226	46,429,902	0.009395	996,288	9,360	71
72	IMPL. DEV. CHARGED TO PATIENT	338,262	55,193,408	0.006129	26,992	165	72
73	DRUGS CHARGED TO PATIENTS	625,877	93,541,540	0.006691	4,382,373	29,322	73
76	CARDIOLOGY	3,835,441	90,373,939	0.042440	325,581	13,818	76
76.97	CARDIAC REHABILITATION	53,051	1,352,776	0.039216	245	10	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	271,565	3,853,202	0.070478	1,430	101	90
91	EMERGENCY	1,241,226	58,403,230	0.021253			91
92	OBSERVATION BEDS	326,004	11,709,215	0.027842			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	20,464,532	874,485,362	874,485,362	20,430,792	363,926	200

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

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[XX]	IRF (15-T125)	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOO							62
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
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	[ ] TITLE V	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA
BOXES	[ ] TITLE XIX	[XX] IRF (15-T125)	[ ] NF		

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	130,711,680			139,901				50
52	DELIVERY ROOM & LABOR ROOM	5,932,806							52
54	RADIOLOGY-DIAGNOSTIC	172,482,703			780,469				54
60	LABORATORY	124,818,229			1,999,679				60
62	WHOLE BLOOD & PACKED RED BLO	10,065,138			192,640				62
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	28,709,498			665,489				65
66	PHYSICAL THERAPY	33,394,459			10,827,518				66
70	ELECTROENCEPHALOGRAPHY	7,513,637			92,187				70
71	MEDICAL SUPPLIES CHRGED TO P	46,429,902			996,288				71
72	IMPL. DEV. CHARGED TO PATIEN	55,193,408			26,992				72
73	DRUGS CHARGED TO PATIENTS	93,541,540			4,382,373				73
76	CARDIOLOGY	90,373,939			325,581				76
76.97	CARDIAC REHABILITATION	1,352,776			245				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3,853,202			1,430				90
91	EMERGENCY	58,403,230							91
92	OBSERVATION BEDS	11,709,215							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	874,485,362			20,430,792				200

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

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[XX]	IRF (15-T125)	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.334900							50
52	DELIVERY ROOM & LABOR ROOM	0.791338							52
54	RADIOLOGY-DIAGNOSTIC	0.146989							54
60	LABORATORY	0.132094							60
62	WHOLE BLOOD & PACKED RED BLOOD	0.442992							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.213587							65
66	PHYSICAL THERAPY	0.367323							66
70	ELECTROENCEPHALOGRAPHY	0.232283							70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.372646							71
72	IMPL. DEV. CHARGED TO PATIENT	0.557628							72
73	DRUGS CHARGED TO PATIENTS	0.228331							73
76	CARDIOLOGY	0.213099							76
76.97	CARDIAC REHABILITATION	0.715313							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.873522							90
91	EMERGENCY	0.252216							91
92	OBSERVATION BEDS	0.466703							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	4,253,899		4,253,899	90,740	46.88	2,993	140,312	30
31	INTENSIVE CARE UNIT	1,063,362		1,063,362	9,764	108.91	216	23,525	31
32	CORONARY CARE UNIT								32
32.01	NEONATAL INTENSIVE CARE	285,513		285,513	6,177	46.22	693	32,030	32.01
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	631,629		631,629	14,812	42.64	75	3,198	41
42	SUBPROVIDER I								42
43	NURSERY	82,065		82,065	4,895	16.77	450	7,547	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	6,316,468		6,316,468	126,388		4,427	206,612	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-0125)	[ ]	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) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,961,793	130,711,680	0.030309	1,083,246	32,832	50
52	DELIVERY ROOM & LABOR ROOM	429,329	5,932,806	0.072365	112,043	8,108	52
54	RADIOLOGY-DIAGNOSTIC	6,132,376	172,482,703	0.035554	1,831,688	65,124	54
60	LABORATORY	1,192,313	124,818,229	0.009552	1,999,156	19,096	60
62	WHOLE BLOOD & PACKED RED BLOO	102,497	10,065,138	0.010183	228,827	2,330	62
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	366,016	28,709,498	0.012749	419,358	5,346	65
66	PHYSICAL THERAPY	754,821	33,394,459	0.022603	237,257	5,363	66
70	ELECTROENCEPHALOGRAPHY	397,735	7,513,637	0.052935	41,736	2,209	70
71	MEDICAL SUPPLIES CHRGED TO PA	436,226	46,429,902	0.009395	726,549	6,826	71
72	IMPL. DEV. CHARGED TO PATIENT	338,262	55,193,408	0.006129	478,067	2,930	72
73	DRUGS CHARGED TO PATIENTS	625,877	93,541,540	0.006691	2,602,269	17,412	73
76	CARDIOLOGY	3,835,441	90,373,939	0.042440	909,222	38,587	76
76.97	CARDIAC REHABILITATION	53,051	1,352,776	0.039216	5,945	233	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	271,565	3,853,202	0.070478	307	22	90
91	EMERGENCY	1,241,226	58,403,230	0.021253	577,910	12,282	91
92	OBSERVATION BEDS		11,709,215	11,709,215			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	20,138,528	874,485,362	874,485,362	11,253,580	218,700	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
32.01	NEONATAL INTENSIVE CARE						32.01
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	90,740		2,993		30
31	INTENSIVE CARE UNIT	9,764		216		31
32	CORONARY CARE UNIT					32
32.01	NEONATAL INTENSIVE CARE	6,177		693		32.01
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	14,812		75		41
42	SUBPROVIDER I					42
43	NURSERY	4,895		450		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	126,388		4,427		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-0125)	[ ]	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							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOO							62
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
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	[ ]	TITLE V	[XX]	HOSPITAL (15-0125)	[ ]	SUB (OTHER)		[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF				[ ]	TEFRA
BOXES	[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								
50	OPERATING ROOM	130,711,680			1,083,246				50
52	DELIVERY ROOM & LABOR ROOM	5,932,806			112,043				52
54	RADIOLOGY-DIAGNOSTIC	172,482,703			1,831,688				54
60	LABORATORY	124,818,229			1,999,156				60
62	WHOLE BLOOD & PACKED RED BLO	10,065,138			228,827				62
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	28,709,498			419,358				65
66	PHYSICAL THERAPY	33,394,459			237,257				66
70	ELECTROENCEPHALOGRAPHY	7,513,637			41,736				70
71	MEDICAL SUPPLIES CHRGED TO P	46,429,902			726,549				71
72	IMPL. DEV. CHARGED TO PATIEN	55,193,408			478,067				72
73	DRUGS CHARGED TO PATIENTS	93,541,540			2,602,269				73
76	CARDIOLOGY	90,373,939			909,222				76
76.97	CARDIAC REHABILITATION	1,352,776			5,945				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3,853,202			307				90
91	EMERGENCY	58,403,230			577,910				91
92	OBSERVATION BEDS	11,709,215							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	874,485,362			11,253,580				200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (15-0125)	[ ]	SUB (OTHER)	[ ] S/B-SNF
APPLICABLE	[ ]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ] S/B-NF
BOXES	[XX]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ] ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.334900							50
52	DELIVERY ROOM & LABOR ROOM	0.791338							52
54	RADIOLOGY-DIAGNOSTIC	0.146989							54
60	LABORATORY	0.132094							60
62	WHOLE BLOOD & PACKED RED BLOOD	0.442992							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.213587							65
66	PHYSICAL THERAPY	0.367323							66
70	ELECTROENCEPHALOGRAPHY	0.232283							70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.372646							71
72	IMPL. DEV. CHARGED TO PATIENT	0.557628							72
73	DRUGS CHARGED TO PATIENTS	0.228331							73
76	CARDIOLOGY	0.213099							76
76.97	CARDIAC REHABILITATION	0.715313							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.873522							90
91	EMERGENCY	0.252216							91
92	OBSERVATION BEDS	0.466703							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ] SUB (OTHER)	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF		[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[XX]	IRF (15-T125)		[ ]	OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,961,793	130,711,680	0.030309	721	22	50
52	DELIVERY ROOM & LABOR ROOM	429,329	5,932,806	0.072365			52
54	RADIOLOGY-DIAGNOSTIC	6,132,376	172,482,703	0.035554	7,569	269	54
60	LABORATORY	1,192,313	124,818,229	0.009552	12,925	123	60
62	WHOLE BLOOD & PACKED RED BLOO	102,497	10,065,138	0.010183			62
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	366,016	28,709,498	0.012749	2,407	31	65
66	PHYSICAL THERAPY	754,821	33,394,459	0.022603	58,839	1,330	66
70	ELECTROENCEPHALOGRAPHY	397,735	7,513,637	0.052935			70
71	MEDICAL SUPPLIES CHRGED TO PA	436,226	46,429,902	0.009395	4,565	43	71
72	IMPL. DEV. CHARGED TO PATIENT	338,262	55,193,408	0.006129			72
73	DRUGS CHARGED TO PATIENTS	625,877	93,541,540	0.006691	45,131	302	73
76	CARDIOLOGY	3,835,441	90,373,939	0.042440	1,978	84	76
76.97	CARDIAC REHABILITATION	53,051	1,352,776	0.039216			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	271,565	3,853,202	0.070478			90
91	EMERGENCY	1,241,226	58,403,230	0.021253			91
92	OBSERVATION BEDS		11,709,215	11,709,215			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	20,138,528	874,485,362	874,485,362	134,135	2,204	200

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

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[XX]	IRF (15-T125)	[ ]	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							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOO							62
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
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	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[ ] PPS
	[ ] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[XX] TITLE XIX	[XX] IRF (15-T125)	[ ] 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								
50	OPERATING ROOM	130,711,680			721				50
52	DELIVERY ROOM & LABOR ROOM	5,932,806							52
54	RADIOLOGY-DIAGNOSTIC	172,482,703			7,569				54
60	LABORATORY	124,818,229			12,925				60
62	WHOLE BLOOD & PACKED RED BLO	10,065,138							62
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	28,709,498			2,407				65
66	PHYSICAL THERAPY	33,394,459			58,839				66
70	ELECTROENCEPHALOGRAPHY	7,513,637							70
71	MEDICAL SUPPLIES CHRGED TO P	46,429,902			4,565				71
72	IMPL. DEV. CHARGED TO PATIEN	55,193,408							72
73	DRUGS CHARGED TO PATIENTS	93,541,540			45,131				73
76	CARDIOLOGY	90,373,939			1,978				76
76.97	CARDIAC REHABILITATION	1,352,776							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3,853,202							90
91	EMERGENCY	58,403,230							91
92	OBSERVATION BEDS	11,709,215							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	874,485,362			134,135				200

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

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[ ]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[XX]	TITLE XIX - O/P	[XX]	IRF (15-T125)	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.334900							50
52	DELIVERY ROOM & LABOR ROOM	0.791338							52
54	RADIOLOGY-DIAGNOSTIC	0.146989							54
60	LABORATORY	0.132094							60
62	WHOLE BLOOD & PACKED RED BLOOD	0.442992							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.213587							65
66	PHYSICAL THERAPY	0.367323							66
70	ELECTROENCEPHALOGRAPHY	0.232283							70
71	MEDICAL SUPPLIES CHRGED TO PATI	0.372646							71
72	IMPL. DEV. CHARGED TO PATIENT	0.557628							72
73	DRUGS CHARGED TO PATIENTS	0.228331							73
76	CARDIOLOGY	0.213099							76
76.97	CARDIAC REHABILITATION	0.715313							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.873522							90
91	EMERGENCY	0.252216							91
92	OBSERVATION BEDS	0.466703							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 (15-0125)	[ ]	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)	90,740	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	90,740	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,000	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	80,740	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)	50,380	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)	71,307,543	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	71,307,543	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	67,581,390	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,365,795	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	59,215,595	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.055136	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	836.58	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	733.41	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	103.17	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	108.86	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	1,088,600	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	70,218,943	37

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

CHECK APPLICABLE BOXES: [ ] TITLE V-INPT [XX] HOSPITAL (15-0125) [ ] SUB (OTHER) [XX] PPS
[XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA
[ ] 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)	785.84	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	39,590,619	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)	39,590,619	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	15,179,227	9,764	1,554.61	5,422	8,429,095	43
44	CORONARY CARE UNIT						44
44.01	NEONATAL INTENSIVE CARE	5,898,664	6,177	954.94			44.01
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)					64,086,447	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					112,106,161	49

	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	2,952,324	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	4,795,310	51
52	TOTAL PROGRAM EXCLUDABLE COST	7,747,634	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	104,358,527	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)	6,954	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	785.84	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	5,464,731	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	4,253,899	71,307,543	0.059656	5,464,731	326,004	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[XX]	IRF (15-T125)	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	14,812	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	14,812	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,524	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,288	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)	13,316	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)	1,317	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)	10,663,996	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	10,663,996	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,447,659	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	646,362	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,801,297	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.957537	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	424.12	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	361.33	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	62.79	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	122.91	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	187,315	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	10,476,681	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[XX]	IRF (15-T125)			[ ]	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)	719.96	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	9,586,987	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)	9,586,987	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	6,110,775	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	15,697,762	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	567,794	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	363,926	51
52	TOTAL PROGRAM EXCLUDABLE COST	931,720	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	14,766,042	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (LINE 54 x LINE 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT		57
58	BONUS PAYMENT (SEE INSTRUCTIONS)		58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET		59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E		61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (15-0125)	[ ]	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)	90,740	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	90,740	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10,000	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	80,740	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)	2,993	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	4,895	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	450	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)	71,307,543	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	71,307,543	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	67,581,390	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,365,795	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	59,215,595	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.055136	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	836.58	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	733.41	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	103.17	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	108.86	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	1,088,600	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	70,218,943	37

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

CHECK APPLICABLE BOXES: [ ] TITLE V-INPT [XX] HOSPITAL (15-0125) [ ] 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)	785.84	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	2,352,019	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	2,352,019	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)	3,138,808	4,895	641.23	450	288,554	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	15,179,227	9,764	1,554.61	216	335,796	43
44	CORONARY CARE UNIT						44
44.01	NEONATAL INTENSIVE CARE	5,898,664	6,177	954.94	693	661,773	44.01
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					2,751,083	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					6,389,225	49

	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	203,414	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	218,700	51
52	TOTAL PROGRAM EXCLUDABLE COST	422,114	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	5,967,111	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)	6,954	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)		88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)		89

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

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ] TEFRA
BOXES	[XX]	TITLE XIX-INPT	[XX]	IRF (15-T125)	[ ]	NF			[ ] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	14,812	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	14,812	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,524	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,288	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)	75	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)	10,663,996	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	10,663,996	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,447,659	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	646,362	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,801,297	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.957537	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	424.12	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	361.33	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	62.79	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	122.91	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	187,315	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	10,476,681	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX-INPT	[XX]	IRF (15-T125)			[ ] 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)	719.96	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	53,997	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)	53,997	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	37,622	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	91,619	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	3,198	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	2,204	51
52	TOTAL PROGRAM EXCLUDABLE COST	5,402	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	86,217	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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART A

CHECK [XX] HOSPITAL (15-0125)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	84,138,506	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	1,781,456	2
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	386.95	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0280	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.1525	31
32	SUM OF LINES 30 AND 31	0.1805	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0448	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	3,769,405	34
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	89,689,367	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	89,689,367	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	7,227,545	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART A

CHECK [XX] HOSPITAL (15-0125)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	96,916,912	59
60	PRIMARY PAYER PAYMENTS	79,806	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	96,837,106	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	7,689,605	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	673,595	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	1,117,935	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	782,555	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	707,733	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	89,256,461	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SEQUESTRATION PER PSR)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	89,256,461	71
72	INTERIM PAYMENTS	89,309,975	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-53,514	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	230,551	75

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (15-0125) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	16,248	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	34,203,619	2
3	PPS PAYMENTS	32,456,021	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	27,848	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)	16,248	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	71,160	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)	71,160	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)	71,160	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)	54,912	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)	16,248	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)	32,483,869	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	7,308,961	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	25,191,156	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)	25,191,156	30
31	PRIMARY PAYER PAYMENTS	9,678	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	25,181,478	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)	1,090,099	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	763,069	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	689,800	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	25,944,547	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (FDO LOSS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	25,944,547	40
41	INTERIM PAYMENTS	25,869,555	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	74,992	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [XX] IRF (15-T125)
[ ] 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 (15-0125) [ ] 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				88,099,138		25,165,229	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.				729,447		666,972	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	02/10/2011	481,390	02/10/2011	37,354	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		481,390		37,354	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)				89,309,975		25,869,555	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		NONE		NONE	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		NONE		NONE	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				74,992	6.01
	PROVIDER TO PROGRAM	.02		-89,309,975			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)						25,944,547	7

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

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

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [XX] IRF (15-T125) [ ] 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				18,472,202			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)				18,472,202			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		NONE		NONE	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		NONE		NONE	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		-12,209			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				18,459,993			7

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

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

CHECK APPLICABLE BOX [XX] HOSPITAL (15-0125) [ ] CAH

	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	22,062	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	55,802	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	2,211	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	99,727	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	986,442,209	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	15,500,389	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART III

CHECK [ ] HOSPITAL
APPLICABLE BOX: [XX] IRF (15-T125)

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	18,481,631	1
2	MEDICARE SSI RATIO (SEE INSTRUCTIONS)	0.008300	2
3	INPATIENT REHABILITATION LIP PAYMENTS (SEE INSTRUCTIONS)	70,600	3
4	OUTLIER PAYMENTS	131,043	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)	40.580822	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)	18,683,274	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)	18,683,274	17
18	PRIMARY PAYER PAYMENTS	34,776	18
19	SUBTOTAL LINE 17b LESS LINE 18)	18,648,498	19
20	DEDUCTIBLES	146,565	20
21	SUBTOTAL (LINE 19 MINUS LINE 20)	18,501,933	21
22	COINSURANCE	56,363	22
23	SUBTOTAL (LINE 21 MINUS LINE 22)	18,445,570	23
24	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	20,604	24
25	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	14,423	25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	17,284	26
27	SUBTOTAL (SUM OF LINES 23 AND 25)	18,459,993	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)	18,459,993	32
33	INTERIM PAYMENTS	18,472,202	33
34	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		34
35	BALANCE DUE PROVIDER/PROGRAM (LINE 32 MINUS THE SUM OF LINES 33 AND 34)	-12,209	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 (15-0125)	[ ]	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	2,840,599	8
9	ANCILLARY SERVICE CHARGES	11,253,580	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)	14,094,179	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)	14,094,179	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)	14,094,179	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)		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)	8,525,794	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 (REMOVE IP COSTS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
BOXES:			[XX]	IRF (15-T125)	[ ]	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	134,135	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)	134,135	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)	134,135	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)	134,135	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)		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	19,003,983				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	94,162,520				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-39,719,396				6
7	INVENTORY	8,454,200				7
8	PREPAID EXPENSES	2,441,053				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	84,342,360				11
	FIXED ASSETS					
12	LAND	2,393,212				12
13	LAND IMPROVEMENTS	6,444,488				13
14	ACCUMULATED DEPRECIATION	-4,505,104				14
15	BUILDINGS	233,737,515				15
16	ACCUMULATED DEPRECIATION	-155,685,197				16
17	LEASEHOLD IMPROVEMENTS	1,116,869				17
18	ACCUMULATED AMORTIZATION	-715,272				18
19	FIXED EQUIPMENT	51,293,115				19
20	ACCUMULATED DEPRECIATION	-9,756,774				20
21	AUTOMOBILES AND TRUCKS	404,955				21
22	ACCUMULATED DEPRECIATION	-319,668				22
23	MAJOR MOVABLE EQUIPMENT	122,472,412				23
24	ACCUMULATED DEPRECIATION	-85,462,845				24
25	MINOR EQUIPMENT DEPRECIABLE	1,447				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)	161,419,153				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	598,299				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	598,299				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	246,359,812				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	13,042,224				37
38	SALARIES, WAGES & FEES PAYABLE	27,497,161				38
39	PAYROLL TAXES PAYABLE	1,864,271				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	464,773				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	12,272,989				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	55,141,418				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	68,171,034				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	68,171,034				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	123,312,452				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	123,047,360				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)	123,047,360				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	246,359,812				60

STATEMENT OF CHANGES IN FUND BALANCES — WORKSHEET G-1

		GENERAL FUND 1	GENERAL FUND 2	SPECIFIC PURPOSE FUND 3	SPECIFIC PURPOSE FUND 4	ENDOWMENT FUND 5	ENDOWMENT FUND 6	PLANT FUND 7	PLANT FUND 8	
1	FUND BALANCES AT BEGINNING OF PERIOD		122,987,147							1
2	NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		21,224,723							2
3	TOTAL (SUM OF LINE 1 AND LINE 2)		144,211,870							3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5	NET ASSETS TRANSFERRED TO AF	-42,501,018								5
6	PENSION-RELATED CHGS-NOT NET	21,192,370								6
7	RELEASED ASSETS									7
8	RESTRICTED CONTRIBUTIONS	521,138								8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)		-20,787,510							10
11	SUBTOTAL (LINE 3 PLUS LINE 10)		123,424,360							11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13	NET ASSETS RELEASED FROM RES	377,000								13
14										14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)		377,000							18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		123,047,360							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	70,842,879		70,842,879	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	8,438,120		8,438,120	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)	79,280,999		79,280,999	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	13,255,593		13,255,593	11
12	CORONARY CARE UNIT				12
12.01	NEONATAL INTENSIVE CARE	9,952,548		9,952,548	12.01
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)	23,208,141		23,208,141	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	102,489,140		102,489,140	17
18	ANCILLARY SERVICES	438,377,750		438,377,750	18
19	OUTPATIENT SERVICES		472,786,675	472,786,675	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		6,701,269	6,701,269	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
27.01	PHYSICIAN REVENUES		24,549,616	24,549,616	27.01
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	540,866,890	504,037,560	1,044,904,450	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		396,243,071	29
30	ADD (SPECIFY)			30
31	BAD DEBTS	15,636,538		31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)		15,636,538	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)		411,879,609	43

STATEMENT OF REVENUES AND EXPENSES — WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	1,044,904,450	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	623,271,072	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	421,633,378	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	411,879,609	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	9,753,769	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	3,050	6
7	INCOME FROM INVESTMENTS	317,728	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	2,450	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	1,598,469	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	4,156,553	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	25,259	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	24,170	21
22	RENTAL OF HOSPITAL SPACE	925,704	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER REVENUE)	141,703	24
24.01	OTHER (REVENUE-CLASSES)	84,120	24.01
24.02	OTHER (ASSETS RELEASED FROM RESTRICTION)	362,314	24.02
24.03	OTHER (FITNESS REVENUE)	3,960,947	24.03
24.04	OTHER (SALE OF XRAY SCRAP)	10,025	24.04
24.05	OTHER (OTHER INVESTMENT GAINS)	13,660	24.05
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	11,626,152	25
26	TOTAL (LINE 5 PLUS LINE 25)	21,379,921	26
27	OTHER EXPENSES (LOSS ON SALE OF ASSETS)	155,198	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	155,198	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	21,224,723	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS HHA NO.: 15-7487 WORKSHEET H

		SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR-TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (SEE INSTRUCTIONS)							4
5	ADMINISTRATIVE AND GENERAL	584,637		27,518	3,694	74,218	690,067	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE	1,006,022					1,006,022	6
7	PHYSICAL THERAPY				886,795		886,795	7
8	OCCUPATIONAL THERAPY				194,827		194,827	8
9	SPEECH PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES	1,727					1,727	10
11	HOME HEALTH AIDE	86,832					86,832	11
12	SUPPLIES (SEE INSTRUCTIONS)					114,857	114,857	12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING	275,259				6,043	281,302	17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
24	TOTAL (SUM OF LINES 1-23)	1,954,477		27,518	1,085,316	195,118	3,262,429	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS HHA NO.: 15-7487 WORKSHEET H (CONTINUED)

		RECLASS-IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (SEE INSTRUCTIONS)					4
5	ADMINISTRATIVE AND GENERAL	-60,095	629,972	-14	629,958	5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		1,006,022		1,006,022	6
7	PHYSICAL THERAPY		886,795		886,795	7
8	OCCUPATIONAL THERAPY		194,827		194,827	8
9	SPEECH PATHOLOGY					9
10	MEDICAL SOCIAL SERVICES		1,727		1,727	10
11	HOME HEALTH AIDE		86,832		86,832	11
12	SUPPLIES (SEE INSTRUCTIONS)		114,857		114,857	12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING		281,302		281,302	17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
24	TOTAL (SUM OF LINES 1-23)	-60,095	3,202,334	-14	3,202,320	24

COST ALLOCATION - HHA GENERAL SERVICE COST HHA NO.: 15-7487 WORKSHEET H-1 PART I

		NET EXPENSES FOR COST ALLOCATION 0	CAP REL COSTS BLDG & FIXTURES 1	CAP REL COSTS MVBL EQUIPMENT 2	PLANT OPERATN & MAINT 3	TRANSPORT-ATION 4	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	GENERAL SERVICE COST CENTER									
1	CAPITAL RELATED-BLDGS & FIXT									1
2	CAPITAL RELATED-MOVABLE EQUIP									2
3	PLANT OPERATION & MAINTENANCE									3
4	TRANSPORTATION (SEE INSTR.)									4
5	ADMINISTRATIVE AND GENERAL	629,958					629,958	629,958		5
	HHA REIMBURSABLE SERVICES									
6	SKILLED NURSING CARE	1,006,022					1,006,022	246,270	1,252,292	6
7	PHYSICAL THERAPY	886,795					886,795	217,340	1,104,135	7
8	OCCUPATIONAL THERAPY	194,827					194,827	47,692	242,519	8
9	SPEECH PATHOLOGY									9
10	MEDICAL SOCIAL SERVICES	1,727					1,727	423	2,150	10
11	HOME HEALTH AIDE	86,832					86,832	21,256	108,088	11
12	SUPPLIES (SEE INSTRUCTIONS)	114,857					114,857	28,116	142,973	12
13	DRUGS									13
14	DME									14
	HHA NONREIMBURSABLE SERVICES									
15	HOME DIALYSIS AIDE SERVICES									15
16	RESPIRATORY THERAPY									16
17	PRIVATE DUTY NURSING	281,302					281,302	68,861	350,163	17
18	CLINIC									18
19	HEALTH PROMOTION ACTIVITIES									19
20	DAY CARE PROGRAM									20
21	HOME DELIVERED MEALS PROGRAM									21
22	HOMEMAKER SERVICE									22
23	ALL OTHERS									23
24	TOTAL (SUM OF LINES 1-23)	3,202,320					3,202,320		3,202,320	24

COST ALLOCATION - HHA STATISTICAL BASIS | HHA NO.: 15-7487 | WORKSHEET H-1 PART II

		CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT-ATION (MILEAGE) 4	RECONCIL-IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXT							1
2	CAPITAL RELATED-MOVABLE EQUIP							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (SEE INSTR.)							4
5	ADMINISTRATIVE AND GENERAL					-629,958	2,573,416	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						1,006,022	6
7	PHYSICAL THERAPY					1,054	887,849	7
8	OCCUPATIONAL THERAPY						194,827	8
9	SPEECH PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES						1,727	10
11	HOME HEALTH AIDE						86,832	11
12	SUPPLIES (SEE INSTRUCTIONS)						114,857	12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING						281,302	17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (SUM OF LINES 1-23)					-628,904	2,573,416	24
25	COST TO BE ALLOC (PER W/S H)						629,958	25
26	UNIT COST MULTIPLIER						0.244794	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 15-7487 WORKSHEET H-2
PART I

	HHA COST CENTER	HHA TRIAL BALANCE 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	ADMINIS-TRATIVE & GENERAL 5	MAIN-TENANCE & REPAIRS 6	
1	ADMINISTRATIVE AND GENERAL		42,277	49,310		514,158	605,745	104,576		1
2	SKILLED NURSING CARE	1,252,292					1,252,292	216,196		2
3	PHYSICAL THERAPY	1,104,135					1,104,135	190,618		3
4	OCCUPATIONAL THERAPY	242,519					242,519	41,868		4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES	2,150					2,150	371		6
7	HOME HEALTH AIDE	108,088					108,088	18,660		7
8	SUPPLIES	142,973					142,973	24,683		8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING	350,163					350,163	60,452		13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	3,202,320	42,277	49,310		514,158	3,808,065	657,424		20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 15-7487 WORKSHEET H-2
PART I

	HHA COST CENTER	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	8	9	10	11	12	13	14	
1	ADMINISTRATIVE AND GENERAL	116,466		10,802		44,687				1
2	SKILLED NURSING CARE									2
3	PHYSICAL THERAPY									3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE									7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	116,466		10,802		44,687				20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 15-7487 WORKSHEET H-2
PART I

	HHA COST CENTER	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	
		15	16	17	19	20	21	22	23	
1	ADMINISTRATIVE AND GENERAL									1
2	SKILLED NURSING CARE									2
3	PHYSICAL THERAPY									3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE									7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)									20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 15-7487 WORKSHEET H-2
PART I

	HHA COST CENTER	SUBTOTAL (SUM OF COL.4A-23) 24	I&R COST & POST STEP-DOWN ADJS 25	SUBTOTAL (SUM OF COL.4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1	ADMINISTRATIVE AND GENERAL	882,276		882,276			1
2	SKILLED NURSING CARE	1,468,488		1,468,488	345,021	1,813,509	2
3	PHYSICAL THERAPY	1,294,753		1,294,753	304,202	1,598,955	3
4	OCCUPATIONAL THERAPY	284,387		284,387	66,817	351,204	4
5	SPEECH PATHOLOGY						5
6	MEDICAL SOCIAL SERVICES	2,521		2,521	592	3,113	6
7	HOME HEALTH AIDE	126,748		126,748	29,779	156,527	7
8	SUPPLIES	167,656		167,656	39,391	207,047	8
9	DRUGS						9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING	410,615		410,615	96,474	507,089	13
14	CLINIC						14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
20	TOTAL (SUM OF LINES 1-19)	4,637,444		4,637,444	882,276	4,637,444	20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.234950		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 15-7487 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES NEW- SQ FT	CAP MOVABLE EQUIPMENT NEW- $ VALUE	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		1	2	3	4	4A	5	6	7	
1	ADMINISTRATIVE AND GENERAL	3,575	37,724		1,954,477		605,745		3,575	1
2	SKILLED NURSING CARE						1,252,292			2
3	PHYSICAL THERAPY						1,104,135			3
4	OCCUPATIONAL THERAPY						242,519			4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES						2,150			6
7	HOME HEALTH AIDE						108,088			7
8	SUPPLIES						142,973			8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING						350,163			13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTAL (SUM OF LINES 1-19)	3,575	37,724		1,954,477		3,808,065		3,575	20
21	TOTAL COST TO BE ALLOCATED	42,277	49,310		514,158		657,424		116,466	21
22	UNIT COST MULTIPLIER	11.825734								22
22	UNIT COST MULTIPLIER		1.307125		0.263067		0.172640		32.577902	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 15-7487 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	LAUNDRY + LINEN SERVICE POUNDS 8	HOUSE-KEEPING TIME SPENT 9	DIETARY PATIENT MEALS 10	CAFETERIA FTES 11	MAINTENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINISTRATION NURSING HOURS 13	CENTRAL SERVICES & SUPPLY COSTED REQ. 14	PHARMACY COSTED REQ. 15	
1	ADMINISTRATIVE AND GENERAL		1,200		3,431					1
2	SKILLED NURSING CARE									2
3	PHYSICAL THERAPY									3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE									7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTAL (SUM OF LINES 1-19)		1,200		3,431					20
21	TOTAL COST TO BE ALLOCATED		10,802		44,687					21
22	UNIT COST MULTIPLIER									22
22	UNIT COST MULTIPLIER		9.001667		13.024483					22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 15-7487 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	
		16	17	19	20	21	22	23	
1	ADMINISTRATIVE AND GENERAL								1
2	SKILLED NURSING CARE								2
3	PHYSICAL THERAPY								3
4	OCCUPATIONAL THERAPY								4
5	SPEECH PATHOLOGY								5
6	MEDICAL SOCIAL SERVICES								6
7	HOME HEALTH AIDE								7
8	SUPPLIES								8
9	DRUGS								9
10	DME								10
11	HOME DIALYSIS AIDE SERVICES								11
12	RESPIRATORY THERAPY								12
13	PRIVATE DUTY NURSING								13
14	CLINIC								14
15	HEALTH PROMOTION ACTIVITIES								15
16	DAY CARE PROGRAM								16
17	HOME DELIVERED MEALS PROGRAM								17
18	HOMEMAKER SERVICE								18
19	ALL OTHERS								19
19.50	TELEMEDICINE								19.50
20	TOTAL (SUM OF LINES 1-19)								20
21	TOTAL COST TO BE ALLOCATED								21
22	UNIT COST MULTIPLIER								22
22	UNIT COST MULTIPLIER								22

APPORTIONMENT OF PATIENT SERVICE COSTS | HHA NO.: 15-7487 | WORKSHEET H-3 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

	COST PER VISIT COMPUTATION PATIENT SERVICES	FROM WKST H-2, PART I, COL 28, LINE	FACILITY COSTS (FROM WKST H-2, PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS COLS. 1+2)	TOTAL VISITS	AVERAGE COST PER VISIT (COL.3 ÷ COL.4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	1,813,509		1,813,509	20,847	86.99	1
2	PHYSICAL THERAPY	3	1,598,955		1,598,955	14,596	109.55	2
3	OCCUPATIONAL THERAPY	4	351,204		351,204	3,219	109.10	3
4	SPEECH PATHOLOGY	5				320		4
5	MEDICAL SOCIAL SERVICES	6	3,113		3,113	31	100.42	5
6	HOME HEALTH AIDE	7	156,527		156,527	4,918	31.83	6
7	TOTAL (SUM OF LINES 1-6)		3,923,308		3,923,308	43,931		7

	PATIENT SERVICES		
8	SKILLED NURSING CARE		8
9	PHYSICAL THERAPY		9
10	OCCUPATIONAL THERAPY		10
11	SPEECH PATHOLOGY		11
12	MEDICAL SOCIAL SERVICES		12
13	HOME HEALTH AIDE		13
14	TOTAL (SUM OF LINES 8-13)		14

	SUPPLIES AND DRUGS COST COMPUTATIONS OTHER PATIENT SERVICES	FROM WKST H-2, PART I, COL 28, LINE	FACILITY COSTS (FROM WKST H-2, PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS COLS. 1+2)	TOTAL CHARGES (FROM HHA RECORD)	RATIO (COL.3 ÷ COL.4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	207,047		207,047	374,766	0.552470	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS — HHA NO.: 15-7487 — WORKSHEET H-3 PARTS I & II (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

	COST PER VISIT COMPUTATION	PROGRAM VISITS		COST OF SERVICES			
			PART B		PART B		
	PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	TOTAL PROGRAM COST (SUM OF COLS.9-10)	
		6	7	8	9	10	11	12	
1	SKILLED NURSING CARE	10,972	5,864		954,454	510,109		1,464,563	1
2	PHYSICAL THERAPY	8,778	3,631		961,630	397,776		1,359,406	2
3	OCCUPATIONAL THERAPY	2,312	560		252,239	61,096		313,335	3
4	SPEECH PATHOLOGY	257	47						4
5	MEDICAL SOCIAL SERVICES	21	12		2,109	1,205		3,314	5
6	HOME HEALTH AIDE	2,467	2,285		78,525	72,732		151,257	6
7	TOTAL (SUM OF LINES 1-6)	24,807	12,399		2,248,957	1,042,918		3,291,875	7

	PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		
			PART A	PART B NOT SUBJ TO DEDUCTIBLES & COINSUR	PART B SUBJECT TO DEDUCTIBLES & COINSUR
		1	2	3	4	
8	SKILLED NURSING CARE	23844	10,972	5,864		8
9	PHYSICAL THERAPY	23844	8,778	3,631		9
10	OCCUPATIONAL THERAPY	23844	2,312	560		10
11	SPEECH PATHOLOGY	23844	257	47		11
12	MEDICAL SOCIAL SERVICES	23844	21	12		12
13	HOME HEALTH AIDE	23844	2,467	2,285		13
14	TOTAL (SUM OF LINES 8-13)		24,807	12,399		14

	SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES			
			PART B			PART B		
	OTHER PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
		6	7	8	9	10	11	
15	COST OF MEDICAL SUPPLIES	105,909	106,137		58,512	58,638		15
16	COST OF DRUGS							16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
			1	2	3	4	
1	PHYSICAL THERAPY	66	0.367323			COL 2, LINE 2	1
2	OCCUPATIONAL THERAPY	67				COL 2, LINE 3	2
3	SPEECH PATHOLOGY	68				COL 2, LINE 4	3
4	MEDICAL SUPPLIES CHRGED TO PAT	71	0.372646			COL 2, LINE 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.228331			COL 2, LINE 16	5

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT — HHA NO.: 15-7487 — WORKSHEET H-4 PARTS I & II

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

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	DESCRIPTION	PART A 1	PART B NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)				1
2	TOTAL CHARGES				2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)				3
4	AMOUNT 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(B)				4
5	RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)				6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)				7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)				8
9	PRIMARY PAYER PAYMENTS				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10	TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	3,577,843	5,160,314	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	24,616	49,160	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	37,784	55,970	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	17,297	43,357	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	4,423	10,625	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22	SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	3,661,963	5,319,426	22
23	EXCESS REASONABLE COST (FROM LINE 8)			23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	3,661,963	5,319,426	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26	NET COST (LINE 24 MINUS LINE 25)	3,661,963	5,319,426	26
27	REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	3,661,963	5,319,426	29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31	SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	3,661,963	5,319,426	31
32	INTERIM PAYMENTS (SEE INSTRUCTIONS)	3,661,963	5,319,426	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 15-7487

WORKSHEET H-5

DESCRIPTION			PART A MO/DAY/YR 1	PART A AMOUNT 2	PART B MO/DAY/YR 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				3,661,963		5,319,426	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 H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)				3,661,963		5,319,426	4
	TO BE COMPLETED BY INTERMEDIARY						
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		NONE		NONE	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		NONE		NONE	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 (SEE INSTR.)	PROGRAM TO	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				3,661,963		5,319,426	7

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

CALCULATION OF CAPITAL PAYMENT — WORKSHEET L

CHECK APPLICABLE BOXES	[ ]	TITLE V	[XX]	HOSPITAL ((15-012)	[XX]	PPS	
	[XX]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD	
	[ ]	TITLE XIX					

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	6,862,298	1
2	CAPITAL DRG OUTLIER PAYMENTS	109,970	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	273.22	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.0280	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.1525	8
9	SUM OF LINES 7 AND 8	0.1805	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0372	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	255,277	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	7,227,545	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT — WORKSHEET L

CHECK APPLICABLE BOXES	[ ]	TITLE V	[XX]	HOSPITAL ((15-012)	[XX]	PPS	
	[ ]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD	
	[XX]	TITLE XIX					

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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