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

PART I - COST REPORT STATUS

PROVIDER USE ONLY
1. [X] ELECTRONICALLY FILED COST REPORT DATE: 05-16-2012 TIME: 18:08_____
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 HEALTHSOUTH DEACONESS REHAB (15-3025) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2011 AND ENDING 12/31/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDE IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		152,804			114,899	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		152,804			114,899	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: 4100 COVERT AVENUE P.O.BOX: 1
2 CITY: EVANSVILLE STATE: IN ZIP CODE: 47714 COUNTY: VANDERBURGH 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	HEALTHSOUTH DEACONESS REHAB	15-3025	21780	5	06/08/1989	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2011		TO: 12/31/2011						20
21	TYPE OF CONTROL			5						21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	737	46	356	199	77	17	25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

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

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

		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 2148? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60

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

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

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

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

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

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

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

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

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

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

INPATIENT PSYCHIATRIC FACILITY PPS

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

71 IF LINE 70 YES: — 71
COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO.
COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO.
COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.

INPATIENT REHABILITATION FACILITY PPS

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

76 IF LINE 75 YES: — N — 76
COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO.
COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO.
COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.

LONG TERM CARE HOSPITAL PPS

80 IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO. — N — 80

TEFRA PROVIDERS

85 IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO. — N — 85

86 DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO. — N — 86

	V	XIX	
TITLE V AND XIX INPATIENT SERVICES	1	2	
90 DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	Y	N	90
91 IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	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

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

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

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

MISCELLANEOUS COST REPORTING INFORMATION			1	2	
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.		N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.		Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.		1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		250,000	5,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.		N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		121
TRANSPLANT CENTER INFORMATION					
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(MM/DD/YYYY) BELOW.			N	125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				134
ALL PROVIDERS					
			1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.		Y	019005	140

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

141	NAME: HEALTHSOUTH CORPORATION	CONTRACTOR'S NAME: CAHABA GBA	CONTRACTOR'S NUMBER: 10101	141
142	STREET: 3660 GRANDVIEW PARKWAY, SUIT P.O. BOX:			142
143	CITY: BIRMINGHAM	STATE: AL	ZIP CODE: 35243	143

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

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

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

MULTICAMPUS

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

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

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

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

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

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

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

BED COMPLEMENT

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

		PART A		PART B		
		Y/N	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		Y	03/04/2012	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	03/04/2012	N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS: SPLIT UB CODES FOR SUA SITUATION. S	Y		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

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

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

CAPITAL RELATED COST

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

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

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

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

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

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

INTEREST EXPENSE

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

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

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

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

PURCHASED SERVICES

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

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

PROVIDER-BASED PHYSICIANS

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

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

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

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

	COMPONENT	WKST A LINE NO.	NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	80	29,200			14,595	888	21,915	1
2	HMO							544		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.)		80	29,200			14,595	888	21,915	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)		80	29,200			14,595	888	21,915	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		80							27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES --- TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					1,010	48	1,476	1
2	HMO									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)			191.73			1,010	48	1,476	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)			191.73						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART II & III

PART II - WAGE DATA

		WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	9,621,681			398,798.40		1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A							4
4.01	PHYSICIANS-PART A - DIRECT TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)			34,921		1,049.60		10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)							11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A		85,013			605.00		13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		795,684			10,415.00		14
15	HOME OFFICE: PHYSICIAN-PART A							15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		1,646,097					17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		5,996					19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A							22
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS			91,705		3,806.40		26
27	ADMINISTRATIVE & GENERAL		1,655,276	-124,453		47,694.00		27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		227,417			10,961.60		30
31	LAUNDRY & LINEN SERVICE			25,737		2,070.49		31
32	HOUSEKEEPING		231,881	-25,737		17,534.40		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		268,767			20,924.80		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		297,661			10,545.60		38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		121,338			7,051.20		41
42	SOCIAL SERVICE		454,187			16,952.00		42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	9,621,681		9,621,681	398,798.40	24.13	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		34,921	34,921	1,049.60	33.27	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	9,621,681	-34,921	9,586,760	397,748.80	24.10	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	880,697		880,697	11,020.00	79.92	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	1,646,097		1,646,097		17.17%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	12,148,475	-34,921	12,113,554	408,768.80	29.63	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,256,527	-32,748	3,223,779	137,540.49	23.44	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	130,052	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	QUALIFIED AND NON-QUALIFIED PENSION PLAN COST		3
4	PRIOR YEAR PENSION SERVICE COST		4
	PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5	401K/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	1,087,672	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	18,456	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	62,514	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	689,149	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	30,463	20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION		21
22	DAY CARE COSTS AND ALLOWANCES	-366,213	22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	1,652,093	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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI-CATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		910,126	910,126	119,816	1
2	00200	CAP REL COSTS-MVBLE EQUIP		263,463	263,463	105,994	2
3	00300	OTHER CAPITAL RELATED COSTS		203,068	203,068	-203,068	3
4	00400	EMPLOYEE BENEFITS		1,719,881	1,719,881	137,239	4
5	00500	ADMINISTRATIVE & GENERAL	1,655,276	2,452,536	4,107,812	-206,867	5
7	00700	OPERATION OF PLANT	227,417	559,230	786,647	2,725	7
8	00800	LAUNDRY & LINEN SERVICE		18,803	18,803	25,737	8
9	00900	HOUSEKEEPING	231,881	72,105	303,986	-26,479	9
10	01000	DIETARY	268,767	308,417	577,184		10
11	01100	CAFETERIA					11
13	01300	NURSING ADMINISTRATION	297,661	15,472	313,133		13
16	01600	MEDICAL RECORDS & LIBRARY	121,338	84,707	206,045		16
17	01700	SOCIAL SERVICE	454,187	10,257	464,444		17
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	3,139,711	185,291	3,325,002	-45,078	30
		ANCILLARY SERVICE COST CENTERS					
54	05400	RADIOLOGY-DIAGNOSTIC		151,910	151,910	176,177	54
54.01	05401	RADIOLOGY SUA				27,419	54.01
60	06000	LABORATORY		258,133	258,133	-2,725	60
65	06500	RESPIRATORY THERAPY	176,945	61,391	238,336		65
66	06600	PHYSICAL THERAPY	1,117,562	22,175	1,139,737	-3,683	66
67	06700	OCCUPATIONAL THERAPY	967,326	9,640	976,966	1,615	67
68	06800	SPEECH PATHOLOGY	520,732	6,368	527,100	1,941	68
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	51,806	155,566	207,372	127	71
73	07300	DRUGS CHARGED TO PATIENTS	343,494	583,661	927,155		73
76	03550	PSYCHOLOGY	47,578	3,561	51,139	2,538	76
76.01	03950	AMBULANCE		198,336	198,336	-150,521	76.01
76.02	03020	DAY TREATMENT					76.02
76.03	03951	AMBULANCE SUA				1,738	76.03
		OUTPATIENT SERVICE COST CENTERS					
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
		SPECIAL PURPOSE COST CENTERS					
113	11300	INTEREST EXPENSE		7,120	7,120		113
118		SUBTOTALS (SUM OF LINES 1-117)	9,621,681	8,261,217	17,882,898	-35,355	118
		NONREIMBURSABLE COST CENTERS					
192	19200	PHYSICIANS' PRIVATE OFFICES		1,204	1,204	1,289	192
194	07950	NRCC MARKETING				34,066	194
194.01	07951	GUEST MEALS					194.01
200		TOTAL (SUM OF LINES 118-199)	9,621,681	8,262,421	17,884,102		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	1,029,942	179,414	1,209,356	1
2	00200	CAP REL COSTS-MVBLE EQUIP	369,457	-22,781	346,676	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	1,857,120	-90,048	1,767,072	4
5	00500	ADMINISTRATIVE & GENERAL	3,900,945	305,767	4,206,712	5
7	00700	OPERATION OF PLANT	789,372	-69,777	719,595	7
8	00800	LAUNDRY & LINEN SERVICE	44,540		44,540	8
9	00900	HOUSEKEEPING	277,507	-96	277,411	9
10	01000	DIETARY	577,184	-22,939	554,245	10
11	01100	CAFETERIA				11
13	01300	NURSING ADMINISTRATION	313,133	-7,863	305,270	13
16	01600	MEDICAL RECORDS & LIBRARY	206,045	-57	205,988	16
17	01700	SOCIAL SERVICE	464,444	-175	464,269	17
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	3,279,924	-4,881	3,275,043	30
		ANCILLARY SERVICE COST CENTERS				
54	05400	RADIOLOGY-DIAGNOSTIC	328,087	-90,713	237,374	54
54.01	05401	RADIOLOGY SUA	27,419	-7,814	19,605	54.01
60	06000	LABORATORY	255,408	-205,760	49,648	60
65	06500	RESPIRATORY THERAPY	238,336	-23,627	214,709	65
66	06600	PHYSICAL THERAPY	1,136,054	-540	1,135,514	66
67	06700	OCCUPATIONAL THERAPY	978,581		978,581	67
68	06800	SPEECH PATHOLOGY	529,041		529,041	68
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	207,499	-858	206,641	71
73	07300	DRUGS CHARGED TO PATIENTS	927,155	-9,216	917,939	73
76	03550	PSYCHOLOGY	53,677	-1,145	52,532	76
76.01	03950	AMBULANCE	47,815	-38,421	9,394	76.01
76.02	03020	DAY TREATMENT				76.02
76.03	03951	AMBULANCE SUA	1,738	-495	1,243	76.03
		OUTPATIENT SERVICE COST CENTERS				
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
		SPECIAL PURPOSE COST CENTERS				
113	11300	INTEREST EXPENSE	7,120	-7,120		113
118		SUBTOTALS (SUM OF LINES 1-117)	17,847,543	-119,145	17,728,398	118
		NONREIMBURSABLE COST CENTERS				
192	19200	PHYSICIANS' PRIVATE OFFICES	2,493		2,493	192
194	07950	NRCC MARKETING	34,066		34,066	194
194.01	07951	GUEST MEALS				194.01
200		TOTAL (SUM OF LINES 118-199)	17,884,102	-119,145	17,764,957	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	CAP REL COSTS-BLDG & FIXT	1		12,067	1
2	INSURANCE	A	CAP REL COSTS-MVBLE EQUIP	2		10,675	2
3	INSURANCE	A					3
500	TOTAL RECLASSIFICATIONS					22,742	500
	CODE LETTER - A						
1	MARKETING	B	NRCC MARKETING	194	32,428	1,638	1
2	MARKETING	B					2
500	TOTAL RECLASSIFICATIONS				32,428	1,638	500
	CODE LETTER - B						
1	PHYSICIANS	C	ADULTS & PEDIATRICS	30		11,166	1
2	PHYSICIANS	C	PSYCHOLOGY	76		2,538	2
3	PHYSICIANS	C					3
500	TOTAL RECLASSIFICATIONS					13,704	500
	CODE LETTER - C						
1	SERVICE UNDER ARRANGEMENT	D	RADIOLOGY SUA	54.01		27,419	1
2	SERVICE UNDER ARRANGEMENT	D	AMBULANCE SUA	76.03		1,738	2
3	SERVICE UNDER ARRANGEMENT	D					3
4	SERVICE UNDER ARRANGEMENT	D					4
500	TOTAL RECLASSIFICATIONS					29,157	500
	CODE LETTER - D						
1	HR RECLASS	E	EMPLOYEE BENEFITS	4	91,705	45,534	1
2	HR RECLASS	E					2
500	TOTAL RECLASSIFICATIONS				91,705	45,534	500
	CODE LETTER - E						
1	RELATED PARTY DEACONESS	F	RADIOLOGY-DIAGNOSTIC	54		742	1
2	RELATED PARTY DEACONESS	F					2
500	TOTAL RECLASSIFICATIONS					742	500
	CODE LETTER - F						
1	DAY TREATMENT	G	OCCUPATIONAL THERAPY	67		1,615	1
2	DAY TREATMENT	G	SPEECH PATHOLOGY	68		1,941	2
3	DAY TREATMENT	G					3
500	TOTAL RECLASSIFICATIONS					3,556	500
	CODE LETTER - G						
1	LAB RECLASS	H	OPERATION OF PLANT	7		2,725	1
2	LAB RECLASS	H	RADIOLOGY-DIAGNOSTIC	54		112,208	2
3	LAB RECLASS	H					3
4	LAB RECLASS	H					4
500	TOTAL RECLASSIFICATIONS					114,933	500
	CODE LETTER - H						
1	COMS RECLASS	I	MEDICAL SUPPLIES CHRGED TO PA	71		127	1
2	COMS RECLASS	I					2
500	TOTAL RECLASSIFICATIONS					127	500
	CODE LETTER - I						
1	LAUNDRY RECLASS	J	LAUNDRY & LINEN SERVICE	8	25,737		1
2	LAUNDRY RECLASS	J					2
500	TOTAL RECLASSIFICATIONS				25,737		500
	CODE LETTER - J						
1	PHYSICIAN RECLASS	K	PHYSICIANS' PRIVATE OFFICES	192	2,493		1
2	PHYSICIAN RECLASS	K					2
3	PHYSICIAN RECLASS	K					3
500	TOTAL RECLASSIFICATIONS				2,493		500
	CODE LETTER - K						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	INCREASE LINE #	INCREASE SALARY	INCREASE OTHER	
		1	2	3	4	5	
1	MISC RECLASS	L	ADMINISTRATIVE & GENERAL	5		1,204	1
2	MISC RECLASS	L	RADIOLOGY-DIAGNOSTIC	54		90,646	2
3	MISC RECLASS	L	AMBULANCE	76.01		54,071	3
4	MISC RECLASS	L					4
5	MISC RECLASS	L					5
6	MISC RECLASS	L					6
500	TOTAL RECLASSIFICATIONS					145,921	500
	CODE LETTER - L						
	GRAND TOTAL (INCREASES)				152,363	378,054	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	ADMINISTRATIVE & GENERAL	5		22,742		3
500	TOTAL RECLASSIFICATIONS					22,742		500
	CODE LETTER - A							
1	MARKETING	B						1
2	MARKETING	B	ADMINISTRATIVE & GENERAL	5	32,428	1,638		2
500	TOTAL RECLASSIFICATIONS				32,428	1,638		500
	CODE LETTER - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C						2
3	PHYSICIANS	C	ADMINISTRATIVE & GENERAL	5		13,704		3
500	TOTAL RECLASSIFICATIONS					13,704		500
	CODE LETTER - C							
1	SERVICE UNDER ARRANGEMENT	D						1
2	SERVICE UNDER ARRANGEMENT	D						2
3	SERVICE UNDER ARRANGEMENT	D	RADIOLOGY-DIAGNOSTIC	54		27,419		3
4	SERVICE UNDER ARRANGEMENT	D	AMBULANCE	76.01		1,738		4
500	TOTAL RECLASSIFICATIONS					29,157		500
	CODE LETTER - D							
1	HR RECLASS	E						1
2	HR RECLASS	E	ADMINISTRATIVE & GENERAL	5	91,705	45,534		2
500	TOTAL RECLASSIFICATIONS				91,705	45,534		500
	CODE LETTER - E							
1	RELATED PARTY DEACONESS	F						1
2	RELATED PARTY DEACONESS	F	HOUSEKEEPING	9		742		2
500	TOTAL RECLASSIFICATIONS					742		500
	CODE LETTER - F							
1	DAY TREATMENT	G						1
2	DAY TREATMENT	G						2
3	DAY TREATMENT	G	PHYSICAL THERAPY	66		3,556		3
500	TOTAL RECLASSIFICATIONS					3,556		500
	CODE LETTER - G							
1	LAB RECLASS	H						1
2	LAB RECLASS	H						2
3	LAB RECLASS	H	LABORATORY	60		2,725		3
4	LAB RECLASS	H	AMBULANCE	76.01		112,208		4
500	TOTAL RECLASSIFICATIONS					114,933		500
	CODE LETTER - H							
1	COMS RECLASS	I						1
2	COMS RECLASS	I	PHYSICAL THERAPY	66		127		2
500	TOTAL RECLASSIFICATIONS					127		500
	CODE LETTER - I							
1	LAUNDRY RECLASS	J						1
2	LAUNDRY RECLASS	J	HOUSEKEEPING	9	25,737			2
500	TOTAL RECLASSIFICATIONS				25,737			500
	CODE LETTER - J							
1	PHYSICIAN RECLASS	K						1
2	PHYSICIAN RECLASS	K	ADMINISTRATIVE & GENERAL	5	320			2
3	PHYSICIAN RECLASS	K	ADULTS & PEDIATRICS	30	2,173			3
500	TOTAL RECLASSIFICATIONS				2,493			500
	CODE LETTER - K							

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	MISC RECLASS	L					1
2	MISC RECLASS	L					2
3	MISC RECLASS	L					3
4	MISC RECLASS	L	ADULTS & PEDIATRICS	30		54,071	4
5	MISC RECLASS	L	AMBULANCE	76.01		90,646	5
6	MISC RECLASS	L	PHYSICIANS' PRIVATE OFFICES	192		1,204	6
500	TOTAL RECLASSIFICATIONS					145,921	500
	CODE LETTER - L						
	GRAND TOTAL (DECREASES)				152,363	378,054	

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

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES (1)	ACQUISITIONS: PURCHASE (2)	ACQUISITIONS: DONATION (3)	ACQUISITIONS: TOTAL (4)	DISPOSALS AND RETIREMENTS (5)	ENDING BALANCE (6)	FULLY DEPRECIATED ASSETS (7)	
1	LAND								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES								3
4	BUILDING IMPROVEMENTS	1,931,940	214,901		214,901		2,146,841		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	2,021,100	100,285		100,285	222,218	1,899,167		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	3,953,040	315,186		315,186	222,218	4,046,008		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	3,953,040	315,186		315,186	222,218	4,046,008		10

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

	DESCRIPTION	SUMMARY OF CAPITAL: DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (SEE INSTR.) (12)	TAXES (SEE INSTR.) (13)	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) (14)	TOTAL(1) (SUM OF COLS. 9-14) (15)	
1	CAP REL COSTS-BLDG & FIXT	135,408	774,718					910,126	1
2	CAP REL COSTS-MVBLE EQUIP	144,905	118,558					263,463	2
3	TOTAL (SUM OF LINES 1-2)	280,313	893,276					1,173,589	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	2,146,840		2,146,840	0.530607		107,749		107,749	1
2	CAP REL COSTS-MVBLE EQUIP	1,899,168		1,899,168	0.469393		95,319		95,319	2
3	TOTAL (SUM OF LINES 1-2)	4,046,008		4,046,008	1.000000		203,068		203,068	3

	DESCRIPTION	SUMMARY OF CAPITAL: DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (SEE INSTR.) (12)	TAXES (SEE INSTR.) (13)	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) (14)	TOTAL(2) (SUM OF COLS. 9-14) (15)	
1	CAP REL COSTS-BLDG & FIXT	270,259	774,718	49,339	12,067	102,973		1,209,356	1
2	CAP REL COSTS-MVBLE EQUIP	127,774	117,133		10,675	91,094		346,676	2
3	TOTAL	398,033	891,851	49,339	22,742	194,067		1,556,032	3

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-4,574				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	405,994				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS						14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-7,120	INTEREST EXPENSE	113	11	37
37.03	INSURANCE	A	-67,787	EMPLOYEE BENEFITS	4		37.03
37.04	INSURANCE	A	-24,304	ADMINISTRATIVE & GENERAL	5		37.04
37.05	PROPERTY TAX	A	-4,776	CAP REL COSTS-BLDG & FIXT	1	13	37.05
37.06	PROPERTY TAX	A	-4,225	CAP REL COSTS-MVBLE EQUIP	2	13	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-173,405	ADMINISTRATIVE & GENERAL	5		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-88	OPERATION OF PLANT	7		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-48	HOUSEKEEPING	9		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-7,733	NURSING ADMINISTRATION	13		37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-40	PHYSICAL THERAPY	66		37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-40	MEDICAL SUPPLIES CHRGED TO PATI	71		37.12
37.13	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-46	DRUGS CHARGED TO PATIENTS	73		37.13
37.14	PATIENT TELEPHONE	A	-3,347	EMPLOYEE BENEFITS	4		37.14
37.15	PATIENT TELEPHONE	A	-25,773	ADMINISTRATIVE & GENERAL	5		37.15
37.16	PATIENT TELEVISION	A	-486	ADMINISTRATIVE & GENERAL	5		37.16
37.17	PRINTING	A	-21,515	ADMINISTRATIVE & GENERAL	5		37.17
37.18	PRINTING	A	-22	OPERATION OF PLANT	7		37.18
37.19	PRINTING	A	-48	HOUSEKEEPING	9		37.19
37.20	PRINTING	A	-31	NURSING ADMINISTRATION	13		37.20
37.21	PRINTING	A	-23	PHYSICAL THERAPY	66		37.21
37.22	LOBBYING EXPENSE	A	-72	EMPLOYEE BENEFITS	4		37.22
37.23	LOBBYING EXPENSE	A	-2,087	ADMINISTRATIVE & GENERAL	5		37.23
37.24	MISCELLANEOUS INCOME	B	-4,351	CAP REL COSTS-BLDG & FIXT	1	11	37.24
37.25	MISCELLANEOUS INCOME	B	-3,029	ADMINISTRATIVE & GENERAL	5		37.25
37.26	MISCELLANEOUS INCOME	B	-22,939	DIETARY	10		37.26

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
37.27	MISCELLANEOUS INCOME	B	-57	MEDICAL RECORDS & LIBRARY	16		37.27
37.28	PATIENT TRANSPORTATION	A	-17,123	CAP REL COSTS-MVBLE EQUIP	2	9	37.28
37.29	PATIENT TRANSPORTATION	A	-9,288	EMPLOYEE BENEFITS	4		37.29
37.30	PATIENT TRANSPORTATION	A	-69,109	OPERATION OF PLANT	7		37.30
37.31	PATIENT TRANSPORTATION	A	-38,421	AMBULANCE	76.01		37.31
37.32	PROFESSIONAL FEES	A	-8,467	ADMINISTRATIVE & GENERAL	5		37.32
37.33	PHYSICIAN SUPPORT STAFF	A	455	ADMINISTRATIVE & GENERAL	5		37.33
37.34	WAYPORT WIRELESS	A	-5,095	ADMINISTRATIVE & GENERAL	5		37.34
37.35	PHYSICIAN ADJUSTMENT	A	-125	ADMINISTRATIVE & GENERAL	5		37.35
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-119,145				50

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

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ-USTMENTS (COL. 4-5)	WKST A-7 REF	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	TO OFFSET MANAGEMENT FEES		1,515,609	-1,515,609		1
2	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFI	134,851		134,851	9	2
3	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFI	53,690		53,690	11	3
4	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFI	1,605,538		1,605,538		4
4.01	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFI	487,159		487,159		4.01
4.02	2	CAP REL COSTS-MVBLE EQUIP	INTERCOMPANY WAGE AND EXPENSE	23,341	23,341		10	4.02
4.03	4	EMPLOYEE BENEFITS	INTERCOMPANY WAGE AND EXPENSE	2,716,370	2,716,370			4.03
4.04	5	ADMINISTRATIVE & GENERAL	INTERCOMPANY WAGE AND EXPENSE	302,865	302,865			4.04
4.05	7	OPERATION OF PLANT	INTERCOMPANY WAGE AND EXPENSE	22,159	22,159			4.05
4.06	8	LAUNDRY & LINEN SERVICE	INTERCOMPANY WAGE AND EXPENSE	493	493			4.06
4.07	9	HOUSEKEEPING	INTERCOMPANY WAGE AND EXPENSE	5,817	5,817			4.07
4.08	10	DIETARY	INTERCOMPANY WAGE AND EXPENSE	-5,984	-5,984			4.08
4.09	13	NURSING ADMINISTRATION	INTERCOMPANY WAGE AND EXPENSE	1,966	1,966			4.09
4.10	16	MEDICAL RECORDS & LIBRARY	INTERCOMPANY WAGE AND EXPENSE	246	246			4.10
4.11	17	SOCIAL SERVICE	INTERCOMPANY WAGE AND EXPENSE	1,924	1,924			4.11
4.12	30	ADULTS & PEDIATRICS	INTERCOMPANY WAGE AND EXPENSE	6,948	6,948			4.12
4.13	54	RADIOLOGY-DIAGNOSTIC	INTERCOMPANY WAGE AND EXPENSE	-5,781	-5,781			4.13
4.14	60	LABORATORY	INTERCOMPANY WAGE AND EXPENSE	1	1			4.14
4.15	65	RESPIRATORY THERAPY	INTERCOMPANY WAGE AND EXPENSE	8	8			4.15
4.16	66	PHYSICAL THERAPY	INTERCOMPANY WAGE AND EXPENSE	3,130	3,130			4.16
4.17	67	OCCUPATIONAL THERAPY	INTERCOMPANY WAGE AND EXPENSE	2,052	2,052			4.17
4.18	68	SPEECH PATHOLOGY	INTERCOMPANY WAGE AND EXPENSE	2,318	2,318			4.18
4.19	71	MEDICAL SUPPLIES CHRGED TO PATI	INTERCOMPANY WAGE AND EXPENSE	-1,254	-1,254			4.19
4.20	73	DRUGS CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENSE	457,351	457,351			4.20
4.21	76	PSYCHOLOGY	INTERCOMPANY WAGE AND EXPENSE	160	160			4.21
4.22	76.01	AMBULANCE	INTERCOMPANY WAGE AND EXPENSE	-4,451	-4,451			4.22
4.23	113	INTEREST EXPENSE	INTERCOMPANY WAGE AND EXPENSE	7,102	7,102			4.23
4.24	192	PHYSICIANS' PRIVATE OFFICES	INTERCOMPANY WAGE AND EXPENSE	-75	-75			4.24
4.25	2	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY - MCD ADJUSTMENT	150	158	-8	9	4.25
4.26	2	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY - DEACONESS	525	1,950	-1,425	10	4.26
4.27	4	EMPLOYEE BENEFITS	RELATED PARTY - DEACONESS	3,522	13,076	-9,554		4.27
4.28	5	ADMINISTRATIVE & GENERAL	RELATED PARTY - DEACONESS	2,706	10,196	-7,490		4.28
4.29	7	OPERATION OF PLANT	RELATED PARTY - DEACONESS	206	764	-558		4.29
4.30	13	NURSING ADMINISTRATION	RELATED PARTY - DEACONESS	36	135	-99		4.30
4.31	17	SOCIAL SERVICE	RELATED PARTY - DEACONESS	65	240	-175		4.31
4.32	30	ADULTS & PEDIATRICS	RELATED PARTY - DEACONESS	660	967	-307		4.32
4.33	54	RADIOLOGY-DIAGNOSTIC	RELATED PARTY - DEACONESS	26,208	116,921	-90,713		4.33
4.34	54.01	RADIOLOGY SUA	RELATED PARTY - DEACONESS	2,258	10,072	-7,814		4.34
4.35	60	LABORATORY	RELATED PARTY - DEACONESS	52,214	257,974	-205,760		4.35
4.36	65	RESPIRATORY THERAPY	RELATED PARTY - DEACONESS	10,010	33,637	-23,627		4.36
4.37	66	PHYSICAL THERAPY	RELATED PARTY - DEACONESS	143	620	-477		4.37
4.38	71	MEDICAL SUPPLIES CHRGED TO PATI	RELATED PARTY - DEACONESS	273	1,091	-818		4.38
4.39	73	DRUGS CHARGED TO PATIENTS	RELATED PARTY - DEACONESS	2,861	12,031	-9,170		4.39
4.40	76	PSYCHOLOGY	RELATED PARTY - DEACONESS	2,105	3,250	-1,145		4.40
4.41	76.03	AMBULANCE SUA	RELATED PARTY - DEACONESS	143	638	-495		4.41
4.42	2	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY - MOTORIKA	8,470	8,470		9	4.42
4.43	66	PHYSICAL THERAPY	RELATED PARTY - MOTORIKA	554	554			4.43
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		5,931,053	5,525,059	405,994		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.

	SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	B		78.00	HEALTHSOUTH CORPORATION		HEALTHCARE	6
7	B		22.00	DEACONESS		HEALTHCARE	7
8	G	HEALTHSOUTH CORPORATION				HEALTHCARE	8
9	G	MED CENTER DIRECT				MEDICAL SUPPLIES	9
10	G	MOTORIKA					10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERATION INCL FRINGES	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT	
	1	2		3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS	AGGREGATE	11,166		11,166	171,400	80	6,592	330	1
200		TOTAL		11,166		11,166		80	6,592	330	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18	
1	30	ADULTS & PEDIATRICS	AGGREGATE					6,592	4,574	4,574	1
200		TOTAL						6,592	4,574	4,574	200

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	1,209,356	1,209,356				1
2	CAP REL COSTS-MVBLE EQUIP	346,676		346,676			2
4	EMPLOYEE BENEFITS	1,767,072	3,972	1,139	1,772,183		4
5	ADMINISTRATIVE & GENERAL	4,206,712	118,739	34,038	284,670	4,644,159	5
7	OPERATION OF PLANT	719,595	24,030	6,889	42,290	792,804	7
8	LAUNDRY & LINEN SERVICE	44,540	13,461	3,859	4,786	66,646	8
9	HOUSEKEEPING	277,411	9,788	2,806	38,334	328,339	9
10	DIETARY	554,245	85,917	24,629	49,980	714,771	10
11	CAFETERIA						11
13	NURSING ADMINISTRATION	305,270	10,170	2,915	55,353	373,708	13
16	MEDICAL RECORDS & LIBRARY	205,988	9,140	2,620	22,564	240,312	16
17	SOCIAL SERVICE	464,269	7,262	2,082	84,460	558,073	17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	3,275,043	501,496	143,757	583,450	4,503,746	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	237,374	10,702	3,068		251,144	54
54.01	RADIOLOGY SUA	19,605				19,605	54.01
60	LABORATORY	49,648	897	257		50,802	60
65	RESPIRATORY THERAPY	214,709	2,559	734	32,905	250,907	65
66	PHYSICAL THERAPY	1,135,514	150,962	43,275	207,821	1,537,572	66
67	OCCUPATIONAL THERAPY	978,581	78,705	22,562	179,883	1,259,731	67
68	SPEECH PATHOLOGY	529,041	40,333	11,562	96,835	677,771	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	206,641	20,773	5,955	9,634	243,003	71
73	DRUGS CHARGED TO PATIENTS	917,939	6,647	1,906	63,876	990,368	73
76	PSYCHOLOGY	52,532	4,786	1,372	8,848	67,538	76
76.01	AMBULANCE	9,394				9,394	76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA	1,243				1,243	76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	17,728,398	1,100,339	315,425	1,765,689	17,581,636	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	2,493	108,718	31,165	464	142,840	192
194	NRCC MARKETING	34,066	299	86	6,030	40,481	194
194.01	GUEST MEALS						194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	17,764,957	1,209,356	346,676	1,772,183	17,764,957	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	4,644,159					5
7	OPERATION OF PLANT	281,062	1,073,866				7
8	LAUNDRY & LINEN SERVICE	23,627	13,603	103,876			8
9	HOUSEKEEPING	116,402	9,892		454,633		9
10	DIETARY	253,398	86,827		37,581	1,092,577	10
11	CAFETERIA					163,718	11
13	NURSING ADMINISTRATION	132,486	10,278		4,449		13
16	MEDICAL RECORDS & LIBRARY	85,195	9,237		3,998		16
17	SOCIAL SERVICE	197,846	7,339		3,177		17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,596,661	506,804	103,876	219,359	863,784	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	89,035	10,816		4,681		54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY	18,010	907		393		60
65	RESPIRATORY THERAPY	88,951	2,586		1,119		65
66	PHYSICAL THERAPY	545,095	152,560		66,033		66
67	OCCUPATIONAL THERAPY	446,596	79,538		34,427		67
68	SPEECH PATHOLOGY	240,281	40,760		17,642		68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	86,149	20,993		9,086		71
73	DRUGS CHARGED TO PATIENTS	351,102	6,718		2,908		73
76	PSYCHOLOGY	23,943	4,837		2,094		76
76.01	AMBULANCE	3,330					76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA						76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	4,579,169	963,695	103,876	406,947	1,027,502	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	50,639	109,869		47,555		192
194	NRCC MARKETING	14,351	302		131		194
194.01	GUEST MEALS					65,075	194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	4,644,159	1,073,866	103,876	454,633	1,092,577	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		11	13	16	17	24	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	163,718					11
13	NURSING ADMINISTRATION	6,702	527,623				13
16	MEDICAL RECORDS & LIBRARY	2,732		341,474			16
17	SOCIAL SERVICE	10,226			776,661		17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	70,649	527,623	112,616	776,661	9,281,779	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC			3,274		358,950	54
54.01	RADIOLOGY SUA					19,605	54.01
60	LABORATORY			7,334		77,446	60
65	RESPIRATORY THERAPY	3,984		13,047		360,594	65
66	PHYSICAL THERAPY	25,163		69,928		2,396,351	66
67	OCCUPATIONAL THERAPY	21,780		69,919		1,911,991	67
68	SPEECH PATHOLOGY	11,725		30,079		1,018,258	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,166		5,949		366,346	71
73	DRUGS CHARGED TO PATIENTS	7,734		25,687		1,384,517	73
76	PSYCHOLOGY	1,071		3,186		102,669	76
76.01	AMBULANCE			455		13,179	76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA					1,243	76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	162,932	527,623	341,474	776,661	17,292,928	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	56				350,959	192
194	NRCC MARKETING	730				55,995	194
194.01	GUEST MEALS					65,075	194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	163,718	527,623	341,474	776,661	17,764,957	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT			1
2	CAP REL COSTS-MVBLE EQUIP			2
4	EMPLOYEE BENEFITS			4
5	ADMINISTRATIVE & GENERAL			5
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
13	NURSING ADMINISTRATION			13
16	MEDICAL RECORDS & LIBRARY			16
17	SOCIAL SERVICE			17
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS		9,281,779	30
	ANCILLARY SERVICE COST CENTERS			
54	RADIOLOGY-DIAGNOSTIC		358,950	54
54.01	RADIOLOGY SUA		19,605	54.01
60	LABORATORY		77,446	60
65	RESPIRATORY THERAPY		360,594	65
66	PHYSICAL THERAPY		2,396,351	66
67	OCCUPATIONAL THERAPY		1,911,991	67
68	SPEECH PATHOLOGY		1,018,258	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		366,346	71
73	DRUGS CHARGED TO PATIENTS		1,384,517	73
76	PSYCHOLOGY		102,669	76
76.01	AMBULANCE		13,179	76.01
76.02	DAY TREATMENT			76.02
76.03	AMBULANCE SUA		1,243	76.03
	OUTPATIENT SERVICE COST CENTERS			
92	OBSERVATION BEDS			92
	OTHER REIMBURSABLE COST CENTERS			
	SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE			113
118	SUBTOTALS (SUM OF LINES 1-117)		17,292,928	118
	NONREIMBURSABLE COST CENTERS			
192	PHYSICIANS' PRIVATE OFFICES		350,959	192
194	NRCC MARKETING		55,995	194
194.01	GUEST MEALS		65,075	194.01
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	TOTAL (SUM OF LINES 118-201)		17,764,957	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		3,972	1,139	5,111	5,111	4
5	ADMINISTRATIVE & GENERAL		118,739	34,038	152,777	821	5
7	OPERATION OF PLANT		24,030	6,889	30,919	122	7
8	LAUNDRY & LINEN SERVICE		13,461	3,859	17,320	14	8
9	HOUSEKEEPING		9,788	2,806	12,594	110	9
10	DIETARY		85,917	24,629	110,546	144	10
11	CAFETERIA						11
13	NURSING ADMINISTRATION		10,170	2,915	13,085	160	13
16	MEDICAL RECORDS & LIBRARY		9,140	2,620	11,760	65	16
17	SOCIAL SERVICE		7,262	2,082	9,344	243	17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		501,496	143,757	645,253	1,685	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC		10,702	3,068	13,770		54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY		897	257	1,154		60
65	RESPIRATORY THERAPY		2,559	734	3,293	95	65
66	PHYSICAL THERAPY		150,962	43,275	194,237	599	66
67	OCCUPATIONAL THERAPY		78,705	22,562	101,267	518	67
68	SPEECH PATHOLOGY		40,333	11,562	51,895	279	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		20,773	5,955	26,728	28	71
73	DRUGS CHARGED TO PATIENTS		6,647	1,906	8,553	184	73
76	PSYCHOLOGY		4,786	1,372	6,158	26	76
76.01	AMBULANCE						76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA						76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)		1,100,339	315,425	1,415,764	5,093	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES		108,718	31,165	139,883	1	192
194	NRCC MARKETING		299	86	385	17	194
194.01	GUEST MEALS						194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		1,209,356	346,676	1,556,032	5,111	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	153,598					5
7	OPERATION OF PLANT	9,296	40,337				7
8	LAUNDRY & LINEN SERVICE	781	511	18,626			8
9	HOUSEKEEPING	3,850	372		16,926		9
10	DIETARY	8,381	3,261		1,399	123,731	10
11	CAFETERIA					18,541	11
13	NURSING ADMINISTRATION	4,382	386		166		13
16	MEDICAL RECORDS & LIBRARY	2,818	347		149		16
17	SOCIAL SERVICE	6,543	276		118		17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	52,806	19,036	18,626	8,167	97,821	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	2,945	406		174		54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY	596	34		15		60
65	RESPIRATORY THERAPY	2,942	97		42		65
66	PHYSICAL THERAPY	18,028	5,731		2,458		66
67	OCCUPATIONAL THERAPY	14,770	2,988		1,282		67
68	SPEECH PATHOLOGY	7,947	1,531		657		68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	2,849	789		338		71
73	DRUGS CHARGED TO PATIENTS	11,612	252		108		73
76	PSYCHOLOGY	792	182		78		76
76.01	AMBULANCE	110					76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA						76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	151,448	36,199	18,626	15,151	116,362	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	1,675	4,127		1,770		192
194	NRCC MARKETING	475	11		5		194
194.01	GUEST MEALS					7,369	194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	153,598	40,337	18,626	16,926	123,731	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		11	13	16	17	24	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	18,541					11
13	NURSING ADMINISTRATION	759	18,938				13
16	MEDICAL RECORDS & LIBRARY	309		15,448			16
17	SOCIAL SERVICE	1,158			17,682		17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	8,001	18,938	5,095	17,682	893,110	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC			148		17,443	54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY			332		2,131	60
65	RESPIRATORY THERAPY	451		590		7,510	65
66	PHYSICAL THERAPY	2,850		3,163		227,066	66
67	OCCUPATIONAL THERAPY	2,467		3,163		126,455	67
68	SPEECH PATHOLOGY	1,328		1,361		64,998	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	132		269		31,133	71
73	DRUGS CHARGED TO PATIENTS	876		1,162		22,747	73
76	PSYCHOLOGY	121		144		7,501	76
76.01	AMBULANCE			21		131	76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA						76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	18,452	18,938	15,448	17,682	1,400,225	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	6				147,462	192
194	NRCC MARKETING	83				976	194
194.01	GUEST MEALS					7,369	194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	18,541	18,938	15,448	17,682	1,556,032	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT			1
2	CAP REL COSTS-MVBLE EQUIP			2
4	EMPLOYEE BENEFITS			4
5	ADMINISTRATIVE & GENERAL			5
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
13	NURSING ADMINISTRATION			13
16	MEDICAL RECORDS & LIBRARY			16
17	SOCIAL SERVICE			17
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS		893,110	30
	ANCILLARY SERVICE COST CENTERS			
54	RADIOLOGY-DIAGNOSTIC		17,443	54
54.01	RADIOLOGY SUA			54.01
60	LABORATORY		2,131	60
65	RESPIRATORY THERAPY		7,510	65
66	PHYSICAL THERAPY		227,066	66
67	OCCUPATIONAL THERAPY		126,455	67
68	SPEECH PATHOLOGY		64,998	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		31,133	71
73	DRUGS CHARGED TO PATIENTS		22,747	73
76	PSYCHOLOGY		7,501	76
76.01	AMBULANCE		131	76.01
76.02	DAY TREATMENT			76.02
76.03	AMBULANCE SUA			76.03
	OUTPATIENT SERVICE COST CENTERS			
92	OBSERVATION BEDS			92
	OTHER REIMBURSABLE COST CENTERS			
	SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE			113
118	SUBTOTALS (SUM OF LINES 1-117)		1,400,225	118
	NONREIMBURSABLE COST CENTERS			
192	PHYSICIANS' PRIVATE OFFICES		147,462	192
194	NRCC MARKETING		976	194
194.01	GUEST MEALS		7,369	194.01
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	TOTAL (SUM OF LINES 118-201)		1,556,032	202

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	72,772					1
2	CAP REL COSTS-MVBLE EQUIP		72,772				2
4	EMPLOYEE BENEFITS	239	239	9,529,975			4
5	ADMINISTRATIVE & GENERAL	7,145	7,145	1,530,822	-4,644,159	13,099,950	5
7	OPERATION OF PLANT	1,446	1,446	227,417		792,804	7
8	LAUNDRY & LINEN SERVICE	810	810	25,737		66,646	8
9	HOUSEKEEPING	589	589	206,144		328,339	9
10	DIETARY	5,170	5,170	268,767		714,771	10
11	CAFETERIA						11
13	NURSING ADMINISTRATION	612	612	297,661		373,708	13
16	MEDICAL RECORDS & LIBRARY	550	550	121,338		240,312	16
17	SOCIAL SERVICE	437	437	454,187		558,073	17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	30,177	30,177	3,137,538		4,503,746	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	644	644			251,144	54
54.01	RADIOLOGY SUA				-19,605		54.01
60	LABORATORY	54	54			50,802	60
65	RESPIRATORY THERAPY	154	154	176,945		250,907	65
66	PHYSICAL THERAPY	9,084	9,084	1,117,562		1,537,572	66
67	OCCUPATIONAL THERAPY	4,736	4,736	967,326		1,259,731	67
68	SPEECH PATHOLOGY	2,427	2,427	520,732		677,771	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,250	1,250	51,806		243,003	71
73	DRUGS CHARGED TO PATIENTS	400	400	343,494		990,368	73
76	PSYCHOLOGY	288	288	47,578		67,538	76
76.01	AMBULANCE					9,394	76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA				-1,243		76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	66,212	66,212	9,495,054	-4,665,007	12,916,629	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	6,542	6,542	2,493		142,840	192
194	NRCC MARKETING	18	18	32,428		40,481	194
194.01	GUEST MEALS						194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,209,356	346,676	1,772,183		4,644,159	202
203	UNIT COST MULT-WS B PT I	16.618425	4.763865	0.185959		0.354517	203
204	COST TO BE ALLOC PER B PT II			5,111		153,598	204
205	UNIT COST MULT-WS B PT II			0.000536		0.011725	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY + LINEN SERVICE PATIENT DAYS 8	HOUSE-KEEPING SQUARE FEET 9	DIETARY MEALS SERVED 10	CAFETERIA GROSS SALARIES 11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT	63,942					7
8	LAUNDRY & LINEN SERVICE	810	21,915				8
9	HOUSEKEEPING	589		62,543			9
10	DIETARY	5,170		5,170	83,159		10
11	CAFETERIA				12,461	7,271,088	11
13	NURSING ADMINISTRATION	612		612		297,661	13
16	MEDICAL RECORDS & LIBRARY	550		550		121,338	16
17	SOCIAL SERVICE	437		437		454,187	17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	30,177	21,915	30,177	65,745	3,137,538	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	644		644			54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY	54		54			60
65	RESPIRATORY THERAPY	154		154		176,945	65
66	PHYSICAL THERAPY	9,084		9,084		1,117,562	66
67	OCCUPATIONAL THERAPY	4,736		4,736		967,326	67
68	SPEECH PATHOLOGY	2,427		2,427		520,732	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,250		1,250		51,806	71
73	DRUGS CHARGED TO PATIENTS	400		400		343,494	73
76	PSYCHOLOGY	288		288		47,578	76
76.01	AMBULANCE						76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA						76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	57,382	21,915	55,983	78,206	7,236,167	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	6,542		6,542		2,493	192
194	NRCC MARKETING	18		18		32,428	194
194.01	GUEST MEALS				4,953		194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,073,866	103,876	454,633	1,092,577	163,718	202
203	UNIT COST MULT-WS B PT I	16.794376	4.739950	7.269127	13.138410	0.022516	203
204	COST TO BE ALLOC PER B PT II	40,337	18,626	16,926	123,731	18,541	204
205	UNIT COST MULT-WS B PT II	0.630837	0.849920	0.270630	1.487885	0.002550	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINIS-TRATION PATIENT DAYS 13	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	SOCIAL SERVICE PATIENT DAYS 17	
	GENERAL SERVICE COST CENTERS				
1	CAP REL COSTS-BLDG & FIXT				1
2	CAP REL COSTS-MVBLE EQUIP				2
4	EMPLOYEE BENEFITS				4
5	ADMINISTRATIVE & GENERAL				5
7	OPERATION OF PLANT				7
8	LAUNDRY & LINEN SERVICE				8
9	HOUSEKEEPING				9
10	DIETARY				10
11	CAFETERIA				11
13	NURSING ADMINISTRATION	21,915			13
16	MEDICAL RECORDS & LIBRARY		50,647,889		16
17	SOCIAL SERVICE			21,915	17
	INPATIENT ROUTINE SERV COST CENTERS				
30	ADULTS & PEDIATRICS	21,915	16,702,759	21,915	30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC		485,657		54
54.01	RADIOLOGY SUA				54.01
60	LABORATORY		1,087,777		60
65	RESPIRATORY THERAPY		1,935,125		65
66	PHYSICAL THERAPY		10,372,062		66
67	OCCUPATIONAL THERAPY		10,370,646		67
68	SPEECH PATHOLOGY		4,461,436		68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		882,426		71
73	DRUGS CHARGED TO PATIENTS		3,809,948		73
76	PSYCHOLOGY		472,504		76
76.01	AMBULANCE		67,549		76.01
76.02	DAY TREATMENT				76.02
76.03	AMBULANCE SUA				76.03
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
	SPECIAL PURPOSE COST CENTERS				
118	SUBTOTALS (SUM OF LINES 1-117)	21,915	50,647,889	21,915	118
	NONREIMBURSABLE COST CENTERS				
192	PHYSICIANS' PRIVATE OFFICES				192
194	NRCC MARKETING				194
194.01	GUEST MEALS				194.01
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	COST TO BE ALLOC PER B PT I	527,623	341,474	776,661	202
203	UNIT COST MULT-WS B PT I	24.075884	0.006742	35.439699	203
204	COST TO BE ALLOC PER B PT II	18,938	15,448	17,682	204
205	UNIT COST MULT-WS B PT II	0.864157	0.000305	0.806845	205

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	9,281,779		9,281,779	4,574	9,286,353	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	358,950		358,950		358,950	54
54.01	RADIOLOGY SUA	19,605		19,605		19,605	54.01
60	LABORATORY	77,446		77,446		77,446	60
65	RESPIRATORY THERAPY	360,594		360,594		360,594	65
66	PHYSICAL THERAPY	2,396,351		2,396,351		2,396,351	66
67	OCCUPATIONAL THERAPY	1,911,991		1,911,991		1,911,991	67
68	SPEECH PATHOLOGY	1,018,258		1,018,258		1,018,258	68
71	MEDICAL SUPPLIES CHRGED TO	366,346		366,346		366,346	71
73	DRUGS CHARGED TO PATIENTS	1,384,517		1,384,517		1,384,517	73
76	PSYCHOLOGY	102,669		102,669		102,669	76
76.01	AMBULANCE	13,179		13,179		13,179	76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA	1,243		1,243		1,243	76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	17,292,928		17,292,928	4,574	17,297,502	200
201	LESS OBSERVATION BEDS						201
202	TOTAL (SEE INSTRUCTIONS)	17,292,928		17,292,928		17,297,502	202

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

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	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	16,702,760		16,702,760				30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	700,768	1,928	702,696	0.510818	0.510818	0.510818	54
54.01	RADIOLOGY SUA	59,414		59,414	0.329973	0.329973	0.329973	54.01
60	LABORATORY	1,087,423	354	1,087,777	0.071197	0.071197	0.071197	60
65	RESPIRATORY THERAPY	1,935,125		1,935,125	0.186341	0.186341	0.186341	65
66	PHYSICAL THERAPY	8,740,194	1,631,868	10,372,062	0.231039	0.231039	0.231039	66
67	OCCUPATIONAL THERAPY	9,345,672	1,024,974	10,370,646	0.184366	0.184366	0.184366	67
68	SPEECH PATHOLOGY	3,229,625	1,231,811	4,461,436	0.228235	0.228235	0.228235	68
71	MEDICAL SUPPLIES CHRGED TO	871,612	10,814	882,426	0.415158	0.415158	0.415158	71
73	DRUGS CHARGED TO PATIENTS	3,808,433	1,515	3,809,948	0.363395	0.363395	0.363395	73
76	PSYCHOLOGY	470,804	1,700	472,504	0.217287	0.217287	0.217287	76
76.01	AMBULANCE	64,292		64,292	0.204987	0.204987	0.204987	76.01
76.02	DAY TREATMENT							76.02
76.03	AMBULANCE SUA	3,765		3,765	0.330146	0.330146	0.330146	76.03
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	47,019,887	3,904,964	50,924,851				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	47,019,887	3,904,964	50,924,851				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	893,110		893,110	21,915	40.75	14,595	594,746	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	893,110		893,110	21,915		14,595	594,746	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-3025)	[ ]	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)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	17,443	702,696	0.024823	489,858	12,160	54
54.01	RADIOLOGY SUA		59,414	59,414	57,200		54.01
60	LABORATORY	2,131	1,087,777	0.001959	738,147	1,446	60
65	RESPIRATORY THERAPY	7,510	1,935,125	0.003881	1,471,750	5,712	65
66	PHYSICAL THERAPY	227,066	10,372,062	0.021892	5,782,871	126,599	66
67	OCCUPATIONAL THERAPY	126,455	10,370,646	0.012194	6,237,925	76,065	67
68	SPEECH PATHOLOGY	64,998	4,461,436	0.014569	2,086,399	30,397	68
71	MEDICAL SUPPLIES CHRGED TO PA	31,133	882,426	0.035281	489,237	17,261	71
73	DRUGS CHARGED TO PATIENTS	22,747	3,809,948	0.005970	2,653,449	15,841	73
76	PSYCHOLOGY	7,501	472,504	0.015875	301,326	4,784	76
76.01	AMBULANCE	131	64,292	0.002038	28,920	59	76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA		3,765	3,765	3,483		76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	507,115	34,222,091	34,222,091	20,340,565	290,324	200

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

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

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

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

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	21,915		14,595		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	21,915		14,595		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-3025)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY SUA							54.01
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHRGED TO PA							71
73	DRUGS CHARGED TO PATIENTS							73
76	PSYCHOLOGY							76
76.01	AMBULANCE							76.01
76.02	DAY TREATMENT							76.02
76.03	AMBULANCE SUA							76.03
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX | [XX] HOSPITAL (15-3025) [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	702,696			489,858		1,723		54
54.01	RADIOLOGY SUA	59,414			57,200				54.01
60	LABORATORY	1,087,777			738,147				60
65	RESPIRATORY THERAPY	1,935,125			1,471,750				65
66	PHYSICAL THERAPY	10,372,062			5,782,871				66
67	OCCUPATIONAL THERAPY	10,370,646			6,237,925				67
68	SPEECH PATHOLOGY	4,461,436			2,086,399		391		68
71	MEDICAL SUPPLIES CHRGED TO P	882,426			489,237		463		71
73	DRUGS CHARGED TO PATIENTS	3,809,948			2,653,449		1,507		73
76	PSYCHOLOGY	472,504			301,326		1,344		76
76.01	AMBULANCE	64,292			28,920				76.01
76.02	DAY TREATMENT								76.02
76.03	AMBULANCE SUA	3,765			3,483				76.03
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	34,222,091			20,340,565		5,428		200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (15-3025)	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	0.510818	1,723			880			54
54.01	RADIOLOGY SUA	0.329973							54.01
60	LABORATORY	0.071197							60
65	RESPIRATORY THERAPY	0.186341							65
66	PHYSICAL THERAPY	0.231039							66
67	OCCUPATIONAL THERAPY	0.184366							67
68	SPEECH PATHOLOGY	0.228235	391			89			68
71	MEDICAL SUPPLIES CHRGED TO PATI	0.415158	463			192			71
73	DRUGS CHARGED TO PATIENTS	0.363395	1,507			548			73
76	PSYCHOLOGY	0.217287	1,344			292			76
76.01	AMBULANCE	0.204987							76.01
76.02	DAY TREATMENT								76.02
76.03	AMBULANCE SUA	0.330146							76.03
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)		5,428			2,001			200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)		5,428			2,001			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	893,110		893,110	21,915	40.75	888	36,186	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	893,110		893,110	21,915		888	36,186	200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-3025)	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[XX] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	17,443	702,696	0.024823	46,191	1,147	54
54.01	RADIOLOGY SUA		59,414	59,414			54.01
60	LABORATORY	2,131	1,087,777	0.001959	46,474	91	60
65	RESPIRATORY THERAPY	7,510	1,935,125	0.003881	60,586	235	65
66	PHYSICAL THERAPY	227,066	10,372,062	0.021892	376,985	8,253	66
67	OCCUPATIONAL THERAPY	126,455	10,370,646	0.012194	476,991	5,816	67
68	SPEECH PATHOLOGY	64,998	4,461,436	0.014569	208,246	3,034	68
71	MEDICAL SUPPLIES CHRGED TO PA	31,133	882,426	0.035281	39,201	1,383	71
73	DRUGS CHARGED TO PATIENTS	22,747	3,809,948	0.005970	156,535	935	73
76	PSYCHOLOGY	7,501	472,504	0.015875	23,877	379	76
76.01	AMBULANCE	131	64,292	0.002038	3,700	8	76.01
76.02	DAY TREATMENT						76.02
76.03	AMBULANCE SUA		3,765	3,765			76.03
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	507,115	34,222,091	34,222,091	1,438,786	21,281	200

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

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

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

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

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	21,915		888		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	21,915		888		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-3025)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY SUA							54.01
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHRGED TO PA							71
73	DRUGS CHARGED TO PATIENTS							73
76	PSYCHOLOGY							76
76.01	AMBULANCE							76.01
76.02	DAY TREATMENT							76.02
76.03	AMBULANCE SUA							76.03
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES	[ ]	TITLE V	[XX]	HOSPITAL (15-3025)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	702,696			46,191				54
54.01	RADIOLOGY SUA	59,414							54.01
60	LABORATORY	1,087,777			46,474				60
65	RESPIRATORY THERAPY	1,935,125			60,586				65
66	PHYSICAL THERAPY	10,372,062			376,985				66
67	OCCUPATIONAL THERAPY	10,370,646			476,991				67
68	SPEECH PATHOLOGY	4,461,436			208,246				68
71	MEDICAL SUPPLIES CHRGED TO P	882,426			39,201				71
73	DRUGS CHARGED TO PATIENTS	3,809,948			156,535				73
76	PSYCHOLOGY	472,504			23,877				76
76.01	AMBULANCE	64,292			3,700				76.01
76.02	DAY TREATMENT								76.02
76.03	AMBULANCE SUA	3,765							76.03
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	34,222,091			1,438,786				200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (15-3025)	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[ ]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[XX]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	0.510818		205			105		54
54.01	RADIOLOGY SUA	0.329973							54.01
60	LABORATORY	0.071197		50			4		60
65	RESPIRATORY THERAPY	0.186341							65
66	PHYSICAL THERAPY	0.231039		111,888			25,850		66
67	OCCUPATIONAL THERAPY	0.184366		81,220			14,974		67
68	SPEECH PATHOLOGY	0.228235		74,290			16,956		68
71	MEDICAL SUPPLIES CHRGED TO PATI	0.415158		1,070			444		71
73	DRUGS CHARGED TO PATIENTS	0.363395		8			3		73
76	PSYCHOLOGY	0.217287							76
76.01	AMBULANCE	0.204987							76.01
76.02	DAY TREATMENT								76.02
76.03	AMBULANCE SUA	0.330146							76.03
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)			268,731			58,336		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			268,731			58,336		202

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (15-3025)	[ ]	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)	21,915	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	21,915	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,922	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	19,993	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)	14,595	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)	1,233	14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	9,286,353	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	9,286,353	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	16,702,759	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,499,160	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	15,203,599	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.555977	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	780.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	760.45	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	19.55	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	10.87	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	20,892	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	9,265,461	37

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

CHECK APPLICABLE BOXES	[ ]	TITLE V-INPT	[XX]	HOSPITAL (15-3025)	[ ]	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)	423.74	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	6,184,485	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)	6,184,485	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					4,798,135	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					10,982,620	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					594,746	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					290,324	51
52	TOTAL PROGRAM EXCLUDABLE COST					885,070	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					10,097,550	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)		87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	423.74	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)		89

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

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (15-3025)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ] TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[XX] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	21,915	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	21,915	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,922	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	19,993	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)	888	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	9,281,779	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	9,281,779	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	16,702,759	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,499,160	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	15,203,599	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.555703	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	780.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	760.45	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	19.55	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	10.86	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	20,873	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	9,260,906	37

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

CHECK APPLICABLE BOXES	[ ]	TITLE V-INPT	[XX]	HOSPITAL (15-3025)	[ ]	SUB (OTHER)	[ ] PPS
	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
	[XX]	TITLE XIX-INPT	[ ]	IRF			[XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	422.58	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	375,251	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)	375,251	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					339,867	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					715,118	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					36,186	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					21,281	51
52	TOTAL PROGRAM EXCLUDABLE COST					57,467	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCT (TITLE XVIII ONLY)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

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

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

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-3025)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		11,113,058		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	0.510818	489,858	250,228	54
54.01	RADIOLOGY SUA	0.329973	57,200	18,874	54.01
60	LABORATORY	0.071197	738,147	52,554	60
65	RESPIRATORY THERAPY	0.186341	1,471,750	274,247	65
66	PHYSICAL THERAPY	0.231039	5,782,871	1,336,069	66
67	OCCUPATIONAL THERAPY	0.184366	6,237,925	1,150,061	67
68	SPEECH PATHOLOGY	0.228235	2,086,399	476,189	68
71	MEDICAL SUPPLIES CHRGED TO PATI	0.415158	489,237	203,111	71
73	DRUGS CHARGED TO PATIENTS	0.363395	2,653,449	964,250	73
76	PSYCHOLOGY	0.217287	301,326	65,474	76
76.01	AMBULANCE	0.204987	28,920	5,928	76.01
76.02	DAY TREATMENT				76.02
76.03	AMBULANCE SUA	0.330146	3,483	1,150	76.03
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		20,340,565	4,798,135	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		20,340,565		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-3025)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		744,340		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	0.510818	46,191	23,595	54
54.01	RADIOLOGY SUA	0.329973			54.01
60	LABORATORY	0.071197	46,474	3,309	60
65	RESPIRATORY THERAPY	0.186341	60,586	11,290	65
66	PHYSICAL THERAPY	0.231039	376,985	87,098	66
67	OCCUPATIONAL THERAPY	0.184366	476,991	87,941	67
68	SPEECH PATHOLOGY	0.228235	208,246	47,529	68
71	MEDICAL SUPPLIES CHRGED TO PATI	0.415158	39,201	16,275	71
73	DRUGS CHARGED TO PATIENTS	0.363395	156,535	56,884	73
76	PSYCHOLOGY	0.217287	23,877	5,188	76
76.01	AMBULANCE	0.204987	3,700	758	76.01
76.02	DAY TREATMENT				76.02
76.03	AMBULANCE SUA	0.330146			76.03
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		1,438,786	339,867	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		1,438,786		202

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (15-3025) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	2,001	2
3	PPS PAYMENTS	1,496	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)	1,496	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	376	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)	1,120	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)	1,120	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	1,120	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)	1,120	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)	1,120	40
41	INTERIM PAYMENTS	1,120	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 (15-3025) [ ] 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				16,123,763		1,120	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)				16,123,763		1,120	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01					5.01
		TO	.02					5.02
		PROVIDER	.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER	.50					5.50
		TO	.51					5.51
		PROGRAM	.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01					6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)							7

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

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART III

CHECK [XX] HOSPITAL (15-3025)
APPLICABLE BOX: [ ] IRF

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	16,021,105	1
2	MEDICARE SSI RATIO (SEE INSTRUCTIONS)	0.038000	2
3	INPATIENT REHABILITATION LIP PAYMENTS (SEE INSTRUCTIONS)	743,556	3
4	OUTLIER PAYMENTS	3,291	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)	60.041096	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)	16,767,952	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)	16,767,952	17
18	PRIMARY PAYER PAYMENTS	3,176	18
19	SUBTOTAL LINE 17b LESS LINE 18)	16,764,776	19
20	DEDUCTIBLES	330,878	20
21	SUBTOTAL (LINE 19 MINUS LINE 20)	16,433,898	21
22	COINSURANCE	219,237	22
23	SUBTOTAL (LINE 21 MINUS LINE 22)	16,214,661	23
24	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	88,437	24
25	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	61,906	25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	82,963	26
27	SUBTOTAL (SUM OF LINES 23 AND 25)	16,276,567	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)	16,276,567	32
33	INTERIM PAYMENTS	16,123,763	33
34	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		34
35	BALANCE DUE PROVIDER/PROGRAM (LINE 32 MINUS THE SUM OF LINES 33 AND 34)	152,804	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 (15-3025)	[ ]	SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
BOXES:			[ ]	IRF	[ ]	ICF/MR	[XX]	OTHER
			[ ]	SUB (OTHER)				

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

	COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	715,118	1
2	MEDICAL AND OTHER SERVICES	58,336	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	773,454	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	773,454	7
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	744,340	8
9	ANCILLARY SERVICE CHARGES	1,707,517	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)	2,451,857	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)	2,451,857	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)	1,678,403	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS)		18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	773,454	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	773,454	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)	773,454	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)	773,454	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)	773,454	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)	773,454	40
41	INTERIM PAYMENTS	658,555	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	114,899	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,835,720				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	4,579,406				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,438,620				6
7	INVENTORY	30,223				7
8	PREPAID EXPENSES	28,213				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	6,034,942				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS					15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS	2,146,841				17
18	ACCUMULATED AMORTIZATION	-1,685,426				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	1,899,168				23
24	ACCUMULATED DEPRECIATION	-1,389,596				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	970,987				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	12,307,840				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	12,307,840				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	19,313,769				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	276,622				37
38	SALARIES, WAGES & FEES PAYABLE	559,140				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	1,977,943				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,813,705				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	3,806,184				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	3,806,184				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	6,619,889				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	12,693,880				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)	12,693,880				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	19,313,769				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

			GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
			1	2	3	4	5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD			12,997,569							1
2	NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)			7,514,698							2
3	TOTAL (SUM OF LINE 1 AND LINE 2)			20,512,267							3
4	ADDITIONS (CREDIT ADJUST-MENTS)										4
5											5
6											6
7											7
8											8
9											9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)										10
11	SUBTOTAL (LINE 3 PLUS LINE 10)			20,512,267							11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)										12
13	MINORITY INTEREST	1,653,233									13
14	DISTRIBUTIONS	6,165,154									14
15											15
16											16
17											17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)			7,818,387							18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)			12,693,880							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	16,702,759		16,702,759	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	16,702,759		16,702,759	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	16,702,759		16,702,759	17
18	ANCILLARY SERVICES	30,317,338		30,317,338	18
19	OUTPATIENT SERVICES		3,904,751	3,904,751	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	47,020,097	3,904,751	50,924,848	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		17,884,102	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		17,884,102	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	50,924,848	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	25,664,701	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	25,260,147	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	17,884,102	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	7,376,045	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	14,505	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	11	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	78,711	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER INCOME)	46,008	24
24.01	OTHER (LOSS ON SALE OF FIXED ASSETS)	-582	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	138,653	25
26	TOTAL (LINE 5 PLUS LINE 25)	7,514,698	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	7,514,698	29